| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 535017 | A. BUILDING _____ B. WING _____ | 11/18/2021 |

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| SUBLETTE CENTER | 333 N BRIDGER AVE PINEDALE, WY 82941 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by Healthcare Licensing and Surveys from 11/15/21 through 11/18/21.<br><br>The following common abbreviations are used in this report; less frequently used terms are defined in the text:<br><br>CNA: Certified Nurse Aide<br>DON: Director of Nursing<br>IDT: Interdisciplinary Team<br>MDS: Minimun Data Set<br>RN: Registered Nurse | F 000 | | |
| F 604 SS=E | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must- | F 604 | | 12/31/21 |

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

Electronically Signed | 12/13/2021

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 604 | Continued From page 1<br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, policy and procedure review and staff interview, the facility failed to ensure physical restraints were evaluated to determine they were the least restrictive method and to ensure they were used to treat medical symptoms for 2 of 2 sample residents (#2, #6). The findings were:<br><br>1. Review of the 8/16/21 quarterly MDS assessment showed resident #2 had diagnoses that included Parkinson's disease and dementia. The resident required extensive assistance for transfer and walking with one person physical assistance. The assessment further showed the resident used a physical restraint daily coded as "other" and used a bed and chair alarm daily. Review of the care plan with a revision date of 8/20/21 showed the use of the physical "pelvic restraint" was used for "agitation and freedom of movement...staff to reposition every 2 hours." There was also an approach with a start date of 3/2/21 for a pressure alarm to be used when in bed and in the recliner. Review of the physician's orders showed the start date for the "pelvic restraint in wheelchair" was 5/7/21, and there was no end date. The following concerns were identified:<br>a. Observation on 11/16/21 at 4:01 PM | F 604 | F604: The facility failed to ensure physical restraints were evaluated to determine they were the least restrictive method and to ensure they were used to treat medical symptoms for residents #2 and #6.<br>a) Observation noted that resident #2 had a pelvic restraint with inadequate evaluation for continued use.<br>To correct the initial non-compliance, the facility, in cooperation with physical therapy, removed the pelvic restraint for resident #2.<br>To ensure further compliance, all residents in the facility were re-examined for presence of restraints, which were eliminated as appropriate. For any residents for whom restraints were continued, updated assessments and consents will be obtained.<br>Assessments for restraint reduction were uploaded into the EMR to ensure appropriate follow through.<br>The facility'□s restraint policy was updated to reflect current protocols.<br>Nursing staff attended preliminary training on restraints 12/08/2021 and facility will hold all-staff meeting to provide education | |

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| F 604 | Continued From page 2<br>showed the resident was in the wheelchair at the dining table with a soft cloth restraint that came between the resident's legs and tied to the wheelchair back. The restraint prevented the resident from rising from the chair or falling forward. Additional observations showed the resident used the restraint daily and was released from the restraint to ambulate with staff and to be transferred to the recliner in the TV area.<br>b. Observation on 11/17/21 at 2:13 PM showed the resident was in the recliner in the TV room and a chair alarm was attached to the resident which would alarm if the resident moved too far.<br>c. Review of the pre-restraining assessment dated 5/7/21 and the corresponding IDT note dated 5/7/21 showed the need for a "pelvic restraint" and "The resident's doctor and family along with staff agree that at this time the above measures are necessary for safety." However, further record review showed there were no more current notes or re-evaluation regarding the continued use of the pelvic restraint. In addition, there was no evaluation or assessment found regarding the use of the alarms.<br>d. Interview with the DON on 11/17/21 at 6:03 PM confirmed the facility did not have a process to assess the position alarms as potential restraints. She also confirmed the alarms were used to alert staff if the resident was at risk for falling, and the process was to re-evaluate the pelvic restraint at least quarterly which had not been done.<br><br>2. Review of the 9/2/21 Admission MDS assessment showed resident #6 had diagnoses that included dementia, was severely impaired for cognitive skills for daily decision making, required | F 604 | regarding restraint protocols.<br>b) Observation noted that resident #6 had a position change alarm with inadequate assessment.<br>To correct the initial deficiency, a position change alarm assessment was completed on resident #6.<br>To ensure safety for all other residents, position change alarm assessments were completed for all other residents and unnecessary alarms were removed.<br>To promote further compliance, position change alarm assessments will be performed prior to placing alarms and then again quarterly.<br>Nursing staff attended training on position change alarms on 12/08/2021 and facility will hold all staff meeting to provide education regarding position change alarms.<br>To prevent future non-compliance, the Director of Nursing will audit all residents monthly for restraints and alarms, and the MDS nurse will bring a list of all residents with restraints and alarms for review of reduction evaluations to QAPI. | |

