STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535058	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

(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 10/23/23 to 10/26/23. Also reviewed in the course of the survey was complaint intake WY00003636. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant QIDP: Qualified Intellectual Disabilities Professional DON: Director of Nursing MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on resident fund account review, staff interview, and facility investigation review, the facility failed to protect the residents' right to be free from misappropriation of resident property by a staff member for 5 of 9 sample residents (#2, #3, #4, #5, #6). Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 9/1/23.	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christine K. Szymanski	Nursing Home Administrator	12/8/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 602	Continued From page 1	F 602		

The findings were:

1. Review of a facility incident report dated 7/12/23 showed accounting staff identified several receipts for resident item purchases they determined were "questionable." The incident report showed all the receipts were provided for residents #2, #3, #4, #5, and #6 by CNA #1. An investigation was initiated and the CNA was placed on leave pending the investigation. The following concerns were identified:

a. The incident report showed the facility interviewed the CNA on 7/14/23 at 9:30 AM and the CNA admitted she took money intended for resident purchases and generated the receipts on a computer in her office. The incident report review showed the CNA admitted to taking approximately $450.00 from April 2023 through June 2023. Further review showed the residents were not interviewed due to mental status, law enforcement was notified on 7/12/23 at 1:59 PM, the Department of Family Services was notified on 7/12/23 at 1:56 PM, and the resident representatives were notified on 7/12/23 between 2:05 PM and 2:20 PM.

b. Review of the "Client Served Funds Request" logs for April 2023, May 2023, June 2023, and July 2023 confirmed there were unaccounted for funds for residents #2, #3, #4, #5, and #6. Review of the receipts attached to the logs showed some of the receipts for the same vendor did not have the same format or information, such as a bar code or vendor telephone number.

c. Review of an "Administrative Leave with Pay" letter issued to the CNA dated 7/12/23 showed the leave was effective on 7/12/23 and the CNA signed a copy of the letter on 7/14/23.

d. Review of an email to the facility from CNA

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F 602	Continued From page 2	F 602		

#1 dated 7/14/23 at 2:06 PM showed the CNA admitted to taking the money intended for resident purchases and then created receipts for purchases which were not made.

e. Review of a "Notice of Conclusions" dated 7/18/23 showed the facility verified misappropriation of resident property.

f. Review of an email from the Wyoming State Board of Nursing showed that agency was notified of the incident on 7/19/23.

2. Review of the "Wyoming State Board of Nursing" website for CNA #1 on 10/24/23 showed the CNA certificate was "Inactive-Suspended" as of 8/8/23.

3. Attempted interview with CNA #1 on 10/24/23 at 1:41 PM revealed there was no answer and the recorded message indicated the mailbox was full and could not accept messages at that time.

4. Interview with the administrator, support services administrator, and accounting manager on 10/25/23 at 4:17 PM revealed the CNA was also a "guide" and as a result, had access to resident funds. The interview revealed the previous process for obtaining resident funds for purchases was for staff members to submit a form indicating the amount of money needed and the indication for use. After the submission was made, money would be issued for resident purchases directly from the resident's account and the staff member was expected to submit receipts when the purchase was made. The interview revealed when the business officer received some receipts from CNA #1 that did not match previous receipts obtained from the same vendors, an investigation was initiated. The interview confirmed CNA #1 admitted to creating

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F 602 Continued From page 3

the receipts on a facility computer because she was keeping the money. The interview revealed the first identified date of misappropriation from residents by CNA #1 was 4/7/23 and the last date was 7/7/23. The interview revealed during the investigation audits were performed and identified the total amount of misappropriated money from the residents was $887.32, which was returned by the facility to the individual resident accounts and no additional residents were identified. The interview revealed the residents were not prevented from making additional purchases as a result of insufficient funds following the misappropriation. Further interview revealed a new process for resident purchases was implemented following the incident which included a timeline of 1 week to submit left over money and receipts for resident purchases, a tracking log to monitor all outstanding money and receipts, all funds and receipts must be turned in by the approved staff member in person, the staff member was required to participate in accounting of the receipts and funds at the time of submission, and each purchase was required to be documented in detail, including the amount spent for each resident, what was purchased, and initialed by the individual who made the purchase. The interview revealed the new process was implemented on 9/1/23.

