STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	**4255 30TH AVE S FARGO, ND 58104**

(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 and complaint survey started on 03/27/23 and concluded 03/30/23. The concerns identified by the complainants were unsubstantiated.	F 000		
F 550 SS=E	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	F 550		5/3/23

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

Electronically Signed | 04/21/2023

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F 550	Continued From page 1 interference, coercion, discrimination, or reprisal 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 resident and family interviews and facility policy, the facility failed to provide care in a manner that maintains or enhances resident dignity for 7 of 7 (Resident A, B, C, D, E, F, and G) confidential sampled resident interviews and 3 confidential family interviews. Failure to answer call lights promptly, provide care in a dignified manner, and treat residents respectfully does not enhance the resident's quality of life and may result in decreased self-esteem, incontinence, and skin breakdown. Findings include: Review of the facility policy titled "Dignity" occurred on 03/30/23. This policy, revised January 2018, stated, "It is the practice of this facility to protect and promote residents rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing resident's individuality. . . . Respond to requests for assistance in a timely manner. . . . Groom and dress residents according to resident preference. . . . Speak respectfully to residents . . ."	F 550	1. The facility is unable to identify the confidential residents and families with alleged concerns. 2. Resident who use a call light and need care provided have the potential to be impacted 3. Email re-education related to dignity/customer service and answering call lights was provided to direct care staff. This same education was provided at In-services on April 24th through April 28th, May 1st and May 2nd as well as at daily huddles. 4. Social Workers and/or Unit Managers and/or their designees will conduct 5 Dignity and call light audits weekly for four consecutive weeks. The audits will then move to 5 every two weeks for four weeks and then move to 5 audits quarterly for one year. Audit results will be reported by Director of Social Service or DON at the bi-monthly Quality/Medical Director Meeting.	

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F 550	Continued From page 2 Review of the facility policy titled "Routine Care" occurred on 03/30/23. This policy, revised December 2018, stated, ". . . Answer call lights promptly . . ." During a resident interview on the afternoon of 03/27/23, Resident A referred to a daytime certified nurse aide (CNA) as a "bully." Resident A could not recall the CNAs name. Resident A also voiced concerns that it takes at least 20 minutes for staff to answer the call light and at times staff walk by the call light. During an interview on 03/27/23 at 12:58 p.m., Resident B reported there is a CNA that is "really rough" on their arms when the CNA gets the resident ready in the morning and at night. Resident B also reported that staff do not let the resident choose what they want to wear. During a resident interview on the afternoon of 03/27/23, Resident C reported "One of the morning workers gets mad at me, sometimes she does not dress me, and she makes me cry." The resident later reported "One day when she did help me I told her my pants were too tight and she made me wear them." During a resident interview on 03/28/23 at 1:55 p.m., Resident D reported a few months ago, a CNA would take their knuckles and dig them into the resident's side and back when repositioning or changing the resident. Resident D stated they would tell the CNA to stop but the CNA wouldn't. Resident D also stated a CNA entered the resident's room and yelled at the resident, calling them "old...fat...and lays in bed all the time."	F 550		

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F 550	Continued From page 3	F 550		

- During an interview on the afternoon of 03/27/23, Resident E stated he/she waits for the call light to be answered, usually in the evenings and on weekends. Resident E stated, "Sometimes it's 30-35 minutes. For example- last night after supper I had to use the commode. I turned on my light and waited for 20 minutes. My CNA came in and turned it off, said she'd be right back but never came back. So then I waited another 30 minutes and turned it on again. A different CNA came in and took my supper tray, and said she'd find someone to help. No one ever came back. So I turned it on a third time and waited another 30 minutes. Finally my CNA did come in and answer the light, she came back within 10-15 minutes with another person and the Hoyer [full body mechanical lift]. But all told, it was like an hour and a half from the time I put my light on until I actually got help to the commode." Resident E further identified staff are sometimes rough with cares and stated, "Would I call it abuse, no. But rough handling? Definitely. It's like I'm not even a person, I'm just a body."

