STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	**2311 SHIRLEY COVE SHERIDAN, WY 82801**

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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 10/25/21 to 10/28/21. Also reviewed in the course of the survey was complaint intake WY00003282. The Following common abbreviations are used throughout this document: DON: Director of Nursing RN: Registered Nurse MDS: Minimum Data Set Shahbaz: Certified Nursing Assistant Shahbazim: Certified Nursing Assistants BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 577		11/18/21

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

Electronically Signed | 11/19/2021

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F 577	Continued From page 1 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to place, in a readily accessible location, the results of the last 3 years of facility surveys for 4 of 4 cottages (Scott, Whitney, Watt, Founders). The findings were: 1. Observation on 10/26/21 at 3:10 PM showed posted signs in the foyers of all 4 cottages which stated "The survey results for the last 3 years are available in the den." however, the dens were being utilized as staff break rooms and the survey results could not be located in any of the cottages. 2. Interview with the DON on 10/28/21 at 9:30 AM revealed the expectation of the facility was for survey results to be available to the elders without the need to ak for them.	F 577	The notebooks of required information are in place in each of the four (4) cottages. The location for each notebook is located in the foyer and contains all the information, i.e. surveys for the past three years, certifications, and complaint investigations during the three preceding years. Notice has been posted to insure accessibility to public.	
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 582		11/18/21

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F 582	Continued From page 2 Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.	F 582		

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F 582	Continued From page 3 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of beneficiary protection notice information and staff interview, the facility failed to ensure the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) form and Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) form were provided for 3 of 3 sample elders (#9, #35, #92) who were reviewed. The findings were: 1.Review of the beneficiary protection notification provided for elder #9 showed the elder's last covered day was 4/30/21. Further review showed no SNF ABN or NOMNC had been provided to the elder or elder's representative. 2. Review of the beneficiary protection notification provided for elder #35 showed the elder's last covered day was 5/16/21. Further review showed no SNF ABN or NOMNC had been provided to the elder or elder's representative. 3. Review of the beneficiary protection notification provided for elder #92 showed the elder's last covered day was 6/25/21. Further review showed no SNF ABN or NOMNC had been provided to the elder or elder's representative. 4. Interview with the DON on 10/27/21 at 4:30 PM revealed the facility was not using the CMS forms	F 582	GHLS will ensure proper notice for Medicare benefit changes by: " MDS Coordinator created two templates/checklists to be used for each Med A covered elder (11/16/21). o Delivery Tracking Form- tracks and documents phone notifications, confirmation of follow-up by mail, and refusals. Also includes a checklist of items to cover during telephone notifications with initial verification next to each item. o Checklist for Valid Delivery of Notices- check list for starting the notification process including what forms to complete, what to document in resident chart, when and how to send items, what documentation to keep on hand, when notice is not requires, and a chart identifying the notification date in different situations (e.g., If main is undeliverable) " MDS Coordinator to monitor remaining Medicare A benefit days remaining or skilled care status for elders residing in facility " MDS to notify Finance Manager or designee about last covered skilled day for completion of forms as follows unless notice is not required by CMS guidelines: o Notice of Medicare Provider	

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F 582	Continued From page 4 and confirmed the facility did not meet the requirements of this section.	F 582	Non-Coverage (NOMNC)- GHLS to use CMS forms for completion and accuracy o Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN)- GHLS to use CMS forms for completion and accuracy " Finance Manager or designee to: o Complete the Checklist for Valid Deliver of Notice of Medicare Provider Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) o Complete the Delivery Tracking Form Currently we have no Med A elders in facility.	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, elder, elder representative and staff interview, medical record review, and policy and procedure review, the facility failed to ensure activities were performed in 1 of 4 cottages (Founder's) which affected sample residents #2, #9, #38, and #41. The findings were:	F 679	Plan of corrective action on all four (4)cottages but specifically "Founders" to support residents in their choice of activities, both facility-sponsored group and individual activities to support their physical, mental and psycho social well-being.	12/28/21

