STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	**242 10TH ST W DICKINSON, ND 58601**

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey and complaint started 08/30/21 and concluded 09/02/21	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		9/27/21

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

Electronically Signed | 09/19/2021

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner that enhanced or maintained, resident's dignity for 2 of 12 sampled residents (Resident #53 and #70). Failure to knock on doors/announce themselves, and wait for permission prior to entering residents' rooms, does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Review of the policy titled, "Quality of Life - Dignity" occurred on 09/01/21. This policy, revised January 01/25/2016, stated, ". . . Residents' private space and property shall be respected at all times . . . Staff will knock and request permission before entering residents' rooms . . ." - Observation on 08/30/21 at 12:11 p.m., showed two certified nurse aides (CNA's) (#11 and #12) provided personal cares for Resident #233. CNA (#12) left the resident's room. A few minutes later the CNA (#12) knocked on the resident's door and immediately entered. The CNA failed to request permission before entering the room.	F 550	1. Observation while personal cares were being done on two separate incidence involving Resident #233 and #53, CNA□s and Nurse□s entered the residents□ rooms knocking, but failing to wait for permission to enter the room. 2. All residents in the facility have the potential to be affected. 3. All nursing staff was educated on 09/23/2021 the nurses meeting regarding the residents□ rights and dignity with an emphasis on how to knock on the doors, announce themselves, and wait for permission prior to entering residents□ rooms. 4. Audits on knocking and waiting for permission to enter residents□ rooms will begin on 09/20/2021 and be completed by nurse managers or Director of Nursing on Residents #233, #53 and five other residents daily Monday to Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All results will be brought to the Director of Nursing and the Quality Assurance for review and concerns.	

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F 550	Continued From page 2 - Observation on 08/31/21 at 7:19 a.m. showed: * A nurse (#16) provided personal cares for Resident #53. A CNA (#6) opened the resident's door and immediately entered the room. The CNA failed to knock on the door and request permission before entering the resident's room. * An unidentified CNA knocked on Resident #53's door and immediately entered as the nurse (#16) stated, "Resident cares." The CNA failed to request permission before entering the resident's room. During and interview on 09/02/21 at 8:40 a.m., when asked questions pertaining to dignity, an administrative nurse (#13) stated staff should knock and announce themselves before entering a room.	F 550		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FORM THE STANDARD SURVEY CONDUCTED ON 01/16/20 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 6 of 21 sampled residents (Resident #7, #26, #31, #65, #71, and #78), and 2 supplemental residents (Resident #9	F 641	Section C: Cognitive patterns and Section D: Mood 1. For residents #7, #9, #26, #31, #40, #65, #71, and #78 sections C0100 and Section D0100 were not completed by the MDS coordinator. 2. BIMS/PHQ-9: All residents have the risk of being affected by this deficiency. BIMS/PHQ-9 interviews will be attempted on all residents regardless of cognitive impairment going forward starting 9/2/2021.	9/27/21

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F 641	Continued From page 3 and #40). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION C: COGNITIVE PATTERNS and SECTION D: MOOD The Long-Term Care Facility RAI Manual, revised October 2019, Pages C-1 to C-2 stated, ". . . C0100: Should Brief Interview for Mental Status Be Conducted? . . . Code 0, no: if the interview should not be conducted because the resident is rarely/never understood, cannot respond verbally, in writing, or using another method . . . Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood . . . Pages D-2 to D-3 states, ". . . D0100: Should Resident Mood Interview Be Conducted? . . . Code 0, no: if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally . . . Code 1, yes: if the resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method . . . Attempt to conduct the interview with ALL residents . . . " - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and psychotic disorder. The quarterly MDS, dated 08/20/21, identified facility staff coded both C0100 and D0100 as rarely/never understood.	F 641	3. St Luke's Home is aware of these 8 incorrectly coded MDS in section C and D. The coding on these individuals will be corrected when the next quarterly MDS is to be completed.. Education will be provided individually to both Social Services personnel on reading the RAI manual section C-1 to C-33 and D-1 to D-14 by 10/15/2021. Both social services personnel will be provided education from HealthCare Academy module titles, MDS 3.0 Certificate Program: Section C: Cognitive Patterns and Section D: Mood with completion by 9/27/2021. 4. Social Services staff will review 3 random MDS assessments per week for 4 weeks, then monthly for 3 months and then quarterly for three months for accuracy of BIMS and PHQ-9 entry starting 9/20/2021 Section J: Health Conditions 1. Resident #65 quarterly MDS dates 07/28/2021 identified a fall with a major injury with corrections done on 9/2/2021 coded fall without major injury completed by MDS Nurse. 2. Any resident that has a fall during MDS look back period is at risk for incorrect documentation. 3. Education will be provided individually to the two MDS nurses on reading the RAI manual pages Section J1900 of the RAI Manual by 9/27/2021. The two MDS nurses will also be provided education from HealthCare Academy module titles, MDS 3.0 Certificate	

