



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
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aApril 26, 2019

Darrin Radeke, Administrator  
Mini-Cassia Care Center  
Po Box 1224  
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **April 11, 2019**, a survey was conducted at Mini-Cassia Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 6, 2019**. Failure to submit an acceptable PoC by **May 6, 2019**, may result in the imposition of penalties by **May 29, 2019**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 16, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 11, 2019**. A change in the seriousness of the deficiencies on **May 26, 2019**, may result in a change

Darrin Radeke, Administrator  
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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 11, 2019** includes the following:

Denial of payment for new admissions effective **July 11, 2019**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 11, 2019**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, LTC, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 11, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Darrin Radeke, Administrator  
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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **May 6, 2019**. If your request for informal dispute resolution is received after **May 6, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

bd/dr

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

PRINTED: 05/15/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/11/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MINI-CASSIA CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1729 MILLER AVENUE BURLEY, ID 83318</b>		
(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  The following deficiencies were cited during the federal recertification and complaint survey conducted April 8, 2019 to April 11, 2019.  The surveyors conducting the survey were:  Jenny Walker, RN, Team Coordinator Teresa Kobza, RDN, LD Presie Billington, RN Kate Johnsrud, RN  Abbreviations:  CDM= Certified Dietary Manager DON = Director of Nursing F = Fahrenheit MDS = Minimum Data Set RD = Registered Dietitian	F 000			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would	F 622		4/26/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/06/2019

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 622	<p>Continued From page 1 otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p>	F 622			

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F 622	<p>Continued From page 2</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to ensure information was provided to the receiving hospital for emergent situations of 1 of 1 resident (#4) reviewed for transfers. This deficient practice had the potential to cause harm if the resident was not treated in a timely manner due to lack of information. Findings include:</p>	F 622	<p>F622 Transfer and Discharge Requirements **Nursing**</p> <p>When the facility transfers or discharges a resident, the facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated</p>		

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F 622	Continued From page 3  The facility's Transfer and Discharge policy, revised 9/1/14, documented when it was necessary to transfer or discharge a resident to a hospital, staff were to:  *notify the resident's attending physician *notify the receiving facility that the transfer was being made *prepare a transfer form to send with the resident  Resident #4 was readmitted to the facility on 4/9/19, with multiple diagnoses including urinary tract infection and stroke with hemiplegia (paralysis) on the left side.  A Nursing Progress Note, dated 4/7/19 at 3:00 AM, documented Resident #4 had an elevated temperature, complained of abdominal pain, and not feeling well. The physician assistant was notified and ordered Resident #4's transfer to the hospital. Resident #4 was transported to the hospital via emergency transport. The progress note also documented a report was called to the emergency room nurse.  Resident #4's medical record did not document information was provided to the hospital to ensure a safe and effective transition of care.  On 4/11/19 at 9:49 AM, the DON said the facility sent the face sheet, physician's orders, Physician's Order Scope of Treatment (POST), History and Physical, and the most recent progress note, with Resident #4 to the hospital.  On 4/11/19 at 10:37 AM, the Regional Nurse said the facility did not retain a copy of the medical	F 622	to the receiving health care institution or provider.  Resident #4: was not injured due to the non-compliant practice. The hospital received all needed documentation in a timely manner to provide proper care of the resident while Resident #4 was in the hospital.  The Director of Nursing/Designee will conduct an audit of all residents who have discharged in the past 30 days to identify if the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider.  An In-service on proper discharge procedures and bed hold policy procedures was given to the licensed nurses on 4/11/2019 and 4/26/2019 and will reoccur monthly X 3 with all nurses.  The Director of Nursing/Designee will conduct weekly focused audits of transferred/discharged residents for completion of the discharge/transfer form.  Identified trends will be reviewed / reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate.		

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F 622	Continued From page 4 records sent and did not document what was sent.	F 622			
F 625 SS=D	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <ul style="list-style-type: none"> <li>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</li> <li>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</li> <li>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</li> <li>(iv) The information specified in paragraph (e)(1) of this section.</li> </ul> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure a bed-hold policy was provided to a</p>	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer **Nursing**	4/26/19	

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F 625	<p>Continued From page 5</p> <p>resident or their representative upon transfer to the hospital. This was true for 1 of 1 resident (#4) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed-Hold Readmission policy, revised on 12/19/16, documented the facility will reserve the bed of a resident who has been transferred to a hospital or left the facility with expectation of returning in the near future, as long as payment was made in advance to reserve the bed.</p> <p>Resident #4 was readmitted to the facility on 4/9/19, with multiple diagnoses including urinary tract infection and stroke with hemiplegia (paralysis) on the left side.</p> <p>A Nursing Progress Note, dated 4/7/19 at 3:00 AM, documented Resident #4 was transferred to the hospital. Resident #4's medical record did not include documentation she or her representative received a bed-hold notification when she was transferred to the hospital.</p> <p>On 4/11/19 at 9:56 AM, RN #1 said she was not aware of the facility's bed-hold policy.</p> <p>On 4/11/19 at 10:13 AM, the Regional Nurse said the facility could not locate a copy of a bed-hold policy provided to Resident #4 when she was transferred to the hospital on 4/7/19.</p>	F 625	<p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility shall provide to the resident and the resident representative written notice which specifies the bed-hold policy.</p> <p>Resident #4 was not injured due to the non-compliant practice. The resident was readmitted back to her prior bed after her hospital stay.</p> <p>Transferred/discharged/therapeutic leave residents will be audited weekly for completion/provision of the bed hold policy by the DON/designee.</p> <p>An In-service on proper discharge procedures and bed hold policy procedures was given to the licensed nurses on 4/11/2019 and 4/26/2019 and will reoccur monthly X 3 with all nurses.</p> <p>Focused rounds of transferred/discharged/therapeutic leave residents will occur weekly for completion/provision of the bed hold policy by the DON/designee.</p> <p>Identified trends will be reviewed / reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate.</p>		
F 657	Care Plan Timing and Revision	F 657		4/26/19	

