STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 Standard Medicare/Medicaid recertification survey and complaint survey started 06/07/21 and concluded 06/10/21.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident	F 565		7/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2021

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 565	Continued From page 1 representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on information provided by a complainant, resident council interview, review of facility policy, review of resident council minutes, and staff and resident interviews, the facility failed to ensure 1 of 4 residents (Resident B) attending the Resident Council interview and two supplemental residents (Resident A and E) obtained follow up and resolution of grievances. Failure to implement the facility's resident council and grievance policies inhibited the residents' right to ensure prompt resolution of all grievances. Findings include: Review of the facility policy/procedure titled "Resident Council" occurred on 06/10/21. This policy, dated 06/26/17, stated, "All grievances discussed at the council meeting will be written in the minutes and filed on the Suggestion or Concern form, the procedure for handling the grievances as requested and as appropriate, with plan of correction submitted to the administrator for final disposition." Review of the facility policy titled "Patient/Resident Grievance and Complaint Policy and Procedure" occurred on 06/10/21. This policy, dated August 2019, stated, "Within 7 days of receiving the grievance/complaint, the Grievance Officer, will notify the patient/resident of the status and/or resolution of the investigation. . . . All information, communication	F 565	1)Social Services will change their practice, make sure a grievance form is filled out for any complaints, and make sure to implement the facility's resident council and grievance policies to ensure prompt resolution of all grievances/complaints made by residents. 2) Any resident who has a complaint/grievance about anything has the potential to be affected. 3) Social work designee will be instructed on 7/7/2021 on the importance of following the resident council and grievance policies on resident A, B, and E and any other resident who has a compliant/ grievance and also instructed on policies titled, " Resident Council and Patient/Resident Grievance and Complaint". 4) Social Work designee or Director of Nursing will monitor all residents that have a complaint/grievance to make sure that within 7 days of receiving the grievance/complaint that the resident is notified of the status and our resolution of the investigation. Monitoring will be done weekly x4, monthly x3, then quarterly x1 year. Monitoring to begin on 7/8/2021. If concerns are identified, immediate corrective action will be implemented. Social work designee will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

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F 565	Continued From page 2 and follow up will be maintained in the Grievance Officer's office." Review of Resident Council meeting minutes from December 1, 2020 to May 7, 2021 showed five of six meetings included food related concerns with issues unresolved. Review of information from a complainant identified concerns communicated to the facility without follow up on the status and/or resolution of the grievances regarding overcooked, undercooked, and tough food. - During a confidential interview on the afternoon of 06/07/21, Resident A stated, "they need a decent cook," and reported the dinner rolls used to be raw and now they are burned. - During the group interview on 06/08/21 at 2:00 p.m., Resident B stated, "you can complain but it doesn't seem like anything gets done about it including food." - During a confidential interview on 06/09/21 at 2:34 p.m., Resident E stated, "The supper last night was terrible. I have never seen macaroni and cheese like that with cottage cheese as the cheese and it being hot. The fish was pale and looked uncooked. I have told them at Resident Council over and over about the food issues, but it hasn't changed." During an interview on 06/10/21 at 11:32 a.m., an administrative staff member (#1) confirmed staff did not document the grievances/concerns from the resident council meeting, staff did not notify residents or family members with concerns	F 565	5) 7/9/2021	

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F 565	Continued From page 3 voiced to the facility within seven days of the status or resolution of the investigation, the involved departments failed to provide written investigative results along with a plan for resolution/auditing of action items, and/or final resolution of the concern.	F 565		
F 657 SS=D	Care Plan Timing and Revision 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:	F 657		7/9/21

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F 657	Continued From page 4 THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 09/12/19 AND THE FEDERAL SURVEY ON 10/24/19. Based on observation, record review, and resident and staff interview, the facility failed to review and revise comprehensive care plans to reflect the residents' current status for 1 of 12 sampled residents (Resident #7). Failure to review and accurately revise the care plan limited the staff's ability to provide a physician ordered diet. Findings include: Observation and resident interview on 06/07/21 at 4:56 p.m. showed Resident #7 with a regular diet, regular texture, thin liquids, regular size portions, and a salt packet. Resident #7 stated, "I was under the impression they would have low sodium diets when I was admitted here." Review of Resident #7's medical record occurred on all days of survey. Medical conditions included edema, pulmonary hypertension, and End Stage Renal Disease (ESRD). A current physician's order identified, "Low-sodium diet Level 4 (no changes in food consistency) texture, Regular (thin) consistency." A current care plan identified, "DIET: Low-sodium diet Level 4 (no changes in food consistency) texture, Regular (thin) consistency. Provide, serve diet as ordered. I am served a REGULAR diet, small portion . . ." Resident #7's meal tray card showed a regular diet and regular portions.	F 657	1)The interdisciplinary team (care plan team) will change their practice and make sure care plans are reviewed, updated, and revises and also they will make sure that all residents diets are care planned as ordered. 2) Any resdisent requiring a care plan review and any resident who has had a change in their diet has the potential to be affected. 3)The interdisciplinary team (care plan team) will be instructed on 7/7/2021 on the importance of updating all care plans to reflect the residents current status, the importance of making sure all diets reflect the current physician orders, and on the policy titled "Skilled nursing facility resident care planning." This instruction was for resident #7 and any other resident requiring care plan revisions or needing current care plans. Resident #7 care plan was updated on 6/25/2021 in regards to the diet. 4) MDS coordinator or designee will monitor resident #7 and any other residents for ensuring care plans are updated. Monitoring will be done weekly x4, monthly x3, then quarterly x 1 year. Monitoring to begin on 7/8/2021. If concerns are identified, immediate corrective action will be implemented. MDS coordinator will submit a report of the monitoring results tro eh QA committee at each scheduled meeting.	