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F 641	Continued From page 4 Facility staff failed to attempt interviews for sections C0100 and D0100. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included aphasia, hemiplegia or hemiparesis, and anxiety. The quarterly MDS, dated 08/20/21, identified facility staff coded both C0100 and D0100 as rarely/never understood. Facility staff failed to attempt interviews for sections C0100 and D0100. - Review of Resident #26's medical record occurred on all days of survey. Diagnoses included hemiplegia and hemiparesis, unspecified psychosis, and vascular dementia with behavioral disturbance. The quarterly MDS, dated 06/10/21, identified facility staff coded both C0100 and D0100 as rarely/never understood. Facility staff failed to attempt interviews for section C0100 and D0100. - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with behavioral disturbance, and Psychotic disorder. The quarterly MDS, dated 06/23/21, identified facility staff coded both C0100 and D0100 as rarely/never understood. Facility staff failed to attempt interviews for section C0100 and D0100. - Review of Resident #40's medical record occurred on August 30-31, 2021. Diagnoses included Alzheimer's, dementia with behavioral disturbance, and psychosis. The quarterly MDS, dated 07/05/21, identified facility staff coded both C0100 and D0100 as rarely/never understood. Facility staff failed to attempt interviews for	F 641	Program: Section J: Health Conditions with completion by 09/27/2021. 4. Monitoring for ensuring MDS section J1900A and J1900C are completed correctly prior to submission will be done on Resident #65 and four other residents in a week look back period by the MDS nurse and then by the Director of Nursing starting 09/20/2021. These audits will be done weekly for 4 weeks, monthly for 3 months, then quarterly 3 times. All results will be taken to the Director of Nursing and QA committee for review of results and concerns.	

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F 641	Continued From page 5 section C0100 and D0100. - Review of Resident #71's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with behavioral disturbance, and psychotic disorder. The quarterly MDS, dated 08/03/21, identified facility staff coded both C0100 and D0100 as rarely/never understood. Facility staff failed to attempt interviews for section C0100 and D0100. - Review of Resident #78's medical record occurred on all days of survey. Diagnoses included vascular dementia with behavioral disturbance, anxiety disorder, major depression, and psychosis. The admission MDS, dated 08/04/21, identified faciltiy staff coded both C0100 and D0100 as rarely/never understood. Facility staff failed to attempt interviews for section C0100 and D0100. During an interview on 09/01/21 at 2:21 p.m., an MDS coordinator (#3) confirmed facility staff failed to complete sections C0100 and section D0100 correctly for Residents #7, #9, #26, #31, #40, #65, #71 and #78. SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI Manual, revised October 2019, page J-34, states, ". . . Coding Instructions for J1900C, Major Injury: · Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS). Code 1, one: if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS). · Code	F 641		

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F 641	Continued From page 6 2, two or more: if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS). . . ." Review of Resident #65's medical record occurred on all days of survey. The quarterly MDS, dated 07/28/21, identified a fall with major injury. Resident #65's progress notes identified the following: * 06/05/21 at 7:26 p.m.: ". . . resident reported he fell in his room when his sheet got tangled around his legs when he got up yo [sic] walk and he fell on his right side. He got himself up. . . . He is not sure if he hit his head and no noted redness or lumps to his head. Resident able to move all 4 limbs and denies pain. Resident alert and oriented as per norm. . . ." * 06/06/21 at 12:30 a.m.: "Resident voiced his back is sore from his fall, but resident able to ambulate as per norm. . . ." * 6/07/21 at 3:15 p.m.: "Resident had a witnessed fall in the dining room during activities. Resident was standing up to sing karaoke and tripped over the stand of the large computer. Resident had no skin issued [sic] noted after the fall and VS [vital signs] were stable. Resident denied having any pain . . ." During an interview on 08/31/21 at 3:47 p.m., an MDS coordinator (#3) confirmed the resident had no major falls during the MDS time frame, and confirmed the quarterly MDS dated 07/28/21 was inaccurately coded.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		9/27/21

