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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING _____ B. WING _____	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SERVS	802 2ND ST NW BOWMAN, ND 58623

(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 November 13, 2012 and completed on November 15, 2012 the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	1. Notified residents (#12, #13 and #14) or their authorized representative and have issued a SNF ABN which stated that skilled Medicare services would be discontinued, the effective date and the reasons for the discontinuation of benefits. Explanation was given regarding Option #1 being checked, which meant that they wished to have a demand bill sent and that they wanted Medicare to make the decision whether or not they qualified to receive these services. Upon receiving this explanation, all residents stated that they had understood at the time of the denial that a demand bill would not be sent to Medicare, even though Option #1 had been checked.	11.28.12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Becky Hansen | TITLE: CEO | (X6) DATE: 12/18/12

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	All residents stated that they did not want the demand bill sent to Medicare at this time and that the services given would be their responsibility. This is noted on the original SNF ABN and initialed by the responsible parties. 2. Notified all residents (or their authorized representative) who have received skilled Medicare services from 12/1/2011 to date and have issued a SNF ABN which stated that skilled Medicare services would be discontinued, the effective date and the reasons for the discontinuation of benefits. Explanation was given regarding Option #1 being checked, which meant that they wished to have a demand bill sent and that they wanted Medicare to make the decision whether or not they qualified to receive these services.	12.12.12

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records and staff interview, the facility failed to ensure 1 of 1 closed record (Resident #12) and 2 of 2 supplemental residents (Resident #13 and #14) whose Medicare coverage ended, understood their options regarding Medicare Part A benefits, including the option to request a demand bill. Failure to provide an explanation of demand billing and submit demand bills is a violation of	F 156	Upon receiving this explanation, all residents stated that they had understood at the time of the denial that a demand bill would not be sent to Medicare, even though Option #1 had been checked. All residents stated that they did not want the demand bill sent to Medicare at this time and that the services given would be their responsibility. This is noted on the original SNF ABN and initialed by the responsible parties. 3. Reimbursement Specialist will be responsible for this process by following our policy for Notification of Non-Coverage of Medicare Services. (See attached policy.) 4. CFO ~~Reimbursement Specialist~~ will monitor this process and submit quarterly audits for 4 quarters to the QI manager for review by the QI committee. (See attached monitoring tool.)	12-28-12 1:40p.m per Becky Hansen

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F 156	Continued From page 3 resident rights. This failure has the potential to affect all Medicare beneficiaries at this facility. Findings include: Review of the facility's Medicare billing records occurred on 11/13/12. The records identified Resident #12, #13, and #14's Medicare coverage ended on the following dates: *Resident #12: 06/14/12 *Resident #13: 07/04/12 *Resident #14: 09/12/12 The above residents received a "Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)" (a denial notice - including the option to request a demand bill), the facility failed to provide the residents with a correct explanation regarding their options as their Medicare benefits ended. The form included the following two options: *"Option 1. YES I want to receive these items or services. I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision." [This option should be selected to request a demand bill]. *"Option 2. NO. I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't	F 156		

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F 156	Continued From page 4 pay. I understand that, in the case of any physician-ordered items or services, I should notify my doctor who ordered them that I did not receive them." Resident #12, #13, and #14's denial notices identified the residents (or their responsible parties) selected "Option 1" [requesting a demand bill]. During an interview on 11/14/12 at 7:40 a.m., an office manager (#1) stated she explained to residents and/or their responsible parties to select "Option 1" if they wanted to continue services as listed previously on the form. This staff member explained she failed to submit demand bills for these residents.	F 156		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278	Resident # 3 medical record documentation assessed related to the resident's voiding pattern to accurately reflect the resident's status and provides sufficient data to determine the resident's potential for monitoring / retaining continence consistent with the resident's determined needs and voiding patterns. Corrective changes were made. See attachment.	12.13.12

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F 278	Continued From page 5 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessment which accurately reflected the resident's status for 1 of 2 sampled residents (Residents #3) coded on the MDS for a toileting program. Failure to accurately assess and code the MDS may affect the level of care provided by staff to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, dated April 2012, pages H-5 and H-6, states "Toileting programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to simply tracking continence status . . . random assistance with toileting or hygiene." Requirements include, "implementation of an individualized, resident-specific toileting program that was based on an assessment of the	F 278	All other Residents (8) under the Restorative Nursing for toileting; their respective medical record was assessed to ensure documentation accurately reflects the resident status related to toileting. Corrective changes were made. See attachment - "Restorative Nursing Toileting Audit". 1. CNA's educated to document at time of cares, all toileting events for resident's on Restorative Nursing toileting program to ensure timeliness of charting. See attachment: Nurse meeting minutes. 2. Restorative Nursing Coordinator will be responsible for all areas, including Toileting Program, to ensure continuity, with input by the interdisciplinary team members. Policy revised. See attachment.	11.19.12 12.13.12 12.12.12

