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	53A051	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/25/24 through 3/28/24. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant CMS: Centers for Medicare and Medicaid Services DON: Director of Nursing FDA: Food and Drug Administration MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		4/18/24

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

Electronically Signed | 04/19/2024

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F 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 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 an advanced directive was formulated for 2 of 16 residents (#11, #14) reviewed. The findings were: 1. Review of the electronic medical record (EMR) showed resident #11 was listed as do not resuscitate (DNR). Further review of the medical record showed a WyoPOLST (Providers Orders for Life Sustaining Treatment), dated 1/18/21, which showed DNR with comfort-focused therapy was chosen. However, the form had not been signed by the resident or the resident's representative.	F 578	Unsigned POLST forms reviewed with resident, resident representative, and primary care provider and signatures were obtained for incomplete POLST forms. - For Resident #11 the resident representative met with DON and discussed POLST form, representative signed the form continuing to agree with the chosen therapy and choices. Resident #11 POLST form has been completed. - For Resident #14 the resident's primary health care provider reviewed the selected therapy and choices and signed the POLST form, this form is now completed for Resident #14.	

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F 578	Continued From page 2 2. Review of the EMR showed resident #14 was listed as DNR. Further review of the medical record showed a WyoPOLST, dated 1/7/24, which showed DNR with selective treatment had been chosen. However, the form had not been signed by the resident's primary health care provider. 3. Interview with the director of quality and compliance officer on 3/26/24 at 4:20 PM confirmed the WyoPOLST form was incomplete. 4. Review of the 10/26/23 policy and procedure titled "Clinical Protocol/Procedure Advance Directives" showed "...4. All residents will be provided a copy of the Wyoming POLST form at time of admission. The DON and nursing center staff will work with the resident and/or their representative as well as their provider to ensure completion of this form."	F 578	- On New Admit Checklist a POLST form completion box has been added to ensure that POLST forms are not left incomplete in the future. Completion box includes Director of Nursing initialing and stating the date that the form is completed, initialing and stating the date that it is signed by the resident/POA, and initialing and stating the date that it has been signed by the primary care provider. - All POLST forms have been reviewed and are in compliance at this time. - After each new admission, each new admission chart will be audited for compliance and completion of POLST form. This will be tracked through the QAPI committee for sustainment.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		4/15/24

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F 584	Continued From page 3 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and complaint log review, the facility failed to ensure procedures were in place for the protection of resident property from loss or theft for 1 of 16 residents reviewed (#4). The findings were: 1. Interview with resident #4 on 3/26/24 at 8:28 AM revealed s/he was missing 6 undergarments and their little mesh bag the undergarments go into to be washed.	F 584	Following report of Resident #4 missing religious undergarments from 03/27/2024 DON had placed notes on 03/29/2024 in the resident's electronic record discussing the report of the missing garments and mesh bags, and how many pairs of undergarments and mesh bags were present within the facility at this time. While continuing efforts to find the misplaced undergarments and mesh bags, on 04/03/2024 it was found that Resident #4 had 4 undergarment bottoms	