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F 644	Continued From page 7 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 7 sampled residents (Resident #43) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual, revised August 2015, page 13, stated, ". . .	F 644	1. Resident #43 has had her diagnoses reviewed and her PASRR has been updated though Ascend Maximus. 2. All residents have the risk of being affected by this deficiency. All potential affected residents have had their diagnoses reviewed and if needed, status changes have been submitted to Ascend by 9/3/2021. 3. Social Services Staff will review the PASARR manual on Ascend in regard to status changes by 9/20/2021 and have signed off as completed by the Administrator. 4. Monitoring of resident: Resident #s43 and 8 random residents will be done by	

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F 644	Continued From page 8 Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC] was not identified at the Level 1 screen process, and condition later emerged to was discovered . . ." Review of Resident #43's medical record occurred on all days of survey and identified an original PASARR completed on 12/20/19. The record showed Resident #43 received a new diagnosis of schizophrenia and major depressive disorder on 04/26/21 but lacked evidence the facility completed an updated Level I screening/change in status assessment following the new diagnosis. During an interview on 09/01/21 at 2:30 p.m., a social services staff member (#1) confirmed the facility failed to submit another PASARR for Resident #43 following the new diagnosis.	F 644	social services personnel weekly starting 9/20/2021 for 4 weeks and then monthly for 3 months and then quarterly for 3 months.	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		9/27/21

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F 692	Continued From page 9 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: HYDRATION 1. Based on observation, record review, information provided by the complainant, and staff interview, the facility failed to provide sufficient fluid intake to maintain proper hydration and health for 4 of 6 sampled residents (Resident #26, #53, #71, and #72) needing assistance with fluids. Failure to frequently offer fluids placed residents at risk for dehydration, urinary tract infections (UTI) and fluid/electrolyte imbalances. Findings include: Staff failed to provide a copy of the policy addressing hydration. - Review of Resident #26's medical record occurred on all days of survey. The resident's care plan identified, ". . . Dehydration/Fluid Maintenance [resident] has the potential for dehydration related to pertinent diagnoses, poor	F 692	1. Resident #26 #53, #71, and #72, CNA□s and Nurse□s failed to offer fluids on multiple occasions during interactions with residents. 2. All residents in the facility have the potential to be affected by dehydration. 3. All nursing staff will be educated on 09/23/2021 at the nurses meeting regarding the hydration and the importance of offering fluids during every interaction. In addition, all nurses and cna□s will complete "HealthCare Academy Course titled HCA Survey Introduction, Mandatory Tasks and Critical Element Pathways Certificate Program: Hydration" with completion by 9/27/2021. Facility Hydration Policy will be review and updated with Dietary Manager and Nursing by 9/16/2021. Hydration Policy was review on 9/16/2021. All nursing staff will be updated on policy by 9/27/2021. 4. Audits on offering hydration with all	

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F 692	Continued From page 10 meal intakes . . . Keep fluids accessible to her at meals and in her room. Offer, encourage, or assist with intake throughout the day upon interactions . . ." The quarterly Minimum Data Set (MDS), dated 06/10/21, stated, ". . . resident is rarely/never understood . . . Extensive assist of 1 with dressing, eating, and personal hygiene . . ." Observation on 08/31/21 at 9:32 a.m. showed two certified nursing aides (CNA) (#9 and #10) assist Resident #26 with a transfer and failed to offer fluids prior to exiting the resident's room. - Review of Resident #53's medical record occurred on all days of survey. The resident's care plan identified, ". . . Ensure [resident] proper hydration by offering fluids with interactions and after cares . . . [resident] has the potential for dehydration related diagnosis of Alzheimer's disease and dementia . . ." The significant change MDS, dated 07/21/21, identified severe cognition and supervision required for eating. Observation on 08/31/21 at 07:19 a.m. showed a nurse (#16) performed a dressing change and failed to offer fluids prior to exiting the resident's room. Observation on 08/31/21 at 9:32 a.m., showed two certified nursing aides (CNAs) (#9 and #10) assisted Resident #26 with a transfer and failed to offer fluids prior to exiting the resident's room. - Resident #71's medical record occurred on all days of survey. The resident's care plan identified, ". . . Dehydration/Fluid Maintenance [resident] has the potential for dehydration related to diagnosis of Alz/Dementia	F 692	resident interactions will be begin on 09/20/2021 and be completed by nurse managers or Director of Nursing on Residents #26 #53, #71, #72 and 6 other residents daily Monday to Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All results will be brought to the Director of Nursing and the Quality Assurance for review and concerns. Nutrition 1. Observation on resident #72, CNA failed to provide assistance during meal time to ensure resident had sufficient intake for a resident needing assistance. CNA failed to ensure that tray was setup appropriately, which included cutting up food to appropriate size, uncovering drinking glasses, and appropriate utensil were used. 2. All residents in the facility have the potential to be affected. 3. All nursing staff was educated on 09/23/2021 at the nurses meeting regarding need for adequate nutrition, resident cue cards, and appropriate assistance during meals times. All staff will be educated on 09/23/2021 at the nurses meeting regarding appropriate interactions during mealtime. In addition HealthCare Academy module will be assigned to all nursing staff titled "HCA Professional Requirements, Remediation, Care Competency: Nursing Assistant: Nutritional Promotion in the Older Adult" with completion by 9/27/2021.	