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F 679	Continued From page 5 1. Review of the annual MDS assessment dated 10/14/21 showed elder #41 had diagnoses which included depression and had a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of the care plan last revised on 4/29/21 showed the elder was independent with meeting his/her emotional, intellectual, physical, and social needs. Further review showed interventions which included "...I attend the majority of the daily activities in the cottage. I enjoy assisting and encouraging others during the activities...I enjoy most any activity that is offered to me. I especially enjoy music. I enjoy having visits from animals. I enjoy socializing with others but also enjoy my alone time because I grew up as an only child and I find it relaxing...Invite and encourage me to attend activities but remind me that I may leave activities at any time, and am not required to stay for entire activity...Modify my daily schedule, treatment plan PRN [as needed] to accommodate activity participation as requested by me...Provide me with a monthly activity calendar to keep in my room..." The following concerns were identified: a. Interview with the elder on 10/26/21 at 9:55 AM revealed the cottage did not have routine activities because the Shabazim were "too busy" to perform the scheduled activities. b. Review of the "activities group" participation record from 9/27/21 to 10/27/21 showed the elder was coded as having participated in activities for 26 out of 61 entries. Further review showed the participation record was coded as "-97" which indicated "not applicable" for 28 out of 61 entries and was coded as "-98" which indicated "resident refused" for 7 out of 61 entries.	F 679	1. Activities Coordinator will do weekly audits throughout the campus to insure that the scheduled activities are being completed as presented and documented accordingly. 2. Specifically in "Founders" a program will be implemented that supports a 1:1 program for each elder designed specifically for that elder. Weekly audits to be performed by the Activities Coordinator. 3. Each elder "resident" will be interviewed to further determine what activity/activities they prefer to do either individually or in group settings a minimum of every quarter (corresponding with MDS Schedule). 3b. Quarterly Activities assessment updated by QA manager to include section for elder interviews. 4. Activities Coordinator will provide education to all Shahbaz at monthly team meetings to emphasize the benefits and improvements to the quality of life associated with active elders. Thus enhancing the quality of life by 12/28/21. 5. Quality Assurance Manager assigned campus wide updated Activities Task documentation for scheduled events as designated by the Activities Coordinator for documentation tracking. 6. Activities Coordinator to report to the QA Manager a minimum of monthly, results from weekly audits. Education to be provided as necessary depending on audit data by Activities Director or designee. Specific examples of corrective action for those elders surveyed:	

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F 679	Continued From page 6 2. Review of the quarterly MDS assessment dated 7/31/21 showed elder #9 had diagnoses which included hemiplegia, anxiety disorder, and manic depression. Further review showed the elder had short-term and long-term memory impairment. Review of the activity care plan last revised on 4/8/21 showed interventions which included "I need a variety of activity types and locations to maintain interests. I like to stay busy and will attend almost any cottage activity that is offered to me. I enjoy gardening...Invite and encourage me to attend activities but remind me that I may leave activities at any time, and am not required to stay for entire activity...Modify my daily schedule, treatment plan PRN to accommodate activity participation as requested by me...My behaviors may affect my activity attendance. If there is an activity that I like that is occurring during an episode of behaviors, offer the activity to me as a distraction. If I become disruptive during a group activity, remove me from the group...Provide me with activities that match my abilities. I am unable to use the left side of my body d/t [due to] hemiplegia..." The following concerns were identified: a. Interview with the elder's representative on 10/26/21 at 11:01 AM revealed the elder would participate in certain activities if staff offered the activity to the elder. b. Review of the "activities group" participation record from 9/27/21 to 10/27/21 showed the elder was coded as having participated in activities for 8 out of 61 entries. Further review showed the participation record was coded as "-97" which indicated "not applicable" for 37 out of 61 entries and was coded as "-98" which indicated "resident refused" for 16 out of 61 entries.	F 679	#41: Elder will be asked to each activity scheduled on the calendar. More complex activities such as crafts will be offered. #9: Elder will be offered more sensory type activities as well as one on one with staff. #38: Elder will be invited to each activity plus offered additional sensory type activities. Elder will be offered to view or watch others participate in all activities in the house. #2: Elder will be invited to all activities plus have the assistance from staff to engage in the specific activity of choice. Plus elder will be offered sensory and music programs to further enhance the elder's. Continue to update and monitor MDS assessments for all elders on a regular (quarterly) basis.	

