DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(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 2/26/24 through 2/29/24. Also reviewed in the course of the survey was complaint intake WY00003793. The following common abbreviations are used throughout this document: CDC: Centers for Disease Control and Prevention CNA: Certified Nursing Assistant FDA: Food and Drug Administration LPN: Licensed Practical Nurse NHA: Nursing Home Administrator RAC: Resident Assessment Coordinator 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	F 578		4/14/24

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

Electronically Signed | 03/20/2024

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 578	Continued From page 1 residents concerning the right to accept or refuse 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 and staff interview, the facility failed to ensure an advanced directive was formulated for 1 of 16 residents (#25) reviewed. The findings were: 1. Review of the electronic medical record (EMR) showed resident #25 was listed as do not resuscitate (DNR). Further review of the medical record showed no evidence of an advanced directive signed by the resident or the resident's representative. 2. Interview on 2/27/24 at 2:21 PM with the NHA and the RAC confirmed the facility did not have a	F 578	The facility will ensure each resident living at Amie Holt Care Center has an advanced directive formulated and in their nursing home chart. A- Resident #25 completed a POLST on 2/27/24, indicating her wishes for DNR and comfort focused care. Resident #25□s primary care physician reviewed and signed this POLST on 2/27/24. This POLST was uploaded to Resident #25□s chart on 2/27/24. B- All residents admitted to AHCC have the potential to be affected by not having	

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F 578	Continued From page 2 record of the DNR status of the resident.	F 578	clear advanced directives documented in their medical chart. Achart audit of all residents residing at AHCC will be completed to ensure all resident charts have documentation of advanced directives including code status. If any further residents are found to NOT have advanced directives or code status in their chart DRC will immediately discuss and complete POLST with resident and/or their representative as well as their primary care physician. The POLST will then be completed and uploaded to the resident chart. C- DON or designee will provide education to Nurse Team Leaders, Social Worker, Administrator and Director of Resident Care on the regulation and expectation that all residents admitted to AHCC have documentation of advanced directives and code status D- DON or designee will develop a performance tool to ensure residents admitted to AHCC have advanced directives, including code status, in their nursing home chart. This tool will be competed monthly and reviewed by the QAPI team quarterly.	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and	F 583		4/14/24

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F 583	Continued From page 3 telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure residents' private health information was protected for 3 out of 16 (#11, #19, #26) resident rooms observed and during multiple random observations of the medication cart. The census was 28. The findings were: 1. Random observation on 2/26/24 from 4 PM to 6 PM showed LPN #1 left the medication cart unattended (not in the vicinity) several times with	F 583	The facility will ensure residents□ private health information in protected at all times. A- Care plans for residents # 11, 19, and 26 have been removed from public view and placed appropriately in their closets. Note placed on computers to remind nurses to minimize screen for privacy. B- All residents have the potential to be affected by failing to ensure that protected	

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F 583	Continued From page 4 private medical information observable on the computer screen (EMR) which included the resident's name, medication, medication dose, and administration time, and was visible for unauthorized people to read. Staff from different departments, visitors, and other residents were noted to pass by the medication cart during this timeframe. 2. Observation on 2/27/24 at 8:03 AM showed LPN #2 left the medication cart with the EMR visible and unsecured in the dining room. 3. Observation on 2/28/24 at 9:21 AM showed LPN #1 had left the medication cart unsecured with visible EMR in the intersection of the 100 and 200 hallways. 4. Observation on 2/28/24 showed residents (#11, #19, #26) had their care plans pinned to the cork board immediately upon entrance into each of the resident's rooms and visible from the hallway. The information included the resident's birth date, medications, their incontinence status, transfer requirements and wound information. 5. Interview on 2/28/24 at 4:52 PM with the RAC confirmed the resident care plans should have been located inside the resident's closet and not pinned to the cork board. 6. Interview on 2/29/24 at 11:12 AM with the RAC, while observing EMR unsecured information on the medication cart, revealed it was the facility's expectation to follow HIPAA (Health Insurance Portability and Accountability Act) policies. 7. Review of the facility policy titled "HIPAA 0042", dated April 14, 2003 showed: "1. The purpose of	F 583	health information is protected. DON or designee will randomly observe at least 6 med passes a month, paying special attention to the computer screen, and immediately intervene if resident health information not protected. Nurse Team Leaders will check all rooms to ensure a care plans are protected from public view, followed by random checks, and make corrections as needed. C- DON or designee will educate all nursing/CNA staff on regulation and importance of protecting health information. Specifically, minimizing the EHR window when away from computer and making sure all resident care plans are placed appropriately out of public view. D- DON or designee will develop a tool to ensure all resident PHI is protected. This tool will be completed monthly and reviewed by the QAPI team quarterly.	