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F 278	Continued From page 6 resident's unique voiding pattern . . . notations of the resident's response to the toileting program and subsequent evaluations . . ." Review of Resident #3's medical record occurred on all days of survey. The annual Minimum Data Set (MDS), date 09/16/12, identified the resident occasionally incontinent of urine and on a urinary toileting program. The resident's current care plan identified the resident is toileted between 6:00 a.m. to 6:30 a.m. and then every 2 to 2.5 hours. Resident #3's previous MDS, dated 06/16/12, identified the resident occasionally incontinent of urine and not on a toileting program. Resident #3's "Bladder Incontinence Evaluation" identified the resident with daily incontinence episodes. This evaluation, completed quarterly, stated on 06/21/12, "[Resident's name] toilets self [plus] she also needs reminders. Staff does this on a scheduled basis [and] needs peri [perineal] cares done while in bed. . . ." and on 09/20/12 the form stated, "[no] [change] from prior assessment . . ." A progress noted, dated 09/27/12, stated " . . . Is occ [occasionally] incontinent of bladder. Does usually toilet herself . . . See toileting care plan. Staff to remind, cue or assist as needed. During look back did have a positive Ua [urine analysis] . . ." During an interview on 11/14/12 at 3:30 p.m., a supervisory nurse manager (#2) identified staff toilet Resident #3 between 6:00 a.m. to 6:30 a.m. as this is the time the resident wakes up in the morning. This staff member reported Resident #3 will toilet independently during the day. The staff	F 278	Restorative Nursing Coordinator will monitor each resident in the Restorative Nursing Toileting program for documentation accuracy monthly for 4 quarters. Restorative Nursing Coordinator will submit quarterly audits for 4 quarters to the QI manager for review by the QI Committee. See attachment - "Restorative Nursing Toileting Audit".	12.24.12 & on- going

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F 278	Continued From page 7 member stated Resident #3's medical record lacked documentation related to the resident's voiding pattern and why staff implemented a toileting program when the last bladder assessment reported no changes in bladder incontinence. Resident #3's "Bladder Incontinence Evaluation," completed on 06/21/12 and 09/20/12, failed to provide sufficient data to determine the resident's potential for maintaining/retaining continence. Further, the data did not provide sufficient information to establish an appropriate individualized, scheduled toileting program consistent with the resident's determined needs and voiding patterns.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services during meals to 1 of 1 sampled resident (Resident #7) with specific recommendations from the speech pathologist. Failure to assist Resident #7 at mealtime according to the recommended plan of care placed the resident at risk of pocketing food and/or choking.	F 309	Resident # 7 feeding instructions were reviewed from the Speech Therapist (swallowing specialist) assessment and implemented. Staff educated to follow feeding guidelines as given by the swallow specialist: check for pocketing on both sides, cold stimulation between bites, pressure on the tongue while feeding, gently massage under chin, cues to swallow.	11.19.12 12.13.12

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F 309	Continued From page 8 Findings include: Review of Resident #7's medical record occurred on November 13-14, 2012. Medical diagnoses included Alzheimer's disease, aphagia, dysphagia, and esophogeal reflux. The current Minimum Data Set (MDS), dated 10/06/12, identified short and long term memory problems, total assistance with eating, and loss of liquids/solids; holding [pocketing] food when eating. The current comprehensive care plan stated, ". . . Focus . . . is on a mechanically altered meal plan due to swallowing problems. . . . needs total assistance with all meals and fluids. Goals. . . . will tolerate new diet order with no S/S [signs/symptoms] of pocketing or coughing. . . . Interventions. . . . Offer diet as ordered by swallow specialist. Follow guidelines as given by swallow specialist, . . ." Review of the "Speech Therapy Plan of Treatment for Dysphagia," dated 05/11/12, stated ". . . Summary, . . . Res. [resident] is pocketing foods and liquids during meal. . . . Res. spit out liquid being held in mouth. . . . Presentation of cold stimulus . . . btw [between] bites to trigger swallow. . . ." The plan of treatment also identified the following recommendations to decrease pocketing of food: ". . . Check for pocketing, Both sides. sherbet/ice cream/cold stimulus btw bites to [decrease] pocketing. gentle pressure to tongue when feeding w/ [with] utensil. gentle massage to [sic] under tongue or cheeks. . ." A speech therapy progress note, dated 06/05/12,	F 309	All other residents were audited for feeding techniques, as recommended by Speech Therapist. See Attachment. 1. All current Speech Therapist assessments are scanned into the EMR and any new assessments will also be scanned into EMR for interdisciplinary team review. 2. All resident's with feeding techniques are discretely noted on back of the name placement card at table and/or room tray. ~~See attachment sample for MLC~~ took off after talking with Becky Hanson 3. All nursing associated staff and Paid Feeding Assistants educated on Dysphagia, feeding techniques, and location of instructions. See attachments. 4. See attached "Specialized Feeding Techniques" policy.	11.19.12 11.19.12 12.13.12 12-24-12 12:57pm 12.13.12