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F 657	Continued From page 5 During an interview on 06/09/21 at 3:14 p.m.., an administrative nurse (#11) stated, "Yes I would put the current physician ordered diet on the care plan." He/she was unsure why Resident #7's care plan listed a regular and low sodium diet.	F 657	5)7/09/2021	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to follow professional standards of practice when priming an insulin pen (injection device) for 2 of 2 residents (Resident #5 and #11) observed during insulin administration. Failure to properly prime the insulin pen prior to administration may result in the resident receiving an inaccurate dose of insulin. Findings include: Review of the "Instructions for Use" (uspl.lilly.com) for the Humalog KwikPen (brand of insulin injection device), revised April 2020 . . . , stated, ". . . Step 5: Pull off the Outer Needle Shield. . . . Pull off the Inner Needle Shield. . . . Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little	F 658	1)Nursing will change their practice and make sure they remove the insulin cover on the insulin pens so they can visualize the insulin when priming the pen with 2 units of insulin, Dietary will change their practice and make sure they follow the diet for residents and use the menu extensions as prescribed by the physician. 2) Any resident requiring the administration of insulin or a resident who has a special therapeutic diet has the potential to be affected. 3) Nursing will be instructed on 7/7/2021 on the importance of removing the cap on a insulin pen so they can visualize the insulin and on the instructions for use for novolog flex pen, this instruction was for resident #5 and #11 and any other resident requiring insulin. Dietary will be instructed on 7/7/2021 on the importance of following the prescribed therapeutic diet, using the diet extension and the	7/9/21

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F 658	Continued From page 6 insulin. Step 6. To prime your Pen, turn the Dose Knob to select 2 units. Step 7. Hold your Pen with the needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle and repeat priming steps 6 to 8. . . ." Review of "Instructions for Use" (Novomedlink.com) for the NovoLog Flexpen (brand of insulin injection device), revised April 2015 . . . stated, ". . . Preparing your NovoLog FlexPen . . . C. Pull off the big outer needle cap. D. Pull off the inner needle cap and dispose of it. . . . Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: e. Turn the dose selector to select 2 units. F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. . . . A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 tries, do not use the NovoLog FlexPen . . ." - Observation on 06/08/21 at 5:28 p.m. showed a nurse (#2) prepare a Humalog Kwikpen to administer insulin to Resident #5. The nurse	F 658	policy titled," Responsibility for transmitting diet orders, this instruction was for resident #7 and #2 and any other resident that has the potential to be affected. Potassium and low sodium extensions will be added to the menus. 4) DON or designee will monitor resident #5, and #11 and any other resident that utilizes insulin. Dietary will monitor resident #7 and #2 to make sure they are following the prescribed therapeutic diet and using diet extension and any other resident that has a therapeutic diet. Monitoring will be done weekly x4, monthly x3, then quarterly x 1 year. Monitoring to begin on 7/8/2021. If concerns are identified, immediate corrective action will be implemented. Dietary and Nursing will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 7/9/2021	

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F 658	Continued From page 7	F 658		

removed the outer and inner covers, held the pen horizontally and turned the dose knob to one unit. The nurse (#5) failed to hold the device upright and failed to select 2 units to prime the pen per the manufacturer's instructions.

- Observation on 06/09/21 at 7: 59 a.m. showed a nurse (#3) prepare a NovoLog FlexPen to administer insulin to Resident #11. Without removing the covers, the nurse held the pen horizontally, stated she would select "one to two" on the dose knob, dialed the pen to two and pressed the push button. The nurse (#3) failed to hold the device upright and failed to remove the cover in order to visualize the insulin.

During an interview in the afternoon of 06/10/21, an administrative staff member (#1) confirmed staff should follow the manufacturer's instructions when using insulin pens.

2. Based on observation, record review, review of facility policy, review of meal tray cards, and resident and staff interview, the facility failed to follow professional standards of practice for or 2 of 2 sampled residents (Resident #2 and #7) who had a physician's order for a low sodium diet or low potassium diet. Failure to serve a diet as ordered by the physician may cause adverse consequences for the resident.

Findings include:

Review of the facility policy titled "Responsibility for Transmitting Diet Orders" occurred on 06/10/21. This undated policy, stated, ". . . Meals shall be assembled in accordance with the diet order prescribed for the patient."