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| F 604 | Continued From page 3 | F 604 | | |

extensive assistance with 2 person physical assist for transfers, walking in the room, and for locomotion on the unit. The assessment did not show any use of physical restraints or alarms being used. Review of the care plan related to risk of falls showed it was implemented on 9/7/21. The approaches included 11/13/21 updates to include: "Pressure alarm in bed" and "personal alarm in recliner [and] wheelchair for safety with frequent reposition." The following concerns were identified:

a. Observation on 11/17/21 at 12:33 PM showed the resident was eating his/her meal in the TV room while seated in a specialized wheelchair. The resident had an alarm attached to his/her clothing and the chair. Interview with RN #2 at that time confirmed the alarm was active and was attached to the resident's shirt. The RN stated the resident did not attempt to get up from this wheelchair; however, s/he was known to do so when seated in the recliner. The resident had been transitioned to the wheelchair because of a foot injury and they were better able to position the resident.

b. Review of the medical record failed to show any assessment related to the use of the chair or bed alarm.

c. Interview with the DON on 11/17/21 at 6:03 PM confirmed the facility did not have a process to assess the position alarms as potential restraints. She further stated the alarms were used to alert staff if the resident was at risk for falling.

3. Review of the "Restraint Policy" last reviewed October 2019, showed if a restraint needed to be placed, "1. The physician must be notified and an order must be obtained; 2. The family must be notified and consent must be obtained; 3. The

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| F 604 | Continued From page 4<br>DON must be notified; 4. A pre-restraining assessment must be completed as soon as possible; 5. Documentation in the nurses notes must be completed q [every] shift for 72 hours; 6. The restraint must be re-evaluated within 24 hours for appropriateness; 7. IDT [Interdisciplinary team] will re-evaluate for appropriateness within a week and then quarterly." | F 604 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, resident and staff interview, and policy and procedure review the facility failed to ensure safety assessments were completed as required for 1 of 1 residents (#4) reviewed for smoking. The findings were:<br><br>1. Review of the 8/20/21 quarterly MDS assessment showed resident #4 was admitted on 10/11/19 with diagnoses which included hypertension, chronic obstructive pulmonary disease, transient ischemic disease, anxiety and pain. Further review showed a Brief Interview for Mental Status (BIMS) score of 12 which was indicative of moderate cognitive impairment. Continued review showed a health condition for | F 689 | F689: The facility failed to ensure safety assessments were completed as required for resident who smoke.<br>a) Observation noted resident had smoking materials at bedside and lacked an updated assessment for safety with smoking and responsibility for personal smoking items.<br>To correct the initial deficiency and ensure safety for all other residents, updated assessments were completed for all residents who smoke.<br>Both residents who smoke and were considered capable to monitor their own items, education was provided to keep smoking materials in their personal purse | 12/16/21 |

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| F 689 | Continued From page 5<br>tobacco use. Observation on 11/16/21 at 10 AM of the resident's room showed a pack of cigarettes and a lighter on the bedside table. Interview with the resident at that time revealed s/he went outside twice a day to smoke. S/he further stated, "they let me keep my cigarettes and lighter in my room because it was too difficult to find a nurse to get them where they were locked up." The following concerns were identified:<br>a. Medical record review showed a safe smoking assessment form was completed on 9/20/20. The assessment failed to address the resident having smoking materials in the room.<br>b. Interview with the DON on 11/17/21 at 9:16 AM revealed she completed the smoking assessment on 9/20/20. She further revealed the process was to re-evaluate the resident for safe smoking quarterly, and confirmed that had not been done.<br>c. Review of the Resident Smoking Policy, last revised on 4/21 showed, "...3. The smoking assessment will be reviewed quarterly and if there is a significant change in the resident's condition or in the resident's compliance with the smoking policy. " | F 689 | or walker bags and not to have items stored on bedside tables where they could be accessed by other residents.<br>To promote further compliance and consistent follow through on assessment, smoking assessments were uploaded onto the EMR for quarterly completion.<br>Nursing staff were educated on 12/08/2021 and all staff will be educated on 12/16/2021.<br>The Director of Nursing will audit weekly for 12 weeks then monthly and report on assessment completion and safe storage of cigarettes and lighters as a function of QAPI. | |
| F 700 SS=E | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of | F 700 | | 12/18/21 |