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F 657 SS=D	Continued From page 6 CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents' care plans were updated to include resident-specific behaviors and interventions related to the use of antipsychotic medication. This was true for 1 of 12 residents (Resident #13) whose care plans were reviewed. This failure	F 657	F657 Care Plan Timing and Revision **Nursing**  The facility shall ensure residents' care plans are updated to include resident-specific behaviors and interventions related to the use of		

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F 657	<p>Continued From page 7</p> <p>created the potential for residents to receive unnecessary antipsychotic medication. Findings include:</p> <p>Resident #13 was admitted to the facility on 4/12/18, with multiple diagnosis including dementia with behavioral disturbances, and weakness.</p> <p>Resident #13's Quarterly MDS assessment, dated 1/15/19, documented Resident #13 experienced severe cognitive impairment with depressed mood.</p> <p>A physician's order, dated 10/30/18, documented Resident #13 was to receive Seroquel 100 mg every morning, and Seroquel XR (extended release), 50 mg every night for treatment of depression.</p> <p>Resident #13's care plan, revised on 1/24/19, did not include resident-specific depressive mood/behavior symptoms staff were to monitor her for or interventions staff were to implement to prevent and respond to them.</p> <p>On 4/10/19 at 2:49 PM, LPN #1 stated Resident #13's depression symptoms were exhibited by tearful and angry outbursts. LPN #1 said Resident #13's care plan did not include interventions related to her depression.</p> <p>On 4/10/19 at 3:02 PM, the DON stated Resident #13's care plan did not include interventions related to her depression.</p>	F 657	<p>antipsychotic medication.</p> <p>Resident #13 was not injured by the non-compliant practice. The care plan was updated to reflect the psychiatric medications that are used by the resident. The resident's psychiatric care plan will be reviewed monthly X 3 to ensure compliance.</p> <p>An audit of all residents with psychotropic medications has been performed for appropriate diagnosis, care planning, and monitoring. Care plans were updated to include resident specific interventions related to each diagnosis/medication and class.</p> <p>The DON/Designee will in-service the nursing staff regarding psychotropic medications for appropriate diagnosis, care planning, and monitoring.</p> <p>The DON/ Designee will perform weekly focus rounds to ensure residents' care plans are updated to include monitoring of resident-specific behaviors and interventions are in place related to the use of antipsychotic medication.</p> <p>Identified trends will be reviewed / reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate.</p>		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		4/26/19	

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NAME OF PROVIDER OR SUPPLIER  <b>MINI-CASSIA CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1729 MILLER AVENUE BURLEY, ID 83318</b>		
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F 803	<p>Continued From page 8</p> <p>§483.60(c) Menus and nutritional adequacy. Menus must-</p> <p>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;</p> <p>§483.60(c)(2) Be prepared in advance;</p> <p>§483.60(c)(3) Be followed;</p> <p>§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;</p> <p>§483.60(c)(5) Be updated periodically;</p> <p>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and</p> <p>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of recipes, and staff interviews, the facility failed to ensure menus were updated to reflect the residents' dietary needs. This affected 7 of 7 (#7, #13, #16, #32, #34, #42, and #50) residents who required fortified foods. This failed practice had the potential for harm if residents were dissatisfied with their meals or experienced weight loss. Findings include:</p>	F 803	<p>F803 Menus Meet Resident Needs/Prep in Adv/Followed **Dietary**¿</p> <p>The facility shall ensure menus are developed and updated to reflect the residents' dietary needs.</p> <p>Resident¿ #7 was not injured by the non-compliant practice as she was receiving mighty shakes two times a day</p>		