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F 658	Continued From page 8 - Review of Resident #2's medical record occurred on all days of survey. The physician's orders stated Consistent Carbohydrate diet, cut-up meat texture, Regular (thin) consistency, low potassium, and small portion. Resident #2's meal tray card contained a green dot which alerted staff to the low potassium diet as ordered. The current care plan stated, "I have a nutritional problem related to . . . a history of anorexia and protein calorie malnutrition. . . Intervention: Provide and serve diet as ordered. Consistent CHO [carbohydrate], small portions, level 4. Cut up all meats, fruits and other food that is bulky. . ." During an interview on 06/09/21 at 11:06 a.m., when asked an administrative dietary staff (#9) confirmed staff should use diet extensions (a guide that explains what foods are allowed on each therapeutic or texture modified diet). The extension did not contain guidelines for a low potassium diet. - Observation and resident interview on 06/07/21 at 4:56 p.m. showed Resident #7 with a regular diet, regular texture, thin liquids, regular size portions, and a salt packet. Resident #7 stated, "I was under the impression they would have low sodium diets when I was admitted here." Review of Resident #7's medical record occurred on all days of survey. Medical conditions included edema, pulmonary hypertension, and End Stage Renal Disease (ESRD). A current physician's order identified, "Low-sodium diet Level 4 (no changes in food consistency) texture, Regular (thin) consistency."	F 658		

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F 658	Continued From page 9 A current care plan identified, "DIET: Low-sodium diet Level 4 (no changes in food consistency) texture, Regular (thin) consistency. Provide, serve diet as ordered. I am served a REGULAR diet, small portion . . ." Resident #7's meal tray card showed a regular diet and regular portions. - During an interview on 06/09/21 at 11:06 a.m., when asked an administrative dietary staff (#9) confirmed staff should use diet extensions.	F 658		
F 800 SS=F	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. 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 information provided by a complainant, observation, review of professional reference, review of facility policy, Resident Council meeting minutes; review of employee education records, review of dietary department staffing schedule, meal test trays, review of facility diets/meal tray cards/menus, record review, and staff and resident interviews, the facility failed to ensure sufficient and competent dietary staff to maintain a functional food and nutrition services on 4 of 4 days of survey (June 7-10, 2021). The failure to ensure sufficient and competent dietary staff, provide education on physician ordered diets, provide education on food preparation methods that provide palatable and attractive food, and provide food in a form	F 800	1)Dietary will change their practice and make sure dietary staff receive food and nutrition related training, will utilize the dietary menu extensions, utilize menu's guide or meal tray cards for residents, will provide palatable and attractive food, and will provide food in a form designed to meet the individual resident needs. 2) Any resident who is on a therapeutic or specialized diet has the potential to be affected. 3) Dietary will be instructed on 7/7/2021 on the importance making sure staff receive food and nutrition training, that the CDM works 35 hours per week at the Care Center, utilizing the dietary menu	7/9/21

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F 800	Continued From page 10 designed to meet individual resident needs may result in decreased meal intakes, unintended weight changes, inadequate nutrition, choking, aspiration, aspiration pneumonia, and worsening medical conditions. Findings include: - The facility failed to employ sufficient staff to ensure functional food and nutrition services. See F801. - The facility failed to ensure dietary staff members including a supervisor received food and nutrition related training. See F802. - The facility failed to utilize the dietary menu extensions (a guide that shows what to serve for each therapeutic and texture modified diet) for residents with physician's orders for therapeutic or texture modified diets. See F803. - The facility failed to utilize menu guide and/or meal tray cards for residents with physician's orders for therapeutic or texture modified diets. See 803. - The facility failed to provide palatable and attractive food for residents. See F804. - The facility failed to provide food in a form designed to meet individual resident needs for residents with physician's orders for texture modified diets. See F805.	F 800	extensions, utilize meal tray cards, providing palatable and attractive food, and provide to meet the individual residents needs. This instruction was for all residents. See F801, F802, F803, F804, F805. 4) Dietary will monitor residents to make sure that when serving food staff is using a meal card, utilizing the dietary extensions, providing palatable food, make sure staff education completed prior to starting, and providing food to meet the needs of the resident. Monitoring will be done weekly x4, monthly x 3, then quarterly x one year. Monitoring to begin on 7/8/2021. If concerns are identified, immediate corrective action will be implemented. Dietary will submit a report of the monitoring results to the QA committee at each scheduled meeting 5)7/9/2021	
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing	F 801		7/9/21

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F 801	Continued From page 11 The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F 801		

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F 801	Continued From page 12 November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 09/12/19 Based on review of facility policy, review of	F 801	1) The Dietary Manager will be instructed on 7/7/2021 on the importance of working 35 hours per week at the Care Center and also on the importance of making sure dietary personnel have specific	

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F 801	Continued From page 13 dietary department staffing schedule, review of employee education records, and staff interviews, the facility failed to employ sufficient staff to ensure functional food and nutrition services. Failure to ensure sufficient competent staff to train and evaluate the dietary staff on providing therapeutic diets, texture modified diets, and food preparation methods that result in safe, palatable, and attractive food may result in decreased meal intakes, weight loss, choking, aspiration, aspiration pneumonia, and worsening medical conditions. Findings include: Review of the facility policy titled "St. Luke's Sunrise Center Facility Assessment" occurred on 06/10/21, this undated policy stated, ". . . Dietary: . . . Full time Food Service Manager . . ." Review of the dietary department schedule occurred on 06/10/21 and showed the Certified Dietary Manager (CDM) scheduled from 20-32 hours per two-week period from March 28, 2021 to June 5, 2021 (i.e., not full time). During an interview on the morning of 06/07/21, an administrative dietary staff member (#9) stated, "The supervisor (#10) is not a CDM, but she fills in for me because I am often working at the hospital, but I haven't trained her yet." Review of the staff education for dietary staff occurred on the morning of 06/10/21. Each of these records included a "Yearly Education Transcript" dated from June 11, 2020 to June 10, 2021. No dietary specific education was included in the transcript for 9 of 15 dietary staff members	F 801	dietary education upon hire and yearly there after. 2)Any dietary manager that does not work full time our provide staff with specific dietary education has the potential to be affected and has the potential to affect all residents. 3) The current dietary manager is a CDM, she will make sure her hours at the Care Center are 35 hours per week and that dietary personnel have specific dietary education. Dietary staff completed the Serve Safe Handler Course and Assessment. Dietary staff will have monthly meetings on food safety, and nutrition. 4) Human Resources will monitor the dietary manager to ensure that she has 35 hours per week at the Care Center, and the dietary manager will monitor dietary personnel to make sure they have specific education; monitoring will be done weekly x4, monthly x 3, and then quarterly x one year. Monitoring will begin on 7/8/2021. If concerns are identified immediate corrective action will be implemented. HR and Dietary manager will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 7/9/2021	

