STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE SHERIDAN, WY 82801**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 10/2/23 through 10/5/23. Also reviewed in the course of the survey was complaint intake WY00003651. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing FDA- Food and Drug Administration MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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 policy and procedure review, the facility failed to ensure residents received timely care in accordance with professional standards for 1 of 24 sample residents (#15). The findings were: 1. Review of the quarterly MDS assessment dated 8/24/23 showed resident #15 had severe	F 684	F684 Quality of Care 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	10/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/26/2023

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F 684	Continued From page 1 cognitive impairment and diagnoses which included non-Alzheimer's dementia, anxiety, history of falls, muscle wasting and atrophy, and a history of traumatic brain injury. The resident required extensive physical assistance for bed mobility, locomotion, and dressing and total physical assistance for transfers, eating, toileting, hygiene, and bathing. Further review showed the resident had no falls since admission or the prior assessment. Review of the "Behavior" care plan last revised on 7/19/23 showed interventions which included "...Floor mat or spare mattress will be placed on floor next to [resident's name] bed to ensure s/he is able to safely roll and reposition out of [his/her] bed. [Resident name] at times prefes (sic) to roll off of his/her bed..." Review of the "Falls" care plan last revised on 9/22/23 showed the resident had a fall on 9/22/23 and interventions which included anticipate and meet the resident's needs, be sure the call light is within reach, and encourage the resident to use the call light for assistance as needed. Further review showed "...due to my behaviors with movement while in bed, I need my staff to place me in the center of the bed or by the wall to aid in prevention of rolling/falling to the floor..." Review of the progress notes from 9/1/23 through 10/2/23 showed the resident had falls on 10/2/23, 9/30/23, 9/24/23, and 9/22/23. The following concerns were identified: a. Observation on 10/2/23 at 5:10 PM showed resident #15 was in his/her room calling out for help. At that time, no staff were observed on the resident's hallway. The resident was lying on the fall mat next to the bed, with his/her legs on the floor and his/her torso positioned between the night stand and the head of the bed. During the observation the call light location was unable to be found and the surveyor attempted to get	F 684	STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE 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 THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: a. Resident # 15 needs are anticipated with increased rounding. Care plan has been updated to reflect his needs and status. b. All residents identified as need anticipated have had orders, care plan and Kardex updated. II. THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by alleged deficient practice. III.MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:	

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F 684	Continued From page 2 staff assistance by turning on the emergency call light. At 5:24 PM a social services staff member was observed in the hallway and notified of the resident's position, as no staff members had responded to the emergency call light. The DON, administrator, and a nurse arrived to the resident's room at 5:25 PM, 15 minutes after the resident's initial calls for help. b. Interview with the administrator on 10/2/23 at 5:25 PM revealed the staff member assigned to the 500 hall was expected to answer the call lights, as most the staff members were in the dining areas assisting with resident meal service. Further interview revealed the social services staff member should have checked on the emergency call light to identify what the resident's needs were. c. Interview with the administrator on 10/2/23 at 5:25 PM revealed the staff member assigned to the 500 hall was expected to answer the call lights, as most the staff members were in the dining areas assisting with resident meal service. Further interview revealed the social services staff member should have checked on the resident upon notification of a need for assistance. 2. Interview with the administrator on 10/4/23 at 2 PM revealed he expected staff to answer call lights within 8 minutes, barring certain circumstances. 3. Review of policy "Call Lights: Accessibility and Timely Response" last revised 8/1/23 showed "...10. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified."	F 684	a. Education of proper placement of call lights has been provided to the entire facility staff by SDC/NHA on 10/19/2023 to ensure proper accessibility to all neighbors. b. Beginning 10/10/2023 the IDT completed a full house audit to ensure call lights are accessible and within reach for every neighbor. c. All nursing staff educated on 10/27/23 residents who require “needs anticipated”. Order placed. Care Plans updated and Kardex triggered. IV.HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Starting date 10/06/2023 DON/designee will complete audits of rooms 3 x weekly for four weeks then weekly for two months to ensure call lights are placed within reach of our community members and to their desired placement. Starting 10/25/23 facility completing rounds 3x per week x 4 weeks then monthly x 2 months on resident with needs anticipated. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. V. Date of Compliance 10/27/2023	

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F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, the facility failed to follow up to ensure	F 729	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF	10/27/23

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F 729	Continued From page 4 CNA registration on the state nurse aide abuse registry for 1 of 1 CNA (#1) who was recently certified at the time of hire. The findings were: Review of the employee records for CNA #1 showed the hire date was on 3/13/23 and there was no evidence the state nurse aide abuse registry was checked prior to resident contact. Interview with the DON on 10/4/23 at 4:14 PM revealed CNA #1 was hired and certified on 3/13/23. Further interview confirmed the facility attempted to register the CNA on 10/4/23. Interview with the administrator on 10/4/23 at 4:34 PM confirmed the facility did not have evidence the CNA was on the state nurse aide abuse registry.	F 729	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 FEDERAL AND STATE 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 THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I.CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: a. Identified CNAs have been registered with the Wyoming CNA Abuse Registry and documentation placed in their file on date 10/6/2023. II.THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE No residents were identified. All residents are at risk for this deficient practice. III.MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT	