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F 584	Continued From page 4 2. Review of the 2/27/24 at 4 PM quarterly care conference showed the facility had talked to the daughter related to (r/t) religious undergarments and found 2 in his/her dresser. The facility had looked in laundry without success; it was unknown if the resident was soiling and throwing them away. 3. Observation of laundry services on 3/28/24 at 9:31 AM showed only a pair of socks that were in the unknown resident box. The laundry service employee stated there was 1 mesh bag in the dryer at that time. 4. Interview with the DON on 3/28/24 at 9:33 AM revealed the facility did not track the missing items and show the outcome. She stated prior to this recent loss of belongings, she had searched all the residents' linen and did not find any. She stated she did not document it in the record or concern log. Further, she stated the resident did come and see her last night at 5:30 PM about the missing items. 5. Interview with resident #4 on 3/28/24 at 10:01 AM revealed the 6 religious undergarments have be replaced 3 different times. The resident stated s/he was down to 1 at this time. The resident further stated this was the only concern s/he had with the facility. Additionally, the resident stated s/he spoke to the DON the previous night about the missing items. 6. Review of the grievance/concerns log failed to show the resident had a concern with the missing religious undergarments.	F 584	and 2 mesh bags present in the facility at that time. The DON also made use of a Grievance complaint log to log and track the progress of the complaint, as well as a Grievance report sheet to track the complaint in more detail. Notes were placed in the electronic record for Resident #4 as additional updates came, and were also placed in the Grievance complaint log and Grievance report sheet specific to Resident #4. As of 04/15/2024 Resident #4 has 7 new pairs of undergarment bottoms as well as 2 mesh bags present, Resident #4's POA requested that money for reimbursement for the new undergarments be place in Resident #4's petty cash account. Money for reimbursement was placed in Resident #4's petty cash account on 04/15/2024. The undergarments were labeled in 3 different areas on 04/15/2024 and Resident #4 was notified of where these were placed in the bathroom. There has also been a garbage check log placed in Resident #4's bathroom to ensure that these are not being soiled and thrown away due to embarrassment as noted by the POA and DON in discussion. - For complaints, lost items, or grievances in the future the DON will track these on the grievance tracking log with updates as appropriate. - The DON will make use of the grievance report sheet will be used to put in detail what has occurred related to the grievance. - The DON will place notes in the resident electronic record to continue to ensure that updates related to the grievance are	

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F 584	Continued From page 5	F 584	clear and documented. - The garbage check log will remain in the bathroom to ensure staff continue to check the garbage and undergarments remain in the facility. - This will be added to the huddle board. At daily safety huddle, DON will ask staff about any missing belongings or complaints from residents to start this process. Any resident can be affected by this issue so it will be important to ask staff about all residents. - This will be added to the QAPI goals and any grievances, lost items, or complaints will be tracked during by the QAPI committee.	
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 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	F 688		5/6/24

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F 688	Continued From page 6 by: Based on medical record review and staff interview, the facility failed to ensure residents with limited range of motion received the appropriate restorative services to increase range of motion and/or prevent further decline for 1 of 2 residents (#9) reviewed for restorative services. The findings were: 1. Review of the 2/15/24 quarterly MDS assessment showed resident #9 had a primary diagnosis of "stroke". Review of the resident's care plan, last revised 2/23/24 showed "AROM (active range of motion): [resident] is at risk for not being able to feed himself related to [his/her] history of cerebral infarction as evidenced by decreased ROM (range of motion) and fine motor skills in [his/her] upper extremities." The approaches included the restorative nurse aide (RNA) to assist the resident with 3 sets of 10 repetitions of upper and lower extremity AROM activities for 6 out of 7 days per week. The following concerns were identified: a. Review of the January 2024 restorative aide time tracking sheet showed the resident received AROM services on 1/25, and refused services on 1/15, 1/16, 1/23, 1/28, and 1/31. There was no documentation the resident was offered restorative services on the remaining days the RNA was present in the facility (17 days). b. Review of the February 2024 restorative aide time tracking sheet showed AROM was refused by the resident on 2/8, 2/9, 2/20, 2/21, and 2/22. There was no documentation the resident was offered restorative services on the remaining days the RNA was present in the facility (23 days). c. Review of the 3/1 through 3/27/24	F 688	A PowerPoint has been created to educate restorative aides on the purpose of the restorative program, requirements of the restorative program, and charting that is required in the electronic record as well as on the restorative aide time tracking sheet related to restorative services offered. After reviewing the voiced over PowerPoint the restorative aides will be required to take a quiz associated with the PowerPoint to test their knowledge and sign the form stating that they have reviewed the content provided and taken the quiz. Restorative Aides will be provided the PowerPoint and quiz on Monday, April 22nd, and be required to review this and complete the quiz by Monday, May 6th. The PowerPoint entails that each resident must be offered services related to each goal by the restorative aides 6 out of 7 days per week and total number of minutes, sleeping, or refusal should be charted accurately for each goal. - An example of Resident #9's deficiency was discussed within the PowerPoint to educate restorative aides on what to do in this situation in the future. DON has discussed Resident #9 with restorative aides in detail to ensure that aides offer restorative services and document care that was provided related to each goal or document care that the resident chose to refuse. - To ensure compliance and sustainment DON will do bi-monthly chart audits of restorative care and charting on all residents who have restorative	