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F 801	Continued From page 14 (Staff #10, #14, #15, #16, #17, #18, #19, #20, and #21). During an interview on the morning of 06/10/21, a human resources staff member (#7) confirmed the facility had not provided dietary training for their employees on their electronic education system, nor had the department provided dietary related training for the personnel files. During an interview on 06/09/21 at 11:32 a.m. an administrative staff member (#1) confirmed the CDM splits his/her hours between the hospital and the long-term care center.	F 801		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by:	F 802		7/9/21

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F 802	Continued From page 15 Based on review of dietary department schedule, staff education records, and staff interviews, the facility failed to ensure that 9 of 15 dietary staff members including a supervisor (Staff #10, #14, #15, #16, #17, #18, #19, #20, and #21) received food and nutrition related training/orientation. Failure to provide education on physician ordered diets may result in suboptimal nutritional status, unplanned weight changes, choking, aspiration, aspiration pneumonia, and worsening medical conditions. Findings include: Review of the staff education for Dietary Staff (Staff #10, #14, #15, #16, #17, #18, #19, #20, and #21) occurred on the morning of 06/10/21. Each of these records included a "Yearly Education Transcript" dated from June 11, 2020 to June 10, 2021. No dietary specific training was included in the transcript. During an interview on the morning of 06/07/21, an administrative dietary staff member (#9) stated, "the supervisor is not a Certified Dietary Manager (CDM) but she fills in for me because I am often working at the hospital, but I haven't trained her yet." Review of the dietary department schedule occurred on 06/20/21 and showed a dietary staff member (#10) scheduled as a supervisor since February 2021. During an interview on 06/08/21 at 9:50 a.m., an administrative dietary staff member (#10) confirmed the facility lacked department specific training and orientation for the dietary staff.	F 802	1)THe Dietary Manager will be instructed on 7/7/2021 on the importance of all dietary staff receiving the necessary education to safely carry out the function of the food service. 2)Any dietary personnel that does not have the correct education has the potential to be affected and has the potential to affect all residents. 3) Dietary Manager and personnel will be instructed on 7/7/2021 on the importance of completing Serve Safe food handler course and assessment and to have monthly nutrition and dietary inservices. 4) Dietary manager will monitor dietary personnel to make sure all required training courses are completed upon hire and yearly there after. Monitoring will be done weekly x4, monthly x3, the yearly x 1 year. Monitoring to begin on 7/8/2021. If concerns are identified, immediate corrective action will be implemented. Dietary manager will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 7/9/2021	

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F 802	Continued From page 16 During an interview on the morning of 06/10/21, a human resources staff member (#7) confirmed the facility failed to provide dietary training for their employees on their electronic education system, nor had the department provided dietary related training for the personnel files.	F 802		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 803		7/9/21

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F 803	Continued From page 17 1. Based on observation, review of facility menus, review of facility diet type report, review of facility policy, record review, review of facility meal tray cards, review of professional reference, and staff interviews, the facility failed to utilize the dietary menu extensions (a guide that shows what to serve for each therapeutic and texture modified diet) for 9 of 9 sampled residents (Resident #1, #3, #5, #6, #7, #11, #13, #17, and #19) and 5 of 5 supplemental residents (Resident #2, #8, #14, #15, and #18) with physician's orders for therapeutic or texture modified diets. Failure to serve food according to facility's menus and physician's diet orders placed residents at risk for inadequate nutrition, unplanned weight loss/gain, choking, aspiration, aspiration pneumonia, and worsening of medical conditions. Findings include: Review of the facility policy titled "Responsibility for Transmitting Diet Orders" occurred on 06/10/21. This undated policy, stated, "Tray cards shall contain the patient's name, the room number, and the prescribed diet order. . . . Meals shall be assembled in accordance with the diet order prescribed for the patient." Review of the facility policy titled "Resident Menus" occurred on 06/10/21. This undated policy, stated, ". . . Established national guidelines will be used to assure menus meet the nutritional needs of residents. . . . Resident menus shall include, but not be limited to: Regular, No Added Salt, Consistent Carbohydrate, Level 3 (Dysphagia [swallowing difficulties] Advanced/Soft), Level 2 (Dysphagia Mechanically Altered/Mechanical Soft), and Level	F 803	1) The Dietary Manager will change her practice and make sure all residents have meal tray cards, and will utilize the dietary menu extensions during all meals. 2) Any resident who requires a therapeutic diet, or who is admitted here that is required to have a meal tray card has the potential to be affected. 3) Dietary manager and dietary personnel will be instructed on 7/7/2021 on the importance of utilizing the dietary menu extensions, and making sure all residents have a meal tray card, this instruction was for residents # 1,#3, #5, #6, #7, #11, #13, #17, # 19, #2, #8, #14, #15, #18, and any other resident who has the potential to be affected. Dietary personnel also instructed on policies title, "Responsibility for Transmitting Diet Orders,", " Diet Type Report", "Resident Menus". Dietary staff instructed on how to use the menu extensions. All residents have meal tray cards as of 7/9/2021. 4) Dietary Manager will monitor resident #1, #2, #7 to make sure they have meal tray cards, and will monitor resident # 1, #3,#5, #6, #7, #11, #13, #17, #19, #2, #8, #14, #15, #18 to make sure they are utilizing the dietary menu extensions and for all other residents. Monitoring will be done weekly x4, monthly x3, then yearly x 1 year. Monitoring to begin on 7/8/2021. If concerns are identified, immediate corrective action will be implemented. Dietary manager will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 7/9/2021	

