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	355096	A. BUILDING _____ B. WING _____	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANETA PARKVIEW HEALTH CTR	113 5TH ST S ANETA, ND 58212

(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 For the standard Medicare/Medicaid recertification survey started on June 27, 2017 and completed on June 29, 2017, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 221		8/3/17

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

Electronically Signed | 07/21/2017

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F 221	Continued From page 1 symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to identify and assess a one piece zip up garment as a restraint for 2 of 2 sampled residents (Resident #3 and #4). Failure to recognize the use of this garment as a restraint and attempt less restrictive measures to control a behavior limited freedom of movement and the resident's access to their own body. Findings include: Review of the facility policy titled "Physical Restraints" occurred on 06/29/17. This policy, dated August 2015, stated, "POLICY: It shall be the policy of Aneta Parkview Health Center that every resident has the right to be free from any physical restraint imposed for the purpose of discipline or convenience, and not required to treat the resident's medical condition. . . . A physician's order is necessary for the use of a physical restraint, . . . The use of the restraining device must first be explained to the resident family member or legal representative and used only after their approval . . . DEFINITION: 1. A physical restraint is defined as a manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom or movement or normal access to ones body. . . . 2. Discipline is any	F 221	1)Corrective action will be completed on Resident #3 by completing a restraint assessment and obtaining a physician order prior to the completion date. Resident #4 is deceased. 2)All residents who wear a one-piece clothing garment may be affected. 3)Staff education of nursing staff will be conducted at the nurses meeting on 7/26/17 on restraint assessments and policy. SSD will be educated prior to completion date on same. Restraint policy was updated 7/19/17. QA of all residents who wear one piece garments will be completed prior to completion date. 4)QA of restraint policy and assessment will be completed monthly X1 and quarterly X3. QA will be conducted by nursing staff and reviewed by the QA Coordinator.	

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F 221	Continued From page 2	F 221		

action taken for the purpose of punishing or penalizing the resident. 3. Convenience is any action taken to control resident behavior or maintain residents with a lesser amount of effort which is not in the best interest of the resident. . . ."

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia and Alzheimer's disease. Medications included Seroquel (an antipsychotic medication) twice a day.

Observation on 06/29/17 at 8:45 a.m. showed Resident #3 sleeping in bed with a one piece garment on. At 12:30 p.m., while sleeping on the bed the resident remained in the same garment.

Resident #3's care plan stated, "Problem: My mood may fluctuate and I may have behaviors because of having dementia and depression. At times I wander, may become physically and verbally aggressive, disrobe, shake my fists, and bite. I like to rummage and I may refuse cares. . . . Approach: . . . I may wear onesies [a one piece zip up garment] PRN [as need] [initiated 04/04/17] . . ."

During an interview on 06/29/17 at 11:05 a.m., an administrative nurse (#1) stated Resident #3's family approved the use of the one piece garment, however, the facility failed to obtain a physician's order and conduct an assessment prior to utilizing the garment.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, anxiety, and psychosis. A

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F 221	Continued From page 3 physician's order, dated 06/14/17, stated, "May wear onesies PRN." The care plan stated, "Problem: My mood may fluctuate and I may have behaviors because of having dementia, psychosis, anxiety, and depression. I have a history of . . . disrobing in public . . . Approach: . . . Onesies PRN [initiated on 06/14/17] . . ." Observation on all days of survey showed Resident #4 in a one piece zip up garment. The facility failed to identify and assess Resident #4's one piece garment as a restraint.	F 221		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225		8/3/17

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F 225	Continued From page 4 actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to immediately report 1 of 1 alleged violation of neglect (Resident #1) to the State Survey Agency and report the results of the investigation within five working days. Failure to identify and report all alleged violations of neglect placed all residents at risk of neglect and subsequent injury. Findings include: Review of the facility policy titled "ABUSE POLICY AND PROCEDURE" occurred on 06/29/17. This policy, dated November 2016, stated, ". . . Definitions: . . . H. Neglect: Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect includes failure to carry out resident services as directed or ordered by the physician or other authorized personnel, failure to give proper attention to residents, or failure to carry out resident services through careless oversight. . . . 6. Investigation: . . . e. All suspected violations . . . will be promptly reported to state agencies and other entities or individuals as may be required by law. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia with behavioral disturbance. A physician's order, dated 04/13/17, stated, "Hoyer lift [full body mechanical lift] for functional transfers with assist of 2 staff . . ." The resident's current care plan identified the use of a full body mechanical lift for	F 225	1) Corrective action for Resident #1 was accomplished by reporting Resident #1's non-validated allegation of neglect to the State Survey Agency on 7/21/17. 2)All residents have the potential to be affected. 3)DON, SSD, and Administrator will be educated on reporting of abuse allegation prior to the completion date. 4)QA of proper reporting of potential abuse will be conducted by nursing staff on incident reports in the past month prior to the completion date, monthly X1, and quarterly X3. QA will be completed by nursing staff and reviewed by the QA coordinator.	