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F 688	Continued From page 7 restorative aide time tracking sheet showed the resident received AROM services on 3/27 and refused the service on 3/14. There was no documentation the resident was offered restorative services the remaining 23 days the RNA was present in the facility. 2. Interview with the DON on 3/27/24 at 2:45 PM revealed it was the facility's expectation that all residents be offered restorative services 6 out 7 days per week.	F 688	orders/care plans. As new orders or residents are under the service of restorative care, these will be added to the DON's chart audits. Any deficiencies will be tracked and presented to QAPI committee for continued tracking and process improvement.	
F 758 SS=D	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: (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	F 758		4/25/24

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F 758	Continued From page 8 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 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were monitored for side effects of psychotropic medications for 2 of 5 residents (#5, #9) reviewed for unnecessary medications. The findings were: 1. Review of the 3/27/24 quarterly MDS assessment showed resident #5 was admitted to the facility on 10/1/19 and had diagnoses which included anxiety disorder, depression, and intermittent explosive disorder. Review of the most recent physician orders showed the resident was prescribed fluoxetine HCl (an antidepressant) 20 milligrams (mg) daily on 12/30/19 and Abilify (an antipsychotic) 2.5 mg	F 758	To address the lack of a system being in place to monitor the side effects of psychoactive medications, each resident will have a treatment order in place to "Monitor for side effects related to _____(the psychotropic drug) each shift. Did side effects including sedation, lethargy, agitation, mental status changes, or behavior changes occur? Did these side effects affect the resident's ability to perform ADLs, interact with others, cause withdrawal, social decline, decreased engagement, or diminished ability to think?" This treatment order will be for each resident and be in place for each	

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F 758	Continued From page 9 every other day on 11/5/21. The following concerns were identified: a. Review of the 1/25/24 "Physician Rationale for Clinical Contraindication of Gradual Dose Reduction" worksheet showed the side effects for fluoxetine HCl were identified as insomnia, fatigue, increased appetite, loss of sexual desire, and nausea. The side effects for Abilify were identified as blurred vision, dry mouth, drowsiness, muscle spasms, weight gain, and involuntary movements. Further review of the resident's medical record showed no evidence a system had been developed to monitor the side effects of each medication. 2. Review of the 2/15/24 quarterly MDS assessment showed resident #9 was admitted to the facility on 8/1/18 and had a diagnosis of depression. Review of the most recent physician orders showed the resident was prescribed sertraline HCL (an antidepressant) 150 mg daily with a start date of 5/6/19. The following concerns were identified: a. Review of the 1/25/24 "Physician Rationale for Clinical Contraindication of Gradual Dose Reduction" worksheet showed the side effects for sertraline HCl were identified as insomnia, fatigue, increased appetite, loss of sexual desire, and nausea. Review of the resident's care plan, dated 1/30/23, showed staff should evaluate the effectiveness and side effects of medications for possible need or ability to increase or decrease psychotropic drugs. Further review of the resident's medical record showed no evidence a system had been developed to monitor the side effects of the medication. 3. Interview on 3/27/24 at 4:35 PM with the DON confirmed a system had not been developed to	F 758	specific psychotropic medication each resident is taking. A form has also been updated that will allow each resident to be reviewed quarterly and on an as needed basis with the psychotropic drug committee. The form includes review of each psychoactive medication the resident is taking, including drug category, medication name, dose ordered, diagnosis, and expected benefit. The form also will review common side effects related to each specific medication the resident is on, further discussing the medication, dosage, common side effects (specific to this medication), if the side effects have occurred (the DON will discuss this with nurses prior to the psychotropic meeting), and how frequently in the last 30 days the resident exhibited the monitored side effects from the treatment order. These aspects will ensure that side effects for psychoactive medications are reviewed every shift and quarterly specifically related to each medication in the future. - To address Resident #5 and Resident #9, each will be reviewed using this process, starting on April 25th, 2024. General side effects of psychoactive drugs will be reviewed by nursing staff through a treatment order, and further Resident #5 and Resident #9 will be reviewed during the psychotropic drug committee, reviewing each psychotropic medication taken and side effects directly related to these medications. Medication adjustments will be made accordingly. - When a psychotropic medication is ordered, this process will begin	

