STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 82801**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 9/19/22 to 9/22/22. Also reviewed in the course of the survey were complaint intake WY000003455. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing LA: Laundry Assistant LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		11/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2022

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F 623	Continued From page 1	F 623		

and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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F 623	Continued From page 2	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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F 623	Continued From page 3 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy review the facility failed to ensure a written notice of transfer was provided as required for 3 of 4 sample residents (#9, #23, #54) reviewed for facility-initiated transfer. The findings were: 1. Review of current physician orders showed resident #9 was admitted to the facility on 9/4/22 with diagnoses that included dementia. The following concerns were identified: a. Review of the resident's order history showed two separate physician orders, written on 5/30/22 and 9/1/22, to transfer the resident to the hospital for evaluation. b. Review of the medical record showed no evidence the resident, representative, family members, or the ombudsman were provided a written notice of either transfer to the hospital. 2. Review of the medical record for resident #23 showed the resident was admitted with diagnoses which included non-Alzheimer's dementia, and other abnormalities of gait and mobility. The following concerns where identified: a. Review of the progress notes showed the resident was hospitalized on 8/16/22 following a fall causing right hip pain. Further review of the medical record failed to show evidence a written notice of transfer was provided to the resident's representative. 3. Review of the progress notes showed resident #54 was admitted with diagnoses which included rheumatoid arthritis, diabetes mellitus, and atrial	F 623	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual F623 Notice Requirements before transfer/discharge 1. Residents #9, #23 and #54 had no adverse effects by the facility failing to provide a notice of transfer/discharge. Transfer notice was sent to responsible party of residents #9, #23 and #54 with disclaimer stating facility failed to issue this notice upon discharge and requesting signature. Discharge packets were completed to include the correct forms and a checklist to ensure the notice was issued appropriately and upon each discharge 2. All residents are at risk of the facility failing to provide a notice of transfer/discharge upon leaving the	

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F 623	Continued From page 4 fibrillation with a cardiac pacemaker. The following concerns were identified: a. Review of the nursing progress notes showed the resident was transferred to the emergency department on 9/14/22 with an irregular heart rate. b. Review of the medical record failed to show a written notice of transfer was provided to the resident and the resident representative. c. Interview on 9/22/22 at 9:03 AM with the administrator confirmed the resident and the resident representative were not provided with a notice of transfer. 4. Interview with the DON on 9/21/22 at 5:44 PM confirmed written notices of transfer had not been provided to the residents or resident representatives. 5. Review of the facility policy "Bedhold/Reservation of Room," effective 5/2/19, showed "Procedure ... 2. Before the resident transfers to a hospital or the resident goes on therapeutic leave, the facility will provide written information for the resident or responsible party that specifies: ...In cases of emergency transfer, notice "at the time of transfer" means that the family, surrogate, or responsible party are provided with written notification within 24 hours of the transfer."	F 623	facility. 3. Discharge packets were completed to include the correct forms and a checklist to ensure the notice was issued appropriately. DON or designee will provide education to all nurses regarding the requirement to ensure the notice of transfer/discharge is completed appropriately and timely. 4. DON or designee will conduct a 100% audit of all residents who discharge to ensure the notice of transfer/discharge was completed. These audits will be completed weekly for 4 weeks and monthly for 3 months or until substantial compliance is achieved. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective. Performance improvement meetings consistent of at a minimum the Executive Director, Director of Nursing, and Medical Director, and additional staff as needed. The Performance Improvement committee identifies issues with respect to which quality assessment, assurance activities are necessary and develops, and implements appropriate plans of action to correct identified quality deficiencies.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		11/11/22

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F 625	Continued From page 5 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policy, the facility failed to provide written information on the bed-hold policy for 3 of 4 sample resident (#9, #23, #54) reviewed for facility-initiated transfers. The findings were: 1. Review of current physician orders showed resident #9 was admitted to the facility on 9/4/22 with diagnoses that included dementia. The following concerns were identified: a. Review of the resident's order history showed two separate physician orders, written on	F 625	1. Residents #9, #23 and #54 had no adverse effects by the facility failing to provide the bed hold policy upon transfer or discharge. Bed hold policy was sent to responsible party of residents #9, #23 and #54 with disclaimer stating facility failed to issue this notice upon discharge and requesting signature. Discharge packets were completed to include the correct forms and a checklist to ensure the bed hold policy was issued appropriately and upon each discharge.	