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F 803	<p>Continued From page 9</p> <p>a. Resident #7 was admitted to the facility on 1/5/18, with diagnoses that included nausea, heart failure, and chronic obstructive pulmonary disease.</p> <p>A physician's order, dated 1/4/19, documented Resident #7 required fortified foods with her meals for a consistent carbohydrate diet.</p> <p>b. Resident #13 was admitted to the facility on 4/12/18, with diagnoses that included heart disease and dementia.</p> <p>A physician's order, dated 12/28/18, documented Resident #13 required fortified foods with her meals with a regular mechanical soft meats diet, due to her teeth.</p> <p>c. Resident #16 was admitted to the facility on 1/22/18, with diagnoses that included pain and dementia.</p> <p>A physician's order, dated 1/25/19, documented Resident #16 required fortified foods with his meals for a regular diet.</p> <p>d. Resident #32 was admitted to the facility on 1/2/13, with diagnoses that included dysphagia (loss of or deficiency in the power to use or understand language as a result of injury to or disease of the brain), heartburn, nutritional anemia, and dementia.</p> <p>A physician's order, dated 1/4/19, documented Resident #32 required fortified foods with her meals for a regular finger food diet to promote intake.</p>	F 803	<p>as a supplement and offered pudding or yogurt at each snack time three times a day.¿</p> <p>Resident #13 was not injured by the non-compliant practice as she was receiving mighty shakes three times a day as a supplement and offered pudding or yogurt at each snack time three times a day.¿</p> <p>Resident #16 was not injured by the non-compliant practice as he was receiving ice cream at every meal and snack time to fortify his diet.¿</p> <p>Resident #32 was not injured by the non-compliant practice as she was given ensure at every meal as a supplement and offered pudding or yogurt at each snack time three times a day.¿</p> <p>Resident #34 was not injured by the non-compliant practice as she was receiving yogurt or pudding at every meal to fortify the meal¿</p> <p>Resident #42 was not injured by the non-compliant practice as she was offered ensure at meals and offered pudding or yogurt at each snack time three times a day¿¿</p> <p>Resident #50 was not injured by the non-compliant practice as she was receiving ice cream at meals and offered pudding or yogurt at each snack time three times a day.¿</p> <p>¿</p> <p>The residents of the facility will be protected against the future non-compliance by audits of food preparation which will be documented on the kitchen QAPI audits 2 times weekly X</p>		

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F 803	<p>Continued From page 10</p> <p>e. Resident #34 was admitted to the facility on 6/8/15, with diagnoses that included nutritional and metabolic disease, heartburn, and dementia.</p> <p>A physician's order, dated 2/22/19, documented Resident #34 required fortified foods with her meals for a regular pureed diet to promote weight maintenance.</p> <p>f. Resident #42 was admitted to the facility on 6/11/18, with diagnoses that included epilepsy.</p> <p>A physician's order, dated 3/11/19, documented Resident #42 required fortified foods with her meals for a regular diet.</p> <p>g. Resident #50 was admitted to the facility on 12/10/18, with diagnoses that included brain and skin cancer and seizures.</p> <p>A physician's order, dated 4/8/19, documented Resident #50 required fortified foods with her meals for a regular diet to discourage weight loss.</p> <p>The facility's Fortified Recipes included milkshakes, pudding parfaits, mashed potatoes, hot cereal, creamed soup, streusel topping, and milk.</p> <p>On 4/10/19 at 10:58 AM, Cook #2 was observed placing the lunch meal items into the steam table compartments. The meal consisted of pork loin, roasted potatoes, sautéed zucchini, scalloped apples, dinner roll, Swedish meat balls, parsley herbed noodles, and broccoli florets. The steam table included mechanical soft options and pureed options. The steam table did not include</p>	F 803	<p>3, then weekly X 4, the monthly. On 4/12/2019 there was a training of kitchen staff on the proper way to fortify a diet. ¿</p> <p>Dietitian will in-service staff and provide protocol/recipes.</p> <p>Dietitian /designee will audit weekly to ensure compliance.</p> <p>The audits will be brought to the Quality Assurance Committee for review monthly. ¿</p>		

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F 803	Continued From page 11 fortified food items.  On 4/10/19 at 1:55 PM, Cook #2 stated she did not know how to prepare fortified food. She said the kitchen was not currently providing fortified foods to residents. Cook #2 stated the previous CDM never provided the education on preparing fortified foods. Cook #2 stated there were a few residents who required fortified foods and none of them were receiving them.  On 4/10/19 at 3:50 PM, the Interim CDM stated she became aware this week that the kitchen staff was not providing fortified foods to residents and she was currently in the process of teaching kitchen staff how to prepare fortified food items.  On 4/11/19 at 9:04 AM, the RD stated the facility had recipes for fortified mashed potatoes, eggs, cereals, and pudding. The RD stated she implemented the fortified foods program in November of 2018 and she discussed with the previous CDM about implementing the program. The RD stated she was unaware the program was not implemented.	F 803			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;  §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced	F 804		4/26/19	

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F 804	<p>Continued From page 12</p> <p>by: Based on observation, temperature log review, resident interview, Resident Group interview, and staff interview, it was determined the facility failed to ensure palatable food was served. This directly impacted 3 of 3 (#40, #41, and #44) residents in Resident Group interview and had the potential to affect the other 45 residents who dined in the facility. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:</p> <p>a. Review of the Resident Council Meeting Minutes documented the following concerns with the food.</p> <p>- 11/5/18: Six residents were in attendance and concerns with the food included a lack of flavor and appearance, not happy with the temperatures, and the meat tough.</p> <p>- 12/3/18: Six residents were in attendance and concerns with the food included sandwiches with dry and hard bread, grilled cheese sandwiches offered without cheese, meat is too tough, and meals were unappealing, and the residents would not "feed the food" to their "dogs." The meeting minutes documented the concerns from last month still were not dealt with and there were issues with the food.</p> <p>- 1/7/19: Five residents were in attendance and concerns with the food included the vegetables were "too mushy" and residents wanted baked potatoes, spaghetti, potato salad, BBQ, chef salads, other vegetable options, and meat with breakfast.</p>	F 804	<p>F804 Nutritive Value/Appear, Palatable/Prefer Temp **Dietary**</p> <p>The facility shall provide food prepared by methods that conserve nutritive value, flavor, and appearance; food and drink that is palatable, attractive, and at a safe and appetizing temperature.</p> <p>¿</p> <p>Resident #40 has not been adversely affected by the deficient practice as demonstrated by steadily increasing weights over the last year. The Dietary Manager will conduct regular interviews with the resident to ensure the continued improvement and quality of the food. Interviews will be tracked on the Kitchen Quality and Safety Audit. ¿</p> <p>Resident #41 has not been adversely affected by the deficient practice as demonstrated by stable weights over the last year. The Dietary Manager will conduct regular interviews with the resident to ensure the continued improvement and quality of the food. Interviews will be tracked on the Kitchen Quality and Safety Audit. ¿</p> <p>Resident #44 has not been adversely affected by the deficient practice as demonstrated by steadily increasing weights over the last year. The Dietary Manager will conduct regular interviews with the resident to ensure the continued improvement and quality of the food. Interviews will be tracked on the Kitchen Quality and Safety Audit. ¿</p> <p>¿</p>		