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F 679	Continued From page 7	F 679		

3. Review of the quarterly MDS assessment dated 10/5/21 showed elder #38 had diagnoses which included non-Alzheimer's dementia and had short-term and long-term memory impairment. Review of the care plan last revised on 10/29/20 showed the elder was dependent on staff for meeting his/her emotional, intellectual, physical, and social needs related to cognitive deficits, immobility, and physical limitations. Further review showed the interventions included "...Ensure that the activities I am attending are: Compatible with my physical and mental capabilities; Compatible with my known interests and preferences; adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation, compatible with my individual needs and abilities; and Age appropriate...Establish and record my prior level of activity involvement and interests by talking with me, my caregivers, and my family on admission and as necessary...I like to passively participate in activities. I have a hard time communicating or understanding activities, but I like to watch people and be talked with...I need assistance/escort to activity functions..." The following concerns were identified:

a. Review of the "activities group" participation record from 9/27/21 to 10/27/21 showed the elder was coded as having participated in activities for 5 out of 61 entries. Further review showed the participation record was coded as "-97" which indicated "not applicable" for 35 out of 59 entries, was coded as "-98" which indicated "resident refused" for 17 out of 59 entries, and was coded "-99" which indicated "resident not available" for 2 out 59 entries.

4. Review of the quarterly MDS assessment

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F 679	Continued From page 8	F 679		

dated 7/24/21 showed elder #2 had diagnoses which included mild cognitive impairment and had a BIMS score of 4 out 15 which indicated the resident was severely cognitively impaired. Review of the activity care plan last revised on 10/25/21 showed interventions which included "I prefer to socialize with: staff, family, and the other gentlemen in the cottage...Invite and encourage me to attend activities but remind me that I may leave activities at any time, and am not required to stay for the entire activity...Provide me with activities calendar. Notify me of any changes to the calendar of activities...Provide me with activities that match my abilities..." The following concerns were identified:

a. Review of the "activities group" participation record from 9/27/21 to 10/27/21 showed the elder was coded as having participated in activities for 7 out of 61 entries. Further review showed the participation record was coded as "-97" which indicated "not applicable" for 42 out of 61 entries and was coded as "-98" which indicated "resident refused" for 12 out of 61 entries.

5. Observation on 10/26/21 at 9:19 AM showed the activity "Moving in Motion" was scheduled to be performed at 9 AM; however, no activity was performed.

6. Observation on 10/27/21 from 9:02 AM until 12:07 PM showed the activity "Moving in Motion" was scheduled to be performed at 9 AM and "Daily Chronicles" was scheduled to be performed at 12 PM; however, no activity was performed.

7. Interview with activities coordinator on 10/28/21 at 9:31 AM revealed the Shahbazim in each

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F 679	Continued From page 9 cottage were responsible for the completion of activities and were expected to complete activities at the assigned times indicated on the activity schedule. Further interview confirmed activities should have been performed on 10/26/21 and 10/27/21 at 9 AM and 12 PM. 8. Review of the policy titled "Green House Activity Policy" last revised on 2/11/21 showed "...4. All staff will participate in encouraging engagement of the Elders in those activities they have indicated are interesting to them; 5. If an Elder is refusing to participate in activities, the Activities Coordinator and/or Social Worker will attempt to determine why and to supply needed items or materials;..."	F 679		
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, staff interview, and medical record review, the facility failed to provide care and services in accordance with the elder's goals for 1 of 15 sample elders (#28). The findings were: 1. Review of the quarterly MDS assessment dated 1/15/21 showed elder #28 had diagnoses	F 684	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Quality Assurance Officer will perform a walk-through 3 times per week to ensure that Elder #28 is wearing bilateral lower extremity ace wraps upon rising or that	11/18/21