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1 (Dysphagia Puree) . . . Diet orders should be consistent with the approved diet manual at all times."

Review of facility menus occurred on all days of survey. Menu extensions showed:
* Regular Diet
* DB-CCO Diet (Diabetic-Consistent Carbohydrate)
* NAS (No Added Salt) "a Regular Diet with the salt shaker removed from the table"
* LF (Low Fat)
* MS Chp (Mechanical Soft Chopped)
* MS Grd (Mechanical Soft Ground)
* PUR (Pureed)

Review of the facility report titled, "Diet Type Report" occurred on 06/10/21. This report identified 14 residents (Resident #1, #2, #3, #5, #6, #7, #8, #11, #13, #14, #15, #17, #18, and #19) with physician's orders for therapeutic or texture modified diets.

Observations during meal service on June 7-10, 2021, showed staff failed to utilize the menu extension guide during 6 of 6 meals observed (evening meal of 06/07/21, noon meal of 06/08/21, evening meal of 06/08/21, noon meal of 06/09/21, evening meal of 06/09/21, and noon meal of 06/10/21).

During an interview on 06/09/21 at 11:06 a.m., when asked an administrative dietary staff (#9) confirmed staff should use diet extensions.

During an interview on 06/10/21 at 10:01a.m., when asked how he/she knows what is served on therapeutic and texture modified diets, a dietary

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F 803	Continued From page 19 staff member (#14) stated, "we look at the dots on the tray cards and the orange dot is for cut up meat or chopped meats but oh that is not really clarified if it is for Level 3, 2, or 1, the yellow dot is consistent carbohydrate, the green dot is low potassium, the red dot is low salt and we just omit the salt, and the blue dot is low fat and we just decrease butter/fat and offer lean meats." A second dietary staff member (#13) stated, he/she "looks at the diet menu extension for scoop sizes before serving but we do not use the menu extensions when serving we look at the typed sheet by the serving line that lists the resident's names, preferences, and diet order." When asked how they knew what foods, consistencies, or amounts are to be served when the extension guide is not used he/she did not have an answer. 2. Based on observation, review of facility menus, review of facility diet type report, review of facility policy, record review, review of facility meal tray cards, review of professional reference, and staff interviews, the facility failed to utilize menu guide and/or meal tray cards for 3 of 14 residents (Resident #1, #2, and #7) with physician's orders for therapeutic or texture modified diets. Failure to serve food according to facility's menus and physician's diet orders, utilizing a menu guide or meal tray card placed residents at risk for inadequate nutrition, unplanned weight loss/gain, choking, aspiration, aspiration pneumonia, and worsening of medical conditions. Findings include: Review of the facility policy titled "Responsibility for Transmitting Diet Orders" occurred on	F 803		

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06/10/21. This undated policy, stated, "Tray cards shall contain the patient's name, the room number, and the prescribed diet order. . . . Meals shall be assembled in accordance with the diet order prescribed for the patient."

Review of the facility policy titled "Resident Menus" occurred on 06/10/21. This undated policy, stated, ". . . Established national guidelines will be used to assure menus meet the nutritional needs of residents. . . . Resident menus shall include, but not be limited to: Regular, No Added Salt, Consistent Carbohydrate, Level 3 (Dysphagia [swallowing difficulties] Advanced/Soft), Level 2 (Dysphagia Mechanically Altered/Mechanical Soft), and Level 1 (Dysphagia Puree) . . . Diet orders should be consistent with the approved diet manual at all times."

Review of facility menus occurred on all days of survey. Menu extensions showed:
* Regular Diet
* DB-CCO Diet (Diabetic-Consistent Carbohydrate)
* NAS (No Added Salt) "a Regular Diet with the salt shaker removed from the table"
* LF (Low Fat)
* MS Chp (Mechanical Soft Chopped)
* MS Grd (Mechanical Soft Ground)
* PUR (Pureed)

Review of the facility report titled, "Diet Type Report" occurred on 06/10/21. This report identified 14 residents (Resident #1, #2, #3, #5, #6, #7, #8, #11, #13, #14, #15, #17, #18, and #19) with physician's orders for therapeutic or texture modified diets.

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- Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, "I have potential for nutritional problem related to poor fitting lower denture, I have diagnosis of protein calorie malnutrition . . . Intervention: . . . serve diet as ordered: Regular-small portion, level 2 (dysphagia mechanical altered) ground meat." The physician's order stated, "Regular - Small Portion diet Level 2 (dysphagia, mechanically altered) texture, Regular (thin) consistency, ground meat. May have fruits in the diet." The resident did not have a meal tray card for dietary staff to refer to/follow.