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F 625	Continued From page 6 5/30/22 and 9/1/22, to transfer the resident to the hospital for evaluation. b. Review of the medical record showed no evidence the resident or the resident's representative were provided a bed hold policy for either transfer to the hospital. 2. Review of the medical record for resident #23 showed the resident was admitted with diagnoses which included non-Alzheimer's dementia, and other abnormalities of gait and mobility. The following concern where identified: a. Review of the progress notes showed the resident was hospitalized on 8/16/22 following a fall causing right hip pain. Further review of the medical record failed to show evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative. 3. Review of the progress notes showed resident #54 was admitted with diagnoses which included atrial fibrillation with a cardiac pacemaker. The following concerns were identified: a. Review of the nursing progress notes showed the resident was transferred to the emergency department on 9/14/22 with an irregular heart rate. b. Review of the medical record showed no evidence the bed hold policy was provided to the resident and the resident representative. c. Interview on 9/22/22 at 9:03 AM with the administrator confirmed the resident and the resident representative were not provided with a bed hold policy. 4. Interview with the DON on 9/21/22 at 5:44 PM confirmed the facility had not issued a bed hold policy to the residents or resident representatives.	F 625	2. All residents are at risk of the facility failing to provide a bed hold policy upon leaving the facility. 3. Discharge packets were completed to include the correct forms and a checklist to ensure the bed hold policy was issued appropriately and upon each discharge. DON or designee will provide education to all nurses regarding the requirement to ensure the bed hold policy is completed appropriately and timely. 4. DON or designee will conduct a 100% audit of all residents who discharge to ensure the bed hold policy was completed upon transfer or discharge. These audits will be completed weekly for 4 weeks and monthly for 3 months or until substantial compliance is achieved. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	

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F 625	Continued From page 7 5. Review of the facility policy "Bedhold/Reservation of Room," effective 5/2/19, showed "Procedure ... 2. Before the resident transfers to a hospital or the resident goes on therapeutic leave, the facility will provide written information for the resident or responsible party that specifies: ... The duration of the state bed hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility ...The reserve bed payment policy in the state plan, if any ...The facility policies regarding bed-hold ...In cases of emergency transfer, notice "at the time of transfer" means that the family, surrogate, or responsible party are provided with written notification within 24 hours of the transfer."	F 625		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of professional standards of practice for feeding tubes, the facility failed to ensure professional standards of practice were followed for 1 of 1 observation of medication administration via a feeding tube (resident #13). The findings were: 1. Observation on 9/21/22 at 1 PM showed LPN #2 administered medications to resident #13, who had a feeding tube. Continued observation showed the resident lying flat in bed. The following concerns were identified:	F 658	1. DON assessed resident upon notification of receiving medications through feeding tube while lying flat and found that Resident #13 received no adverse side effects from lying flat during medication administration through his feeding tube. Order was placed into MAR/TAR for each shift to ensure head of bed is elevated during medication administration or while feeding for both residents who have feeding tubes. DON observed the next medication	11/11/22

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F 658	Continued From page 8 a. Interview with the LPN on 9/21/22 at 1 PM confirmed the patient was lying flat in bed, and the head of the bed should have been elevated while administering medication through the feeding tube to prevent aspiration. b. Review of Lippincott Nursing Procedures, Seventh Edition showed "...Keep the head of the patient's bed elevated at a 30-to 45-degree angle at all times during the enteral tube feeding administration and for 30 to 60 minutes after the feeding has been completed or stopped for any reason..."	F 658	administration and feeding to ensure both residents were not lying flat during the procedure. 2. Any resident who receives medication through a feeding tube is at risk for aspiration caused by lying flat during administration. 3. DON or designee will educate all nurses on the Lippincott Nursing Procedures for appropriate medication administration for those with feeding tubes. 4. DON or designee will conduct random audits of medication administration through a feeding tube 4 times per week for 4 weeks and once a week for 3 months thereafter or until substantial compliance is achieved. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		11/11/22