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F 804	Continued From page 13  - 2/4/19: Nine residents were in attendance and concerns with the food included the food temperatures were not good, the food was cold, and the food was "horrible." The meeting minutes documented the food temperature concerns from last month were still not dealt with and there continued to be an issue with the temperatures of the food.  - 3/4/19: Nine residents were in attendance and the meeting minutes documented the food temperature concerns from last month were still not dealt with and there continued to be an issue with the temperatures of the food.  - 4/1/19: Eight residents were in attendance and concerns with the food included the food was "terrible." The meeting minutes documented the food temperature concerns from last month were still not dealt with and there continued to be an issue with the temperatures of the food.  b. On 4/9/19 at 10:54 AM, during the Resident Group interview, Residents #40, #41, and #44 said the food was an issue and had been an ongoing issue for months. The residents stated the food was not good and they had spoken to the Dietitian about their concerns and nothing had changed. The residents stated the hot food was served cold and the warm food was served cold. The residents stated the food that was supposed to be cold warmed up before they received it, such as the ice cream.  c. On 4/10/19 at 10:58 AM, Cook #2 was observed placing the lunch meal items into the steam table compartments. Steam could be seen	F 804	Other residents affected by the deficient practice will be identified in resident council held monthly. ; Dietitian will request attendance at resident council to ensure concerns are followed up on. ; Other residents of the facility will be protected against the future non-compliance by audits of food documented on the Kitchen Quality and Safety Audit form 2 times weekly X 3, then weekly X 4, the monthly. ; Administrator/designee will conduct test tray audits 3 times a week. ; Dietitian will conduct weekly audits of logs to ensure compliance.  The audits will be brought to the Quality Assurance Committee for review monthly. ;		

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F 804	<p>Continued From page 14</p> <p>on the left side of the steam table and the right side was observed without steam drifting up. There was a cold breeze coming from above and blowing directly onto the right side of the steam table.</p> <p>On 4/10/19 at 11:13 AM, Cook #2 was observed uncovering the food items on the steam table and started preparing pureed breads to add to the steam table.</p> <p>On 4/10/19 at 11:18 AM, Cook #2 began assessing the temperatures of the foods most of the food items where within appropriate temperatures. The ground pork was assessed at 143 degrees F, a potato dish was assessed at 156 degrees F, and the baked fruit was assessed at 103 degrees F.</p> <p>On 4/10/19 at 11:30 AM, the food remained uncovered and the cool breeze continued to blow onto the left side of the steam table.</p> <p>On 4/10/19 at 11:39 AM, the Interim CDM stated she did notice the cool breeze blowing onto the food on the left side of the steam table and she stated the food was uncoverd which could allow heat to escape. The Interim CDM assessed the temperature of the steam table water and it was 178 degrees F. The Interim CDM stated the water temperature should be 190 degrees F minimally.</p> <p>d. On 4/10/19 at 12:04 PM, the Interim CDM stated the facility was missing multiple days of temperature logs. She provided copies of the last four months' worth of temperature logs that she could locate. The Interim CDM stated the</p>	F 804			

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F 804	<p>Continued From page 15</p> <p>previous CDM was on maternity leave and according to the staff, the previous CDM had not provided adequate training to new staff on how to and when to assess temperatures of the food items before service.</p> <p>The facility's Meal Temperature logs were not completed at each meal as follows:</p> <ul style="list-style-type: none"> <li>- Lunch and dinner not assessed: 1/13/19 and 1/15/19</li> <li>- Dinner not assessed: 1/1/19, 1/4/19, 1/5/19, 1/6/19, 1/7/19, 1/8/19, 1/10/19, 1/11/19, 1/12/19, 1/14/19, 1/16/19, 1/17/19, 1/18/19, 1/21/19, 1/22/19, 1/23/19, 1/24/19, 2/9/19, 3/31/19, 4/2/19, 4/3/19, and 4/10/19</li> <li>- Breakfast not assessed: 4/9/19</li> <li>- Temperatures were not assessed for all three meals: 1/19/19, 1/20/19, 1/25/19 through 2/8/19, 2/10/19 through 3/30/19, 4/1/19, and 4/4/19 through 4/8/19</li> <li>- The temperature of the milk was not assessed on 1/19/19, 1/20/19, and 1/25/19 through 4/10/19.</li> <li>- The cold food items temperature was higher than 41 degrees on 1/24/19 when the milk was 46 degrees F.</li> <li>- The facility assessed the meal temperatures 57 out of 300 opportunities or 19%.</li> </ul> <p>On 4/10/19 at 3:50 PM, the Interim CDM stated the exhaust fan was blowing cold air onto the</p>	F 804			