- During an interview on 03/27/23 at 2:50 p.m., Resident F stated "It often takes an hour for my light to be answered."

- During an interview on the afternoon of 03/27/23, Resident G stated staff will often answer the call light, shut it off, and not help or come back.

- During a confidential interview on the afternoon of 03/27/23, a family member (AA) stated she has been in the resident room with the call light on for 45 minutes.

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F 550	Continued From page 4 - During a confidential family interview on 03/27/23 at 1:17 p.m., a family member (BB) reported that staff is quick and rough with the resident in the morning and staff does not allow the resident to choose their own outfit. - During a confidential family interview on the afternoon of 03/29/23, a family member (CC) voiced concerns of staff pulling on the resident arms during cares, being gruff, and not very nice. The family member stated while on the phone they overheard staff saying, "Now what do you want?" and when the resident requested to use the bathroom staff said "No you don't, you just went." Failure to provide care in a dignified manner and interact respectfully with the residents is a violation of their rights and may result in emotional/physical harm and a decreased quality of life.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily	F 609		5/3/23

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F 609	Continued From page 5 injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and resident and family interview, the facility failed to report alleged violations of misappropriation of resident property to the State Survey Agency (SSA) for 2 of 2 sampled residents (Resident #5 and #51) with reports of missing items. Failure to report allegations and submit investigation results placed all residents at risk for misappropriation of property. Findings include: Review of the facility policy titled "Reporting Alleged Abuse and Neglect Violations" occurred on 03/30/23. This undated policy stated, ". . . All alleged violations involving abuse, neglect, exploitation or mistreatment must be reported immediately. This includes injury of unknown source and misappropriation of resident property. . . . If the alleged violation does not involve abuse or does not involve serious bodily injury it must be reported no later than 24 hours after the	F 609	1. Reports were submitted to the ND Department of Health for allegations of missing items for resident #5 and resident #51. 2. Residents that have allegations related to missing property have the potential to be impacted. 3. The facility provided re-education to nursing staff on when to report allegations of missing items to the North Dakota Department of Health at In-services on April 24th through April 28th, May 1st and May 2nd . E-mail education was provided to all staff. A prompt was also added to our Loss Report asking if the “resident feels items was stolen”. Staff also have Healthcare Academy sessions assigned annually related to reporting missing items.	

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F 609	Continued From page 6 allegation is made. . . . The alleged violations must be reported to . . . other officials (including to the state survey agency and adult protective services where state law provides jurisdiction in long term care facilities) in accordance with state law through established procedures. . . ." - During an interview on 03/28/23 at 9:41 a.m., Resident #5 stated "[I] had some perfume stolen. Now I keep it in the locked drawer. The perfume cost $150.00 and they won't replace it." The facility initiated a "Loss Report Form" for the perfume on 02/05/22. A progress note from social services on 02/17/22 at 4:47 p.m., stated "Late Entry: Note text: SS [social services] checked in with [Resident #5] on this date. [Resident #5] voiced she bought new perfume and came today. SS provided education to [Resident #5] in depth on keeping her items of value in her drawer locked and keeping the key on her. [Resident #5] voiced she understood this and planned to keep her perfume in her locked drawer." - During an interview on the afternoon of 03/27/23, Resident #51 stated she had a new cell phone from her sister. She placed it on the overbed table when she went to bed one night, and when she woke up it was gone. Resident #51 stated, "Now I keep it right here [indicating along side her body]." She identified she told a social services staff member, and stated, "We looked everywhere for it but couldn't find it." Resident #51 stated facility staff told her they would not replace her phone. During a phone interview on the morning of 03/29/23, Resident #51's family member stated	F 609	4. The DON and/or designees will conduct random audits of progress notes and/or concerns that we are alerted to on 5 residents weekly for 4 weeks. The audits will then move to 5 residents every two weeks for 4 weeks and then 5 residents quarterly for one year. Audit results will be reported by DON at the bi-monthly Quality/Medical Director Meeting.	