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F 583	Continued From page 5 this policy is to maintain an adequate level of security to protect patient, resident, client and facility information from unauthorized access...".	F 583		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of temperature log sheets, staff interview, and manufacturer's instructions, the facility failed to ensure the temperature of 1 of 1 medication storage refrigerator was monitored. The findings were:	F 761	The facility will ensure that the temperatures of medication storage refrigerator is monitored and temperature range is maintained per manufacture□s and medication recommendations.	4/14/24

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F 761	Continued From page 6 1. Observation on 2/28/24 at 10:25 AM of the medication storage room showed a GE refrigerator contained medications for resident use which included "Ozempic" (a diabetic medication) and eye drops. The follow concerns were identified: a. Review of the temperature monitoring logs from 2/24/24 to 2/28/24 showed the facility failed to record the temperature of the medication storage refrigerator. b. Observation on 2/28/24 at 10:25 AM showed the thermometer inside the refrigerator read 32 degrees Fahrenheit. 2. Interview on 2/28/24 at 4:11 PM with the RAC revealed it was the facility's expectation the temperature of the medication storage refrigerator be monitored every shift and be recorded. 3. Review of the "Temperature Ranges For GE Refrigerators" with no date, provided by the facility on 2/29/24 at 12:38 PM showed " The temperature ranges available...can vary depending on which model you have. However, in general, here's what you can expect:." the coldest setting 34 degrees Fahrenheit and 42 degrees Fahrenheit for the warmest setting with a default of 37 degrees. 4. According to "https://www.ozempic.com/how-to-take/ozempic-pen.html?showisi=true&&utm_source=google&utm_medium=cpc&utm_term=storage%20ozempic&utm_campaign=1_All_Shared_BR_Branded_Specifics_2023&mkwid=s-dc_pcrid_676991889727_pkw_storage%20ozempic_pmt_p_slid__product_&pgrid=158457156870&ptaid=kwd-45054781548	F 761	A- Medication refrigerator temperature will be monitored to ensure safe storage of current and future medications. B- All residents receiving medications stored in the facility medication refrigerator have the potential to be affected by lack of temperature monitoring. DON or designee will develop medication refrigerator temperature log, monitor it randomly at least 6 times per month, and provide immediate correction if data is incomplete. C- DON or designee will educate all nurses and medication aides on the regulation, related deficiency, plan of correction, and importance of maintaining temperature safe for medication storage. D- DON or designee will develop a tool to ensure medication fridge temperature is maintained at a temperature appropriate for safe medication storage. This tool will be completed monthly and reviewed quarterly by the QAPI team.	

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F 761	Continued From page 7 8&gad_source=1&gclid=CjwKCAiAxaCvBhBaEiwAvsLmWA2ppY3FA1OKj4n6UpEAzmPLZfnDsX_O4tvOjCzi7Aw8RF6KM1YmuhoC38EQAvD_BwE&gclsrc=aw.ds" retrieved on 3/6/24 at 11:23 AM showed: "How to store your Ozempic® pen"... " Store your new, unused Ozempic® pens in the refrigerator between 36°F to 46°F (2°C to 8°C) and Do not freeze Ozempic®. Do not use Ozempic® if it has been frozen."	F 761		
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 the dishwasher and refrigerator/freezer temperature log sheets, manufacturer's instructions, hot and cold food temperature logs, policy and procedures, and the 2022 FDA Food	F 812	F812-1 The facility will ensure that temperatures are monitored freezers which store food for residents outside of the kitchen (specifically those in upstairs and	4/14/24

