STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 8/7/23 through 8/10/23. Also reviewed in the course of the survey were complaint intakes WY00003625, WY00003639, WY00003648 and WY00003649. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set mg/dL milligrams per deciliter OT- Occupational Therapy PT- Physical Therapy RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record and policy review, the facility failed to ensure residents who self-administered medications were assessed and determined safe to do so by the interdisciplinary team for 1 of 12 residents (#35) reviewed for medication administration. The	F 554	1)Nurse was made aware of surveyor observations at time of discovery and immediately verbally educated. Resident #35 remains dependent for staff related to medication administration. 2)Audit performed by AED and DNS, of entire building, randomly observing nurses	9/4/23

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

Electronically Signed | 09/01/2023

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F 554	Continued From page 1 findings were: 1. Review of the 6/15/23 quarterly MDS assessment showed resident #35 wore corrective lenses, had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included heart failure, depression, and glaucoma. Review of the August 2023 medication administration record showed on 8/9/23 at 8 AM the resident received a potassium chloride tablet, Systane eye drops, a PreserVision tablet, fluticasone proprionate nose spray, a Floranex tablet, an acetaminophen tablet, a spironolactone tablet, a cholecalciferol tablet, polyethylene glycol powder, a tolterodine tartrate tablet, an apixaban tablet, and a docusate sodium tablet. Observation on 8/9/23 at 7:46 AM showed 12 oral medications were in a small, white paper cup, a cloudy liquid with a spoon was in a plastic cup, a box which contained eye drops, and a plastic cup with a white cream, which was labeled hydrocortisone, were located on the resident's bedside table. There were no nursing staff in the vicinity of the resident's room. The following concerns were identified: a. Review of the 6/15/23 Quarterly Nursing Review showed the resident was not on a self-medication program. b. Review of the resident's medical record showed no evidence a medication self-administration assessment had been completed. c. Interview with the resident on 8/9/23 at 7:46 AM revealed the medication had been in his/her room since 6:30 AM when the nursing staff brought then in and left them. In addition, the resident stated s/he had not been evaluated to self-administer medications. Further, the resident was not able to describe what the medications	F 554	and medication pass, to ensure compliance with medication administration. Any needed corrections were done at that time. 3)Staff were educated on expectations with medication administration. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 554	Continued From page 2 were which were left in his/her possession and admitted that sometimes s/he dropped the medication on the floor. d. Interview with LPN #1 on 8/9/23 at 1:35 PM revealed a resident required an order and an evaluation before the facility would allow a resident to self-administer medications. e. Interview with the DON on 8/9/23 at 5:32 PM confirmed the resident had not been evaluated to self-administer medications. 2. Review of the facility policy titled "Self-Administration of Medication", last updated September 2017, showed "1. If the resident desires to self-administer medication, the Self-Medication Evaluation is completed. This evaluation is completed before the resident is able to self-administer. 2. If it is determined the resident may self-administer medications, the nurse: a. Obtains a physician order for self-administration for the specific medications(s). b. Initiates the Self-Medication Administration Care Plan." 3. Review of the "Medication Administration" policy, dated June 2017, showed "...4. Medications are not to be left at bedside for the resident to take later."	F 554		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		9/4/23

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F 656	Continued From page 3	F 656		

medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 4 Based on observation, medical record review and staff interview, the facility failed to ensure the care plan was implemented for 1 of 29 sample residents (#107). The findings were: 1. Review of the admission MDS assessment dated 7/17/23, showed resident #107 had severely impaired cognition, required extensive assistance with transfers, and had no falls since admission. Review of progress notes showed the resident fell on 7/14/23 and 7/19/23. After the fall on 7/19/23, the facility documented an interdisciplinary team (IDT) fall review in the progress notes on 7/20/23. Review of that progress note showed a pommel cushion was added to the wheelchair as an intervention. Review of the care plan showed on 7/20/23 a pommel cushion to the wheelchair was added due to falls. The following concerns were identified: a. Review of progress notes showed on 8/2/23 the resident was found on the floor in the common room. Further review of an 8/2/23 IDT fall review progress note showed "...Education with staff to make sure pommel cushion is buckled on to the w/c." b. Observation on 8/8/23 at 8:43 AM and 8:56 AM showed the resident was in a wheelchair without a pommel cushion. c. Observation on 8/8/23 at 11:34 AM showed CNA #1 and CNA #2 transferred the resident to a wheelchair. A pommel cushion was not in place. d. Observation on 8/9/23 at 4:31 PM showed CNA #3 transferred the resident to a wheelchair. A pommel cushion was not in place. e. An interview with CNA #3 on 8/9/23 at 4:37 PM revealed the resident only had a regular wheelchair cushion. She stated the resident did not have a pommel cushion.	F 656	1)IDT was made aware of surveyor observations at time of discovery and immediately verbally educated. Resident #107 care plan has be updated. 2)Audit performed by AED and DNS, of resident care plans to ensure fall interventions were in place, to ensure compliance with care plan and fall interventions. Any needed corrections were done at that time. 3)Staff were educated on expectations with fall interventions and care planning. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 656	Continued From page 5 f. During an interview on 8/10/23 at 10:47 AM the administrator and the DON stated the pommel cushion was implemented after the resident fell. They stated staff were reminded to ensure the pommel cushion was buckled on. In addition, they confirmed the pommel cushion was a current intervention that should be used due to falls.	F 656		
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 medical record review, staff interview, and facility policy review, the facility failed to implement interventions to manage diabetes in accordance with physician orders and professional standards of practice for 1 of 3 sample residents (#20) reviewed for diabetes management. The findings were: 1. Review of the most current physician orders for resident #20 showed a 12/4/22 order for the resident's blood glucose level to be checked before meals and at bedtime and to call the physician if the resident's glucose was below 70mg/dl or above 400 mg/dl every shift. The following concerns were identified: a. Review of the resident's blood glucose log	F 684	1)Nurse was made aware of surveyor observations at time of discovery and immediately verbally educated. Notification orders for diabetic cares for resident #20 are in place and being followed. 2)Audit performed by AED and DNS, of residents with diabetes, to ensure notifications of high/low blood sugar readings was done and needed changes were charted, to ensure compliance with physician orders of notifications. Any needed corrections were done at that time. 3)Staff were educated on expectations with diabetic residents and blood sugar	9/4/23

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F 684	Continued From page 6 showed the resident's blood glucose level was below 70 mg/dl on 6/15/23, 7/5/23, 7/19/23, and 7/27/23, and was above 400 mg/dl on 5/30/23, 6/3/23, 6/19/23, 6/21/23, 7/10/23, 7/14/23, and 7/26/23. There were no evidence the physician had been notified as directed. b. Review of the nurse progress notes from 5/29/23 to 8/5/23 showed the resident's insulin had been held with no documentation the physician had been notified on 5/29/23, 6/06/23, 6/11/23, 6/12/23, 6/19/23, 7/03/23, 7/07/23, 7/12/23, 7/13/23, 7/23/23, 7/31/23, and 8/5/23. c. Interview with RN #1 on 8/10/23 at 10:59 AM confirmed medications should be given as ordered and the physician notified if blood glucose levels were outside the specified parameters. 2. Review of the facility policy "Blood Glucose Monitoring Protocol", last updated October 2017 showed "...Policy Statement: Blood glucose levels are monitored per physician orders. The physician is notified when levels are below 80 or above 350 unless otherwise specified by physician."...4. In the event the resident's blood glucose is <80 mg/dl or the resident exhibits signs/symptoms of hypoglycemia, the licensed nurse holds insulin or oral anti-diabetic medication and institutes hypoglycemia protocol, then notifies the physician."	F 684	readings. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		9/4/23