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F 609	Continued From page 7 Resident #51 reported her phone "went missing" during the night. Resident #51's family member stated this happened "about a month ago." A "Loss Report Form," dated 02/23/23, identified staff attempted to find the phone, but lacked evidence of reporting the incident as possible misappropriation of resident property. A nurse's note, dated 03/02/23, stated, ". . . SS spoke with [Resident #51's family] about the loss report for [Resident #51's] phone and confirmed the phone had not been found. SS also provided [Resident #51's family] is always welcome to call the nurses station and ask to speak with [Resident #51]. . . ." The facility failed to report the alleged misappropriation of property within 24 hours and submit the findings of the investigation within five days to the State Survey Agency.	F 609		
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: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), the facility failed to complete a Minimum Data Set (MDS) that accurately reflected the residents' status for 4 of 4 sampled residents (Resident #18, #38, #63, and #64) and 1 supplemental resident (Resident #55) reviewed for Preadmission Screening and Resident	F 641	1. The facility corrected the MDS's that were found coded inaccurately immediately. 2. Residents who have the appropriate diagnosis to trigger a level II PASRR could have the potential to be impacted 3. Email re-education related to	5/3/23

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F 641	Continued From page 8 Review (PASRR). Failure to accurately code the MDS may negatively affect the development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2019, page A22-A23, stated, ". . . A1500: Preadmission Screening and Resident Review (PASRR) . . . Review the Level I PASRR form to determine whether a Level II PASRR was required. Review the PASRR report provided by the State if Level II screening was required. . . . Code 0, no: . . . if any of the following apply: PASRR Level I screening did not result in a referral for Level II screening, or Level II screening determined that the resident does not have a serious MI [mental illness] . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . . continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. . . ." - Review of Resident #18's medical record occurred on all days of survey and identified a level 2 PASRR completed on 01/08/21 with a diagnosis of bipolar disorder. The significant change MDS, dated 07/03/22 failed to identify the Level 2 PASRR and serious mental illness. - Review of Resident #38's medical record occurred on all days of survey and identified a Level 2 PASRR completed on 04/19/21 with a diagnosis of major depression. The annual MDS, dated 08/24/22, failed to identify the Level 2 PASRR and serious mental illness.	F 641	appropriately coding the MDS was provided to those who complete section A of the MDS on 3/31/2023 and then again on 4/14/2023. 4. The Social Services team and/or their designee(s) will conduct 5 MDS accuracy audits weekly for four consecutive weeks. The audits will then move to 5 every two weeks for four weeks and then move to 5 audits quarterly for one year. Audit results will be reported by the Director of Social Services at the bi-monthly Quality/Medical Director Meeting.	

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F 641	Continued From page 9 - Review of Resident #55's medical record occurred on all days of survey and identified a Level 2 PASRR completed on 10/09/17 with a diagnosis of major depressive disorder. The annual MDS, dated 01/10/23, failed to identify the Level 2 PASRR and serious mental illness. - Review of Resident #63's medical record occurred on all days of survey and identified a level 2 PASRR completed on 04/02/20 with a diagnosis of schizophrenia, paranoid type. The significant change MDS, dated 06/16/22, failed to identify the Level 2 PASRR and serious mental illness. - Review of Resident #64's medical record occurred on all days of survey and identified a Level 2 PASRR completed on 04/22/22 with a diagnosis of schizophrenia and anxiety disorder. The significant change MDS, dated 10/06/22, failed to identify the Level 2 PASRR and serious mental illness.	F 641		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		5/3/23