F 758 SS=E Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

F 602

F-758
FREE FROM UNNEC PSYCHOTROPIC MEDS/PRN
SS - E
CFR(s): 483.45(c)(3)(e)(1)-(5)

The findings were: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure target symptoms were identified related to the use of psychotropic medications for 3 of 5 sample residents (#1, #2, #8) reviewed for unnecessary medications.

CORRECTIVE ACTION FOR ALL AFFECTED RESIDENTS:

1) The facility has created a STANDARD OPERATING PROCEDURE (SOP) Psychotropic Medication Monitoring to facilitate the correct use of psychotropic medications and has completed the following steps for residents #1, #2, #8.

a) The providers and the pharmacy have completed new orders requiring documentation with each administration of these psychotropic medications.

b) The nursing supervisors have created resident-focused care plans to capture non-pharmacological interventions, targeted behaviors, and the effectiveness of medical interventions.

2) To address the other residents in the facility that may also be affected by this deficient practice, the pharmacy team and providers are reviewing each resident and resubmitting their

F 758

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F 758	Continued From page 4 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758	**F-758** **FREE FROM UNNEC PSYCHOTROPIC MEDS/PRN** **SS - E** **CFR(s)**: 483.45(c)(3)(e)(1)-(5) **(Continued)** medication orders, if applicable, to follow the SOP related to psychotropic medications monitoring. 3) Three different factors are being put into place to correct the deficient practice. a) When receiving reports of medical intervention needs, the providers will notify nursing leadership to create "at-risk" care plans, which will include targeted behavioral and symptomatic documentation related to frequency, duration, and non-pharmacological interventions used prior to the medication order. b) The nursing leadership team will monitor care plans, and provide real-time feedback to providers regarding documentation collected by the at-risk care plans. c) The pharmacy team will then convey to the providers the medications that address those resident-specific needs. Each part of this team will monitor the effectiveness of the medications and interventions. During the Behavior Medication Review Committee (BMRC) and Drug Regimen Review (DRR), the medication management	

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F 758	Continued From page 5	F 758	F-758 FREE FROM UNNECESSARY PSYCHOTROPIC MEDS/PRN SS - E CFR(s): 483.45(c)(3)(e)(1)-(5) (Continued)	

prescribing practitioner evaluates the resident for the appropriateness of that medication.
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 target symptoms were identified related to the use of psychotropic medications for 3 of 5 sample residents (#1, #2, #8) reviewed for unnecessary medications. The findings were:

1. Review of the significant change MDS assessment dated 9/12/23 showed resident #1 had diagnoses which included cerebrovascular attack, transient ischemic attack, or stroke, non-Alzheimer's dementia, seizure disorder, traumatic brain injury, and a psychotic disorder other than schizophrenia, physical behavioral symptoms directed toward others which occurred on 1 to 3 days during the look-back period, and verbal behavioral symptoms directed toward others which occurred on 1 to 3 days during the look-back period. Further review showed the resident received antipsychotic medication on an as needed basis since the prior assessment and a gradual dose reduction was attempted on 6/12/23. Review of the physician's orders showed the resident received trazadone (sedative/hypnotic) 5 milligrams (mg) by mouth at bedtime for insomnia, sertraline (antidepressant) 100 mg by mouth daily for unspecified psychosis, factitious disorder imposed on self with combined psychological and physical signs and symptoms, and violent behavior, risperidone (antipsychotic) 2 mg by mouth at bedtime and 1 mg by mouth in the morning for unspecified psychosis and anxiety disorder, and lorazepam (antianxiety) 1 mg by mouth as needed 3 times per week for anxiety. The following concerns were identified:

team and behavioral support will evaluate the medication and determine if an increase or decrease is warranted.