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F 758	Continued From page 10 monitor the side effects of the psychoactive medications.	F 758	immediately. Treatment orders will be in place for nursing staff to review general side effects of psychoactive drugs, and the resident will be evaluated during the psychotropic drug committee related to the psychotropic medication they have been placed on and the common side effects that are directly related to this medication. - This will discussed and assessed for sustainment through the QAA Committee and Psychotropic Drug Committee by the DON, pharmacy, and medical director.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization	F 801		5/18/24

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(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 801	Continued From page 11	F 801		

recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or

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	53A051	A. BUILDING _____ B. WING _____	03/28/2024

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F 801	Continued From page 12 (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and personnel file review, the facility failed to ensure qualifications for the dietary manager were met. The census was 17. The findings were: 1. Interview with the dietary manager on 3/27/24 at 10:15 AM revealed she had not received any training before being hired as the dietary manager. 2. Review of the dietary manager's personnel record showed she received certification on 6/19/23 as a "ServSafe Food Protection Manager"; however, this certification had not been approved by CMS. 3. Interview with the human resource business partner on 3/28/24 at 12:29 PM revealed the dietary manager was hired as a food service professional on 9/7/22 and was promoted to supervisor on 1/16/23.	F 801	Amber Eckman, dietary manager, has enrolled in Certified Food Manager training through International Food Service Executives. Her certification will be completed prior to May 18, 2024. - Weekly check ins by Director of Quality and Compliance will occur to assess progress toward certification completion.	

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F 801	Continued From page 13 4. On 3/28/24 at 12:28 PM the director of quality and compliance officer acknowledged the ServSafe certification did not meet CMS guidelines.	F 801		
F 803 SS=F	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 review of the resident council minutes, resident representative and staff interview, and	F 803	When an ingredient is identified as not being able to be prepared, and enough	4/22/24

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F 803	Continued From page 14 review of the menu, the facility failed to follow the menu as written. The census was 17. The findings were: 1. Telephone interview with resident #8's representative on 3/26/24 at 3:34 PM revealed the menus were monotonous and everything seemed to either come out of a box or a can. The representative stated that she had attended a resident council meeting and the residents were unhappy about the food. 2. Review of the January, February, and March 2024 resident council minutes showed the following concerns: a. The January minutes showed "Kitchen hired new staff-hopefully meals will be better." b. The February minutes showed "Meals-Not so good-can't cut meat-too dry." c. The March minutes showed "Meals: Still not the best-no flavor...Taco's good but not warm enough and no salsa." 3. Interview with the dietary manager on 3/27/24 at 1:30 PM revealed the dietitian had prepared a five-week menu; however, the facility started the menu over at the beginning of each month so the day of the week would correspond to the first day of the menu cycle. The last days of the prepared menu were not used. The dietary manager stated the cooks were supposed to follow the menu using the bold printed list first, and if the facility did not have the products on hand to prepare that menu, the cook was to select the menu printed in italics. Finally, if the kitchen still did not have the products in stock, the cook was to pick something from the menu on the days that were not used. 4. Review of the 3/1/24 through 3/25/24 showed	F 803	time is not allowed to obtain from another source, an acceptable substitution will be identified by utilizing a later meal from the menu for later in the month. The substitution will then be written and attached to the LTC spreadsheet. Then the ingredient will be added to the pareto chart and if a trend is seen a countermeasure will be implemented. This will help identify trends and improvement needs surrounding ordering and adherence to the menus for LTC. This was educated to staff during daily huddles and was initiated on April 17, 2024, and will be completed by April 22,2024. During this process the Resident Council will be kept informed during their monthly meetings of process changes that are made to ensure menus are followed. - From data collected on the pareto this will be reported to the QAPI committee with the goal that the menu will be followed 50 out of 60 days each month.	