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F 812	Continued From page 8 Code, the facility failed to ensure a sanitary environment in 1 of 1 kitchen and failed to ensure temperatures were monitored for 5 of 5 refrigerator/freezers which stored food for resident use outside of the kitchen (downstairs pantry, upstairs pantry, 100 hallway, 200 hallway, and 400 hallway). The census was 28. The findings were: Related to temperature monitoring of food storage units: 1. Review of the December 2023, the January 2024, and February 2024 temperature monitoring log sheets for food storage areas outside of the kitchen showed the following concerns: a. Review of the downstairs pantry refrigerator/freezer log sheets showed the temperature of the refrigerator/freezer was to be checked by the evening shift CNA daily. The facility was unable to locate the December log sheet. The January log sheet showed 6 out of 31 days and the February log sheet showed 7 out of 27 days that failed to include documentation of the temperature of the refrigerator/freezer. In addition, the January log sheet showed 22 days and the February log sheet showed 7 days where the temperature of the freezer was not documented. b. Review of the upstairs pantry refrigerator/freezer log sheets showed the temperature of the refrigerator/freezer was to be checked by the evening shift CNA daily. The facility was unable to locate the December log sheet. The January log sheet showed 6 out of 31 days and the February log sheet showed 4 out of 27 days that failed to include documentation of the temperature of the refrigerator/freezer. In addition, the January log sheet showed 5 days	F 812	downstairs pantries and 100, 200, and 400 hallways). A- Temperature logs to monitor temperatures daily for all refrigerators/freezers used to store food for resident use have been created, including pantry refrigerators/freezers both upstairs and downstairs, halls 100, 200, and 400. B- All residents consuming food from these refrigerators/freezers have the potential to be affected by lack of temperature monitoring. DON or designee will develop refrigerator temperature log, monitor it randomly at least 6 times per month, and provide immediate correction if data is incomplete. Logs are to be completed daily by CNA/nursing staff. C- DON or designee will educate nursing/CNA staff on importance monitoring refrigerator/freezer temperatures, as well as when and where to document temperature and when an intervention is needed. D- DON or designee will develop a tool to monitor the temperatures of all refrigerators and freezers that are used to store food for resident use. This tool will be completed monthly and reviewed quarterly by the QAPI team. F812 □ 2 The facility will ensure that the temperatures are monitored for all refrigeration and freezer units 3 times daily. A) Dietary Manager has developed and put into place temperature logs for	

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F 812	Continued From page 9 and the February log sheet showed 1 day where the temperature of the freezer was not documented. c. Observation on 2/28/24 at 4:19 PM showed a small Midea refrigerator was located in the 200 hallway which contained drinks and snacks for resident consumption. There was no evidence the facility monitored the temperature of the refrigerator. d. Observation on 2/28/24 at 4:21 PM showed a small GE refrigerator was located in the 100 hallway which contained drinks and snacks for resident consumption. There was no evidence the facility monitored the temperature of the refrigerator. e. Observation on 2/28/24 at 4:25 PM showed a small Hanai refrigerator was located in the 400 hallway which contained drinks and snacks for resident consumption. There was no evidence the facility monitored the temperature of the refrigerator. f. Interview on 2/28/24 at 12:10 PM with team leader #2 revealed she was unable to locate the December 2023 log sheets for the downstairs and upstairs pantry refrigerator/freezers. g. Interview on 2/28/24 at 4:17 PM with the RAC revealed a system had not been developed to monitor the small refrigerators in the resident common rooms. In addition, the RAC confirmed the temperature log sheets were incomplete. 2. Review of the December 2023, the January 2024, and February 2024 "CC Cooling Unit Temp Log" sheets showed columns to record the temperature of the "Cook's Fridge", the "A la Carte Top & Bottom", the "Office Fridge & Freezer", the "Double Fridge", the "Single Fridge", the "Single Freezer", the "Double Freezer", and the "White Freezer" used for food storage	F 812	monitoring all refrigeration and freezer units, both in AHCC and JCHC. B) Lack of temperature monitoring places all residents at risk. Dietary Manager will check all refrigerator and freezer logs weekly to ensure staff are correctly and consistently completing logs. Immediate in servicing will be provided as needed. C) Dietary management will review the related deficiency and plan of correction with all dietary personnel, educating staff on the importance of temperature monitoring, as well as where and when to monitor. D) Dietary Management team will develop a performance improvement tool to ensure that temperatures are monitored for all refrigeration and freezer units appropriately. Dietary manager will complete monthly and the QAPI Committee will review quarterly. F812 □ 3 The facility will ensure a sanitary environment of the kitchen. A) 1) Director of Resident Care advised dietary worker to don beard restraint. Worker complied, then elected to shave beard. 2) Hand sanitizer was removed from kitchen. Dietary staff were directed not to use this in the kitchen area. 3) Unlabeled/undated bags in the freezer were disposed of. 4) Dietary Manager developed a log to monitor dishwasher temps. Appropriate ranges were posted.	