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F 729	Continued From page 5	F 729	OCCUR AGAIN a. Education provided to new HR director on New Hire checklist, expectations, specifically regarding Wyoming CNA Abuse Registry by NHA on 10/4/2023. b. Starting 10/4/2023 IDT process established to ensure all items are in place for new hires prior to working floor. A checklist including all items to be placed in the employee file must be at the front page on the left-hand flap of each employee file. Those checklists must be initialed by the supervisor, HR Director, and NHA before employee works on the floor. c. All CNA files have been audited to ensure Wyoming CNA Abuse Registry is completed by NHA and HR Director on 10/4/2023. d. A Root cause analysis was completed by NHA and HR Director on 10/4/2023, it was determined the Root Cause was failing to register new CNAs after they have completed their CNA class and have a permanent license. IV.HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED Starting 10/06/2023 NHA/Designee will audit all new hire packets to ensure correct documentation has been completed weekly x 4 weeks then monthly x2 months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is	

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F 729	Continued From page 6	F 729	achieved and determine if further monitoring and evaluation is required. The HR Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee Date of Compliance 10.27.2023	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of policy and procedures, and 2022 FDA Food Code review, the facility failed to ensure a sanitary environment in 1 of 1 food preparation area. The census was 77. The findings were: 1. Observation on 10/4/23 at 9:13 AM showed cook #1 was starting the food preparation tasks	F 812	F812 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	10/27/23

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F 812	Continued From page 7 for the noon meal. The cook was wearing a beard restraint around his neck; however, he had not placed the restraint so it covered his beard. At 9:39 AM the dietary manager entered the kitchen and assisted cook #1 by trimming fat off of the raw chicken pieces. The dietary manager was not wearing a beard restraint. Interview with the dietary manager at 10:08 AM revealed beard restraints were only required while serving food. 2. Observation in the kitchen on 10/4/23 starting at 9:13 AM until 10:10 AM and again from 11:02 AM until 12:27 PM showed cook #1 and dietary aide #1 failed to ensure hand hygiene was performed as required. The following concerns were identified: a. Observation at 9:24 AM showed cook #1 used a hand antiseptic; opened the steam oven door; prepared a baking sheet; and opened a box of pre-made frozen rolls. Without performing hand hygiene the cook donned gloves and placed the rolls onto the pan using his gloved hands. At 9:29 AM cook #1 doffed his gloves and without performing hand hygiene, placed the pan of rolls on the steam table; packaged the unused rolls in the box; and returned the box to the freezer. b. Observation at 9:53 AM showed cook #1 used a hand antiseptic and retrieved a plastic storage bag; donned gloves and placed the discarded raw chicken pieces into the plastic bag. The cook doffed his gloves and used hand antiseptic; however, he did not wash his hands with soap and water. c. Observation at 11:35 AM showed cook #1 used a hand antiseptic; donned gloves, and transferred the baked rolls to a serving pan with his gloved hands, doffed his gloves, and covered the rolls with plastic wrap. Without performing hand hygiene, the cook donned a glove on his	F 812	STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE 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 THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: a. The identified staff member was educated on the spot by the NHA on 10/3/2023 and placed a beard covering. b. All Dietary staff have been educated by the Dietary Manager on requirements for wearing beard guard. c. All hand sanitizers have been replaced in the kitchen by IDT on 10/4/2023 date. d. Dietary staff have been educated by Dietary Manger on 10/3/2023 regarding hand washing hand sanitization in the kitchen. II. THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk due to alleged deficient practice.	

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F 812	Continued From page 8 right hand and retrieved a hamburger patty from the walk-in refrigerator, and placed it on the grill. The cook doffed the glove and without performing hand hygiene, obtained a second serving pan; donned new gloves, and transferred the remaining rolls into the pan. d. Observation at 11:47 AM showed dietary aide #1 used a hand antiseptic; retrieved supplies to make peanut butter and jelly sandwiches; donned gloves, and proceeded to prepare the sandwiches, touching the bread with her gloved hands. e. Observation of the kitchen's supply of hand antiseptic showed 3 bottles of a promotional hand antiseptic with an expiration date of 5/2023; 1 bottle of a scent therapy antiseptic, and one bottle of Epi Clenz hand antiseptic. None of the hand antiseptic bottles indicated they had been FDA approved for use in a kitchen. f. Interview with the dietary manager on 10/4/23 at 4:46 PM confirmed hand antiseptic should not be used in the kitchen area and only on the service line. The dietary manager discarded the hand antiseptic bottles at that time. 3. Review of the policy "Food Safety Requirements", last revised 8/1/23, showed "...7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects...d. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. e. Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad..." 4. Review of the 2022 FDA Food Code showed "2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section,	F 812	III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: a. Audit 3x a week for beard net usage by IDT starting 10/6/2023 b. Audit 3 x a week for proper hand hygiene by IDT starting 10/6/2023 c. Education provided by the Dietary Manager to the dietary staff on the importance and proper use of beard nets/hair nets. d. Education provided by the Dietary Manager to the dietary staff on proper kitchen hand hygiene and using warm water and soap versus hand sanitizer. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: a. Starting 10/6/2023 Dietary manager/designee will complete kitchen audit of beard nets and proper hand hygiene 3 x weekly for 4 weeks then weekly for two months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance 10/27/2023	