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F 684	Continued From page 10 which included heart failure, non-Alzheimer's dementia, and hypertension. Review of the care plan dated 12/1/20 showed "I have congestive heart failure" and interventions which included "I need ace elastic bandages applied every morning to my lower extremities and removed at bedtime due to increased fluid retention in lower extremities." Review of a physician orders for the elder dated 5/20/21 showed "apply 4 inch ace wraps to bilateral lower extremities from toes to knee prior to rising and remove at bedtime. The following concerns were identified: a. Observation on 10/26/21 at 9:30 AM showed the elder was sitting in a wheelchair in the common area with visible edema present in his/her bilateral lower extremities. Further observation showed the ace wraps were not applied. b. Review of the progress note dated 9/23/21 and timed 3:27 PM showed "No wraps today." c. Review of the progress note dated 9/23/21 and timed 1:23 AM showed "Removed elder's socks on first round to avoid edema leaving rings around lower extremities." d. Review of the progress note dated 9/22/21 and timed 6:35 PM showed "No wraps today." e. Interview with Shahbaz #3 on 10/27/21 at 12:24 revealed the wraps were done by the nurses and should have been on every day to stop leg swelling. f. Interview with RN #1 on 10/27/21 at 12:30 PM revealed ace wraps were not applied every day because the resident was frequently up and in the common area by the time of med pass. Further interview confimed the ace wraps should have been applied. e. Interview with the DON on 10/28/21 at	F 684	there is proper documentation provided to justify a refusal or treatment hold. How the facility will identify other residents having the potential to be affected by the same deficient practice: Quality Assurance Officer will monitor documentation and TAR entries for all Elders who are Care Planned or Physician Ordered to have lower extremity compression wraps to ensure treatments are being provided consistently and proper documentation is provided. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: DON will provide education regarding Quality of Care and importance of edema compression to all nursing staff at the next Nursing Meeting scheduled for December 15. All Elders requiring compression wrapping will be reviewed at each monthly Nursing Meeting to ensure that all team members are aware of those with compression wrap orders. Quality Assurance Officer or designee will add a question prompt to the TAR that requires nursing to respond yes or no in relation to application, removal or refusal or that hold rationale has been documented by 11/18/2021. How the facility plans to monitor its performance to make sure that solutions	

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F 684	Continued From page 11 9:30 AM revealed it was the expectation of the facility that all physician orders were followed.	F 684	are sustained: Quality Assurance Officer or designee will cross reference a list of all elders who are ordered a compression wrapping treatment with the TAR orders to ensure proper compliance with application and removal of wrap, as well as proper documentation as to reason for refusal or hold by 11/18/2021.	
F 812 SS=D	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 the Food Code, the facility failed to ensure safe food practices were maintained in 2 of 4 cottages (Watt,	F 812	GHLS will ensure sanitary conditions and safe food practices will be maintained by: 1.Pasteurized eggs have been ordered for	11/18/21

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	535054	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