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F 812	Continued From page 10 equipment inside the kitchen. The following concerns were identified: a. Review of the December 2023 temperature log sheet showed 10 days when the temperature of the food storage equipment was not recorded. b. Review of the January 2024 temperature log sheet showed 5 days when the temperature of the food storage equipment was not recorded. c. Review of the February 2024 temperature log sheet showed 4 out of 27 days where the temperature of the food storage equipment was not recorded. d. Interview with the dietitian on 2/28/24 at 4:30 PM revealed it was her expectation the temperature of the food storage equipment be monitored daily. 3. Review of the policy and procedure titled "PREPARING AND HOLDING FOOD" last reviewed in 2019, showed "POLICY: The use of proper techniques for preparation and holding of foods. Adherence to established sanitation practices in food service and holding, to protect foods from contamination and reduce the potential for food borne illness outbreak. PROCEDURE: ...9. Cold food items are refrigerated at 41 degrees or below..." 4. According to the 2022 FDA Food Code "2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that...(J) FOOD EMPLOYEES are properly maintaining the temperature of TIME/TEMPERATURE CONTROL FOR SAFETY FOODS during thawing through daily oversight of the FOOD EMPLOYEE'S routine monitoring of FOOD temperatures..." Related to the sanitary environment of the	F 812	5) Dietary Manager ensured food temp logs were in place to monitor temperatures prior to meals and cold liquids prior to being put back in storage. B) All residents have the potential to be affected by an unsanitary environment in the kitchen. RD, DM and RN Infection Preventionist will develop updated food service policies, ensuring all 2022 FDA Food Code Items are addressed. RD and DM will observe dietary staff during and outside of meal service at least 8 times per month, including beard restrain use if indicated and not using hand sanitizer in kitchen. Immediate in servicing and correction will be provided for any food service issues identified. RD and DM will complete weekly checks of temperature logs for food storage and dish machine units; they will also check that foods are labeled and dated appropriately in the freezers. C) RD and DM will educate all dietary staff on the updated food service policies, as well as the related deficiency and plan of correction. D RD and DM will develop a performance improvement too to ensure a sanitary environment and temperature monitoring. RD and DM will complete this PI tool monthly and QAPI committee will review quarterly.	

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AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

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F 812	Continued From page 11 kitchen: 1. Observation on 2/27/24 at 8 AM showed cook #1 was preparing "made to order" breakfast for residents in the facility kitchen. The cook was not wearing a beard restraint over his facial hair. Interview with the cook on 2/27/24 at 8:18 AM revealed he had not received any education related to wearing a beard restraint while preparing or serving food. Interview on 2/28/24 at 4:30 PM with the dietitian revealed it was her expectation kitchen staff with facial hair wear a beard restraint while preparing and serving food. 2. Observation on 2/27/24 at 8:07 AM showed cook #1 removed a glove from his left hand and used hand sanitizer before donning a new glove. Interview with the cook at 8:18 AM revealed he used hand sanitizer after removing his gloves unless his hands were visibly soiled and then he would wash them with soap and water. The hand sanitizer used was 3M Avagard and was labeled as "healthcare personnel hand sanitizer". Interview with the dietitian on 2/28/24 at 4:30 PM confirmed hand sanitizer should not be used in the kitchen and removed the bottle at that time. 3. Observation on 2/26/24 at 4:04 PM showed the Traulsen freezer had opened original bags, of what appeared to be breaded meat, which was not labeled with an open or expiration date. The Continental freezer showed multiple plastic bags, with what appeared to be breaded meats, which were not labeled with an open date or an expiration date. The Gibson upright freezer showed multiple plastic bags, both original and resealable, which were unlabeled and undated and had what appeared to be a build-up of frost. Interview with the dietitian on 2/28/24 at 4:30 PM	F 812		