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F 688	Continued From page 7 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of therapy and restorative documentation, the facility failed to provide services to maintain range of motion for 1 of 9 sample residents (#114) with limited range of motion. The findings were: 1. Review of the 4/27/23 and 7/14/23 quarterly MDS assessments showed resident #114 had diagnoses including cerebral palsy, contractures of the right and left hands and had range of motion limitations to both the upper and lower extremities. Observation on 8/8/23 at 11:51 AM showed the resident had contractures to both upper extremities, including the hands, and had a cloth roll in the left hand. Review of restorative documentation provided by the facility showed the resident did not receive range of motion restorative services. Review of a progress note written 6/15/23 by a physician's assistant showed "...Caregiver expresses concerns that patient had been keeping closed tight fists on [his/her] bilateral hands. She confirms that patient has regular followups with orthopedic surgeon for	F 688	1)Team was made aware of surveyor observations at time of discovery and immediately verbally educated. Resident #114 received a new OT order and was evaluated by therapy department for contractures to bilateral hands. 2)Audit performed by AED and DNS, of physician orders for therapy, to ensure compliance with following physician orders. Any needed corrections were done at that time. 3)Staff were educated on expectations with physician orders for therapy. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 688	Continued From page 8 evaluation and management of contractures on left hand. She denies that patient currently has PT sessions...Recommendation:...2. Ordered PT and OT sessions for contractures on fingers of bilateral hands." Review of a physician communication form showed on 6/15/23 the physician's assistant ordered "PT/OT eval & tx [evaluate and treat] left hand contractures." The following concerns were identified: a. Review of therapy documentation provided by the facility showed no evidence the resident had been evaluated by PT or OT since the order was written on 6/15/23. b. During an interview on 8/10/23 at 10:21 AM the administrator and DON confirmed the order for OT and PT on 6/15/23 was in the electronic medical record. They stated they would need to check with therapy to determine if OT or PT evaluated the resident. c. On 8/10/23 at 11:45 AM the DON stated she checked with therapy and they had not received the 6/15/23 order.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide adaptive equipment to prevent accidents for 1 of	F 689	1)IDT was made aware of surveyor observations at time of discovery and immediately verbally educated. Resident	9/4/23

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F 689	Continued From page 9 6 sample residents (#107) who were reviewed for falls or accident hazards. The findings were: 1. Review of the admission MDS assessment dated 7/17/23 showed resident #107 had severely impaired cognition, required extensive assistance with transfers, and had no falls since admission. Review of the care area assessment (CAA) for falls showed the resident scored 90 on the Morse fall rating scale, indicating the resident was at high risk for falls. Review of progress notes showed the resident fell on 7/14/23 and 7/19/23. After the fall on 7/19/23, the facility documented an interdisciplinary team (IDT) fall review in the progress notes on 7/20/23. Review of that progress note showed a pommel cushion was added to the wheelchair as an intervention. Review of the care plan showed on 7/20/23 a pommel cushion to the wheelchair was added due to falls. The following concerns were identified: a. Review of progress notes showed on 8/2/23 the resident was found on the floor in the common room. Further review of an 8/2/23 IDT fall review progress note showed "...Education with staff to make sure pommel cushion is buckled on to the w/c." b. Observation on 8/8/23 at 8:43 AM and 8:56 AM showed the resident was in a wheelchair without a pommel cushion. c. Observation on 8/8/23 at 11:34 AM showed CNA #1 and CNA #2 transferred the resident to a wheelchair. A pommel cushion was not in place. d. Observation on 8/9/23 at 4:31 PM showed CNA #3 transferred the resident to a wheelchair. A pommel cushion was not in place. e. An interview with CNA #3 on 8/9/23 at 4:37 PM revealed the resident only had a regular wheelchair cushion. The CNA stated the resident	F 689	#107 care plan is being followed regarding fall interventions. 2)Audit performed by AED and DNS, of resident care plans to ensure fall interventions were in place, to ensure compliance with care plan and fall interventions. Any needed corrections were done at that time. 3)Staff were educated on expectations with fall interventions and care planning. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 689	Continued From page 10 did not have a pommel cushion. f. During an interview on 8/10/23 at 10:47 AM the administrator and DON stated the pommel cushion was implemented after the resident fell. They stated staff were reminded to ensure the pommel cushion was buckled on. In addition, they confirmed the pommel cushion was a current intervention that should be used due to falls.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, the facility failed to implement the necessary respiratory care for 1 of 8 sample residents (#130) reviewed for oxygen services. The findings were: 1. Review of the 7/23/23 significant change MDS assessment for resident #130 showed the resident had diagnoses which included pneumonia, Alzheimer's dementia, and respiratory failure with hypoxia. Further review showed the resident required oxygen therapy. Review of the care plan, revised on 7/31/23, showed the resident required oxygen for safety and was at risk for altered respiratory status, difficulty with breathing, aspiration pneumonia,	F 695	1)Staff were made aware of surveyor observations at time of discovery and immediately verbally educated. Resident #130 is receiving appropriate respiratory care including oxygen administration as ordered. 2)Audit performed by AED and DNS, to ensure compliance with oxygen use and following oxygen orders. Any needed corrections were done at that time. 3)Staff were educated on expectations with oxygen use and following physician orders. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months.	9/4/23