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F 688	Continued From page 10 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, the facility failed to ensure 2 of 2 sampled residents (Resident #51 and #57) reviewed for restorative therapy received the services developed by the therapy staff. Failure to consistently provide restorative nursing/therapy services may adversely affect the residents' abilities to maintain their range of motion (ROM), balance, strength, and mobility. Findings include: - During an interview on 03/27/23 at 3:10 p.m. Resident #57 stated, "Look at my hands. I can't even open them". Resident #57 reported he/she had not received therapy. Review of Resident #57's medical record occurred on all days of survey. The current care plan stated, ". . . requires a restorative program to maintain or improve functional ROM. At times (resident) may refuse the ROM program. Functional ROM will be maintained or improved to highest practicable level of function. . . . PROM [passive range of motion] up to 4 x Week [four times a week], PROM to UE [upper extremity] and LE [lower extremity] . . . ." The quarterly minimum data set (MDS), dated 01/25/23, identified upper extremity impairment on one	F 688	1. Coaching was completed for staff who did not document refusal of restorative appropriately. 2. Residents that have restorative programs have the potential to be impacted. 3. The facility provided re-education on 3/31/2023 to the restorative team on how to appropriately document when a resident refuses restorative therapy. 4. The MDS and restorative team will conduct random audits of restorative documentation for 5 residents weekly for 4 weeks. The audits will then move to 5 residents every two weeks for 4 weeks and then 5 residents quarterly for one year. Audit results will be reported by the MDS Team at the bi-monthly Quality/Medical Director Meeting.	

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F 688	Continued From page 11 side. A Functional ROM Plan of Care, dated 11/07/22, identified PROM to LE 4 times a week and PROM to UE 4 times a week. Review of provider progress notes identified the following: * 01/12/23 ". . . left hand contracture with decreased ROM, pain and decreased functional use of left hand. . . ." * 01/12/23 ". . . Dupytren Contracture left hand chronic problem, now causing more pain. . . ." * 01/19/23 ". . . secondary discharge diagnosis . . . Dupytrens contracture of left hand . . ." Review of the restorative nursing documentation, dated 01/05/23 -03/30/23 identified staff provided passive range of motion (PROM) 10 times during the 12 week period with one refusal documented on March 20, 2023. The facility failed to provide restorative therapy services four times a week to Resident #57. During an interview the morning of 03/30/23, a restorative CNA (#8) confirmed resident #57 was on a restorative program. - During an interview on the afternoon of 03/27/23, Resident #51 stated, "I was supposed to have therapy this whole last week. A lady stopped in one day when I was in the bathroom but she never came back. Hopefully they will try again this week." Review of Resident #51's medical record occurred on all days of survey. The current care plan stated, ". . . requires restorative program to maintain or improve functional ROM. . . . refuses RNP [restorative nursing program] at times . . .	F 688		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 12 NURSING REHAB: AROM [active range of motion] up to 3X Week: LE, Supine (lying on back) Exercises 10 Reps [repetitions] . . . LE Seated Exercises 2# [pounds] Wts [weights] Red Thera Band 10 Reps or UE Exercises 2# Wt Dowel Exercises . . ." A Functional ROM Plan of Care, dated 03/10/23, identified upper and lower extremity exercises three times per week. The medical record lacked evidence of restorative nursing provided or refused by the resident for the week of March 19-25, 2023. During an interview on 03/30/23 at 11:20 a.m., an MDS Coordinator (#9) confirmed restorative staff focus on the 6 day a week residents and get to the others when they are able.	F 688		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of a professional reference, and staff interview, the facility failed to ensure a resident remained free from significant medication errors for 1 supplemental resident (Resident #95) reviewed for dialysis. Failure to administer medications according to the practitioner's order and report frequently missed doses to the practitioner, may inhibit the effectiveness of the medications and cause subtherapeutic levels. Findings include:	F 760	1. Resident #95 had medications reviewed by consultant pharmacist and rescheduled based on dialysis plan. 2. Residents receiving dialysis and residents out of the facility have the potential to be impacted. 3. Education was provided via email on 4/19/2023 and at In-services on April 24th through April 28th, May 1st and May 2nd as well as at daily huddles to nurses and medication assistants regarding	5/3/23