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F 803	Continued From page 15 the following concerns: a. The noon meal served to the residents failed to match the printed menu or the alternate menu as outlined by the dietary manager on 13 of the 25 days reviewed (3/1, 3/2, 3/3, 3/4, 3/13, 3/14, 3/16, 3/17, 3/20, 3/21, 3/22, 3/23, 3/24). b. The evening meal served to the residents failed to match the printed menu or the alternate menu as outlined by the dietary manager on 13 of the 25 days reviewed (3/2, 3/3, 3/6, 3/9, 3/10, 3/13, 3/14, 3/16, 3/17, 3/18, 3/22, 3/24, 3/25). c. Food items on the menu included parsnips, carrots, cauliflower, red cabbage, sweet potatoes, cucumbers, sugar snap peas, pickled beets, coleslaw, and tomatoes which were not included on the menus served to the residents during the month of March. d. Some form of potatoes were served to the residents for the noon meal on 11 out of 25 days and the evening meal on 13 out of 25 days. 5. Interview with the dietary manager on 3/27/24 at 9:05 AM revealed she was aware the cooks were substituting other meals than what was on the menu because they were easier to prepare. 6. Interview with the dietitian on 3/28/24 at 9:44 AM revealed it was her expectation the cooks follow the menu for the noon and evening meals as written, and thought perhaps either the kitchen did not have the right ingredients or they failed to plan ahead of time to cook what was on the menu. The dietitian confirmed a lot of potatoes were served as well as starchy vegetables. Further the dietitian stated it was the dietary manager's responsibility to order the food so the menu could be followed.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		5/18/24

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F 812	Continued From page 16 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 the dishwasher and refrigerator/freezer temperature log sheets, manufacturer's instructions, the dietitian site visit reports, hot and cold food temperature logs, and the 2022 FDA Food Code, the facility failed to ensure a sanitary environment in 1 of 1 kitchen. The census was 17. The findings were: Related to temperature monitoring of food storage units: 1. Review of the February and March 2024 temperature log sheets for food storage for the reach-in refrigerator, reach-in freezer, walk-in refrigerator and walk-in freezer showed the	F 812	A new temperature log sheet initiated on April 17, 2024, for the reach-in refrigerator, reach-in freezer, walk-in fridge, and walk-in freezer. This log sheet identifies temperature ranges for each fridge and freezer along with a column to identify if out of range how it was corrected. This task was added to do their daily duties on April 17, 2024, and the first completion was on April 18, 2024, staff. The duties log is then verified by another member of staff that the task was completed. Addressing these concerns, the current temperature monitoring log for the	

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F 812	Continued From page 17 temperature of each unit was to be documented twice a day. The following concerns were identified: a. The temperature ranges of each storage unit was not defined on the log sheets. b. No temperatures were recorded on 2/6, 2/11, 2/12, 2/18, 2/23, 2/24, 2/25, 2/26, 3/2, 3/8, and 3/9. c. No evening temperatures were recorded on 2/5, 2/10, 2/16, 2/19, 2/22, 2/27, 3/3, 3/12, 3/19, and 3/20. d. No morning temperatures were recorded on 2/29, 3/1, 3/10, 3/11, 3/16, and 3/17. e. The evening temperature of the walk-in freezer was documented as being 36 degrees Fahrenheit on 2/17 without any corrective action noted. 2. Observation on 3/25/24 at 4:15 PM of the refrigerator/freezer located in the dining room contained snacks for resident consumption. The freezer contained 6 individual cartons of sherbet. The following concerns were identified: a. The temperature range of the refrigerator/freezer was not defined on the log sheet. b. Review of the February and March 2024 temperature log sheet failed to show the temperature of the freezer had been monitored. 3. According to the 2022 FDA Food Code "3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: ...or (2) At 5°C (41°F)	F 812	refrigerator/freezer in the dining room has been updated. There has been a column added to the temperature monitoring log for freezer temperatures, and in the top two corners of the temperature monitoring log are temperature ranges for the refrigerator and freezer. The recommended fridge temperature range is noted in the top left corner and the recommended freezer temperature is noted in the top right corner of the temperature log sheet. It is also noted that if the temperature is not within these ranges to notify the DON and maintenance immediately. The dishwasher temperature log sheet was updated. After review of the owner's manual this dishwasher does not utilize quaternary solution for sanitation but high heat to sanitize. The column for sanitization was removed from the previous log and a column to identify if temperature is out of range and how it was corrected was added. This task was added do they daily duties on the April 17, 2024. This duties log is then verified by another member of staff that the task was completed. Dietary chemical baths Quat 128 arrives in a premeasure administrator to mix with hot water. This must soak for approx. 10 minutes to make sure all contaminants are removed. The items are then air dried. Once dry, items are then rinsed in a bleach bath. Mixture is 1 ounce to 1 gallon of water. Once the bleach bath has been completed then the	