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F 225	Continued From page 6 all transfers. A "Safety Events--Fall Scene Investigation Report" dated 06/20/17, stated, ". . . DESCRIPTION: After bath CNA [should have stated Resident #1's name not CNA] [certified nurse assistant] was sitting on bath chair with feet on standing lift, CNA raised res. [resident] shoulders to place strap around back, res. became stiff, started slipping off of chair and needed to be lowered to floor. Sustained 8 cm [centimeter] x [by] 1.5 cm bruise to top of Lt [left] hand from hitting tub. No other injuries noted, did not hit head. ROM [range of motion] WNL [within normal limits], no s/s [signs/symptoms] of pain. Res. was bare foot, standing lift foot pads dry. . . . EVALUATION: Discussed at manager's meeting 6/20/17. Care plan reveals resident is to use hoyer lift at all times. Staff member re-educated. . . ." During an interview on 06/29/17 at 10:30 a.m., an administrative nurse (#1) confirmed the facility failed to report the incident to the State Survey Agency. The administrative nurse (#1) stated, "she completed a disciplinary action for the staff involved." By failing to identify the potential of neglect involved in Resident #1's fall, the facility subsequently failed to immediately report the incident to the State Survey Agency, failed to conduct a thorough investigation, and failed to report the results of their investigation within five working days.	F 225		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		8/3/17

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F 309	Continued From page 7 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy,	F 309	1)Corrective action for Resident #5 will	

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F 309	Continued From page 8 and staff interview, the facility failed to provide the necessary care and services to manage constipation for 1 of 4 sampled residents (Resident #5) with as needed (PRN) bowel medication. Failure to implement interventions to manage constipation in a timely manner and follow bowel protocol may result in resident discomfort and continued constipation. Findings include: Review of the facility policy titled "Bowel Assessment" occurred on 06/28/17. This policy, dated March 2016, stated, ". . . 3. On day three of constipation, Milk of Magnesia [MOM] will be given. If the resident prefers a different laxative, an order will be obtained from the physician. 4. If no BM [bowel movement] is recorded, the morning of day 4 without a BM a suppository will be given. . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included pain and constipation. PRN medications included polyethylene glycol (laxative) powder 17 gram PRN, and MOM (laxative) 400 milligram (mg) per 5 milliliter (mL) suspension PRN up to 3 times a week. Resident #5's significant change Minimum Data Set (MDS), dated 05/14/17, identified severely impaired cognition and continent of bowel. The current care plan stated, "Problem: I have the potential to be constipated because I am not as active as I used to be and I have a Hx [history] of constipation. . . . Goal: I will have a BM every 1-3 days . . . Approach: prune juice in the AM [morning] . . . Monitor my bowel elimination and	F 309	be accomplished by Dr. Berg and Janel Getz, LRD by completing a chart review for proper bowel regimen prior to the completion date and staff following the bowel protocol. 2)All residents may be affected. 3)Staff education of nursing staff on bowel protocol will be given on 7/26/17 at a nursing meeting. QA of all residents with diagnosis of constipation will be completed prior to completion date for compliance of bowel protocol by nursing staff. 4)QA of bowel protocol compliance will be completed monthly X3 and quarterly X3. QA will be completed by nursing staff and reviewed by QA Coordinator.	

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F 309	Continued From page 9 implement bowel protocol PRN. . . ." The April 01 - June 27th, 2017 bowel movement records and electronic medication administration records (eMARS), identified the following: - No BM for 3 days and MOM administered on day four occurred on three occasions. - No BM for 3 days and no PRN bowel medication administered occurred on one occasion. - No BM for 4 days and no PRN bowel medication administered occurred on two occasions During an interview on 06/29/17 at 9:20 a.m., an administrative nurse (#1) verified staff failed to follow the bowel protocol.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		8/3/17