Observation on 06/08/21 at 12:05 p.m. showed Resident #1 in his/her room with no meal tray card eating regular baked ziti (a type of pasta) with ziti pieces one inch or longer, a regular breadstick cut into four approximately one inch pieces, diced canned beets approximately one fourth inch in diameter, and regular fresh pineapple approximately one inch in length. The menu extension for Resident #1's diet showed, MS (Mechanical Soft) ziti, mashed fruit, minced and moist vegetable, and soaked breadstick.

Observation on 06/09/21 at 11:52 p.m. showed Resident #1 in his/her room with no meal tray card eating regular tater tot casserole, regular canned carrot slices approximately one inch in diameter, regular white bread cut in half, and diced canned peaches approximately one fourth inch in diameter. The menu extension for Resident #1's diet showed, MS tater tot casserole, mashed fruit, minced and moist vegetable, and soaked bread.

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Observation on 06/09/21 at 5:44 p.m. showed Resident #1 in his/her room with no meal tray card eating ground pork chop, mashed potatoes with gravy, cooked yellow squash approximately 1 inch or more in diameter, a regular bun/roll, and regular blueberry dessert. Menu extension for Resident #1's diet showed, soft and bite sized pork chop, moistened mashed potatoes and gravy, soft and bite sized roasted squash, soaked roll, and regular blueberry dessert.

- Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, "I have a nutritional problem related to . . . a history of anorexia and protein calorie malnutrition. . . Intervention: Provide and serve diet as ordered. Consistent CHO [carbohydrate], small portions, level 4. Cut up all meats, fruits and other food that is bulky. . ." The physician's orders stated Consistent Carbohydrate diet, cut-up meat texture, Regular (thin) consistency, low potassium, and small portion. Resident #2's meal tray card contained a green dot which alerted staff to the low potassium diet as ordered.

- Observation and resident interview on 06/07/21 at 4:56 p.m. showed Resident #7 with a regular diet, regular texture, thin liquids, regular size portions, and a salt packet. Resident #7 stated, "I was under the impression they would have low sodium diets when I was admitted here."

Review of Resident #7's medical record occurred on all days of survey. Medical conditions included edema, pulmonary hypertension, and End Stage Renal Disease (ESRD). A current physician's order identified, "Low-sodium diet

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F 803	Continued From page 23	F 803		

Level 4 (no changes in food consistency) texture, Regular (thin) consistency."

A current care plan identified, "DIET: Low-sodium diet Level 4 (no changes in food consistency) texture, Regular (thin) consistency. Provide, serve diet as ordered. I am served a REGULAR diet, small portion . . ." Resident #7's meal tray card showed a regular diet and regular portions.

During an interview on 06/09/21 at 8:19 a.m., a dietary staff member (#12), stated, "there isn't a tray card for Resident #1 yet." Medical record identified Resident #1's admit date was 16 months ago.

During an interview on 06/09/21 at 10:45 a.m. an administrative dietary staff member (#9) stated, "We don't use the tray cards because we are waiting for new ones, and many are in need of significant changes, but we use the menu extensions." When asked if they have a policy or guidelines that specifies what diet extension to follow or what food items should be served for a diet that is not on the menu extensions such as low sodium or low potassium, he/she confirmed they did not.

During an interview on 06/10/21 at 10:01a.m., when asked how he/she knows what is served on therapeutic and texture modified diets, a dietary staff member (#14) stated, "we look at the dots on the tray cards and the orange dot is for cut up meat or chopped meats but oh that is not really clarified if it is for Level 3, 2, or 1, the yellow dot is consistent carbohydrate, the green dot is low potassium, the red dot is low salt and we just omit the salt, and the blue dot is low fat and we

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F 803	Continued From page 24 just decrease butter/fat and offer lean meats." A second dietary staff member (#13) stated, he/she "looks at the diet menu extension for scoop sizes before serving but we do not use the menu extensions when serving we look at the typed sheet by the serving line that lists the resident's names, preferences, and diet order." When asked how they knew what foods, consistencies, or amounts are to be served when the extension guide is not used he/she did not have an answer.	F 803		
F 804 SS=D	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 by: Based on information provided by a complainant, review of Resident Council meeting minutes, meal test trays, and resident interviews, the facility failed to provide palatable and attractive food for 3 of 3 confidential residents (Resident A, B, and E). The failure to provide palatable and attractive food may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of Resident Council meeting minutes from December 1, 2020 to May 7, 2021 showed	F 804	1)Dietary will change their practice and make sure that food and drinks are palatable, attractive, and at a safe and appetizing temperature. 2) Any resident who does receive food or drink that is palatable, atrractive and at a safe and appetizing temperature has the potential to be affected. 3) Dietary will be instructed on 7/7/2021 on the importance of providing food that is palatable, attractive and at an appetizing temperature for resident A, B, and E and any other resident who has concerns with food. The facility will have a resident food	7/9/21