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| F 700 | Continued From page 6<br>entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, review of consent and release, and medical record review, the facility failed to ensure bed rails assessments were completed for 2 of 2 sample residents (#9, #82). The findings were:<br><br>1. Review of the Admission Assessment and Interim Care Plan dated 11/11/21 showed resident #82 was oriented to his/her room, had some ADL limitations, used a walker, was at a high risk for falls, and was mentally alert and oriented. Under the category for room orientation the assessment showed a check mark next to the item "Bed Side Rails Acknowledgement Signed." The following concerns were identified:<br>a. Interview with the resident on 11/17/21 at 11:23 AM revealed s/he was pleased with the care and environment. The resident stated s/he used the side rail bars to move around in bed and had no concerns or issues with them. Observation at that time showed the resident was in bed with the bars in an upright position on both sides of the bed which was not against a wall.<br>b. Observations with the maintenance | F 700 | F700: The facility failed to ensure bed rail assessment were completed for 2 of 2 sample residents.<br>a) Observation noted residents to be utilizing bed rails without pre-assessment, consent and evaluation.<br>To correct the initial deficiency, the facility completed assessment and updated consents for both sample residents.<br>To ensure further compliance, a facility wide inspection will be completed and all bed rails will be removed unless necessary for an individual resident.<br>For residents who will continue to utilize bed rails, updated assessment forms were created to include a risk for entrapment assessment, pre-use assessment and consent, and rail reduction. These forms will be completed for all residents who will continue to utilize bed rails.<br>A bed rails agenda item was placed on the standing safety meeting. Maintenance will report on any new rail use at that monthly | |

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| F 700 | Continued From page 7<br>director on 11/18/21 at 10:16 AM showed, when measured, the openings of the side rails included a 4 inch by 4 and 5/8 inch opening, and a 12 and 1/2 inch by 4 inch opening on each bed rail. Interview with the maintenance director at the time revealed he was not aware of any safety assessment performed related to the bed rails.<br>c. Medical record review failed to show an assessment was completed to determine entrapment risk for the resident, and the signed "Bed Side Rails Acknowledgement" was not found.<br><br>2. Review of the 9/9/21 quarterly MDS assessment showed resident #9 had diagnoses that included cerebrovascular accident (CVA), trans ischemic attack (TIA) or stroke, hemiparesis or hemiplegia, and dementia. The resident required extensive assistance with 1 to 2 person physical assistance for ADLs including bed mobility and transfers. The resident was not shown to use any physical restraints. The following concerns were identified:<br>a. Observation on 11/18/21 at 11:27 AM showed the resident had a mobility bar attached to the side of the bed which was away from the wall. It was approximately a 1/4 of the mattress length located near the head of the bed. Measurements taken at that time by the maintenance director showed openings that measured 8 inches by 3 and 5/8 inches, and 4 7/8 inches by 2 and 3/8 inches.<br>b. Review of the medical record showed a physician order dated 12/24/2020 for "Bed Rails: positioning prn [as needed]." There was nothing to show the bed rails had been evaluated for entrapment risk.<br><br>3. Review of the "Side Rail Informed Consent and | F 700 | meeting.<br>All staff will be provided education regarding bed rails and safety.<br>To prevent future deficiencies, the director of nursing will audit all residents for bed rails monthly and report on assessment follow through and the maintenance director will audit monthly and report on ensuring safe and functioning bed rails as a function of QAPI. | |