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F 692	Continued From page 11 [Alzheimer/dementia] . . . encourage and offer fluids through the day . . . and upon interactions with resident . . ." The quarterly MDS, dated 08/03/21, identified, extensive assistance for eating. Observation on 08/30/21 at 11:00 a.m., showed a CNA (#7) and a nurse (#8) transferred Resident #71 and failed to offer fluids prior to exiting the resident's room. - Resident #72's medical record occurred on all days of survey. Diagnoses include benign prostatic hyperplasia and recent urinary tract infection UTI and history of recurrent UTI's. Review of Resident #72's care plan identified, ". . . Dehydration/Fluid Maintenance: [Resident] has the potential for dehydration related to his diagnosis of Alzheimer's/Dementia, poor meal intakes and his age. Watch for and report signs/symptoms of dehydration . . . [Resident] is to be offered/encouraged/and assisted to drink fluids throughout the day, with meals, at snack pass and in room upon interactions, PRN [as needed] . . . The current MDS, dated 07/29/21, identified supervision required for eating. * Observations on 08/30/21 at 12:20 p.m., 08/31/21 at 8:25 a.m. and 12:06 p.m. showed the staff (#15, #14, and #2) provided cares for Resident #72 and failed to offer fluids prior to exiting the resident's room. During an interview on 09/02/21 at 9:10 a.m. an administrative nurse (#13) confirmed staff are to offer fluids after assisting residents with cares. NUTRITION	F 692	4. Audits on assistance during mealtimes will begin on 09/20/2021 and be completed by nurse managers or Director of Nursing on Residents # 72 and five other residents daily Monday to Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All results will be brought to the Director of Nursing and the Quality Assurance for review and concerns.	

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	355063	A. BUILDING _____ B. WING _____	C 09/02/2021

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F 692	Continued From page 12 2. Based on observation, record review, review of facility policy and staff interview, the facility failed to provide assistance to ensure sufficient meal intake to maintain proper nutrition and health for 1 of 6 sampled residents (Resident #72) needing assistance with meals. Failure to assist with meals placed Resident #72 at risk for weight loss, increase risk of infections, poor wound healing, and muscle weakness. Findings include: Review of the facility policy titled "Assistance with Meals" occurred on 09/02/21. This policy revised 06/25/20, stated, "Resident shall receive assistance with meals in a manner that meets the individual needs of each resident . . . Nursing staff will serve resident trays and will help residents who require assistance with eating." Review of Resident #72's medical record occurred on all days of survey. The resident's care plan identified ". . . Inadequate oral intakes r/t [related to] . . . consuming less than 50% of most meals. [resident] has a diagnosis of Alzheimer's/Dementia and diabetes . . . Recommendations from ST [Speech Therapist] screen performed 11-20-20. Regular Diet . . . Staff to sit with resident for Supervision & [and] Cues. Set up tray. Cut up foods. Give verbal cues to use correct utensils and reminders to keep eating if he stops and does not indicate he is full . . ." The current MDS, dated 07/29/21, identified supervision required for eating. * Observation on 08/30/21 at 12:26 p.m. showed staff served Resident #72 the noon meal. The	F 692		

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F 692	Continued From page 13 resident attempted to eat a hotdog on a bun multiple times, the bun broke apart, and the resident stabbed the hotdog with a fork and brought the entire hotdog to his mouth to take bites. The resident attempted to eat soup with a spoon and due to his shaky hand, very little soup remained on the spoon. A restorative aide (#15) sat at the same table as Resident #72 assisting another resident. The staff failed to assist Resident #72 with the meal. Observation showed Resident #72 consumed less than 25% of the meal. At 12:48 p.m., a restorative aide (#15) approached the resident's table and asked, "Are you ready to go to your room?" * Observation of the noon meal on 08/31/21 at 12:13 p.m. showed Resident #72 sitting at the table and attempted to remove the cover from a water glass. Resident #72 made multiple unsuccessful attempts to remove the cover and pushed the water glass away. Observation showed the resident consumed approximately 25% of the meal. Facility staff failed offer assistance during the meal. At 12:36 p.m. a restorative aide (#14) approached the resident and asked, "How was lunch are you done?" During an interview on 09/02/21 at 8:59 a.m., a certified dietary manager (#3) confirmed facility staff failed to follow Resident #72's care plan related to the recommendations provided by the ST. During an interview on 09/02/21 at 9:10 a.m., an administrative nurse (#13) confirmed facility staff failed to follow Resident #72's care plan related to the recommendations provided by the ST.	F 692		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		9/27/21