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F 812	Continued From page 18 or less." Related to the sanitary environment of the kitchen: 1. Observation on 3/25/24 at 4:15 PM showed the facility used a Jackson high-temperature dishwashing machine. Review of the "Dishmachine Temperature Log" showed the minimum temperature of the wash water should be 150 degrees Fahrenheit and the minimum temperature of the rinse water should be 180 degrees Fahrenheit. The temperatures were to be monitored at breakfast, lunch, and dinner. The log sheet also showed a column to record the quaternary solution used for sanitation which required a reading of 400 parts per million (PPM). The following concerns were identified: a. Review of the February 2024 log sheet showed the temperature of the wash and rinse water was not checked 23 out of 87 opportunities. The temperature of the wash water was documented as being below 150 degrees Fahrenheit on 14 days and the temperature of the rinse water was documented as being below 180 degrees Fahrenheit on 6 days with no noted corrective action taken. b. Review of the March 2024 log sheet showed the temperature of the wash and rinse water was not checked 14 out of 76 opportunities. The temperature of the wash water was documented as being below 150 degrees Fahrenheit on 19 days and the temperature of the rinse water was documented as being below 180 degrees Fahrenheit on 3 days with no noted corrective action taken. 2. Interview with the dietary manager on 3/27/24 at 9:19 AM revealed the kitchen did not use a	F 812	items will be moved to a clean area to air dry. Both the Quat 128 and the bleach bath is emptied and refilled every four hours and if the water becomes soiled. The concentration is checked in both the Quat 128 and bleach baths with specific chemical testing strips when new chemical bath is created. The Quat 128 utilizes a litmus strip, and the bleach has a specific strip for testing. The litmus strips are on hand currently for the Quat 128 with pending response from ECOLAB regarding the bleach sanitizer strips order. This education was given to the dietary staff on April 18, 2024. To address the facial hair concerns along with other personal hygiene issues a dietary personal hygiene policy has been implemented that covers: hand hygiene, fingernail length, clean protective clothing, and no facial hair will be permitted in the kitchen area. In addressing the overall cleanliness of the department a deep clean will be implemented on April 27, 2024. A daily, weekly, and monthly cleaning task list was implemented on April 17, 2024. Each task is assigned per role for the day with the day shift checking off the mornings shifts tasks, the aide checking off the day shift tasks, and the night LTC CNA checking off the aide's tasks. These tasks include: cleaning of the back splash, convection oven, griddle, stove top, microwave, stand mixer, True reach-in freezer, fans in the walk-in freezer, recipe books, spice containers, pots and utensil rack, steam	