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F 761	Continued From page 9 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy and procedure review, the facility failed to ensure medications and supplies for patient use were not expired in 1 of 2 medication rooms (central medication room) observed. Additionally, the facility failed to ensure medications and supplies were kept secure for 1 of 1 random observations of medication rooms (Saddle Ridge Unit medication room). The findings were: 1. Observation on 9/20/22 at 1:36 PM of the central medication room showed the following items were expired: a. 5 Buff NA Citrate 3.2% vacutainers (for blood collection) with an expiration date 7/31/22. b. 3 Universal Viral Transport for viruses, chlamydia, & mycoplasmas & urea plasmas swab & collection containers with an expiration date 6/30/22. c. 1 bottle of Tums Calcium Carbonate Smoothies Berry Fusion with an expiration date 1/22. d. 1 1 ounce tube of Sunmark hydrocortisone cream 1% with an expiration date 5/22.	F 761	1. Vacutainers, universal viral transport tubes, 1 bottle of tums, 1 tube of hydrocortisone cream, 1 dermal curette, A&D ointment, 1 packet of lubricating jelly, 1 cutimed wound dressing, 5 xeroform occlusive gauze patches, 1 melgisorb AG were removed immediately from medication room and discarded. No adverse effects occurred while medication storage room door was open and unattended. DON completed a 100% audit of each medication room and cart as well as medication refrigerators to ensure no additional medications, creams or dressings were expired and discarded those items she found. 2. All residents are at risk for receiving expired medications, dressings or creams. Residents and visitors are at risk for facility failing to keep medications and biologicals inaccessible by ensuring medication room is locked while unattended. 3. 100% audit was completed on all	

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F 761	Continued From page 10 e. 1 4 mm Integra Miltex Disposable Dermal Curette with an expiration date 11/9/21. f. McKesson Skin Protectant Ointment with vitamins A&D 5 G tubes: 3 with an expiration date 8/21, 2 with an expiration date 1/22, 2 with an expiration date 2/22, 1 with an expiration date 6/22, and 2 with an expiration date 7/22. g. 1 packet of McKesson Lubricating Jelly with an expiration date 6/25/21. h. 1 Cutimed Sorbact WCL 4 inch by 5 inch (wound dressing) with an expiration date 5/21. i. 5 Xeroform Occlusive Gauze Patch 4 inch by 4 inch (wound dressing) with an expiration date 5/31/21. j. 1 Melgisorb AG 4 inch by 4 inch (wound dressing) with an expiration date 7/2. k. Interview with LPN #2 confirmed the items in the medication room were for patient use. l. Review of the facility policy "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles," with a revision date 4/5/19, showed "...4. Facility should ensure that medications and biological that: (1) have an expired date on the label; 92) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier..." 2. Observation of the Saddle Ridge Unit medication room on 9/21/22 at 2:55 PM showed the door was open, unattended and no staff was in the area. a. The nurse returned at 3:00 PM, interview at that time with RN #1 confirmed the door to the medication room was left open and it should be kept closed and locked. b. Review of the facility policy "5.3 Storage	F 761	medication rooms, carts and refrigerators to determine if any additional medications, creams, dressings, etc were expired. DON or designee will provide education to all nurses regarding disposal of expired medications including creams and dressings Education will also be provided to nurses regarding the policy of ensuring medication room is closed and locked while unattended. 4. DON or designee will conduct random audits on medication carts, medication rooms and medication refrigerators to monitor for any expired medications including dressings or creams as well as ensuring they are locked and inaccessible to residents and visitors while unattended. These audits will be completed 2-3 times per week for 4 weeks and weekly for 3 months or until substantial compliance has been achieved. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	

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F 761	Continued From page 11 and Expiration Dating of Medications, Biological's, Syringes and Needles," with a revision date 4/5/19, showed "...3.3 Facility should ensure that all medications and biological's, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible to residents and visitors..."	F 761		
F 812 SS=E	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, and policy and procedure review, the facility failed to ensure safe food handling practices were implemented and maintained during inspection of 1 of 1 food preparation and storage areas. The following concerns were identified:	F 812	1. No adverse effects were received by the temperature logs in the upright reach-in refrigerator and freezer, walk in refrigerator and freezer having missed temperatures on various shifts for multiple days. The stove, toaster and range hood were cleaned immediately during the	11/11/22