The BMRC review is completed quarterly to ensure that performance is sustained after implementation. The DRR is completed monthly to ensure that performance is sustained after implementation, and will include an attempt at gradual reduction of medications (GDR).

4) CNA's and nurses will be trained in accordance with their respective roles in the SOP by Dec. 29th, 2023. During the next 30 days, the effectiveness of the medications and interventions will be reviewed weekly and monitored by all parties to identify the plan's accuracy and efficiency. Providers will create documentation annually supporting the use of medications including the risk versus benefit if a resident is to remain on the same dose rather than attempting a GDR, including the last attempted GDR date. Documentation will include targeted behaviors, side effects, effectiveness and the provider assessment of the resident. Providers will address the use of multiple medications to treat the same behaviors or diagnosis.

MONITORING AND TRACKING, RESPONSIBLE PERSON(S): Pharmacy, the Director of Nursing and Provider are responsible for compliance.

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F 758	Continued From page 6	F 758	**F-758** **FREE FROM UNNEC PSYCHOTROPIC MEDS/PRN** **SS - E** **CFR(s)**: 483.45(c)(3)(e)(1)-(5) **(Continued)**	

a. Review of the behavior monitoring for August 2023, September 2023, and October 2023 showed no evidence specific target symptoms were identified for each medication prescribed.

b. Review of the care plan effective "7/11/2022 to present" showed no evidence specific target symptoms were identified for each medication prescribed.

2. Review of the quarterly MDS assessment dated 8/29/23 showed resident #2 had diagnoses which included non-Alzheimer's dementia. Further review showed the resident had delusions, wandered 1 to 3 days during the look-back period, received antipsychotic medication on an as needed basis, and had no gradual dose reduction attempted. Review of the physician orders showed the resident received escitalopram (antidepressant) 10 mg by mouth daily for depression and aripiprazole (antipsychotic) 10 mg by mouth daily for delusional disorders and sequelae of viral encephalitis. The following concerns were identified:

a. Review of the behavior monitoring for August 2023, September 2023, and October 2023 showed no evidence specific target symptoms were identified for each medication prescribed.

b. Review of the care plan effective "7/11/2022 to present" showed no evidence specific target symptoms were identified for each medication prescribed.

3. Review of the admission MDS assessment dated 8/28/23 showed resident #8 had diagnoses which included depression and had other behavioral symptoms not directed toward others

QUALITY ASSURANCE: The results of the monitoring will be reported by the DON to the QAPI Committee monthly x 3 or until the correction is sustained. The provider annual monitoring will be tracked by the DON and reported annually to the QAPI Committee.

The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimizing cause analysis and build best practice. The committee will review and address any compliance issues.

DATE OF CORRECTION: 12/29/2023

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which occurred on 4 to 6 days during the look-back period. Further review showed the resident received antipsychotic medication on 7 out of 7 days, antianxiety medication on 7 out of 7 days, and antidepressant medication on 6 out of 7 days during the look-back period. Review of the physician orders showed the resident received olanzapine (antipsychotic) 7.5 mg by mouth at bedtime for major depressive disorder with psychotic features, desvenlafaxine (antidepressant) extended release 100 mg by mouth daily for major depressive disorder with psychotic features, and clonazepam (antianxiety) 1 mg by mouth three times per day for major depressive disorder with psychotic features. The following concerns were identified:

a. Review of the behavior monitoring for August 2023, September 2023, and October 2023 showed no evidence specific target symptoms were identified for each medication prescribed.

b. Review of the care plan effective "9/8/2023 to present" showed no evidence of psychotropic medication specific target symptoms were identified for each medication prescribed.

4. Interview with the DON on 10/25/23 at 12:04 PM confirmed the facility did not have specific target symptoms identified for each psychotropic medication prescribed.