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F 812	Continued From page 12 revealed opened frozen food should be transferred to a storage bag and labeled with the open date and an expiration date of 6 months. The dietitian was unable to locate a food storage guide for staff to reference. 4. Observation on 2/26/24 at 4:04 PM showed the kitchen contained a Hobart high-temperature dishwashing machine. Review of the December 2023, January 2024, and February 2024 "CC Dishmachine Temps" log sheets showed the temperature of the wash and rinse water was to be measured 3 times per day. Review of the Hobart dishmachine manufacturer's instructions showed the minimum wash temperature was 150 degrees Fahrenheit and the minimum rinse temperature was 180 degrees Fahrenheit. The following concerns were identified: a. Review of the temperature log sheets showed the required temperature of the wash and rinse water was not documented on the form. b. Review of the December 2023 log sheet showed the temperature of the wash and rinse water was not checked 28 out of 93 opportunities. Of the 65 recorded temperatures the wash water was below 150 degrees Fahrenheit 41 times and the temperature of the rinse water was below 180 degrees Fahrenheit 21 times. c. Review of the January 2024 log sheet showed the temperature of the wash and rinse water was not checked 9 out of 93 opportunities. Of the 84 recorded temperatures the wash water was below 150 degrees Fahrenheit 38 times and the temperature of the rinse water was below 180 degrees Fahrenheit 14 times. d. Review of the February 2024 log sheet showed the temperature of the wash and rinse water was not checked 23 out of 77 opportunities. Of the 54 recorded temperatures of the wash	F 812		

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F 812	Continued From page 13 water it was below 150 degrees Fahrenheit 26 times and the temperature of the rinse water was below 180 degrees 2 times. e. Interview with dietary aide #1 on 2/27/24 at 8:15 AM revealed she was not aware of what the temperature ranges for the dishwasher were supposed to be and only recorded the results. The dietary aide stated she had been an employee for approximately 1 month. f. Interview with the dietitian on 2/28/24 at 4:30 PM revealed it was her expectation the temperature of the wash and rinse water be monitored as directed on the log sheet. In addition, the dietitian confirmed the temperature ranges of the wash and rinse water were not readily available for staff to reference. 5. Interview on 2/27/24 at 8:18 AM with cook #1 revealed breakfast was served from 6 AM to 9 AM and was the only meal which was prepared in the facility. The hospital kitchen prepared the noon and evening meals for the residents. The hospital was located across the parking lot and the food was brought to the facility via an enclosed foodservice cart and placed on the steam table. The following concerns were identified: a. Review of the January 2024 food temperature log showed 82 out of 93 opportunities failed to show documentation of the food's temperature before it was served to residents. b. Review of the February 2024 food temperature log showed 64 out of 72 opportunities failed to show documentation of the food's temperature before it was served to residents. c. Review of the December 2023, January 2024, and February 2024 "Cool Check Temp Log"	F 812		