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F 760	Continued From page 13 Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 816, stated, "Because the purpose of most drug therapy is to maintain a constant drug level in the body, repeated doses are required to maintain that level. . . . Another dose is given in order to maintain therapeutic levels. If the client does not receive another dose of the drug . . . the concentration steadily decreases. . . ." Pages 838-841, about medication administration, stated, "Performance . . . Safety . . . All medications . . . 8. Administer the medication at the correct time. . . . Report significant deviations from normal to the primary care provider." Review of Resident #95's medical record occurred on all days of survey. Diagnoses included diabetes, chronic atrial fibrillation, and pain. During an interview on 03/29/23 at 12:05 p.m., a nurse (#15) stated Resident #95's "morning meds are skipped" due to the resident being at dialysis. The medication administration records showed the following: - January 2023: Staff failed to complete the 7:00 a.m. accu checks (a test for blood sugar levels) and failed to administer the following 8:00 a.m. medications: acetaminophen (ordered twice a day for pain), apixaban (ordered twice a day for atrial fibrillation) carboxymethylcellulose sodium (eye drops ordered twice a day for dry eyes), and metoprolol tartrate (ordered twice a day for atrial fibrillation) on 11 dialysis days. - February 2023: Staff failed to administer the	F 760	rescheduling medications or updating the medical provider if the resident is out of the facility when medications are due. Healthcare Academy session on Medication Administration are assigned annually to nurses and medication aides also. 4. The Unit Manager and/or designee will conduct audits of 5 residents on dialysis (dependent on actual number receiving dialysis as number could vary) and their MARs weekly for 4 weeks. The audits will the move to 5 MAR reviews every two weeks for 4 weeks and then 5 MAR reviews quarterly for one year. Audit results will be reported by the DON at the bi-monthly Quality/Medical Director Meeting.	

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F 760	Continued From page 14 8:00 a.m. nutritional supplement (ordered 02/14/23) on 2 dialysis days and the acetaminophen, apixaban, carboxymethylcellulose sodium, and metoprolol tartrate on 11 dialysis days. - March 2023: Staff failed to administer the 8:00 a.m. nutritional supplement on 5 dialysis days (discontinued 03/23/23) and failed to administer the following medications: glipizide (once a day for diabetes, ordered 03/01/23), acetaminophen, apixaban, and carboxymethylcellulose sodium on 10 dialysis days. During the months of January, February, and March 2023, Resident #95 missed 32 doses of pain medication, eye drops, and a medication for atrial fibrillation, 22 doses of another medication for atrial fibrillation, 10 doses of diabetic medication, 11 blood sugar checks, and seven servings of nutritional supplements. The medical record lacked documentation of notification to the provider of these missed doses of medications. On the afternoon of 03/30/23, administrative staff (#7) identified it is not the facility practice for residents to miss medications on dialysis days.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable,	F 804		5/3/23

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F 804	Continued From page 15 attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident interviews, the facility failed to serve foods at palatable temperatures for 2 of 8 units (Meadowlark Lane and Crestwood). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled "Service of Food" occurred on 03/30/23. This policy, revised December 2021, stated, "1. Hot foods will be held until service at 135 degrees F. [Fahrenheit] or above. 2. Hot foods should be at least 120-130 degrees F. when presented to the residents. . . ." Interviews on the afternoon of 03/27/23 identified the following: *Resident #51 - The food is often cold when staff deliver it to her room *Resident #66 - The food is not always hot when it's delivered to the room *Resident #68 - The food is not hot especially breakfast food, sausages, pancakes, and waffles. Sometimes it is so cold "I cannot eat it." *Resident #79 - The food is usually not hot. *Resident #96 - By the time staff deliver food (to the room), it is cold. During an interview on the morning of 03/28/23, Resident #40 stated, "Sometimes it's lukewarm, sometimes it's cold [the food]. Rarely is it hot enough."	F 804	1. Immediate coaching and re-education to Dining Services staff working on Meadowlark and Crestwood households was completed regarding keeping temperatures at or above 135 degrees. 2. Residents who are served hot meals have the potential to be impacted 3. Dining Service staff will be re-educated on the requirement of temperature monitoring for serving hot food on April 20th, 2023 at an in-service as well as ongoing education at daily huddles. 4. Dining Service supervisors and/or designees will conduct daily temperature audits of food served daily for 4 weeks, then weekly audits for 4 weeks and then based on compliance moved to monthly monitoring with periodic checks. Audit results will be reported by the Director of Dining Services at the bi-monthly Quality/Medical Director Meeting.	