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F 812	Continued From page 12 1. Observation of the kitchen, food preparation areas, and food storage areas on 9/19/22 at 3:24 PM showed an upright reach-in freezer with a temperature log for September 2022 posted on the front of the unit. Further review of the log showed AM temperatures were not documented on 9/3/22, 9/9/22, 9/10/22, 9/15/22, or 9/16/22, and PM temperatures were not documented on 9/6/22, 9/7/22, 9/14/22, or 9/18/22. Continued review showed every documented temperature was above 0 degrees Fahrenheit. 2. Observation of the kitchen, food preparation areas, and food storage areas on 9/19/22 at 3:24 PM showed a temperature log for September 2022 posted for documentation of temperatures for the walk-in freezer. Further review of the log showed AM temperatures were not documented on 9/3/22, 9/9/22, 9/10/22, 9/15/22, or 9/16/22, and PM temperatures were not documented on 9/6/22, 9/7/22, 9/13/22, 9/14/22, or 9/18/22. Continued review showed all documented temperatures were above 0 degrees Fahrenheit. 3. Observation of the kitchen, food preparation areas, and food storage areas on 9/19/22 at 3:24 PM showed an upright reach-in refrigerator with a temperature log for September 2022 posted on the front of the unit. Further review of the log showed AM temperatures were not documented on 9/3/22, 9/9/22, 9/10/22, 9/12/22, 9/15/22, or 9/16/22, and PM temperatures were not documented on 9/6/22, 9/7/22, 9/14/22, or 9/18/22. Continued review showed a documented temperature of 45 degrees Fahrenheit. 4. Observation of the kitchen, food preparation areas, and food storage areas on 9/19/22 at 3:24 PM showed a walk-in refrigerator with a	F 812	survey using a new oven cleaner gel to remove all the built on grease/food/debris of noted appliances. A new toaster was ordered as well. Dietary manager implemented a new cleaning schedule to ensure all equipment was cleaned appropriately and timely. 2. All residents are at risk of food being served from appliances that have built on grease/food/debris and temperature or from refrigerators that have missing temperatures on the logs. 3. Dietary manager will educate all dietary staff on the importance of cleanliness of all areas including the stove, toaster and range hood and adhering to the new cleaning schedule as well as recording the temperatures for all of the refrigerators and freezers on the morning and evening shifts to ensure all federal requirements and specifications are met. If any temperatures are ranging outside the parameters noted on the log, staff will immediately notify dietary manager and maintenance director. 4. Dietary manager will audit the cleaning schedule and the completion of cleaning which includes the stove surfaces, toaster and range hood 3 times per week for 4 weeks and weekly for 3 months or until substantial compliance has been achieved. In addition, the Registered Dietician will note compliance on her routine monthly site visit report. Dietary manager will audit the temperature logs for all walk in and reach in refrigerators to ensure they are completed daily for each shift. 5. Results of this audit will be reviewed	

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F 812	Continued From page 13 temperature log for September 2022 posted on the front of the unit. Further review of the log showed AM temperatures were not documented on 9/3/22, 9/9/22, 9/10/22, 9/15/22, or 9/16/22, and PM temperatures were not documented on 9/6/22, 9/7/22, 9/14/22, or 9/18/22. 5. Observation of the kitchen, food preparation areas, and food storage areas on 9/19/22 at 3:24 PM showed a thick build-up of grease on the surfaces of the stove burners and griddle. Further observation showed the burners of the stove had a large build-up of burnt-on food and grease, and the area underneath the burners had a large amount of burnt crumbs and debris. 6. Observation of the kitchen, food preparation areas, and food storage areas on 9/19/22 at 3:24 PM showed the conveyor toaster had a build-up of burnt food and grease on the face, conveyor, and interior surfaces of the appliance. 7. Observation of the kitchen, food preparation areas, and food storage areas on 9/19/22 at 3:24 PM showed the range hood above the stove and a food preparation cart with a large amount of dust and debris along the interior surfaces of the hood. 8. Interview with the dietary manager on 9/21/22 at 1:13 PM confirmed the temperature logs were all lacking multiple temperature checks. She stated a new employee was working those shifts, and she wasn't sure if the new employee was aware of all her responsibilities yet. The dietary manager further confirmed the range hood, stove, and conveyor toaster all were needing cleaned. She stated she was in the process of implementing a new weekly cleaning schedule to	F 812	at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	

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F 812	Continued From page 14 address cleanings as a team on a regular basis. 9. Review of undated facility policy "Food in Storage Areas" showed guidelines for refrigeration as "Keep temperatures between 34oF and 38oF. Record temperatures a minimum of twice daily." Further review showed freezer guidelines as "Keep at 0oF or below or per state regulation." 10. According to Food Code 2017, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54°C (130°F) or above; or (2) At 5ºC (41ºF) or less.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		10/21/22

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F 880	Continued From page 15	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of 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