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F 804	Continued From page 25 five of six meetings included concerns of food being overcooked, undercooked, and tough. Review of information from a complainant identified concerns of food being overcooked, undercooked, and tough. - During a confidential interview during the survey Resident B stated, "They have tough chicken pieces, hamburger buns that are dry, and at times burnt hamburgers." - During a confidential interview during the survey Resident A stated, "they need a decent cook," and reported the dinner rolls used to be raw and now they are burned. The surveyors received an evening meal test tray on 06/08/21 at 5:35 p.m. The meal consisted of under browned parmesan cod tasting of flour, overcooked mixed vegetables, and summer macaroni and cheese with white chunks of cottage cheese mixed with macaroni. - During a confidential interview during the survey Resident E stated, "The supper last night was terrible. I have never seen macaroni and cheese like that with cottage cheese as the cheese and it being served hot. The fish was pale and looked uncooked. I have told them at Resident Council over and over about the food issues, but it hasn't changed." The surveyors received an evening meal test tray on 06/09/21 at 5:56 p.m. The meal consisted of pork chops that were difficult to cut, mashed potatoes/gravy, yellow squash, and a bun/dinner roll that was dough-like in texture and tasted	F 804	committee that meets monthly to discuss any food concerns, new ideas. 4) Dietary manager will monitor all residents food for palatability, attractive, and at a appetizing temperature. THis will be accomplished by having test trays at least twice a week. Monitoring will be done weekly x4, monthly x 3, and quarterly x 1 year. Monitoring to begin 7/8/2021. If concerns are identified, immediate corrective action will be implemented. Dietary manager will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 7/9/2021	

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F 804	Continued From page 26 strongly of yeast.	F 804		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, review of facility menus, review of facility policy, record review, and review of facility meal tray cards, and staff interview, the facility failed to provide food in a form designed to meet individual resident needs for 1 of 5 sampled residents (Resident #1) with physician's orders for texture modified diets. The facility's failure to serve food according to the facility's menus and physician's diet orders placed residents at risk for decreased meal intakes, inadequate nutrition, unplanned weight loss/gain, choking, aspiration, aspiration pneumonia, and worsening of medical conditions. Findings include: Review of the facility policy titled "Responsibility for Transmitting Diet Orders" occurred on 06/10/21. This undated policy, stated, " . . . Meals shall be assembled in accordance with the diet order prescribed for the patient." Review of the Academy of Nutrition and Dietetics Diet Manual NDD (National Dysphagia Diet) Level 2: Mechanically Altered Nutrition Therapy, showed " . . . This diet consists of foods that are	F 805	1)Dietary manager will change her practice and make sure food is provided in a from that meets the individual needs of the resident and the diet prescribed such as a texture modified diet is followed. 2)Any resident who is on a texture modified diet has the potential to be affected. 3) Dietary personnel will be instructed on 7/7/2021 on the importance of following the diet order written by the physician, and on the policy titled, " Responsibility of transmitting diet orders" this instruction was for resident # 1 and any other resident who has a special diet. Staff educated on what a texture modified diet and how to prepare that food. 4) Dietary manager will monitor resident #1 and any other resident on a on a texture modified diet and ensure residents receive correct texture. Monitoring will be done weekly x 4, monthly x 3, then quarterly x 1 year. Monitoring to begin on 7/8/2021. If concerns are identified, immediate corrective action will be implemented. Dietary Manager will submit	7/9/21

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F 805	Continued From page 27 easy to swallow because they are blended, chopped, grinded, or mashed so that they are easy to chew and swallow. . . . Foods you eat should be cut into 1/4-inch pieces . . . Foods recommended . . . Well-cooked chopped pasta, noodles, . . . Purchased pureed bread products . . . Protein foods . . . gravy and sauce for moisture . . . Foods not recommended . . . Stringy, high-pulp fruits such as . . . pineapple . . ." Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, "I have potential for nutritional problem related to poor fitting lower denture, I have diagnosis of protein calorie malnutrition . . . Intervention: . . . serve diet as ordered: Regular-small portion, level 2 (dysphagia mechanical altered) ground meat." The physician's order stated, "Regular - Small Portion diet Level 2 (dysphagia, mechanically altered) texture, Regular (thin) consistency, ground meat. May have fruits in the diet." The resident did not have a meal tray card for dietary staff to refer to/follow. Observation on 06/08/21 at 12:05 p.m. showed Resident #1 in his/her room with no meal tray card eating regular baked ziti (a type of pasta) with ziti pieces one-inch or longer, a regular breadstick cut into four approximately one-inch pieces, diced canned beets approximately one fourth-inch in diameter, and regular fresh pineapple approximately one-inch in length. The menu extension for Resident #1's diet showed, MS (Mechanical Soft) ziti, mashed fruit, minced and moist vegetable, and soaked breadstick. Observation on 06/09/21 at 11:52 p.m. showed	F 805	a report of the monitoring results to the QA committee at each scheduled meeting. 5) 7/9/2021	

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F 805	Continued From page 28 Resident #1 in his/her room with no meal tray card eating regular tater tot casserole, regular canned carrot slices approximately one-inch in diameter, regular white bread cut in half, and diced canned peaches approximately one fourth-inch in diameter. The menu extension for Resident #1's diet showed, MS tater tot casserole, mashed fruit, minced and moist vegetable, and soaked bread. Observation on 06/09/21 at 5:44 p.m. showed Resident #1 in his/her room with no meal tray card eating ground pork chop, mashed potatoes with gravy, cooked yellow squash approximately 1-inch or more in diameter, a regular bun/roll, and regular blueberry dessert. The menu extension for Resident #1's diet showed, soft and bite sized pork chop, moistened mashed potatoes and gravy, soft and bite sized roasted squash, soaked roll, and regular blueberry dessert. During an interview on 06/09/21 at 11:06 a.m., when asked an administrative dietary staff (#9) confirmed staff should use diet extensions.	F 805		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		7/9/21