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F 323	Continued From page 10 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and facility policy review, the facility failed to provide adequate supervision and functioning safety devices to prevent accidents for 1 of 6 sampled residents (Resident #5) with falls. Failure of staff to supervise Resident #5 while in the bathroom and in bed and ensure functioning safety devices placed the resident at risk for falls and injury. Findings include: Review of the facility policy titled "Falls Prevention" occurred on 06/29/17. This policy, dated March 2013, stated, ". . . initiate bed/chair alarms as appropriate. . . . monitor use of assistive devices and/or equipment. . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included cerebral palsy, dementia, and physical deconditioning. A significant change Minimum Data Set (MDS), dated 05/14/17, identified severely impaired cognition and extensive assist of one person with toileting. The current care plan stated, "I'm at risk for falling because I am unaware of my own safety concerns . . . I have a Hx [history] of falls . . . W/C [wheelchair], bed alarm, & hipsters . . . Assist me with walking, transfers and locomotion on/off unit . . ."	F 323	1)Corrective action for Resident #5 will be accomplished by education of staff on safety measures with fall alarms on 7/26/17. 2)All resident with bed and wheel chair alarms may be affected. 3)Staff education on safety measures with fall alarms will be conducted on 7/26/17 at a nurses meeting. 4)QA of safety with fall alarms will be conducted prior to completion date, weekly X1, monthly X1, and quarterly X3. QA will conducted by nursing staff and reviewed by the QA Coordinator.	

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F 323	Continued From page 11 Observation on 06/28/17 at 3:41 p.m. showed two certified nursing assistants (CNAs) (#2 and #3) assisted Resident #5 with toileting in the bathroom. Both the CNAs left the resident alone in the bathroom. Twice the CNAs reentered the bathroom and found the resident standing. After the CNAs transferred the resident to bed, both CNAs left the room to retrieve new batteries for the bed alarm. The resident remained alone in bed without a functioning bed alarm. A CNA (#3) returned to the room after approximately 10 minutes to replace the bed alarm batteries. Review of the Resident #5's progress notes identified seven falls since February 2017 due to the resident self transferring. Staff failed to supervise and ensure functioning safety devices to prevent self transferring and further falls.	F 323		
F 328 SS=E	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments	F 328		8/3/17

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F 328	Continued From page 12 (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the	F 328		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANETA PARKVIEW HEALTH CTR	113 5TH ST S ANETA, ND 58212

(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 328	Continued From page 13 prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of facility policy and professional reference, the facility failed to ensure oxygen tanks were stored securely on 2 of 3 days of survey (June 27 and 28). Failure to secure oxygen tanks placed residents and staff at risk for injury. Findings include: NFPA 55, 7.1.4.4 states, "Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.4.2.7." Review of the facility policy titled "Oxygen" occurred on 06/29/17. This policy, dated March 2013, stated, ". . . 11. . . Cylinder tanks should be secured in place when not being used and be secured on a movable cart when being used." Observations of the oxygen storage room, located in the hallway of the 100 wing, during the survey showed: *06/27/17 at 3:07 p.m. five tanks unsecured *06/28/17 at 8:18 a.m. six tanks unsecured During the environmental tour on 06/29/17 at 9:15 a.m. a staff member (#4), stated, "they [tanks] should always be in a holder."	F 328	1) Corrective action was completed on 6/29/17 by placing oxygen tanks in appropriate secured place. 2)All resident may be affected. 3)Staff education on storage of oxygen tanks will be conducted at a nursing meeting on 7/26/17. A sign was placed in the oxygen supply room on 7/18/17 to indicate proper storage. 4)QA of proper storage of oxygen will be completed weekly X4, monthly X2, and quarterly X3. QA will be conducted by the safety director and reviewed by the QA Coordinator.	
F 360 SS=D	483.60 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT	F 360		8/3/17

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F 360	Continued From page 14 The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide foods to meet the special nutritional needs for 2 of 9 sampled residents (Resident #3 and #5). Failure to provide ice cream as directed by the dietician (Resident #3) and cut foods into bite side pieces (Resident #5) may result in avoidable weight loss or aspiration. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, Alzheimer's disease, and weight loss. Resident #3's care plan stated, "Problem: I have had significant weight loss on 4/13/17 due to a decline and hospital stay . . . Approach: plus 2 [a nutritional supplement] tid [three times a day]; 8oz. [ounces] ensure [a nutritional supplement] tid between meals with a scoop of ice cream in it. dish of ice cream with topping at noon and evening meal. I like pop and ice cream . . ." Review of Resident #3's dietary meal sheet showed the same approaches as the care plan. Resident #3's dietary progress notes showed the facility added interventions to help with weight loss as follows: * 04/19/17 - Ensure (a nutritional supplement) 4	F 360	1) Resident #3 and #5 will be provided with the diet as ordered to meet his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 2)All residents have the potential to the affected and will be included in the plan of correction. 3)Consulting dietician will conduct an in-service to dietary staff on following diets as ordered including special nutritional supplements. Special nourishments will be entered into Matrix and used and followed by dietary staff. This in-service will be held on 7/19/17. 4)The dietary manager will conduct QA on following diet/supplements as ordered. QA will be done weekly X4, monthly X5, and quarterly X1.	