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F 804	Continued From page 16 Observation on 03/29/23 at 8:29 a.m. showed a dietary assistant (#11) dished up food for residents. The steam table items did not have lids covering the food and when requested to check the temperature of the sausage patties the dietary assistant removed approximately six sausage patties and placed them on a plate. The sausage temperature showed 93 degrees F.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacture instructions, review of facility sanitizer logs, and staff interview, the facility failed to prepare, store, and serve food under sanitary conditions in 1 of 1	F 812	1. There were no residents affected by the sanitizer solution surveyors observed 2. Residents who have food prepared	5/3/23

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F 812	Continued From page 17 kitchen (main kitchen) and 2 of 4 kitchenettes (Cottonwood and Sterling House). Failure to monitor the quaternary (quat) sanitizer concentration and follow facility guidelines for quat concentration procedure may result in unsafe preparation of food and foodborne illness. Findings include: Review of the manufacturer instructions for Smart Power Sink and Surface Cleaner Sanitizer posted above the kitchen dishwasher sinks, stated, "EPA-registered cleaner sanitizer for pre-cleaned use on hard, non-porous food prep surfaces and wares, kills foodborne organisms . . . it is a no-rinse sanitizer that is effective across a dilution range of 0.27 to 0.55 oz.[ounce] per gallon of water. Sanitization Range Testing: Testing solution should be at or above room temperature: 65F [Fahrenheit]. Withdraw a test strip from the canister. Dip test strip for 5 seconds in test solution. Shake off excess solution. Compare colors after 10 seconds with colors on the test strip canister to determine concentration (oz/gal) [ounces/gallon] . . . . Testing solution should be between 272-700 ppm [parts per million] DDBSA [dodecylbenzene sulfonic acid] . . ." Review of the Facility Sanitizer Daily Test Strip Log stated, ". . . Test strip must be between 272-700 ppm. If it is out of range, test again. If second test is still out of range, notify the supervisor." The staff failed to record the specific concentration of the sanitizer mix on the logs.	F 812	have the potential to be impacted if the sanitizer solution doesn□t meet manufacture guidelines. 3. Dining Service staff will be re-educated on April 20th, 2023 at an in-service regarding properly mixing/testing sanitizer solution. Facility also made modifications to the sanitizer logs with instructions. There will also be ongoing education at daily huddles. 4. Dining Services supervisors and/or designees will conduct sanitizer log audits daily for 4 weeks, then weekly audits for 4 weeks and then based on compliance moved to monthly monitoring with periodic checks. Audit results will be reported by Director of Dining Services at the bi-monthly Quality/Medical Director Meeting.	