5. Review of the facility policy titled "Psychotropic Medication Use" dated 4/1/22 showed "...1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The medical provider and other staff will gather and document information to clarify a resident's behavior, mood, function, medical

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condition, specific symptoms, and risks to the resident and others. 3. The medical provider will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of psychotropic medications...8. Diagnoses alone do not warrant the use of psychotropic medication. In addition to the above criteria, psychotropic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others; and: (1) The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or (2) Behavioral interventions have been attempted and included in the plan of care, except in an emergency..."

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

F 758

F-812
FOOD PROCUREMENT, STORE, PREPARE, SERVE-SANITARY
SS - F
CFR(s): 483.60(K)(1)(2)

The findings were: 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 2 of 2 food preparation areas (main kitchen, Sunflower cottage). The census was 8.

CORRECTIVE ACTION FOR ALL AFFECTED RESIDENTS:

Hair Restraints - Corrective Action for Main Kitchen

F 812

1, 2 & 3. All staff were in-serviced on proper use of hair restraints. Food service supervisors were in-serviced on 10/25/2023 by the dietitian. Food service specialists were in-serviced by the food service supervisor on 10/25/2023. Food service supervisors and food service specialists were in-serviced on proper use of hair and beard restraints including review of the Food Code on 10/31/2023 and 11/2/2023 by the dietitian and Support Services Administrator. Hair restraints are mandatory. Disposable hair restraints and beard restraints are available for all staff in the main kitchen and are replenished by the food service supervisors.

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F 812	Continued From page 9	F 812		

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 2 of 2 food preparation areas (main kitchen, Sunflower cottage). The census was 8. The findings were:

1. Observation in the main kitchen on 10/25/23 at 11:03 AM showed walk-in freezer #2 had a sign posted on the door which said floors may be icy. Continued observation showed ice was built up on the floor, ceiling, and fans throughout the freezer, including on walk ways.

2. Observation on 10/25/23 at 11:05 AM showed the Blodgett dual oven #1 had dirt, grease, debris, and dead flies on the top. Further observation showed 4 additional oven racks were stored on top of the oven.

3. Observation on 10/25/23 11:09 AM showed the Blodgett dual oven #2 had dirt, grease, debris, and dead flies on the top. Further observation showed 3 additional oven racks were stored on top of the oven and the oven was in use. Interview with kitchen staff member #1 confirmed the oven was being used to prepare turkey for the evening meal. Interview with dietary manager #2 on 10/25/23 at 11:41 AM confirmed the ovens had not been cleaned recently.

4. Observation of meal preparation in the main kitchen on 10/25/23 11:05 AM showed kitchen staff member #1 and kitchen staff member #2 were wearing hair nets; however, the hair net was

F-812
FOOD PROCUREMENT, STORE, PREPARE, SERVE-SANITARY
SS - F
CFR(s): 483.60(K)(1)(2)
(Continued)

4. A daily audit on proper use of hair restraints has been completed for all main kitchen staff present at work and will be conducted by the Food Service Supervisor or Dietitian starting on October 30, 2023 through November 30, 2023. Completed daily audits have been submitted to the Support Services Administrator weekly. Hair restraints including beard restraints have been properly and consistently used by the main kitchen (Nutrition Center) staff.

Starting December 1, 2023, audits of a minimum three days a week (including at least one weekend day) will be conducted by the Food Service Supervisor or Dietitian for another 30 days (until 12/30/2023) to ensure proper use of hair restraints. Starting in January 2024, monthly hair restraint audits will be completed monthly x 3 by the Food Service Supervisor or Dietitian. The dietitian or Support Services Administrator will retain the completed monthly audit.

Hair Restraints - Corrective Action for the Sunflower Cottage

1 & 2 - Hair/beard restraints were delivered on 10/26/23 from the main kitchen to the Sunflower Cottage for immediate staff use during food preparation (to include food replating and reheating).

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MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

(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
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positioned in a way that allowed the staff members' bangs to be uncovered. Kitchen staff member #1 had bangs which were curled and were long enough to reach the middle of her forehead and kitchen staff member #2 had straight bangs which were long enough to reach to her eyes. Further observation showed kitchen staff member #3 was handling resident food and had a full beard, which was not covered or restrained.