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F 309	Continued From page 9 Identified the resident discontinued from speech therapy services with the following ongoing treatment plan: "Present sherbet/ice cream btw bites-sips to help trigger swallow. Also when feeding, gently press on tongue w/ utensil when presenting food. Gentle massage to under chin and cues to swallow needed. . . ." Observation of Resident #7 at mealtime occurred on 11/14/12 during breakfast at 7:20 a.m. and during lunch at 11:40 a.m. Observation at both meals showed the certified nurse assistant (CNA) (#5) did not assist Resident #7 using the techniques described in the Dysphagia Treatment Plan: check for pocketing on both sides; cold stimulus between bites; pressure on the tongue while feeding; gentle massage under the chin; cues to swallow. During an interview on the morning of 11/15/12, two administrative nursing staff members (#2 and #11) did not offer an explanation as to why the CNA did not follow the written feeding techniques. They further stated the information in the record is current regarding the resident's plan of care and treatment to be provided.	F 309	QI manager and/or designee will randomly monitor for compliance for 4 quarters and submit quarterly to the QI committee for review. See attachment: "Feeding Techniques Audit"	12.24.12 & on- going
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312	Resident # 7 and # 6 were assessed to be unable to carry out their grooming and oral hygiene independently. All other residents who are unable to carry out independent ADL's were identified.	12.3.12 12.12.12

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F 312	Continued From page 10 Based on observation, record review, and staff interview, the facility failed to provide the necessary services to maintain grooming and personal hygiene for 2 of 3 sampled residents (Resident #6 and #7) requiring total assistance with oral hygiene/grooming. Failure to provide grooming/oral hygiene placed Resident #6 at risk of dental problems and does not respect the personal dignity of these residents. Findings include: - Record review for Resident #6 occurred on November 13-14, 2012. Medical diagnoses included quadriplegia, multiple sclerosis, dysphagia, diabetes, and a feeding tube. The current Minimum Data Set (MDS), dated 10/02/12, identified Resident #6 with short and long term memory problems, unclear speech, rarely/never able to make self understood, severe impairment with daily decisions, and total assistance with personal hygiene. The current care plan, page 3, stated, ". . . Focus . . . DENTAL: . . . has a history of oral caries. . . . mouth tends to become dry since he has had the feeding tube placed. . . . Interventions . . . CNAs to brush [Resident #6's] teeth every am and pm. . . . May use lemon glycerin swabs to freshen mouth prn [as needed]. . . ." Observation of morning cares on 11/14/12 at 9:45 a.m. did not include toothbrushing. Observation throughout the survey showed various CNAs using lemon toothettes to perform oral care to Resident #6, but did not provide toothbrushing. During an interview on the morning of 11/15/12,	F 312	1. On non-shampoo days Res #7 and all other resident's as needed, staff will be educated to use the dry shampoo cap or designated hair spray water bottle for hair grooming. 2. Care plan of Res #6 was revised to specifically state use of toothbrush for oral cares every am and pm. CNA to do oral cares every 2 - 3 hours while awake. May use swab or toothbrush. See attachment 3. CNA's educated on proper grooming and oral cares for all residents. See attachment. See Grooming Audit monitoring tool attachment. QI manager and/or designee will randomly monitor for compliance for 4 quarters and report submitted to the QI committee via the QI manager quarterly for 4 quarters for QI committee review.	12.13.12 11.20.12 12.12.12 12.13.12 12.24.12 & on-going