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F 695	Continued From page 11 and acute respiratory failure. Interventions were to monitor for respiratory distress using a pulse oximeter (device to measure the oxygen saturation in the blood). Review of the 8/9/23 physician orders showed the resident required 4 liters of oxygen per minute via nasal cannula or oxygen mask, and the oxygen level may be titrated as needed. The following concerns were identified: a. Continuous observation on 8/9/23 at 8:37 AM to 9:10 AM showed the resident was sitting in his/her wheelchair next to the medication cart in the common area in the vicinity of LPN #1 with no oxygen present and indentations on the resident's cheeks from where the nasal cannula had been removed. At 8:37 AM at the request of the surveyor, LPN #1 checked the resident's oxygen saturation level and results showed 90% on room air and the resident's color was pale yellow/tan (no oxygen was applied at that time) and the nurse left the area. At 9:10 AM a second request to check the resident's oxygen saturation from the surveyor from RN #2 showed the resident's oxygen saturation ranged from 82% to 87% on room air. During the continuous observation the resident's skin color worsened from pale yellow to dusky pale gray and yellow. When RN #2 tried to communicate with the resident, the resident was non-verbal at that time. b. LPN #1 arrived at 9:12 AM and confirmed after checking the orders in the medication administration record the resident should have had continuous 4 liters of oxygen per minute via nasal cannula and took the resident to his/her room and placed him/her on oxygen in the room. Observation at 9:51 AM showed the resident was in the hallway with a nasal cannula and oxygen in place and the resident responded that s/he felt better and the resident's color had improved to a	F 695	Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 695	Continued From page 12 normal tan skin color. c. Interview on 8/10/23 at 10:59 AM with RN #1 confirmed all residents should have medications given as ordered including oxygen.	F 695		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of menus, the facility failed to ensure the menu was followed during 1	F 803	1)Staff were made aware of surveyor observations at time of discovery and immediately verbally educated. Residents	9/4/23

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F 803	Continued From page 13 of 2 meal observations. This failure affected resident #36 and #91. The findings were: 1. Review of the menu for the lunch meal on 8/9/23 showed the main meal was a chicken filet sandwich, sweet potato fries, cucumber tomato salad, and fruit tart. The menu for the CCHO [consistent carbohydrate] diet [to manage diabetes] was a chicken filet sandwich, cucumber tomato salad, and canned fruit (no sweet potato fries and fruit instead of the fruit tart). Further review of the menu showed the alternate meal was a taco salad, refried beans, cheese sauce, sour cream and salsa. The menu for the CCHO diet was taco salad, salsa and sour cream (no refried beans or cheese). The following concerns were identified: a. Observation on 8/9/23 from 11:07 AM until 12:02 PM revealed dietary aide #1 prepared and served the meals in the South unit. The aide served resident #36 a taco salad with refried beans and a fruit tart for dessert. Resident #91 was served a chicken filet sandwich, sweet potato fries and a fruit tart for dessert. b. Review of physician orders showed residents #36 and #91 both were ordered CCHO diets. c. During an interview on 8/10/23 at 9:54 AM the certified dietary manager (CDM) stated some residents with CCHO diets were non-compliant, but was not able to provide evidence that residents #36 and #91 specifically had refused the CCHO meal on 8/9/23. d. Review of the care plans for residents #36 and #91 showed "diet as ordered." Neither showed the residents were non-compliant with their CCHO diet.	F 803	#36 and #91 are receiving CCHO diets as ordered. 2)Audit performed by AED and DNS, to ensure compliance with menus and physician orders for diet restrictions. Any needed corrections were done at that time. 3)Staff were educated on expectations with diet restrictions and menus. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		9/4/23