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F 880	Continued From page 29 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 30 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 1 of 1 sampled resident (Resident #4) observed during a dressing change and failed to correctly measure the concentration of a cleaning disinfectant. Failure to follow infection control practices pertaining to hand hygiene during a dressing change and to measure the concentration of a cleaning disinfectant may result in residents, visitors and/or staff being exposed to communicable diseases and/or infections. Findings include: DRESSING CHANGE Review of the facility policy titled "HANDWASHING FACTS FOR HEALTHCARE	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff perform hand hygiene or handwashing during dressing changes in accordance with CDC guidelines. Ensure staff follow manufacturer's guidelines when mixing bleach and water	

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F 880	Continued From page 31 PROVIDERS" occurred on 06/10/21. This undated policy stated, ". . . ALWAYS clean your hands after removing gloves. . . ." Observation on 06/08/21 at 10:00 a.m., showed a licensed nurse (#3) changed Resident #4's bilateral lower leg dressing. The nurse (#3) donned gloves, removed a soiled dressing from the left leg, changed gloves, and applied a new dressing without performing hand hygiene. After completing the left leg dressing the licensed nurse (#3) removed her gloves and without performing hand hygiene donned gloves, removed a soiled dressing from the right leg, changed gloves, and applied a new dressing without performing hand hygiene. After the dressing change the nurse (#3) removed her gloves and without performing hand hygiene donned a clear pair of gloves. The nurse then collected the garbage and laundry and exited the room. The licensed nurse (#3) failed to perform hand hygiene after removing the soiled dressings from the left and right leg, after completing both dressing changes, and before exiting Resident #4's room. During an interview on the afternoon of 06/09/21, an administrative staff (#1) confirmed she expected staff to perform hand hygiene after removing gloves during a dressing change, between dressing changes, and before exiting the room. DISINFECTANT Review of the manufacturer's guidelines for "Monogram Disinfectant Bleach" occurred on 6/10/21. The back of the container stated, ". . .	F 880	to use as a disinfectant in spray bottle. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current hand hygiene and disinfecting of surfaces guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 07/09/2021 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to complete hand hygiene with dressing changes and failure to follow manufacturer's guidelines when mixing a bleach and water disinfectant in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, IP or suitable designee will ensure the following: a. All staff will receive education on hand hygiene during dressing changes and correctly measuring the amount of a bleach disinfectant used in a spray bottle.	

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F 880	Continued From page 32 Work surfaces 1 Tbsp [tablespoon] per one gallon of water . . ." During an interview on 06/09/21 at 3:10 p.m., an environmental supervisor (#8) stated the facility used bleach and water solution to disinfect surfaces such as the handrails. When asked about the concentration of the bleach solution, the environmental supervisor stated, "we use about this much" (holding her fingers out with an approximately one fourth inch between fingers) in the bottom of a spray bottle. She further stated housekeeping staff know how much to add to the spray bottle, once again showing the amount with her fingers. During an interview on the morning of 06/10/21, an administrative staff (#1) confirmed she expected housekeeping staff to measure the amount of bleach they add to a spray bottle.	F 880	4. Monitoring Weekly for no less than 12 weeks, the DON, IP, or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of licensed nursing staff during dressing changes and housekeeping staff mixing bleach and water in a spray bottle for disinfecting surfaces. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director.	

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F 880	Continued From page 33	F 880	5. Correction Date 07/09/2021	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of personnel files, staff education records, and staff interview, the facility failed to include the required in-service training for dementia management/cognitive impairment for 3 of 3 personnel files (Nurse Aides #4, #5, and #6) reviewed. Failure to provide staff training for dementia management and special resident needs such as cognitive impairment limits the ability of staff to be aware of those disease processes and to provide care that meets the resident's behavioral health care needs.	F 947	1) The facility will change their practice and make sure all staff receive annual training on dementia management/ cognitive impairment. 2) Any staff who is employed here has the potential to be affected. 3) All staff will be instructed on 7/7/2021 on the importance of completing the health stream education titled, " Understanding Alzheimer's Disease and managing challenging behaviors", by	7/9/21

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F 947	Continued From page 34 Findings include: Review of the personnel files for Nurse Aides #4, #5, and #6 occurred on the morning of 06/10/21. Each of these files included a "Yearly Education Transcript" dated from June 9, 2020 to June 8, 2021. In addition to the personnel files, the facility provided a binder of in-service education. The education transcripts and in-service documentation identified the facility failed to provide training on dementia/cognitive impairment. During an interview at 9:30 a.m. on 06/10/21, a human resources staff member (#7) confirmed the facility had not included dementia/cognitive impairment training as a yearly training for employees on their electronic education system, nor had provided any other training on these topics. The staff member (#7) provided copies of the facility's "New Hire HealthStream Education" and the "Yearly HealthStream Education". The staff member (#7) stated the new hire education included "Understanding Alzheimer's Disease and Managing Challenging Behaviors" and confirmed the facility had not included this training on a yearly basis.	F 947	7/9/2021, this instruction was for staff # 4, #5, #6, and any other staff who did not complete the required training. 4) HR will monitor staff #4, #5,#6 and all other staff to make sure required education is completed annually. Monitoring will be done weekly x4, monthly x3, then quarterly. Monitoring to begin 7/8/2021. If concerns are identified, immediate corrective action will be implemented. HR will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 7/9/2021	