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F 812	Continued From page 14 which was used to monitor the temperature of the juice and milk which was kept outside of the storage units during each meal. The December log sheet showed 58 out of 93 opportunities had not been recorded. The January log sheet showed 37 of 93 opportunities had not been recorded. The February log sheet showed 57 out of 78 opportunities had not been recorded. d. Observation and interview with dietary aide #1 on 2/27/24 at 8:15 AM showed the dietary aide was checking the temperature of the juice and the milk. The dietary aide stated she was unaware of when the temperature of the cold liquids should be taken and did not know where the temperatures were recorded. e. Interview with the dietitian on 2/28/24 at 4:30 PM revealed it was her expectation the temperature of the cold liquids should be obtained prior to being placed back into storage after the meal service, and the temperature of food items should be taken prior to meal service. 6. Review of the policy and procedure titled "Food Service Uniforms/Grooming", last revised in 2019, showed "Policy: To establish and maintain a high standard of cleanliness...Procedure: 1. Hair must be clean and neatly groomed while on duty...Hair needs to be secured in a surgical cap or hair net. 2. Mustaches should be kept to moderate length and well trimmed. Extremely long or full mustaches will not be permitted." 7. 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	F 812		

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F 812	Continued From page 15 hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." 8. 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,..." 9. 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 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	F 812		

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F 812	Continued From page 16 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." 10. 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 71°C (160°F), 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	F 812		

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F 812	Continued From page 17 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." 11. Review of the policy and procedure titled "PREPARING AND HOLDING FOODS", last reviewed in 2019, showed "PROCEDURE...11. Food Items (sic) will be prepared in batches and placed on the tray line no more than 1/2 hour prior to meal service. Temperatures of foods in heated holding units are recorded previous to service of each meal, and recorded on each hour the food is held in heated holding units to insure (sic) the safety of food is maintained."	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		4/14/24

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F 883	Continued From page 18 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 883		

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F 883	Continued From page 19 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policies and CDC immunization recommendations, the facility failed to ensure residents were offered pneumococcal immunizations based on CDC recommendations for 2 of 5 sample residents (#7, #20) reviewed for immunizations. The findings were: 1. Review of the medical record showed resident #7 was 77 years old. Further review showed the resident received the pneumococcal 13 valent conjugate (PCV13) on 2/1/18. There was no evidence the resident was offered a pneumococcal immunization since the last administration in 2018. 2. Review of the medical record showed resident #20 was 83 years old. Further review showed the resident received the PCV13 on 10/28/14. There was no evidence the resident was offered a pneumococcal immunization since the last administration in 2014. 3. Interview with the NHA on 2/28/24 at 5:53 PM revealed the facility followed CDC recommendations for immunizations and confirmed there was no evidence resident #7 or resident #20 were offered pneumococcal immunizations in accordance with CDC guidelines. 4. Review of the facility's policy "Pneumococcal	F 883	The facility will ensure all residents are offered pneumococcal immunizations based on CDC recommendations. A- Residents #7 and 20 have been offered and received their pneumococcal polysaccharide PPV23 vaccine on 3/15/24. Both of these residents have previously received their pneumococcal conjugate PCV 13. Both residents are now up to date on their pneumococcal vaccines. B- All residents have the potential to be affected by not being offered pneumococcal immunizations based on CDC recommendations. Nurse Team Leaders will complete an audit of all current residents residing at AHCC and if more are found to not be up to date on their pneumococcal vaccinations, they will immediately be offered and given (if they accept) the appropriate vaccination based on CDC recommendations. C- DON or designee will educate Nurse Team Leaders, Social Worker, Administrator and Director of Resident Care on the importance of offering all residents pneumococcal immunizations based on CDC recommendations. Nurse Team Leaders will be responsible for ensuring these immunizations are offered upon admission and afterwards per CDC	

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F 883	Continued From page 20 Immunization", effective 10/9/07, showed "1. Upon admission and annually, resident's immunization history will be obtained, including compliance with current CDC recommendations for pneumococcal vaccination..." 5. According to the "Adult Immunization Schedule by Age" by CDC located at https://www.cdc gov/vaccines/schedules/hcp/adult.html (accessed on 3/12/24) showed individuals 65 years or older who previously received only the PCV13 vaccine should receive 1 dose of either the PCV20 or PCVS23 vaccine at least 1 year after the last PCV13 dose.	F 883	recommendations. D- DON or designee will develop a tool to monitor that all current and future residents are offered, and receive if accepted, pneumococcal immunizations based on CDC recommendations. DON or designee will complete monthly and QAPI team will review quarterly.	