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F 880	Continued From page 16 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and review of manufacturer's instructions, the facility failed to perform hand hygiene as required during one random observation during dining services. In addition, the facility failed to ensure glucometers were disinfected as required for 1 of 2 random observations of glucometer disinfection. The following concerns were identified: 1. Observation on 9/19/22 at 4:45 PM showed LA #1 serving drinks to residents during the dinner service. It was noted he was not wearing gloves at that time. Continued observation showed pushing the beverage cart around to residents, and making contact with the residents and their items. No observations of hand hygiene were observed between resident contacts. Continued observation showed the LA inserted his right hand down the back of his own pants three times to tuck his shirt in. No hand hygiene was observed after these actions.	F 880	The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected unit identified in the deficiency. The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, shall complete the following: (1) Identify and implement hand hygiene procedures, for staff and residents, consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS). (2) Identify and implement equipment and environmental cleaning procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS). Identification of Others: The IP and DON, in conjunction with the	

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F 880	Continued From page 17 2. Observation on 9/19/22 at 5:01 PM showed LA #1 serving drinks from the beverage cart. After preparing a cup of hot chocolate, he plunged his right arm up to his elbow down into a trash bag that was hanging from the side of the cart, which was approximately one quarter of the way full of garbage. He then used his right hand to handle the hot water pitcher and spoon to stir the beverage, then used his right hand to deliver the beverage to the resident. No hand hygiene was observed after these actions. 3. Interview with LA #1 on 9/19/22 at 5:03 PM revealed he typically serves beverages to the residents during the lunch and dinner services. Further, he didn't think about needing to wash his hands after tucking his shirt in, putting his arm in the trash, or in between contact with residents and their items. 4. Observation on 9/20/22 at 4:35 PM with LPN #1 showed she used a Oxyvir TB wipe on a glucometer. She wiped the glucometer and set it down. The surface of the glucometer was dry within 40 seconds. Interview with the LPN at that time revealed she was not aware of the necessary wet contact time to achieve disinfection of the glucometer. Review of the directions for use on the container showed the surface must remain wet for 1 minute. 5. Review of facility policy "Standard Precautions," last reviewed 12/31/20, showed "Standard precautions include: (1) Hand hygiene ... Perform hand hygiene: ... a. Before and after all resident contact; ... c. Contact with blood, body fluids, or visibly contaminated surfaces; ... (5) Safe handling of equipment or items that are likely contaminated with infectious body fluids ...	F 880	interdisciplinary team (IDT) will review current COVID-19 nursing facility guidelines from the CDC and CMS. The IP, DON, and applicable IDT members will evaluate the facility's overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. Guidelines for COVID-19 can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care html System Changes: On or before 10/21/22 the facility shall complete the following actions: Related to hand hygiene: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure hand hygiene was performed before and after contact with a resident. b. Failure to ensure hand hygiene was performed after contact with blood, body fluids, or visibly contaminated surfaces. c. Failure to ensure hand hygiene was performed after contact with objects and surfaces in the residents' environment. Related to Environmental and Equipment cleaning" (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure dedicated or disposable noncritical resident-care equipment (e.g. blood pressure cuffs, blood glucose monitor equipment) was used or if not available then the	

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F 880	Continued From page 18 (6) Cleaning and disinfecting or sterilizing of potentially contaminated surfaces and equipment between resident use ..."	F 880	equipment was cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant prior to use on another resident. (2) The DON and IP will ensure education is provided for the following: Related to hand hygiene: a. All staff are educated on proper hand hygiene procedures in accordance with the current CDC and CMS guidelines. b. All residents are educated on the need for proper hand hygiene. Related to Environmental and Equipment Cleaning and Disinfecting: a. All staff are educated on the use of dedicated or disposable noncritical resident-care equipment, if available, or the procedures for disinfecting the equipment between residents in accordance with the current CDC and CMS guidelines. b. All staff are educated on the appropriate cleaning procedures and approved disinfectants. (3) The facility leadership will contact the Mountain Pacific Quality improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility. Monitoring: Monitoring of approaches to ensure infection control and prevention are effective will include: (1) Weekly for no less than 12 weeks, the IP, DON, and applicable IDT will conduct on-going monitoring via ostentation to ensure staff are complying with requirements for:	

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F 880	Continued From page 19	F 880	a. Compliance of staff with hand hygiene during resident care. (2) Weekly for no less than 12 weeks, the IP, DON, and applicable IDT will conduct on-going monitoring via observation to ensure staff are complying with requirements for: a. Compliance of staff the proper use or disinfecting of noncritical resident-care equipment. b. Compliance of staff the appropriate procedures and disinfecting products for environmental cleaning. (3) After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All Monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the QAPI committee and medical director.	