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F 812	Continued From page 19 quaternary compound for sanitizing and instead used a solution of bleach and water. The dietary manager stated 3 gallons of water and 3 capfuls of bleach were placed in a sink; using their best judgement as to the amount of water. Further, the dietary manager stated the concentration of the sanitizing solution was not tested after it was prepared and it was drained and replaced every four hours; however, there was no documentation to show the task was completed. Observation of the testing strips, located in a drawer near the sink, showed they could be used up to 200 PPM; however, there was not an expiration date on the vials. 3. Observation on 3/27/24 at 11:28 AM showed cook #1 was assisting with the preparation of the noon meal. The cook was not wearing a beard restraint over his facial hair. Interview with the cook at 12:01 PM revealed he had been educated to keep his beard trimmed to 1/8 to 1/4 inch; however, he had not anticipated being called into work and had not trimmed his beard prior to coming to the facility. 4. Observation on 3/25/24 at 4:15 PM and again on 3/27/24 at 9:05 AM showed the following concerns related to the cleanliness of the kitchen: a. The back splash behind the convection oven, griddle, and stove top were covered in grease which extended to the bottom edges of the upper vents. b. The outside of the General Electric microwave was greasy to the touch and the inside glass tray was covered in dried food debris. c. The base and back of the Kitchen Aide stand mixer was covered with dried food debris and the top was caked with what appeared to be dried yellow batter.	F 812	table, work tables, checking and dating food in fridge and freezer, and defrosting of the freeze. It was determined to install bead board to aid in the cleaning of the walls in the kitchen. SLHD's plant operations department will install bead boards on the painted sheetrock walls in the kitchen to allow for easier and more efficient cleaning. The correction will be completed by 05/18/2024. SLHD's dietary manager will ensure that the dietary staff complete their daily cleaning checklist and that all areas of the kitchen have been properly cleaned and sanitized. Educational PowerPoint was completed with a test for hand hygiene, when to wear gloves, and how to keep food at safe temperatures. This was completed on April 18, 2024. Director of Quality and Compliance will conduct bi-weekly random audits (in addition to Dietician audits) to ensure sustainment of implemented changes. - The temp logs for the dishwasher, dietary fridges and freezers, dining room fridge and freezer, and adherence to task lists will be reported to the QAPI committee for sustainment to process changes.	

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d. The bottom of the True reach-in freezer was covered with a dried pink substance and food crumbs.

e. The fans in the walk-in freezer were covered in dirt and debris.

f. The recipe books, which were stored by the microwave, were greasy to the touch.

g. The spice containers located on a shelf below the pot and utensil rack were greasy to the touch and the tops were covered in dust. The lemon-pepper seasoning salt container had a blob of orange colored food debris on the front of the bottle.

h. The wall by the steam table and the wall behind the blender and Robot Coupe were splattered with dried food debris.

5. Interview with dietary manager on 3/27/24 at 9:05 AM confirmed the kitchen was dirty and required cleaning. Further, the dietary manager stated she had not established a cleaning schedule.

6. Review of the 3/21/24 dietitian site visit showed the following ongoing issues needed improvement:

a. The freezer needed to be clean, frost free, and no food on the floor.

b. Food needed to be covered, labeled, and dated.

c. The refrigerator and freezer floor needed cleaned.

d. The microwave needed cleaned.

e. The work tables required cleaning.

f. The oven, stove, griddle, and fryer required cleaning.

7. Observation on 3/27/24 at 9:13 AM showed dietary aide #1 had donned gloves and was

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preparing afternoon and evening snacks for the residents. With the same gloved hands dietary aide #1 entered the walk-in refrigerator, retrieved an apple, and using his fingers held the apple while slicing the apple and placing it in a bowl. At 9:35 AM dietary aide #1 removed his gloves and without performing hand hygiene donned new gloves, entered the dry-storage room, retrieved a small paper plate and labeled it with the date and who the food was for. Using the same gloved hands dietary aide #1 retrieved some sliced bread, placed the bread on the plates, entered the walk-in refrigerator, retrieved some cheese and placed slices of the cheese on the bread. The dietary aide again entered the walk-in refrigerator and retrieved a package of roast beef, opened the bag with a knife, and using the same gloved hands placed the meat onto the sandwich.

8. Interview on 3/27/24 at 1:30 PM with the DON, dietary manager, and the director of quality and compliance officer revealed kitchen staff should change their gloves between tasks; however, the dietary manager stated she did not require hand hygiene to be performed after doffing gloves.

9. Interview with the dietitian on 3/28/24 at 9:44 AM confirmed the kitchen required cleaning and she had noted her concerns on the audit sheets she completed on her site visits twice a month.

