STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 08/28/17 and completed on 08/30/17, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat 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. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident interviews, the facility failed to provide care for 3 of 14 sampled residents (Resident #3, #7 and #9), and 1 supplemental resident (Resident #18) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors and wait for a reply before entering a resident's room does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment or emotional harm. Findings include: Review of the facility policy titled, "Proper Entrance to Resident Rooms" occurred on 08/30/17. This policy, dated August 2012, stated, "Before an employee enters a resident's room,	F 241	Resident #3, #7, #9 and #18 nursing staff were educated through communication board on September 9th to knock and wait for acknowledgement before entering resident rooms. All other facility staff were educated during their huddles the week of September 11th through September 15th. All residents have the potential to be affected. Education given to all nursing staff in regards to dignity and proper entrance to resident rooms at Unit meetings on September 15th and September 18th, policy of Proper Entrance to Resident Rooms was reviewed. Social Services staff educated all other facility staff at their	10/4/17

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

Electronically Signed | 09/15/2017

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F 241	Continued From page 1 the following will be done: 1. Knock, 2. Wait for acknowledgement to enter, 3. Enter as acknowledged. 4. Many residents are unable to acknowledge knock, if no response initially, knock again, announce self and quietly look into room and ask for permission to enter or note if appropriate to enter. . . ." -Observation on the afternoon of 08/28/17, showed a CNA (#3) knocked on Resident #9's door while entering the room. The resident was using a bedside commode and was exposed from the waist down. The CNA (#3) failed to announce herself and/or wait for acknowledgement to enter the room. - During a confidential interview on the afternoon of 08/28/17, Resident A identified staff do not always knock on her door, especially her bathroom door. The resident stated, "They just come barging in; it scares me." - Observation on 08/28/17 at 5:40 p.m. showed an unidentified facility staff member entered Resident #18's room without knocking or announcing herself and/or waiting for acknowledgement to enter the room. - Observation on 08/29/17 at 7:42 a.m. showed an unidentified certified nurse assistant (CNA) knocked once on Resident #3's door and entered the room without announcing herself and/or waiting for acknowledgement to enter the room. - Observation on 08/29/17 at 10:03 a.m. showed an unidentified facility staff member knocked on Resident #3's door as she entered the room during morning cares. She failed to announce	F 241	huddles the week of September 11th through September 15th. QI monitor placed to monitor acceptable entrances to resident room weekly for one month, monthly for one year. Results will be reported at quarterly QAPI meeting and if concerns are identified corrective action will be implemented. Social Services will be responsible. Date of correction October 4, 2017.	

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F 241	Continued From page 2 herself and/or wait for acknowledgement before she entered the room. During an interview on 08/30/17 at 9:15 a.m., Resident #7 identified staff knock on her door and enter her room without announcing himself/herself and/or waiting for acknowledgement to enter the room.	F 241		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on review of Resident Council meeting minutes, resident interview, and staff interview, the facility failed to provide reasonable accommodation of needs for 1 of 4 sampled residents (Resident #11) who ambulated independently in their room. Failure to attempt to individualize a resident's environment to provide access to personal items (such as clothing) may result in falls, injuries, or a loss of independence. Findings include: During the group interview on 08/28/17 at 3:00 p.m., Resident #11 identified she has difficulty reaching the clothing that is hung on the top rod of her closet. Resident #11 stated, "Even if they	F 246	Resident #11 request for her clothes bar to be lowered was completed by the Maintenance department staff on September 6th. All residents with requests for accommodations or adaptations have the potential to be affected. All suggestions in the suggestion box and requests received through other means will be reviewed by a committee to assure that the resident's requests are addressed. The committee will consist of the DON, the Activity Director, OT staff member, Dietary staff member and Social	10/4/17