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F 804	Continued From page 16 food and the steam table. The Interim CDM stated when the exhaust fan was turned off and the food was covered the food items retained their heat. The Interim CDM stated she educated the staff on the appropriate way to maintain temperatures of the food items on the steam table.	F 804			
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, review of facility policy, Cook Cleaning list, temperature logs, sanitation logs, and the 2017 FDA Food Code, and staff interview, it was determined the facility failed to ensure food was handled properly and maintained according to safe practices. This was	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary **Dietary**¿  The facility shall ensure food are handled properly and maintained according to safe	4/26/19	

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F 812	<p>Continued From page 17</p> <p>true when Potentially Hazardous Food (PHF) cold food temperatures were not maintained at safe temperatures. In addition, the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen and the kitchen was routinely cleaned. These failed practices placed 11 of 11 sample residents (#16, #18, #27, #28, #29, #32, #36, #37, #40, #41, and #47) who dined in the facility and the other 36 residents who dined in the facility, at risk of adverse health outcomes. Findings include:</p> <p>1. The facility's Environment and Equipment policies, both dated May 2014, documented the equipment and the physical kitchen were cleaned after each use. The policies documented the kitchen staff were responsible for notifying maintenance when repairs were needed.</p> <p>Kitchen cleanliness Inspection:</p> <p>On 4/8/19 at 2:46 PM, the kitchen was observed with multiple unclean surfaces, unsafe thawing practices, and food and grease debris on and in equipment and on the floor as follows:</p> <p>* The wood cabinets which contained spices were observed with a greasy substance covering the doors and the cupboard surfaces. The wood was exposed; which created a porous surface for bacteria to reside. The grease could be felt when their surfaces were touched. The oven was observed with a greasy substance covering the front door handles and surface. The microwave had a yellow butter like substance on the inside top of the unit and the toaster oven had blackish brown food debris inside the unit.</p>	F 812	<p>practices.</p> <p>Residents #16,#18,#27,#28,#29,#32,#36,#37,#40,#41,#47 have been reviewed by the medical team and shown to not have suffered adverse reactions to the deficient practice.</p> <p>Assessments have been completed on resident that may have been affected by deficient practice of failing to ensure food was handled properly and maintained according to safe practices.</p> <p>1. On 4/11/2019 the kitchen was completely cleaned and sanitized. Cleaning logs are in place and being audited weekly by Dietitian/designee on the Kitchen Quality and Safety Audit form.¿</p> <p>2. New refrigerator/freezers were purchased on 4/11/2019 for the North and South Nurse stations. Temperature Logs for all refrigerators, freezers and are in place and being audited on the Kitchen Quality and Safety Audit form.¿</p> <p>3. Proper Hand hygiene and cross contamination prevention has been taught to the kitchen staff and is being audited on the Kitchen Quality and Safety Audit form.¿</p> <p>4. Beard and mustache restraints are being provided, a sign is posted, and access to the kitchen without proper hair covering is prohibited.</p> <p>¿ Cross contamination and</p>		

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F 812	Continued From page 18  * Food debris and a layer of dirt were observed under the three-compartment sink, behind the ice machine, under the refrigerators, in the dishroom, in the pantry, under the stove, and under the steam table. Food debris particles were observed as small dark pellets, dust, grease, patches of sticky orange substances, multiple patches of black spills of fluids, onion skin, bread crumbs, and more.  * There were three large packages of meat observed sitting in two separate sinks. One sink had two packages of frozen meat thawing without being immersed in water. The other sink had one package of frozen meat thawing with a thin stream of cold water running onto the meat and the drain was not plugged.  * Two refrigerators were observed with sticky food spills and food debris throughout the units.  * The recessed holding compartments of the steam table, for the metal food trays, was observed filled with water and had a slimy brown substance covering the entire bottom and approximately 1 1/2 inches to the water line. When the steam table was in use, trays containing food items were placed over the recessed areas and kept warm by the steam generated by the table.  The observations above presented potential areas for bacterial growth, unsafe thawing practices, and subsequent spread of food-borne illnesses.  On 4/8/19 at 2:46 PM, the facility's April 2019	F 812	cleanliness/hand hygiene training of kitchen staff along with the institution of new shift and position specific cleaning logs, food and equipment temperature logs and audits will be continued. Education held on 4/12/2019 of these areas will be reviewed monthly X 3 and as needed.¿ Other residents of the facility will be protected against potential non-compliance by audits of food preparation which includes temperature controls, and cleanliness of the kitchen and will be documented on the Kitchen Quality and Safety Audit form 2 times weekly X 3, then weekly X 4, the monthly.¿¿  Dietitian will in-service staff on cleaning schedules, proper thawing techniques, hand hygiene and glove use.  The audits will be brought to the Quality Assurance Committee for review monthly.¿		