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| F 700 | Continued From page 8<br>Release" showed the risks and benefits of side rail usage were described and there was a place for signatures and dates to acknowledge these items. The risks showed "...entrapment in the following ways: 1. Through the bars of an individual side rail; 2. Through the space between split side rails; 3. Between the side rail and the mattress; 4. Between the headboard or footboard, side rails and the mattress."<br><br>4. Interview with the DON on 11/17/21 at 10:34 AM verified there was not any assessment done related to entrapment with the use of side rails. She stated they were not considered a restraint so they were not assessed. She was unaware of a policy and procedure related to bed rail assessments. | F 700 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the | F 756 | | 12/16/21 |

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| F 756 | Continued From page 9<br>attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview the facility failed to ensure the physician responded to pharmacy reports of medication irregularities for 1 of 4 sample residents (#9). The findings were:<br><br>Review of the 9/9/21 quarterly MDS assessment showed resident #9 had diagnoses that included dementia, anxiety and depression. The resident received antipsychotic and antidepressant medications daily. Review of the 10/26/21 pharmacy recommendation report showed the resident was receiving duloxetine (an antidepressant medication) 60 milligram (mg) daily and amitriptyline (an antidepressant medication) 25 mg daily at bedtime. The recommendation showed "Please review and consider an attempt at a gradual dose reduction | F 756 | F756: The facility failed to ensure the physician responded to pharmacy reports of medication irregularities for 1 of 4 sample residents.<br>a) Observation noted that a resident had recommendation from the facility pharmacist were not addressed by the physician on 9/15/2021 or 10/26/2021.<br>To correct the initial deficiency, the facility had the resident□s primary care provider address the pharmacist recommendation.<br>To ensure further compliance, the facility audited pharmacy reports and ensured all signatures were updated. Physicians were educated regarding the requirements of F750. The facility will deliver paperwork to physicians twice weekly to promote continued compliance. | |

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| F 756 | Continued From page 10<br>(GDR) while concurrently monitoring for reemergence of depressive and/or withdrawal symptoms." Further, the report showed this was a repeated recommendation from 9/15/21. The following concerns were identified:<br>a. Review of the pharmacy report and the medical record showed there was no physician response to the recommendation.<br>b. Interview with the DON on 11/18/21 at 9:47 AM revealed the physician was on vacation and had not acknowledged the pharmacy irregularity report. She confirmed it had been since 9/15/21 and there was no physician response. | F 756 | Nursing staff were educated regarding physician signature follow up on 12/08/21 and all staff will be provided education during facilities next staff meeting<br>To prevent further non-compliance, the Director of Nursing will audit pharmacy recommendations monthly and report as a function of QAPI. | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, review of resident council minutes, and resident council interview, the facility failed to ensure meals were palatable for 1 of 1 meals tested (the evening meal on 11/17/21). The census was 31. The findings were:<br><br>Review of the 8/30/21 and 9/27/21 resident council meeting minutes showed there was dissatisfaction with the evening meals. Review of the 10/25/21 meeting minutes did not include | F 804 | F804: The facility failed to ensure meals were palatable.<br>a) Observation noted that resident□s choice of chicken strip was replaced with baked chicken breast.<br>To correct the initial non-compliance, the dietary department has changed its process for select menus. The CDM will review alternate choices weekly to ensure facility has the item in stock. If delays are encountered, the facility will notify | 12/18/21 |