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F 312	Continued From page 11 two administrative nursing staff members (#2 and #11) did not provide an explanation why staff did not complete toothbrushing with Resident #6's morning cares. - Record review for Resident #7 occurred on November 13-14, 2012. Medical diagnoses included Alzheimer's Disease, aphagia, and depression. The current MDS, dated 10/06/12, identified short and long term memory problems, rarely makes self understood, severe impairment with daily decision making, and total assistance with personal hygiene. The current care plan, page 7, stated ". . . ADL FUNCTION: Due to dementia, . . . requires assistance with ADLs. . . . Staff to comb hair daily as [resident] will allow. . . . can be resistive to cares at times . . ." Observation on 11/13/12 at 3:00 p.m. showed two CNAs (#12 and #13) transferred Resident #7 from her bed to her wheelchair. Observation showed the resident's hair unkept. The CNAs did not comb the resident's hair. Observation did not show the resident resisting assistance by the CNAs. A CNA (#13) then brought Resident #7 into the activity room for a group-style activity. Observation on 11/14/12 at 6:35 a.m. showed a CNA (#5) assisted Resident #7 with morning cares. Observation showed the resident's hair unkept. The CNA failed to comb the resident's thoroughly, and observation showed the resident's hair unkept in the back. Further observation did not show the resident resisting assistance by the CNA. The CNA (#5) then took the resident to the activity room for breakfast.	F 312		

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	355054	A. BUILDING _____ B. WING _____	11/15/2012

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F 312	Continued From page 12 During an interview on the morning of 11/15/12; two administrative nursing staff members (#2 and #11) agreed staff should comb Resident #7's hair when needed.	F 312		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the appropriate treatment and services (proper positioning) to 1 of 1 resident (Resident #6) with a feeding tube and a history of aspiration pneumonia. Failure to provide appropriate positioning to Resident #6 placed him at risk of aspiration pneumonia. Findings include: Review of Resident #6's medical record occurred on November 13-14, 2012. Medical diagnoses included quadriplegia, multiple sclerosis, dysphagia, diabetes, a history of aspiration pneumonia, and feeding tube placement. The current Minimum Data Set (MDS), dated 10/02/12, identified Resident #6 with short and	F 322	Resident #6 was identified to be at risk for aspiration/illness due to postioning with feeding tube No other residents in our facility have a feeding tube. Bed frame physically marked to designate head of bed elevation. CNA's educated that all cares need to be done with bed remaining at no < 30 degrees. See attachment. All nursing staff educated that all cares need to be done with bed remaining at no <30 degrees.	12.3.12 N/A 11.19.12 11.20.12 12.13.13

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F 322	Continued From page 13 long term memory problems, unclear speech, rarely/never able to make self understood, severe impairment with daily decisions, extensive assistance with transfers and bed mobility. The MDS identified no swallowing disorder; however, the medical record identified feeding tube placement due to dysphagia and a history of aspiration pneumonia. The comprehensive care plan stated "FEEDING TUBE: Feeding tube was placed on 06/21/12. . . . HOB [head of bed] elevated at 30-45 degree angle at all times. . . ." Observation on 11/14/12 from 9:45 a.m.-10:00 a.m. showed two CNAs (#5 and #14) provided morning cares and one staff nurse (#8) completed dressing changes to Resident #6. Observation initially showed the resident's bed positioned at approximately 30 degrees and the resident's enteral nutrition running on a pump. The CNAs then lowered the HOB, and observation showed the enteral nutrition continued to run. After the CNAs provided hygiene care to the resident, the nurse changed the resident's dressings to the coccyx and the resident's suprapubic catheter site. The resident's HOB remained flat for approximately 15 minutes while the staff provided care, and during this time, the resident's feeding continued to run. During an interview on the morning of 11/15/12, two administrative nursing staff members (#2 and #11) agreed staff should stop the feeding prior to laying the head of the bed flat to provide cares. These staff members provided a facility policy; however, this policy did not address correct positioning.	F 322	Staff educated If resident lowered < 30 degrees, nurse to be notified to stop nutrition via feeding tube prior to cares and restart when cares are completed. Staff educated on s/s of aspiration. See attachment. Tube Feeding policy revised to address correct positioning. See attachment. Director of Nursing and/or designee will monitor compliance at random for 4 quarters. Audit will be submitted by Director of Nursing to the QI manager quarterly x4 quarters for QI Committee review. See "Feeding Tube and Cares Protocol Audit" Tool attachment.	12.13.12 12.13.12 12.24.12