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F 812	Continued From page 14 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 review of the 2022 Food Code, the facility failed to ensure hand hygiene/gloving and hair restraint use was done in accordance with accepted standards to minimize cross contamination during 2 of 2 observations of meal service. The findings were: 1. Observation of tray line service in the West unit on 8/7/23 starting at 4:55 PM showed dietary aide #2 was at the steam table dishing up food for residents. The aide was not observed to be wearing a hair restraint. At 5:28 PM the aide was observed to touch handles on the refrigerator and cupboard doors with his gloved hands. Then, with the same gloved hands, he removed two pieces	F 812	1)Staff were made aware of surveyor observations at time of discovery and immediately verbally educated. Dietary staff are using current infection control/dietary procedures related to hair nets and glove use appropriately. 2)Audit performed by AED and DNS, to ensure compliance with hair nets and glove use during meal times. Any needed corrections were done at that time. 3)Staff were educated on expectations with hair nets and glove use with serving food. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months.	

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F 812	Continued From page 15 of bread from a loaf and then used his gloved hands to touch the bread as he spread peanut butter on it. 2. Observation on 8/9/23 from 11:07 AM until 12:02 PM showed dietary aide #1 was in the South unit pantry/kitchen handling food and serving residents' food at the steam table. She was wearing a hairnet, but the hairnet did not cover her bangs. 3. During an interview on 8/10/23 at 9:54 AM the certified dietary manager (CDM) stated staff had recently been inserviced on hand hygiene. She stated staff should not wear gloves unless they will be touching food. Then, she stated, staff should wash their hands and put on gloves. When told of the observations regarding hairnets, she stated dietary aide #2 had short hair and she thought if hair was 1/4 inch or shorter, hairnets did not need to be used. 4. Review of the "2022 Food Code" by the U.S. Food and Drug Administration showed "2-301.14 When to Wash. Food employees shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: ...(E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; ...(H) Before donning gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands." In addition, "2-402.11 Effectiveness. (A) Except as provided	F 812	Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 812	Continued From page 16 in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. (B) This section does not apply to FOOD EMPLOYEES such as counter staff who only serve BEVERAGES and wrapped or PACKAGED FOODS, hostesses, and wait staff if they present a minimal RISK of contaminating exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."	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	F 880		9/4/23

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F 880	Continued From page 17	F 880		

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 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

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F 880	Continued From page 18 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, medical record review, staff interview, policy and procedure review, and professional reference review, the facility failed to ensure infection control procedures were followed for 2 of 2 sample residents (#86, #313) who required wound care. The findings were: 1. Observation on 8/9/23 at 10:23 AM showed LPN #2 (wound care nurse) performed wound care on resident #86. The LPN donned gloves, removed the dressing, and cleansed the wound. Then, using the same gloves, the LPN placed a clean dressing on the wound. Interview at that time with the LPN revealed she considered the whole procedure as dirty. When asked about the glove change and hand hygiene, she stated she normally does not change gloves and hand hygiene between removing the old dressing and applying a new dressing. 2. Review of the admission MDS assessment for resident #313 dated 7/21/23 showed the resident was admitted to the facility with diagnoses that included diabetes mellitus, bipolar disorder, legal blindness, chronic ulcer of the left foot, and acquired absence of the right great toe. Further review showed the resident had a BIMS score of 10/15 which indicated moderate cognitive impairment. Bed mobility, transfers, locomotion on unit, toilet use and personal hygiene required one person physical assist. The following	F 880	1)Nurses were made aware of surveyor observations at time of discovery and immediately verbally educated. Wound care is provided per policy for residents #313 and #86 and any resident requiring wound care services. 2)Audit performed by AED and DNS, of entire building, randomly observing staff and units, to ensure compliance with hand hygiene and PPE. Any needed corrections were done at that time. 3)Staff were educated on expectations with hand hygiene and PPE. 4)DNS/Designee will audit hand hygiene to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 880	Continued From page 19	F 880		