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F 246	Continued From page 3 [the staff] would lower it six inches, I could reach." The resident identified she brought up the concern "a couple months ago," but "I never heard anything about it." Review of Resident Council meeting minutes, dated 04/24/17, identified, ". . . Suggestion box - There were two (2) suggestions in the box this month. 1. Possible to set the top rod in the closet down 6-8 inches? OT [occupational therapy] & PT [physical therapy] looked into this; currently there is nothing available to meet the safety requirements. . . ." The minutes identified Resident #11 did not attend that Resident Council meeting. During an interview on 08/30/17 at 11:08 a.m., an activities staff member (#18) stated she did not follow up with Resident #11 directly after receiving the resident's suggestion regarding the closet rod. The staff person also stated, "[Maintenance staff member] said it couldn't be done [lowering the closet rod]." During an interview on the morning of 08/30/17, a maintenance staff member (#19) stated he did not remember receiving a work order for Resident #11's closet. During an interview on 08/30/17 at 11:30 a.m., an occupational therapy staff member (20) stated he was not aware there was a problem with Resident #11's closet and confirmed he had not done an evaluation. The staff member stated if he had received a request, he would have done an assessment on Resident #11's closet to see if there was something he could do.	F 246	Services staff member. The committee will meet monthly prior to Resident Council meetings to review any requests for accommodation or adaptation and assure communication is established and follow-up with the request is completed. QI monitor will be implemented to monitor resident's requests received monthly for one year. Results will be reported at quarterly QAPI meetings and if concerns are identified, corrective action will be implemented. DON/designee will be responsible. Date of correction October 4, 2017.	
F 323	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323		10/4/17

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F 323 SS=E	Continued From page 4 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: TRANSFERS 1. Based on observation, record review, policy review, and staff interview, the facility failed to ensure staff appropriately used assistive devices for 5 of 8 sampled residents (Resident #1, #2, #5, #6, and #9) observed during a transfer. Failure to properly use a gait belt (Resident #1, #2, and #5), utilize wheelchair foot pedals (Resident #6),	F 323	Residents #1, #2 and 5, #6 and #9 nursing staff were instructed on proper use of gait belt and the need to snug belt tightly to resident's waist; when transferring resident in wheelchair to applying foot pedals for transfer or remind resident to hold his/her feet up; and when transferring resident to a commode to apply brakes through posting on	

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F 323	Continued From page 5 and lock brakes on a bedside commode (Resident #9) increased the risk for sustaining a fall or injury. Findings include: Review of the facility policy titled "Gait Belt" occurred on 08/30/17. This policy, revised June 2014, stated, ". . . Procedure: . . . 2. To use gait belt: a. Place gait belt securely around resident's waist. b. Grasp gait belt with an underhand grasp to provide support for the resident. c. Assist resident to transfer or ambulate." - Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, "Impaired mobility and ADL [activity of daily living] deficit related to chronic back pain, impaired balance, . . . progressive dementia, resistant to cares . . . Nurse directed PAL Lift [type of stand-up mechanical lift] PRN [as needed]. . . . Transfers with assist of gait belt and assist of 2 in room. . . ." On 08/28/17 at 3:50 p.m., observation showed Resident #1 in a recliner with her eyes shut. Two certified nurse aides (CNAs) (#11 and #12) entered the resident's room, attempted to waken and explain to the resident the plan to assist her to the bathroom, and placed a gait belt around her upper waist. Resident #1 kept her eyes closed and mumbled "um hum." One CNA (#11) stated, "She is kind of sleepy." The two CNAs held the gait belt to lift Resident #1 from the recliner and pivot her to the wheelchair. Observation showed the gait belt loose on the resident's waist and sliding up her back during the transfer first to the wheelchair, then to the	F 323	September 9th. Resident #1 was reassessed by Physical Therapy (PT) on August 30, 2017 and order for hoyer for all transfers initiated. Resident #2 was reassessed by Physical Therapy (PT) on September 11th and order for hoyer for all transfers was initiated. Staff instructed per assignment sheet. All residents needing assistance with transfers have the potential to be affected. Unit staff meetings were held on September 15th and September 18th for all nursing/CNA staff to remind and educate staff on proper use of gait belt and the need to snug belt tightly around resident's waist; proper transferring resident in wheelchair to applying foot pedals for transfer or remind resident to hold his/her feet up; and when transferring resident to a commode to apply brakes. Assessments will continue to be completed by PT for transfers of residents. Laminated cards placed on all of CNA/nurse's computers to visually remind staff of gait belt, brakes and wheelchair pedals. QI monitoring placed to monitor proper use of gait belt, proper wheelchair transportation with pedals/or resident's ability to keep feet up with cues, use of brakes with commodes and PT assessments of mechanical lifts for transfer weekly for one month, monthly for one year. Results will be reported at	