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy and procedure review, and staff interview, the facility failed to properly store potentially hazardous food in a safe and sanitary manner in 3 of 4 kitchen/kitchenette areas (main kitchen, Unit 1, and Heritage Wing). Failure to follow safe food sanitation practices has the potential to increase the risk of foodborne illness and can affect all residents who eat food prepared and stored in these areas. Findings include: Review of the facility policy titled "Labeling and Dating of Perishable Foods" occurred on 11/15/12. This policy, dated February 2012, stated, ". . . It is the Southwest Healthcare Services Policy to label and date all perishable foods in freezers, refrigerators, and storerooms to prevent consumption of potentially hazardous foods. . . . Foods will be dated with date in which placed in refrigerator/freezer/storeroom in an airtight container. . . . Foods will then be dated	F 371	Cold refrigerated food storage was checked : 1) Kitchen 2) Activity Room 1 3) Heritage Wing All outdated/unlabeled foods were disposed of. Activity 2 resident refrigerator/freezer was checked for outdated/unlabeled food items. All outdated/unlabeled foods were disposed of.	11.19.12 11.19.12

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F 371	Continued From page 15 with date or day by which the food should be consumed or discarded (unless marked with a use-by-date). . . Immediately discard all food items that do not possess labels, dates, or have expired. . . ." Review of the facility policy titled "Recommend Food Storage Chart" occurred on 11/15/12. This policy, dated February 2012, identified the following storage times for foods in refrigerators: 3 to 5 days for open luncheon meat products, 2-3 weeks for storing open summer sausage in the refrigerator, and 1 week for a cooked ham after opening. Review of resident council minutes occurred on 11/15/12. The minutes, dated 09/11/12, stated the following concern, ". . . Dietary: . . . It was also stated that certain lunch meat had a funny taste, but were unable to identify which day it was served. . . . " During a tour on 11/13/12 starting at 11:00 a.m., the main kitchen's walk-in refrigerator contained the following items: * undated, unopened 32 ounce Mighty Shake supplement with a manufacturer's label to store up to 14 days after thawing. A dietary manager (#3) was unable to identify how long the Mighty Shake had been thawed. * roast beef deli meat resealed in a plastic bag with no date on to identify when the meat had been opened * a ham roast wrapped in plastic, dated 10/30 * an undated serving tray with approximately 16 pieces of sliced salami * an unopened lowfat buttermilk with the sell by date of 10/25/12	F 371	3. Refrigerators with facility stocked food items will have 2 dates: date received and use by date. Any foods with a manufacturer Use By date, that date will be followed. Resident designated foods will be labeled with resident name and date brought into facility. Foods will be disposed of after 3 days, or by manufacturer use by date. Dietary Staff educated to monitor twice weekly resident activity fridges 1 and 2, Heritage Wing and kitchen cold food storage. Monitor forms available for documentation of findings at each fridge. See attachment. Nursing educated to assist family members and/or resident to label foods for resident with resident name and date of food placed in above refrigerators. Nursing educated to assist family members and/or resident to label foods for resident with resident name and date of food placed in above refrigerators.	12.14.12 12.14.12 12.13.12

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F 371	Continued From page 16 During a facility tour on 11/15/12 at 8:50 a.m., the following items were found stored in the facility: * Unit 1 freezer contained Resident #13's two 1/2 gallon ice creams dated best by 08/31/11 and 10/18/11, and a frozen pizza dated better if used by 03/30/11. * Heritage Wing refrigerator contained an open package of summer sausage not completely sealed and dated 10/30/12, heavy whipping cream with use by date 11/14/12, and two yogurts with use by dates of 11/09/12. * Heritage Wing freezer contained an individual cup size ice cream with the lid partially open and half the ice cream gone. The ice cream container had writing which stated "med pass" with a date of 11/13. During an interview on 11/15/12 at 9:10 a.m., a supervisory dietary staff member (#3) stated she does quarterly checks of the units where she will look through the refrigerators and freezers. The dietary staff member confirmed she had discarded the meat and dairy items found on 11/13/12 and collected the items on 11/15/12 to be discarded. The facility failed to follow their established policy and procedures regarding monitoring of expiration and storage dates and failed to monitor perishable food items kept in facility refrigerators and freezers.	F 371	Nurses and CMA's educated to discard, after each use, any food products used for med pass. See attachments for education. Families notified via letter the need to label and date resident foods. See attachment. Dietary will monitor fridges/cold food storage areas for outdated/unlabeled food items for 4 quarters and submit quarter reports x4 to the QI manager for QI Committee review. Outdated/Undated Food Items audit. See attachment.	12.14.12 12.24.12 & on-going