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F 812	Continued From page 9 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." 5. According to the 2022 FDA Food Code showed "2-301.16 Hand Antiseptics. In the 2005 Food Code, the use of the term "hand sanitizer" was replaced by the term "hand antiseptic" to eliminate confusion with the term "sanitizer," a defined term in the Food Code, and to more closely reflect the terminology used in the FDA Tentative Final Monograph for Health-Care Antiseptic Drug Products for OTC Human Use, Federal Register: June 17, 1994." In addition, "2-301.16 Hand Antiseptics (A) A hand antiseptic used as a topical application, a hand antiseptic solution used as a hand dip, or a hand antiseptic soap shall: (1) Comply with one of the following: (a) Be an APPROVED drug that is listed in the FDA publication Approved Drug Products with Therapeutic Equivalence Evaluations as an APPROVED drug based on safety and effectiveness; (b) Have active antimicrobial ingredients that are listed in the FDA monograph for OTC Health-Care Antiseptic Drug Products as an antiseptic handwash,..." 6. According to the 2022 FDA Food Code 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	F 812		

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F 812	Continued From page 10 unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ¶ 2-403.11(B); (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; (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; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 812		
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, staff interview, and policy review the facility failed to provide call light accessibility for 1 of 24 initial pool residents (#15). The findings were:	F 919	F919 Resident Call light system PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT	10/27/23

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	535026	A. BUILDING _____ B. WING _____	C 10/05/2023

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F 919	Continued From page 11 1. Observation on 10/2/23 at 5:10 PM showed resident #15 was observed on the floor calling out for help. Further observation showed the call light location could not be found. 2. Interview with CNA #3 and #4 on 10/4/23 at 3:10 PM revealed the resident had a pull type call light; however, they were unsure if the resident was able to use it. 3. Observation on 10/4/23 at 3:12 PM showed the resident was lying in bed, awake. A full sized mattress was against the wall and a fall mat was on the floor beside bed. Further observation showed the call light was clipped to itself and placed above the mattress on the wall, out of the resident's reach. 4. Observation with the DON on 10/4/23 at 4:15 PM showed the resident was lying in bed and the call light was on top of a full sized mattress which was leaning against the wall. The call light was clipped to itself and positioned just below the call light switch, out of reach of the resident. Interview with the DON at that time revealed the resident should have the call light beside him/her and confirmed the resident was able to pull the call light cord for help. Further interview confirmed the resident could not reach the call light from where s/he was lying. 5. Interview with the administrator on 10/4/23 at 2 PM revealed he expected staff to answer call lights within 8 minutes, barring certain circumstances. 6. Review of policy "Call Lights: Accessibility and Timely Response" last revised 8/1/23 showed	F 919	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 FEDERAL AND STATE 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 THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: a. Community members were interviewed beginning 10/10/2023 date by IDT to identify if their call lights are being answered in a timely manner and are placed where the resident requests them to be placed. b. Starting 10/10/2023 the IDT did call light audits initiated at random times throughout the facility assessing timeliness of answer and placement. No other issues identified. II. THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME	

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F 919	Continued From page 12 "...1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. ...5. Staff will ensure the call light is with reach of resident and secured, as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations with the resident's room. 7. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor...."	F 919	DEFICIENT PRACTICE: All residents requiring assistance are at risk due to this alleged deficient practice. III.MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: a. All residents were interviewed on 10/11/2023 to identify if they felt their call lights were being answered in a timely manner via Ambassador program. b. On 10/25/2023 date the community IDT team met with Resident Council members to review the call light times concerns and the appropriate response times and placement. c. On 10/12/2023 Root cause analysis completed to determine barriers to call light time and placement with systemic changes implemented. d. Education on answering call lights was started on 10/6/2023 by DON and then to the entire facility staff on 10/19/2023 via All Staff meetings. Education includes placement, time expectations, and anticipated needs. e. Call time audits are being conducted via the Ambassador Program and then ongoing by IDT starting 10/10/2023 3 x weekly for four weeks then weekly for two months. IV.HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Starting 10/10/2023 DON/designee will complete audits of rooms 3 x weekly for	

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F 919	Continued From page 13	F 919	four weeks then weekly for two months to ensure call lights are placed within reach of our community members and to their desired placement. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. V. Date of Compliance 10/27/2023	