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F 812	Continued From page 18 Observation of the main kitchen on 03/27/23 at 12:00 p.m. with two directors of dining and nutrition (#1 and #2), and identified a red sanitizer bucket by the kitchen prep area. Using a test strip, staff obtained a reading of 848 (high) of the solution. Staff tested a second red sanitizer bucket located in the dishwasher area with a reading of 848 (high). On 03/28/23 at 10:40 a.m., an assistant director of dining services (#4) tested the two sanitizer buckets located in the main kitchen prep areas. Both buckets registered at 848. The assistant director of dining services (#4) confirmed the concentrations were high and "not safe to use." Observations on 03/29/23 at 1:30 p.m. with two directors of dining services and nutrition (#1 and #3) in the facility kitchenettes and the main kitchen, showed staff obtained strip test readings of the sanitizer buckets that identified the following: * Cottonwood Kitchen: Sanitizer solution reading 848 (high) * Sterling House: Sanitizer solution reading 848 (high). The director of dining services and nutrition (#1), remixed and retested the solution, and obtained a second reading of 848 (high).	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		5/3/23

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F 880	Continued From page 19 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under	F 880		

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F 880	Continued From page 20 the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (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 and review of facility policy, the facility failed to follow infection control practices for 4 of 14 sampled residents (Residents #19, #37, #58, and #93) observed during personal cares. Failure to follow infection control practices has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 03/27/23. This policy, revised February 2021, stated, ". . . Hand Hygiene Table . . . Before applying and after removing personal	F 880	1. Immediate education and coaching provided to staff involved with cares for residents #93, #19, #37, and #58. 2. Residents receiving personal cares have the potential to be impacted 3. Re-education was provided via email on 4/19/2023 and at In-services on April 24th through April 28th, May 1st and May 2nd as well as at daily huddles to nurses and CNAs regarding hand hygiene when using gloves and providing cares Staff also have Healthcare Academy sessions on Hand Hygiene and Infection	

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F 880	Continued From page 21 protective equipment (PPE) including gloves . . . after assistance with personal body functions . . . " - Observation on 03/27/23 at 3:32 p.m. showed two certified nurse aides (CNAs) (#13 and #14) donned gloves and provided perineal care for Resident #93. The CNA (#13) cleansed the rectal area of stool using a wet wipe. The CNA (#13) removed her gloves and without performing hand hygiene, the CNA (#13) applied a clean brief, turned the resident from side to side to change the bed sheet, and changed the resident's shirt. The CNA (#13) failed to perform hand hygiene after removing the soiled gloves and before completing other tasks. - Observation on 03/27/23 at 4:01 p.m. showed a CNA (#8) donned gloves and provided perineal care for Resident #19. The CNA (#8) cleansed the rectal area of stool using a wet wipe. Without removing gloves, the CNA (#8) placed a clean brief, applied ointment to the resident's buttocks and groin, pulled up the resident's pants, placed the transfer sling under the resident, and relocated the resident's wheelchair. The CNA (#8) failed to remove the soiled gloves and complete hand hygiene before touching other surfaces. - Observation on 03/29/23 at 8:19 a.m. showed a CNA (#18) assisted Resident #37 to the bathroom. The CNA donned gloves and provided perineal care. Without removing the gloves, the CNA placed a gait belt around the resident's waist, assisted the resident to stand, placed a new brief, and pulled up the resident's pants. The CNA then placed the resident's call light pendant	F 880	Prevention that are assigned annually. 4. The Unit Managers and/or designees will conduct 5 hand hygiene audits weekly for 4 weeks and then 5 audits every 2 weeks for 4 weeks and then 5 audits quarterly for one year. Audit results will be reported by the DON at the bi-monthly Quality/Medical Director Meeting.	

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F 880	Continued From page 22 around Resident #37's neck and removed the gait belt before removing her gloves. Without performing hand hygiene, the CNA donned new gloves and combed the resident's hair. The CNA failed to remove her soiled gloves and perform hand hygiene after perineal care and before performing other tasks. - Observation on 03/27/23 at 4:02 p.m. showed CNAs (#16 and #17) donned gloves and transferred Resident #58 into the wheelchair, discarded their gloves, and CNA (#17) failed to perform hand hygiene upon exiting the resident's room.	F 880		
F9999	FINAL OBSERVATIONS The complaints investigated in conjunction with the standard Medicare/Medicaid survey were not substantiated.	F9999		