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F 812	<p>Continued From page 19</p> <p>Cook's Cleaning List documented the following cleaning tasks.</p> <ul style="list-style-type: none"> <li>* Daily cleaning tasks included cleaning the sinks, grill, stove, can opener, and ensuring the doors were shut.</li> <li>* AM Cook cleaning tasks included cleaning the microwave, fridges, toasters, produce fridge, and knife rack.</li> <li>* PM cook cleaning tasks included cleaning the steam table, dry bins, garbage cans, walls, shelves above the grill, and floors.</li> <li>* Friday tasks included cleaning the doors, windows, pan shelves, cupboards, can shelves, and the ice machine.</li> <li>* Sunday and Wednesday tasks included cleaning the freezer and pantry area.</li> </ul> <p>The April 2019 Cook's Cleaning List documented the Daily and AM Cook cleaning tasks were completed the 1st through the 3rd and the 4th through the 8th were blank. The PM Cook tasks were completed the 1st, and 4th through the 8th, the 2nd and 3rd were blank. The Friday and Sundays and Wednesdays tasks were blank.</p> <p>The Facility's Sanitizing Bucket Log documented the amount of sanitizer in Parts per Million (PPM) for the sanitizer buckets. The log was completed the 1st through the 3rd for the breakfast and lunch shifts and the 4th through the 8th were blank. The log was completed the 1st through the 7th for the dinner shift and the 8th was blank.</p> <p>The Facility's Dish Machine Log documented the staff assessed the PPM sanitizer level used for the dishwashing wares, and the water temperatures of the wash and rinse cycles. The</p>	F 812			

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F 812	<p>Continued From page 20</p> <p>log was completed for breakfast, lunch, and dinner on the 1st, 2nd, 7th and 8th. The log was incomplete on the 3rd and 4th for lunch and the 5th and 6th were incomplete for breakfast and lunch.</p> <p>On 4/8/19 at 2:53 PM, Cook #2 was observed writing in the missing holes on the Sanitizer Bucket Log. She stated she forgot to complete the documentation when she worked on the 6th through the 8th. She stated someone else worked on the 4th and the 5th and that individual "never" completed the logs, so she filled in those days too. Cook #2 stated she should not have completed the missing information for the 4th through the 8th.</p> <p>On 4/8/19 at 2:55 PM, Cook #2 observed the Cleaning Log with the surveyor and stated she forgot to complete the Cook's Cleaning Log for the 6th through the 8th. Cook #2 was asked to provide a copy of the Cleaning Log, however, when she provided a copy of the Cook's Cleaning Log it now contained her initials on the 6th through the 8th. Cook #2 stated she filled in the missing information on 4/8/19 prior to making the copy.</p> <p>On 4/8/19 at 2:55 PM, Cook #1 was asked to provide a copy of the Dish Machine Log and she stated there was missing information on multiple days.</p> <p>On 4/8/19 at 3:16 PM, the Administrator stated Cook #2 should not have filled in the missing information and he would address the issue with the kitchen. The Administrator stated the current food service company was being replaced with a</p>	F 812			

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F 812	<p>Continued From page 21 new company due to concerns.</p> <p>2. The 2017 FDA Food Code, Chapter 3, Part 3-5, Limitation of Growth of Organisms of Public Health Concern, subpart 3-501.12 Time/Temperature Control for Safety Food, documents refrigerated foods are to be maintained at 5 C (41 F [Fahrenheit]) or less.</p> <p>The facility's Cold Food Storage policy, dated May 2014, documented the food service department was responsible for maintaining all perishable foods at 41 F or less. The policy documented the food service department would ensure the thermometers were accurate and temperatures of the refrigerator and freezers were assessed daily and recorded.</p> <p>The facility's Food brought by Family/Visitors policy, revised February 2014, documented perishable foods would be used by the use by date and thrown out if the items exceeded the use by date. The policy documented potentially hazardous foods that were left out longer than 2 hours without appropriate refrigeration would be discarded.</p> <p>Multiple Kitchen Inspections documented multiple refrigerator units' temperatures were greater than 41 degrees F and contained PHF food items as follows:</p> <p>* On 4/8/19 at 2:49 PM, the kitchen refrigerator unit on the right was observed at 50 degrees F and refrigerator unit on the left was observed at 45 degrees F. Food items in the units consisted of milk (PHF), pudding (PHF), salads (PHF), juices, meats (PHF), cottage cheese (PHF), and</p>	F 812			

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F 812	<p>Continued From page 22 more.</p> <p>* On 4/8/19 at 2:55 PM, a copy of the Refrigerator Temperature Logs for the two units were requested and they documented the following temperatures out of range.</p> <p>The unit on the right:</p> <ul style="list-style-type: none"> <li>- 4/1/19: the AM shift was not assessed, and the PM documented 42 degrees F</li> <li>- 4/2/19: 42 degrees F, AM shift and the PM documented 45 degrees F</li> <li>- 4/3/19: the PM documented 42 degrees F</li> <li>- 4/4/19: the AM shift was not assessed, and the PM documented 45 degrees F</li> <li>- 4/5/19: the AM shift was not assessed, and the PM documented 48 degrees F</li> <li>- 4/6/19: the AM and PM shifts documented 42 degrees F</li> <li>- 4/7/19: the AM shift documented 43 degrees F and the PM documented 45 degrees F</li> <li>- 4/8/19: the AM shift was not assessed</li> </ul> <p>* On 4/9/19 at 11:29 AM, the kitchen refrigerator unit on the left was observed within appropriate temperature range and the unit on the right was observed at 45 degrees F. Two containers of milk (PHF), one from the front and the back were assessed by the Interim CDM. The milk from the front of the unit was assessed at 44 degrees F and the milk from the back of the unit was assessed at 45.2 degrees F. The CDM stated she would move the food items to ensure they were within temperature range and notified the Maintenance Director to correct the issue.</p> <p>* On 4/9/19 at 12:47 PM, the small countertop,</p>	F 812			