5. Observation of meal preparation in the Sunflower cottage on 10/25/23 at 12:09 PM showed 2 staff members removed items from storage containers sent by the main kitchen and placed the food on a plate to be served to residents. No hair restraints were utilized.

6. Interview with dietary manager #1, dietary manager #2, and the dietitian on 10/25/23 at 11:27 AM revealed that previously the janitorial staff cleaned all the kitchen equipment; however, the process at that time was to complete a work order for equipment like the ovens to be cleaned. They revealed the walk-in freezer had been an ongoing problem and after being fixed, the ice build up began about a month later. They revealed they were unable to keep it free from ice buildup. Further interview revealed the facility has always allowed hair restraints to be positioned in a way bangs were not covered. It was confirmed hair and beard restraints should be worn when preparing food in the kitchen and in the cottage.

7. According to Food Code 22, U.S. Public Health Service: 2-402 Hair Restraints 2-402.11 "Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets,

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3. The Sunflower staff were trained on the requirement for the correct use of hair/beard restraints during food preparation on 11/22/23, and 12/5/23.

4. The Guide and Shift Supervisor for the Sunflower Cottage will conduct daily audits x 3 weeks for observation of staff on the correct use of hair/beard restraints during food preparation starting on 11/22/23 through 12/15/23. Monthly audits will be conducted for 3 days/week one week per month x 2 months for correct staff use of hair/beard restraints during meal preparation. A summary report of the audits for the correct use of hair/beard restraints for the main kitchen as well as the Sunflower Cottage, will be reported to the Quality Assurance Committee at regularly scheduled meetings.

Equipment Food-Contact Surfaces and Utensils Shall Be Clean To Sight and Touch - Corrective Action for Main Kitchen

1, 2, and 3. Food service supervisors and food service specialists were in-serviced on 10/31/2023 and 11/2/2023 regarding that the completion of the daily, weekly, and monthly cleaning lists already in place are mandatory. The food code was reviewed in regards to cleaning with the main kitchen (Nutrition Center) staff. The in-service was conducted by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535058	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

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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."

8. According to Food Code 22, U.S. Public Health Service: 4-601.11 " ...(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris ..."

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the dietitian and Support Services Administrator. An additional in-service on cleaning with food service specialists was completed on 11/29/2023 and conducted by the Food service supervisors and dietitian.

4. The daily, weekly, and monthly cleaning lists are in place and are in a binder accessible to all main kitchen staff. The Food Service Supervisor reviews and signs the completed cleaning lists. Since October 30. 2023, the dietitian has audited the completed cleaning lists weekly (for the daily and weekly cleaning lists) and followed up with food service supervisors as needed. A copy of the daily and weekly cleaning lists were submitted to the Support Services Administrator weekly for review. This audit system will continue for another 30 days until December 31, 2023. Starting on January 1, 2024, audits of the completion of the cleaning list will occur monthly x 3. The food service supervisors or the dietitian will retain the completed daily, weekly, and monthly cleaning lists. A summary report of the audits for the kitchen cleaning lists will be reported to the Quality Assurance Committee at regularly scheduled meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 11 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." 8. According to Food Code 22, U.S. Public Health Service: 4-601.11 " ...(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris ..."	F 812	**F-812** **FOOD PROCUREMENT, STORE, PREPARE, SERVE-SANITARY** **SS - F** **CFR(s)**: 483.60(K)(1)(2) **(Continued)** MONITORING AND TRACKING, RESPONSIBLE PERSON(S): The Dietitian/Kitchen Supervisor and Guide for the Sunflower Cottage are responsible for compliance. QUALITY ASSURANCE: The results of the monitoring will be reported by the dietician to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimizing cause analysis and build best practice. The committee will review and address any compliance issues. DATE OF CORRECTION: 12/29/2023	