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F 812	Continued From page 12 Founders). The findings were: 1. Observation on 10/27/21 at 10:14 AM showed Shahbaz #4 prepared 2 eggs "over-easy" for resident #9. The resident was served the eggs and Shahbaz #5 cut the eggs for the resident and revealed the yolks of both eggs were runny. Shahbaz #5 asked the resident if the runny yolk was okay and the resident stated yes. Further observation at that time showed no temperature check was performed on the eggs prior to consumption. Observation on 10/27/21 at 10:43 AM showed the resident ate both eggs and yolk smears were noted on the resident's plate. 2. Observation of the Founder's cottage refrigerator on 10/27/21 at 10:20 AM showed no evidence the facility utilized pasteurized eggs. 3. Interview with the dietary manager on 10/27/21 at 10:42 AM revealed the facility did not utilize pasteurized eggs and confirmed the eggs should not be served unless fully cooked. Further interview revealed the dietary manager was not aware pasteurized eggs should be used for recipes where eggs were not fully cooked. 4. According to Food Code 2017, U.S. Public Health Service: 3-401.11 "(D) A raw animal FOOD such as raw EGG, raw FISH, raw-marinated FISH, raw MOLLUSCAN SHELLFISH, or steak tartare; or a partially cooked FOOD such as lightly cooked FISH, soft cooked EGGS, or rare MEAT other than WHOLE-MUSCLE, INTACT BEEF steaks as specified in (C) of this section, may be served or offered for sale upon CONSUMER request or selection in a READY-TO-EAT form if: (1) As specified under 3-801.11(C)(1) and (2), the	F 812	all elders through an approved supplier as of 10/26/21; Sysco. In the future, all shell eggs that are ordered will be Pasteurized unless not available and then the following will occur: unpasteurized shell eggs that are prepared for residents with runny yolks are to be cooked to the appropriate temperature of 145 degree F. Temperatures for each egg cooked will be logged in a Temperature logbook located in each cottage□s kitchen. a. Monitoring will be done a minimum of Monday-Friday by Dietary Mentor for 30 days to ensure shell eggs are being cooked and served under sanitary conditions. After 30 days of successful monitoring, Dietary Mentor will monitor every week to assure that shell eggs are appropriately cooked. Any deviations from safe food practices will be corrected through training and results will be reported to the QA Committee. b. Education has been provided to staff regarding sanitary measures and unpasteurized egg protocol if needed in the future. 11/16/21 2.Storage of food and supplies will be monitored a minimum of once a week by Dietary Manager for proper storage, labeling, and dating. Staff to be educated on these measures by 12/17/21 and as necessary when observations are made not meeting standards. a. Monthly full kitchen audits will continue to be conducted including sanitation, cleanliness, Green House Policy, and storage guidelines with education provided immediately after audit	

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F 812	Continued From page 13 FOOD ESTABLISHMENT serves a population that is not a HIGHLY SUSCEPTIBLE POPULATION;" 5. According to Food Code 2017, U.S. Public Health Service definitions: "Highly susceptible population" means PERSONS who are more likely than other people in the general population to experience foodborne disease because they are: (1) Immunocompromised; preschool age children, or older adults; and (2) Obtaining FOOD at a facility that provides services such as custodial care, health care, or assisted living, such as a child or adult day care center, kidney dialysis center, hospital or nursing home, or nutritional or socialization services such as a senior center. 6. Observation made in Watt Cottage on 10/26/21 at 10:45 AM showed that in the dry storage area there was a large zip-lok bag with what appeared to be rice grain cereal which had no content label, open date, or use by date. In the freezer there were waffles in a open plastic package without a content label, open date, or use by date. Observation of the refrigerator showed a large plastic bag of what appeared to be cheese without a content label or opened date. 7. Interview with Shahbaz #6 on 10/26/21 at 11 AM revealed the facility practice was to label and date all opened food products. 8. Review of the policy "Storage of Food and Supplies" dated 12/2011 showed "...all opened food items are required to be labeled and dated as to date open..."	F 812	to staff.	