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F 812	<p>Continued From page 23</p> <p>two-foot-high refrigerators on the halls were observed to be unclean, with outdated foods, the temperature logs lacked documentation, and temperatures out of range, as follows:</p> <p>South Hall refrigerator:</p> <ul style="list-style-type: none"> <li>- The fridge was observed with a 1-2-inch-thick buildup of ice in the freezer section. Food items could not fit well into the opening.</li> <li>- There were spills of brown sticky liquids and food debris in the unit.</li> <li>- There were three outdated milks with a use by date of 4/2/19 and 11 outdated Strawberry Ensures with a use by date of 9/1/18.</li> <li>- The Temperature log was incomplete on the AM shifts of the 1st, 4th, and 5th, the PM shifts of the 2nd, 3rd, and 8th.</li> <li>- The temperature was greater than 41 degrees F on 4/4/19: 42 degrees F and 4/7/19 at 48 degrees F.</li> <li>- The fridge contained food items of milk (PHF), sodas, and nutritional supplements.</li> </ul> <p>North Hall refrigerator:</p> <ul style="list-style-type: none"> <li>- The fridge was observed with a 1-2-inch-thick buildup of ice in the freezer section. Food items could not fit well into the opening.</li> <li>- There were spills of sticky liquids and food debris in the unit.</li> <li>- There was a case of outdated chocolate Glucerna dated 12/1/18.</li> <li>- The Temperature log for April 2019 lacked documentation on the AM shift on the 1st, 4th, and 5th and on the PM shift on the 2nd and the 3rd.</li> <li>- The temperature was greater than 41 degrees F</li> </ul>	F 812			

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F 812	<p>Continued From page 24</p> <p>on 4/1/19 at 45 degrees F, 4/2/19 at 42 degrees F, 4/3/19 at 43 degrees F, 4/4/19 at 48 degrees F, 4/5/19 at 45 degrees F, and 4/6/19 at 42 degrees F AM shift, and 43 degrees F on the PM shift. The fridge contained food items of milk (PHF), sodas, and nutritional supplements.</p> <p>On 4/9/19 at 1:22 PM, Cook #1 stated the temperatures of the refrigerators were inappropriate and the kitchen staff were to assess the temperatures of the units. Cook #1 stated if concerns were identified they should report issues to maintenance. Cook #1 stated all facility staff should ensure food items were not retained beyond their expiration dates.</p> <p>On 4/10/19 at 3:38 PM, the Maintenance Director stated he monitored the kitchen refrigerators on a monthly basis. The Maintenance Director stated he did not monitor the hall refrigerators as part of his monthly checklist. He stated the staff were to let him know when the refrigerator units were not working, and he had not received any notices of the units not working until during the survey. He stated he had a refrigerator repair man in to fix the kitchen unit on 4/9/19 and 4/10/19.</p> <p>The Maintenance Rounds documented the kitchen refrigerators were assessed on 3/4/19. The log did not document what the units were running at or the appropriate temperatures for the units.</p> <p>3. The facility's Infection Control: Hand Hygiene policy, revised September 2014, documented staff needed to perform hand hygiene after handling soiled equipment or utensil.</p>	F 812			

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F 812	Continued From page 25 On 4/10/19 at 8:31 AM, Cook #2 was observed on the dirty side of the dish room scrubbing dishes and rinsing off dishes before running them through the dish machine. Cook #2 was not wearing gloves or an apron to protect her clothes. Cook #2 left the dirty dish area and pushed a cart of clean dishes into the kitchen and began putting pots, pans, a knife, and other dishes into their spots. Cook #2 did not perform hand hygiene when she moved from the dirty to clean areas. At the time of the observation, Cook #2 stated she should have cleaned her hands.  On 4/10/19 at 8:37 AM, the Interim CDM stated Cook #2 should have cleaned her hands and she would have Cook #2 rewash the dishes.  4. The facility had people enter the kitchen without wearing hair or bread restraints.  On 4/10/19 at 8:51 AM, the Coffee Delivery person walked into the kitchen with a full beard and mustache, and a full head of hair not restrained in a hair net or beard or mustache restraints.  On 4/10/19 at 8:55 AM, the Interim CDM stated anyone entering the kitchen should be wearing hair restraints and beard restraints if applicable.	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	F 880		4/26/19	

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F 880	Continued From page 26 diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual 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	F 880			

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F 880	<p>Continued From page 27 the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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, record review, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented for hand hygiene during perineal care (peri-care), and care of urinary tubing and the urine collection bag. This was true for 1 of 12 residents (Resident #9) reviewed for infection control. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>1. The facility's Infection Control Hand Hygiene policy, dated 6/2015, documented all staff members were to follow handwashing and/or</p>	F 880	<p>F880 Infection Prevention &amp; Control **Nursing** ¿</p> <p>The facility shall ensure infection control measures are consistently implemented for hand hygiene during perineal care (peri-care), and care of urinary tubing and the urine collection bag.</p> <p>Further monitoring of resident #9 showed no adverse reaction to the noncompliant practice. The resident will be protected from noncompliant practice by training of staff and audits of resident's care.¿</p>		