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F 812	Continued From page 14 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, professional reference, review of facility logs/records, and staff interview, the facility failed to test and/or consistently test sanitizer solutions in 4 of 4 kitchenettes and failed to discard expired chlorine test strips in 3 of 4 kitchenettes (Unit 1, Unit 2, and Unit 3). Failure to test and/or consistently test concentration levels of sanitizing solutions and replace expired test strips may result in the lack of adequate sanitization to surfaces and dishware or if to strong may leave a chemical residue on surfaces. Findings include:	F 812	1. The Certified Dietary Manager (CDM) removed expired test strips and replaced with new strips during the survey on 09/01/21 on units one, two, and three. The CDM placed the procedure for mixing and testing sanitizing solution for surface sanitizing in all unit kitchenettes. The CDM revised the sanitizing record form to include checking the test strips for expired dates on 09/02/21. 2. All residents who receive and consume foods on units (one, two, three, and four) have the potential to be affected by this deficiency. 3. The CDM provided verbal education	

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F 812	Continued From page 15 The "Food Code, U.S. Public Health Service, Food and Drug Administration," U.S. Department of Health and Human Services, 2013, page 499, stated, ". . . Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons: 1. The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitization; and 2. Too much sanitizer in the final rinse water could be toxic. . . ." Review of the facility policy titled, "Sanitization" occurred on 09/02/21. This policy, revised April 2021, stated, " . . . Sanitizing of environmental surfaces must be performed with one of the following solutions: a. 50-100 ppm [parts per million] chlorine solution - (using Ecolab Solid Sanitizer). . . ." Review of the facility's document titled, "Nutrition and Food Services Sanitizing Record" occurred on 09/01/21. The instructions indicated, ". . . 1 tablet of solid sanitizer is to be mixed with 1.2 gallons (4.8 quarts) to 2.2 gallons (8.8 quarts) of water. TEST EACH TIME BUCKET IS FILLED . . ." The Nutrition and Food Services Sanitizing Record contained a section for each mealtime; BREAKFAST, LUNCH, and SUPPER, and each section contained columns to record the time of day, staff initials, and PPM test strip results. Review of the sanitizing records on each unit for the month of August 2021 showed staff failed to complete the mealtime documentation 33 times on Unit 1, 31 times on Unit 2, 54 times on Unit 3, and 33 times on Unit 4. Review of the expiration dates of the sanitizer	F 812	to on duty Dietary employees on 09/02/21. The CDM created written staff education that included the procedure for testing sanitizing solution and checking the chlorine test strips for expiration dates on 09/02/21 and posted on 09/03/21. The dietary procedure for testing sanitizing solution and checking the chlorine test was placed with the sanitizing record on all four units of the facility. On 09/23/21, the dietary staff will receive education on Centers for Medicare and Medicaid Services (CMS) regulation F-812- 483.60 (i), procedure for mixing and testing sanitizing solutions, and checking test strips for expiration dates. 4. Audits to ensure sanitizing solutions are being checked and recorded and all chlorine test strips are not expired will be performed daily starting 09/20/21 five times a week for two weeks, one time weekly for four weeks, two times monthly for two months, and six times quarterly for three quarters. The CDM, Dietitian, or designee will complete the audits. All information obtained from the monitors will be shared and discussed during monthly facility quality meetings and monthly dietary department meetings.	

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F 812	Continued From page 16 strips for each unit showed strips on Unit 1 expired July 2020 and the strips on Unit 2 and Unit 3 expired May 2020. During an interview on the afternoon of 09/01/21, a dietary supervisor (#3) reported she expects staff to test the sanitization of the water prior to wiping down all counter tops in kitchenettes and resident tables in the dining rooms following each meal service. When asked to review the unit documentation of the sanitizing records and the expiration dates of the sanitizing test strips, the dietary supervisor confirmed inconsistent documentation in all 4 units and 3 of the 4 units used expired sanitizing test strips.	F 812		