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F 812	Continued From page 14 9. According to Food Code 2017, U.S. Public Health Service: 3-501.17 "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days."	F 812		
F 880 SS=E	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	F 880		11/19/21

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F 880	Continued From page 15 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 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	F 880		

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F 880	Continued From page 16 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, staff interview, medical record review, and Centers for Disease Control (CDC) guidelines review, the facility failed to ensure infection prevention measures were implemented to ensure appropriate hand hygiene during 1 of 4 observations of perineal care which affected elder #38. In addition, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) in 2 of 4 elder cottages (Founder's and Watt). The findings were: Regarding hand hygiene: 1. Review of quarterly MDS assessment dated 10/5/21 showed elder #38 had diagnoses which included non-Alzheimer's dementia and had short-term and long-term memory problems. Further review showed the resident required extensive physical assistance of 1 person for personal hygiene and total physical assistance of 2 or more people for dressing and toilet use. The following concerns were identified: a. Observation on 10/27/21 at 9:27 AM showed Shahbaz #4 and Shahbaz #5 entered elder #38's room and assisted the elder onto the toilet. When the elder was finished, Shahbaz #5 obtained wipes and provided perineal care to the elder. The Shahbaz used each hand to clean the elder from front to back and clean to dirty. While performing perineal care, feces was observed on the wipes. When perineal care was complete, Shahbaz #5 pulled the elder's brief and pants up.	F 880	F880 Infection Prevention and Control How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Educator or designee to provide perineal care in-service at the team meeting in each cottage. All meetings to be completed by 12/16/2021. Quality Assurance Officer or designee will observe perineal care for Elder #38 at least once per week to ensure proper infection prevention and control procedures are followed. Education will be provided at the time of observation if deficiencies are observed. How the facility will identify other residents having the potential to be affected by the same deficient practice: Quality Assurance Officer or designee to observe each elder requiring extensive to dependent toileting assistance for proper care at least once per month. Following education, each staff member will be required to sign a roster stating that they have received perineal care education and understand the expectations.	

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F 880	Continued From page 17 The Shahbaz did not perform hand hygiene or change gloves between providing perineal care and pulling up the resident's brief and pants. b. Interview with Shahbaz #5 on 10/27/21 at 12:25 PM revealed staff were expected to wash hands when they enter an elder's room and before they exit the room. Further interview revealed gloves should be changed when a staff member "goes from clean to dirty." c. Interview with the DON on 10/28/21 at 9:16 AM revealed staff should wash their hands prior to patient care and when visibly soiled or when in contact with blood or body fluid. Further interview revealed gloves should be changed after providing "dirty" care prior and prior to providing "clean" care. Regarding PPE use: 1. Observation on 10/27/21 at 9:02 AM showed Shahbaz #5 and Shahbaz #4 wore cloth masks while providing resident care. 2. Observation 10/27/21 at 10:03 AM showed RN #1 wore a cloth mask while seated next to an elder at the dining table. Interview with the RN at that time revealed staff chose what type of mask to wear unless the facility was in outbreak status and N95 masks were required. 3. Interview with Shahbaz #5 on 10/27/21 at 12:25 PM revealed staff could wear any mask they chose unless the facility was in outbreak status, at which time staff were required to wear N95 masks. 4. Interview with the DON on 10/28/21 at 9:19 AM revealed staff should wear surgical masks or cloth masks. Further interview revealed some	F 880	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Quality Assurance Officer will create a checklist identifying all of the proper steps to providing perineal care per facility policy and will observe each elder requiring perineal care at least once per month. Educator to provide perineal care in-service at the team meeting in each cottage. All meetings to be completed by 12/16/2021. Educator will add perineal care to the Shahbaz staff annual education list. How the facility plans to monitor its performance to make sure that solutions are sustained: Quality Assurance Officer or designee will observe each elder requiring extensive to dependent toileting assistance for proper perineal care at least once per month for 12 months and document on checklist.	

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F 880	Continued From page 18 staff with skin sensitivities chose to wear the fabric masks; however, the facility had not given permission for staff to wear cloth masks in care areas. 5. Review of the CDC Guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" last revised on 9/10/21 showed "...Cloth Mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel..."	F 880		