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F 880	<p>Continued From page 28</p> <p>hand hygiene procedures to prevent the spread of infection. Hand hygiene or hand washing were to be completed after contact of body fluids or secretions, and the removal of gloves.</p> <p>On 4/9/19 at 10:55 AM, CNA #1 and CNA #2 were observed performing peri-care for Resident #9. After completing the peri-care, CNA #1 placed a new brief on Resident #9. CNA #1 did not remove her gloves or perform hand hygiene after completing the peri-care and before she applied the new brief. CNA #1 then was observed to perform hand hygiene, don new gloves and place soiled linen into a laundry bag. CNA #1 then placed a clean shirt on Resident #9. CNA #1 did not remove her gloves and perform hand hygiene after handling the soiled linen and placing a clean shirt on Resident #9.</p> <p>On 4/9/19 at 11:14 AM, CNA #1 stated she missed opportunities for hand hygiene and glove changes after Resident #9's peri-care, and handling dirty linen.</p> <p>2. The facility's Infection Prevention and Control policy, dated 10/2017, documented to keep urinary collection bags and the tubing off the floor as part of ensuring appropriate techniques in the care and maintenance of foley (urinary) catheters.</p> <p>On 4/8/19 at 1:54 PM, Resident #9's urine collection bag and tubing were observed dragging on the floor.</p> <p>On 4/9/19 at 10:52 AM, Resident #9's urine collection bag and tubing were observed lying on the floor next to his bed.</p>	F 880	<p>All residents who use urinary bags have been identified by the facility and are being audited for proper placement by the Infection control nurse 2 X weekly X 3, then monthly X 2. All hygiene and Urinary Bag and Tubing Audits are being tracked on the Hand hygiene and Urinary Bag and Tubing Audit forms.¿</p> <p>CNA #1 did not show accepted professional practice with hand hygiene and infection prevention and control practices and in-serviced by the Director of Nursing.¿</p> <p>CNA #2 did not show accepted professional practice with hand hygiene and infection prevention and control practices and in-serviced by the Director of Nursing.¿</p> <p>Hand hygiene in-service was given on 4/30/19. Infection control nurse or designee will perform hand hygiene audits 2 X weekly X 3, then monthly X 2.¿</p> <p>Training on proper placement of urinary collection bags and tubing was given on 4/30/19. Infection control nurse or designee will perform urinary bags and tubing placement audits 2 X weekly X 3, then monthly X 2.¿</p> <p>The DON/ Designee will conduct weekly focused rounds to ensure infection prevention and control/hand hygiene is being followed.¿</p> <p>The audits will be brought to the Quality Assurance Committee for review</p>		

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F 880	Continued From page 29  On 4/9/19 at 10:52 AM, CNA #1 stated Resident #9's urine collection bag and tubing were lying on floor next to Resident #9's bed, and they should not have touched the floor.	F 880	monthly.¿		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MINI-CASSIA CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1729 MILLER AVENUE BURLEY, ID 83318</b>
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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) COMPLETE DATE
C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the facility's state licensure survey conducted at the facility from April 8, 2019 to April 11, 2019.</p> <p>The team members conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Teresa Kobza, RDN, LD Presie Billington, RN Kate Johnsrud, RN</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure committee members participated in Infection Control Meetings. This failure created the potential to affect all residents, staff and visitors to the facility. Findings include:</p> <p>On 4/10/19 at 1:54 PM, the Infection Control Nurse (ICN) said the facility held its Infection Control Meetings monthly.</p> <p>Infection Control Committee attendance records, dated 3/27/18, 4/24/18, 5/22/18, 6/19/18, 7/31/18, 8/28/18, 9/25/18, 10/30/18, 11/27/18, 12/18/18, 1/29/19 and 2/26/19 documented:</p> <p>*A representative from the Housekeeping Department did not attend in any of the monthly</p>	C 664	<p>C664Required Members of Committee <b>**Administration**</b></p> <p>The facility will include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative in the quality assurance program.</p> <p>Noting that no residents were identified as being adversely affected.</p> <p>All Quality Assurance Meetings will be audited for compliance monthly X 3 on the meeting signing sheet.</p>	4/26/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>05/06/19</b>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MINI-CASSIA CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1729 MILLER AVENUE BURLEY, ID 83318</b>		
(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) COMPLETE DATE
C 664	Continued From page 1  meetings. *The Dietary Manager and a representative from the Maintenance Department did not attend any of the monthly meetings during the last 2 quarters (9/25/18, 10/30/18,11/27/18, 12/18/18, 1/29/19 and 2/26/19).  On 4/10/19 at 3:45 PM, the ICN said the Dietary Manager was aware of the meetings but had a lot of work to do in the kitchen. The ICN said a representative from the housekeeping did not attend the meeting due to workload in the facility. The ICN said she did not know why a representative from the Maintenance Department did not attend the meetings.	C 664	The housekeeping supervisor, the maintenance manager, and the dietary manager were educated on 4/12/19 to the need to attend the quality assurance meeting at least quarterly. All Quality Assurance Meetings will be audited for compliance monthly X 3 on the meeting signing sheet.  The Administrator will review with the Quality Assurance Committee the need for Housekeeping, Maintenance, and Dietary monthly X 3 on the meeting signing sheet.  All Quality Assurance Meetings will be audited for compliance monthly X 3 on the meeting signing sheet.	