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F 323	Continued From page 6 toilet, and back to the wheelchair. The resident showed poor weight bearing and kept her eyes closed throughout most of the transfers. The CNAs failed to snug the gait belt around the resident's waist or consult the nurse if a mechanical lift should be used due to the resident's sleepiness/lethargy. On 08/29/17 at 7:53 a.m., observation showed a CNA (#13) transported Resident #1 from the dining room to her room after unsuccessfully trying to get the resident to wake up and eat. Two CNAs (#13 and #14) applied a gait belt, lifted Resident #1 who only beared minimal weight, and pivoted her onto the bed. The CNAs failed to consider an alternative means of transfer (mechanical lift at nurse's direction) for Resident #1 who was lethargic. - Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, "Impaired mobility and ADL deficit related to dementia, impaired cognition, impaired balance, unsteady gait, vision and hearing deficit, incontinence, hx [history] of fractures [toes] . . . Hoyer [full body mechanical lift] PRN per nurse discretion . . . Pivot transfer assist of one . . ." On 08/29/17 at 3:12 p.m., observation showed two CNAs (#15 and #16) placed a gait belt around Resident #2, but failed to snug it around her waist. As the CNAs attempted to assist the resident to stand, the resident would not stand upright causing the CNAs to lift and pivot her onto the toilet. The resident cried, "I'm sorry I can't stand or use my feet." The gait belt slid up the resident's back during the transfer. One CNA (#15) asked the other CNA if they should use a	F 323	quarterly QAPI meeting and if concerns are identified corrective action will be implemented. DON/designee will be responsible. Date of correction October 4, 2017. Safe handling of hot liquids: Resident #8 staff on Unit A instructed through communication log on September 9th to serve hot liquids in covered mug as indicated for residents as assessed by OT staff. All residents having been identified for utilization of covered mugs have the potential to receive hot liquids without a covered mug. Unit meetings on September 15th and September 18th instructed all staff on the importance of utilizing covered mugs for residents identified as being beneficial for them. In addition, covered mugs for all residents will be offered for hot liquids. QI monitor placed for utilization of covered mugs for hot liquids as identified weekly times one month, monthly times one year results will be reported at quarterly QAPI meeting and if concerns are identified corrective action will be implemented. DON/designee will be responsible.	

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F 323	Continued From page 7 third person or ask the nurse if they should use the lift, because "this is hard on both our backs." The CNA (#16) asked a third CNA (#11) to assist. The CNAs failed to snug the gait belt around the Resident #2's waist or consider asking the nurse if a mechanical lift should be used in the transfer. During an interview on 08/30/17 at 12:05 p.m., an administrative nurse (#17) stated a gait belt should be snug during transfers. - Review of Resident #5's medical record occurred August 28-30, 2017. A significant change Minimum Data Set (MDS), dated 08/18/17, identified Resident #5 required extensive assistance from two or more staff members for transfer. On 08/29/17 at 8:47 a.m., observation showed two CNAs (#1 and #2) assisted Resident #5 to transfer from her wheelchair to a dining room chair. The CNAs applied a gait belt around the resident's waist as she sat in her wheelchair. As the CNAs (#1 and #2) assisted her to stand, the gait belt slid up to Resident #5's upper chest. The CNAs transferred the resident to the dining room chair with the CNAs hands holding the gait belt at the level of Resident #5 shoulders. - Review of Resident #6's medical record occurred August 28-30, 2017. The medical record showed Resident #6 fractured her right hip on 07/18/17. After lunch on 08/29/17, observation showed a nurse (#10) transported Resident #6 from the dining room without the wheelchair foot pedals in place, and without cueing her to lift her feet. Resident #6's feet bounced across the floor, the	F 323	Date of correction October 4, 2017.	