10. 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, 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

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F 812	Continued From page 22 EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." 11. Review of the 2022 FDA Food Code showed "4-703.11 Hot Water and Chemical. Efficacious sanitization depends on warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization. When surface temperatures of utensils passing through warewashing machines using hot water for sanitizing do not reach the required 71ºC (160ºF), it is important to understand the factors affecting the decreased surface temperature. A comparison should be made between the machine manufacturer's operating instructions and the machine's actual wash and rinse temperatures and final rinse pressure. The actual temperatures and rinse pressure should be consistent with the machine manufacturer's operating instructions and within limits specified in §§ 4-501.112 and 4-501.113. If either the temperature or pressure of the final rinse spray is higher than the specified upper limit, spray droplets may disperse and begin to vaporize resulting in less heat delivery to utensil surfaces. Temperatures below the specified limit will not convey the needed heat to surfaces. Pressures below the specified limit will result in incomplete coverage of the heat-conveying sanitizing rinse across utensil surfaces."	F 812		

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	53A051	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 23 12. Review of the 2022 FDA Food Code showed "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." 13. Review of the 2022 FDA Food Code showed "4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under ¶4-703.11(C) shall meet the criteria specified under §7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions..."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		5/6/24

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F 880	Continued From page 24	F 880		

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 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

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F 880	Continued From page 25 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 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and profession standards review, the facility failed to ensure infection prevention techniques were followed for 3 random staff observations. The census was 17. The findings were: 1. Observation on 3/25/24 at 4:10 PM showed CNA #1 was carrying an unbagged, wadded-up incontinence pad down the hall from a resident's room with his/her bare hands. S/he then put the incontinence pad in the dirty utility room, and directly came out and walked back down the hall. S/he then took a hoyer lift to another resident's room without performing hand hygiene. 2. Observation on 3/25/24 at 4:30 PM showed RN #1 was working with medications and had gloves on. The RN put hand sanitizer on her gloves and scrubbed her hands together. Interview at that time with the nurse revealed it was ok to do that. She then stated she did not need to change her	F 880	A PowerPoint has been created to educate all staff on hand hygiene and glove use, including why it is important, when to use hand hygiene, when to use gloves, and how to properly use gloves and hand hygiene during certain situations. A quiz has been created to go over this information and test the knowledge of all staff based on the voiced over PowerPoint, and a form stating that staff have reviewed the content provided and taken the quiz has been created for all staff to sign and date once the PowerPoint has been reviewed and the quiz has been taken. All staff will be provided the PowerPoint and quiz on Monday, April 22nd, and be required to review this and complete the quiz by Monday, May 6th. - To ensure that compliance is met the infection prevention nurse will do random	

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F 880	Continued From page 26 gloves, and that they were then clean. 3. Observation on 3/25/24 at 5:49 PM showed CNA #1 was served dinner to the residents. The CNA doffed her right hand glove and grabbed a food item out of a cabinet and handed it to another staff. She failed to perform hand hygiene prior to donning another glove and continued to cut up food and serve the food to the residents. 4. Interview with the DON on 3/28/24 at 9:33 AM revealed the facility expectations were for staff to perform hand hygiene between glove use, and to wear gloves when handling dirty linen. Further, she stated it was not ok to hand sanitize gloves, rather then doffing and donning new gloves. 5. Review of the website "cdc.gov/handhygiene/training/interactEducation" access on 4/11/24 showed "... Hand hygiene (handwashing with soap and water or use of an alcohol-based hand sanitizer) before and after patient contact and after contact with the immediate patient care environment." "...Standard Precautions should be used for all patients, all the time." "... Healthcare personnel practice hand hygiene should be done immediately before touching a patient... Immediately after touching a patient, contaminated items or surfaces, or removing gloves. After removing gloves. After touching items or surfaces in the immediate patient care environment, even if you didn't touch the patient while you were there."	F 880	hand hygiene audits 3 times per week. These audits will be reported to the QAPI committee and Infection Prevention Committee by the infection prevention nurse to ensure sustainment.	