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F 360	Continued From page 15 oz three times a day * 05/05/17 - increased Ensure to 8 oz three times a day * 05/31/17 - added a calorie protein enhancement program * 06/02/17 - Plus 2 (a nutritional supplement) 4 oz three times a day * 06/07/17 - ice cream added to Ensure as needed and a dish of ice cream with the noon and evening meals The weight records showed Resident #3 had a weight gain of three pounds from 06/07/17 to 06/28/17. Observation on 06/28/17 at 12:15 p.m. and on 06/29/17 at 12:30 p.m. showed facility staff failed to give Resident #3 ice cream at the noon meal. During an interview on 06/29/17 at 11:05 a.m., an administrative nurse (#1) stated she was unaware the dietary staff were not providing Resident #3 with ice cream at the noon meal. During an interview on 06/29/17 at 12:30 p.m., an unidentified certified nursing assistant (CNA) stated the dietary department is to provide ice cream on Resident #3's meal tray and confirmed Resident #3 did not receive ice cream. - Review of Resident #5's medical record occurred on all days of survey. The current physician order identified a diet order of mechanical soft, thin liquids, and pre-cut foods. The current care plan stated, ". . . Diet as ordered. I receive ground meat and my other foods are cut up due to I like to take big bites. . . . I may have some difficulty chewing or swallowing at times due to cerebral palsy. I have had an [sic]	F 360		

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F 360	Continued From page 16 SLP [speech language pathologist] eval [evaluation]. Suggest to have all foods cut into bite size pieces. . . . It was suggested that I eat in the dining room. . . ." Resident #5's Speech Therapy Evaluation & Plan of Treatment, completed on 02/16/17, recommended ". . . Mechanical Soft textures, thin liquids, and distant supervision. . . . dentures in place for eating. All foods pre-cut to bite size pieces. . . ." Observation on 06/28/17 at 11:05 a.m. showed Resident #5 at the dining table sleeping with his lunch placed in front of him. His lunch included a serving of lasagna, not cut into bite size pieces. Observation on 06/28/17 at 5:36 p.m. showed Resident #5 at the dining table for supper meal. He had a toasted peanut butter and jelly sandwich cut in half. Staff failed to ensure Resident's #5's food items consisted of bite size pieces.	F 360		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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	F 371		8/3/17

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F 371	Continued From page 17 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, and review of facility policy, the facility failed to serve food under sanitary conditions in 1 of 1 kitchen. Failure to ensure staff changed gloves with each task during food service and when handling ready-to-eat (RTE) foods had the potential to result in a food borne illness. Findings include: Review of the facility policy "Use of Plastic Gloves" occurred on 06/29/17. This undated policy stated, ". . . If used, single use gloves shall be used for only one task (such as working with ready to eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation . . . Remember gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed. . . ."	F 371	1) Food will be served under sanitary conditions. Staff will change gloves with each task and during food service and when handling RTE foods to prevent a food borne illness. 2)All resident have the potential to be affected and will all be included in the plan of correction. 3)A dietary in-service will be conducted on proper glove usage. Consulting dietician, Janel Getz, LRD, will conduct the in-service. In-service will be held on 7/19/17. All dietary staff will be retrained on proper glove usage.4) dietary Manager will conduct a QA on glove usage. QA will be done weekly for 4 weeks and then 1 time monthly X5, then quarterly X1.	

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F 371	Continued From page 18 - Observation on 06/28/17 during the lunch meal showed a dietary staff member (#6) wore the same gloves throughout the time of observation and performed the following tasks: * Served food * Left the serving area to butter a slice of bread in the kitchen area * Served RTE food with gloved hands * Left the serving area, opened a drawer in the kitchen to retrieve a serving utensil * Served RTE food with gloved hands * Turned the plastic sleeved pages of the binder containing resident dietary orders/requirements * Served RTE food with gloved hands The staff member failed to change gloves after touching contaminated surfaces and/or leaving the serving area. During review of the dietary binder during the morning of 06/29/17, observation identified several plastic sleeves contained food particles and were greasy to the touch.	F 371		