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F 323	Continued From page 8 right foot more than the left, during transport to the central common area. The pedals for Resident #6's wheelchair hung in a bag on the back of her wheelchair. The nurse failed to remind the resident to hold her feet up or place foot pedals on the wheelchair before transporting the resident. During an interview on 08/30/17 at 11:50 p.m., an administrative nurse (#9) stated a gait belt should be snug around the resident's waist, and staff should use foot pedals when transporting a resident in a wheelchair. - Observation on 08/28/17 at 4:30 showed a CNA (#4) assisted Resident #9 to transfer from her bed to the commode chair. Observation showed Resident #9 unsteady, and her right knee buckled during the transfer. The commode chair rolled back as Resident #9 sat down, and the CNA steadied the chair by putting her foot behind one of the wheels. The CNA failed to engage the commode chair brakes prior to assisting Resident #9 with a transfer. SAFE HANDLING OF HOT LIQUIDS 2. Based on observation and record review, the facility failed to provide adequate supervision and the necessary safety devices to prevent injury from a second coffee spill for 1 of 3 sampled residents (Resident #8) observed who required covered mugs for hot liquids. Failure to provide Resident #8 proper safety devices while consuming hot liquids placed the resident at risk of injury. Findings include:	F 323		

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F 323	Continued From page 9 Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia without behaviors. A significant change Minimum Data Set (MDS), dated 05/27/17, identified moderately impaired cognition and an acute change in mental status. The current care plan stated, "Focus: . . . Progressive Dementia and has significant cognitive deficits and requires cues, supervision, and assistance with activities of daily living (ADL's) . . . hot liquids served in a covered mug . . ." Resident #8's meal card identified hot fluids in a covered mug. A occupational therapy (OT) progress note, dated 07/15/17, identified OT completed a hot beverage screen due to a nurse's report of spilled coffee. OT recommended Resident #8 utilize lidded mugs for hot beverages and the record identified dietary informed of the recommendation. Observation during the breakfast meal on 08/29/17 at 8:25 a.m. showed Resident #8 received coffee in a cup without a lid. Observation during the lunch meal on 08/29/17 at 12:21 p.m. showed Resident #8 received coffee in a cup without a lid. Observation during the lunch meal on 08/30/17 at 12:06 p.m. showed Resident #8 received coffee in a cup without a lid. The facility failed to follow recommendations to ensure Resident #8 handled hot liquids safely. Failure to follow current interventions on care plan/meal card placed Resident #8 at greater risk for a hot liquid spill, and burns.	F 323		

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F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 328		10/4/17

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F 328	Continued From page 11 (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident #9) with physician's orders for continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications and/or hospitalization related to inadequate oxygen saturation levels. Findings include: Review of Resident #9's medical record occurred on all days of survey. Diagnoses included (iron deficiency) anemia, hypertension and history of pulmonary embolism. The current care plan stated " . . . alteration in cardiac and respiratory status . . . Oxygen via n/c [nasal cannula] at 2L [liters] continuously."	F 328	Resident #9 staff on Unit B instructed on leaving oxygen in place when ordered continuous through communication log on September 1st. All residents requiring continuous oxygen have the potential to be affected. Unit meetings on September 15th and 18th staff were educated on the use of oxygen continuous. QI monitor on all residents utilizing oxygen continuous weekly times one month, monthly times one year. Review at quarterly QAPI and if concerns are identified corrective action will be implemented. DON/designee will be responsible.	