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| F 804 | Continued From page 11<br>complaints about the meals. However, the resident counsel interview on 11/16/21 at 2:30 PM revealed 5 of the 5 residents in attendance had concerns that had not been resolved with the evening meals. The residents expressed the meals were not satisfying for quality, temperature or variety. The residents thought it may be due to lack of experience of the cooks and shortages in the dietary department. Review of the menu for the evening meal on 11/17/21 showed quiche of the day, peas, tossed salad, and chocolate mousse. There was an always available menu for those who preferred an alternative. These items included: cottage cheese and fruit, chicken strips, egg salad sandwich, peanut butter and jelly sandwich, hamburger on bun, macaroni and cheese, and a variety of soups. The following concerns were identified:<br>a. Observation during the food preparation and service on 11/17/21 at 4:23 PM showed cook #1 was in the process of cooking. Interview with her at that time revealed she started in October and was still learning. She confirmed some residents picked items from the alternate menu and there were times items were not available. That evening's meal included a resident that had ordered chicken strips for the meal and was receiving a substitute of baked chicken breast.<br>b. Observation of a test tray on 11/17/21 at 6:20 PM showed the quiche had an acceptable taste, was slightly warm and the temperature was 118.8 degrees Fahrenheit (F). The peas were unremarkable for taste and were not warm and the temperature was 93 degrees F. There were pickled beets that were served chilled and they were acceptable at 55 degrees F. There was no chocolate mousse, instead a prepackaged chocolate pudding was served.<br>c. Interview with the certified dietary manager | F 804 | residents and change the alternate menu options.<br>To ensure future compliance, the activities department, which helps fill out alternate menus now, will inform residents verbally of menu changes and use updated alternate menus weekly. Further, they will ask residents weekly about the palatability of food items to ensure issues are addressed in a timely manner.<br>b) Observation noted food temperatures to be too low.<br>To correct the initial non-compliance, the facility changed its procedure for COVID outbreak status to allow for serving out of the facilities located on the nursing wing and removed the requirement for serving out of the central kitchen.<br>To ensure future compliance, the facility is ordering food delivery systems that include temperature controlled carts and plate insulators. These will be used to deliver room trays once they are received in the facility.<br>Dietary department will audit food temperatures and resident surveys regarding food quality to ensure palatability monthly and will report as a function of QAPI. | |

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| F 804 | Continued From page 12<br>(CDM) on 11/18/21 at 10:44 AM verified the food was being delivered to the residents on trays with plate covers due to the current quarantine measures in place. There were no covers for the carts with the trays and no heated plates. The CDM stated she was not surprised the food did not maintain temperature and agreed another process was needed to keep the food hot and more palatable. She further confirmed she was aware of resident complaints regarding the evening meal and they continued to work on a solution. There had been some staff who were out and she was providing coverage which reduced her time to manage the concerns. She was aware communication to residents regarding substitutions was important for meal satisfaction. However, she was uncertain if the resident who received the baked chicken had been informed of the substitution prior to the meal. | F 804 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility. | F 812 | | 12/28/21 |

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| F 812 | Continued From page 13<br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of Food Code standards, the facility failed to ensure food equipment and surfaces were maintained in a sanitary condition in 2 of 3 meal service areas (TV room and sun room) and for 2 of 3 ice machines (kitchen and beauty shop). The census was 31. The findings were:<br><br>1. Observation on 11/15/21 at 4:04 PM showed the ice machine located in the kitchen was not clean. The interior white plastic piece that was located above the full ice bin was soiled with a black and pinkish build-up.<br><br>2. Observation on 11/17/21 at 11:49 AM showed the ice machine on the resident unit was located in the beauty shop. There was no separation between the area where hair was done and the area where the ice machine was located. In addition, the original cover/lid to the ice machine was missing and there was a homemade cover to the ice machine which was made from a thick pliable plastic and duct tape. The interior of the ice making mechanism had a visible dark build-up on the plastic. Observation in the beauty shop on 11/18/21 at 9:36 AM showed a blue garbage can labeled "East Bath" was located in front of the ice machine and was in contact with the ice machine lid. The garbage can contained bagged linen.<br><br>3. Observation on 11/17/21 at 5:47 PM showed 2 tables in the sun room dining area that had not been cleaned. There was visible dried liquid/food | F 812 | F812: The facility failed to ensure food equipment and surfaces were maintained in a sanitary condition.<br>a) Observation showed ice machine in kitchen was not clean. To correct the initial non-compliance, the machine was cleaned.<br>To promote future compliance, the maintenance team will be keeping a log of dates the facility ice machines are cleaned. If a contractor is unable to complete cleaning by the necessary time, the maintenance team will clean the machines.<br>Education was provided to maintenance staff<br>The maintenance team will audit ice machines monthly and report on cleanliness and maintenance of ice machines during the regularly scheduled QAPI meeting.<br>b) Observation showed an ice machine located in the beauty shop and also located near garbage and linen containers.<br>To correct current non-compliance and promote future compliance, the ice machine was disconnected 11/19/2021 and is scheduled for removal with plating of the current lines and electricity to ensure safety.<br>c) Observation showed Sun Room tables and TV room trays to be unclean. To correct current non-compliance, all | |