concerns were identified:

a. Observation on 8/8/23 at 11:28 AM showed LPN #2 (wound care nurse) assisted by RN #4 performed wound care for the resident. The wound care nurse donned gloves, removed the dressings on the open wound areas on the right foot, used wound cleaner, applied medi-honey (an ointment used to aid wound healing), and dressed the wounds individually. The nurse then removed the original gloves. Hand hygiene was not performed after removing gloves and before returning to the dressing cart.

b. Interview with LPN #2 at the time of dressing change revealed they did not maintain a sterile procedure because they considered the entire foot as "dirty" and didn't require glove changes between cleaning the wounds and applying a clean dressing or between wound sites.

3. Review of policy "Handwashing/Hand Hygiene", updated March 2018, showed "...7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; ... g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; m. After removing gloves."

4. Review of the website "Healewoundcare.com" Clean and Aseptic Technique accessed 8/17/23 showed "... 1. Wash hands before starting a procedure and decontaminate before/after glove

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F 880	Continued From page 20 changes. ... 3. Fresh clean gloves are required if it is necessary to directly touch the wound. These gloves should not contact anything other than the wound or the sterile products being used on it. ... 6. The outer surface of the dressing should not be touched by gloves used to clean the wound. This applies to tape and any wraps used for the dressing. 7. Fresh clean gloves should be worn to tuck/pack a primary dressing into a wound."	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to adequately provide a call system to 2 of 44 sample residents (#13, #20) observed for resident call systems. The findings were: 1. Review of the 5/22/23 quarterly MDS assessment for resident #20 showed the resident had a BIMS score of 9 out of 15 which indicated the resident had moderate cognitive impairment. Further review showed the resident was totally dependent on staff for locomotion. The following concerns were identified: a. Observation on 8/8/23 at 2:04 PM showed the resident was sitting in a wheelchair in the	F 919	1)Staff were made aware of surveyor observations at time of discovery and immediately verbally educated. Residents #13 and #20 have call system within reach when staff are not present. 2)Audit performed by AED and DNS, of entire building, to ensure compliance with call light expectations to ensure they are accessible to residents at all times. Any needed corrections were done at that time. 3)Staff were educated on expectations with call lights and placement. 4)DNS/Designee will audit to ensure compliance. Audits will be weekly for 4	9/4/23

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F 919	Continued From page 21 middle of his/her room. The call light was lying on the bed and not within reach of the resident. b. Observation on 8/8/23 at 2:49 PM showed RN #3 entered the resident's room and exited the room after trimming the resident's nails and failed to offer or provide the resident's call light. c. Observation on 8/9/23 at 1:25 PM showed the resident was sitting in a wheelchair in the middle of his/her room. The call light was lying on the bed out of reach or sight of the resident. Observation at that time showed CNA #5 entered and exited the resident's room. Interview with the CNA confirmed she had not given the call light to the resident prior to leaving the room. 2. Review of the 7/23/23 significant change assessment for resident #13 showed the resident was rarely/never understood and was totally dependent on staff for locomotion. The following concerns were identified: a. Observation on 8/9/23 at 10:10 AM showed the resident was sleeping in his/her bed and the call light was wedged between the bed and wall by the foot of the bed. The call light was not within reach of the resident. 3. Interview with RN #1 on 8/10/23 at 10:59 AM confirmed all residents should have their call lights within reach and available.	F 919	weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	