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| F 812 | Continued From page 14<br>on the tables. Additionally, the over bed tables used for dining in the TV room had visible dried food/liquids remaining from previous dining. Observation at 5:47 PM showed a resident was delivered her evening meal to one of the over bed tables in the TV room. CNA #1 did not acknowledge or attempt to clean the dirty over bed table the meal was served on. At 5:52 PM CNA # 2 served the residents seated in the sun room meals on the unclean tables.<br><br>4. Interview with the DON on 11/18/21 at 9:47 AM confirmed there should be a process to ensure the tables were cleaned prior to meal service.<br><br>5. Interview with the maintenance director on 11/17/21 at 10:38 AM revealed an outside service company came in to clean and sanitize the ice machines at least once per year and as needed. He confirmed the service was completed in April 2021. He stated there had been a work order from the dietary manager on 10/22/21 to have the kitchen machine cleaned and sanitized and they were due to come this week. He confirmed the service company had been delayed and he was uncertain when they would arrive.<br><br>6. Interview with the certified dietary manager on 11/18/21 at 10:44 AM verified the kitchen ice machine needed to be cleaned and she had put in the work order, and it was delayed. She stated she had no control over the ice machine located in the beauty shop.<br><br>7. According to Food Code 2017, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS | F 812 | tables and bedside stands were cleaned.<br>To promote future compliance, the housekeeping task list was updated to include table and bedside table cleaning. Activities has updated policies to include cleaning between activities and before any food is served at the tables.<br>All staff will be provided education at an all-staff meeting.<br>To prevent future non-compliance, the housekeeping manager will audit tables and room trays weekly and report findings as a function of QAPI. | |

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| F 812 | Continued From page 15<br>shall be clean to sight and touch.<br><br>8. According to Food Code 2017, U.S. Public Health Service: 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. | F 812 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 12/16/21 |

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| F 880 | Continued From page 16<br>but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | F 880 | | |

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| F 880 | Continued From page 17<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and review of manufacturer instructions for use, the facility failed to ensure point of care equipment was cleaned as required for 2 of 2 random observations. The findings were:<br><br>1. Observation on 11/16/21 at 11:29 AM showed RN #1 obtained a blood glucose using a glucometer. The RN used a Sani-Cloth AF3 wipe and cleansed the glucometer for less than a minute, then placed the glucometer back in its case. Continued observation on 11/16/21 at 11:45 AM showed RN#1 obtain another blood glucose using the same glucometer. The RN used a Sani-Cloth AF3 and wiped the glocumeter for less than a minute and placed the glucometer back in the case. The following concerns were identified:<br>a. Interview on 11/16/21 at 4:35 PM with RN #1 confirmed she did not follow the manufacturer instructions for disinfection time. She stated she did not think about how long the glucometer should stay wet for proper disinfection.<br>b. Interview on 11/17/21 at 9 AM with the DON revealed she had misunderstood the manufacturer instructions for proper disinfection and confirmed the staff was not trained to follow manufacturer instructions for proper disinfection.<br>c. Review of the Sani-Cloth AF3 manufacturer instruction for use showed, "...Cleaning Procedure:...Open and unfold first germicidal cloth to remove heavy soil....Contact Time: use second germicidal cloth to thouroughlyl wet surface. Allow to remain wet three [3] minutes, let air dry." | F 880 | F880: The facility failed to ensure point of care equipment was cleaned as required.<br>a) Observation noted nurse to sanitize glucometer in a manner inconsistent with Sani-Cloth recommendations. Specifically, wet contact was not maintained for the time required.<br>To correct the initial non-compliance, floor nurses were provided education on proper sanitization technique.<br>To promote future compliance, labels were made for point of care equipment reminding nurses to maintain wet contact for the required amount of time. All nursing staff were provided education on 12/08/2021. All staff will receive further education via all-staff in-service.<br>To prevent future non-compliance, the Director of Nursing will audit point of care equipment cleaning weekly x12 weeks then monthly x3 months and report as a function of QAPI. | |