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	355037	A. BUILDING _____ B. WING _____	08/30/2017

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F 328	Continued From page 12 A physician's order, dated 08/24/17, stated, "02 [Oxygen] at 2L nc continuously." On 08/28/17 at 4:26 p.m., observation showed a certified nurse aide (CNA) (#4) placed a gait belt around Resident #9's waist, removed the oxygen from the resident's nose, placed a walker in front of the resident, assisted the resident to stand and ambulate to the bed side commode. While sitting on the commode, observation showed Resident #9 restless, moaning and straining to have a bowel movement. At 4:38 p.m., the CNA assisted Resident #9 to her bed and placed the oxygen on the resident. Staff failed to provide Resident #9's oxygen for 12 minutes. On 08/29/17 at 11:00 a.m., observation showed two CNA's (#5, #6) assisted Resident #9 to a sitting position at the edge of her bed. The CNA (#6) removed the resident's oxygen and assisted the resident to a recliner chair to complete morning cares. While washing the resident's arms and back, Resident #9 inhaled a deep breath and sighed. As the CNA assisted the resident with dressing, a CNA (#6) stated,"you're getting tired on me." At 11:05 a.m., the CNA (#6) placed oxygen on the resident. Staff failed to provide Resident #9 oxygen for five minutes. During an interview on 08/30/17 at 12:00 p.m., an administrative nurse (#9) stated staff should keep Resident #9's oxygen on at all times.	F 328	Date of correction October 4, 2017.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		10/4/17

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F 371	Continued From page 13 (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of the Food and Drug Administration (FDA) Food Code, and staff interview, the facility failed to ensure appropriate sanitization of dishware in 2 of 3 dishwashers (unit A kitchenette and unit B kitchenette). Failure to maintain utensil surface temperatures above 160 F (degrees Fahrenheit) and properly use a dishwasher thermometer has the potential to increase the risk of foodborne illness and can affect all residents who consume food prepared with these dishes. Findings include:	F 371	Hobart Service was on site September 7, 2017 to service, test and adjust the dishwashers in the serving kitchens in compliance with dishwasher temperature regulations. As of September 7, 2017 the Unit B serving kitchen dishwasher was adjusted by Hobbart and is currently in compliance with the dishwasher temperature regulations. All residents have the potential to be affected when dishwashers do not reach proper temperatures.	

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F 371	Continued From page 14 The FDA Food Code 2013, page 145, stated, ". . . Sanitization of equipment and utensils . . . Hot water mechanical operations . . . achieving a utensil surface temperature of 160 F as measured by an irreversible registering temperature indicator. . . ." Review of the facility policy titled "Dishwasher Temperatures" occurred on 08/30/17. This policy, dated 04/13/16, stated, "Policy: It is the policy of this facility to check and record for spray type dishwasher temperatures to ensure sanitation of items in the dishwasher. . . . 1. All items cleaned in the dishwasher will be washed in water that is sufficient to sanitize any and all items. . . . 4. Temperatures below required temperature will require corrective actions, maintenance will be notified. 5. Water temperatures will be measured prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes and recorded on the Dishwasher Temperature Chart. . . ." Observation during the dietary tour on 08/30/17 at 10:00 a.m. showed the following: * No dishwasher temperatures charted in unit A and B kitchenettes. * A hotplate thermometer placed in unit B dishwasher showed the maximum utensil temperature of 157 F was reached after three attempts. During an interview on 08/30/17 while conducting the dietary tour, two administrative dietary staff members (#7) and (#8) stated staff use the dishwashers in the kitchenettes only for breakfast and they did not expect dietary staff to check the	F 371	The CDM has posted a dishwasher temperature log sheet in each serving kitchen. Dietary staff have been instructed by CDM on September 6th to take temperatures daily during breakfast clean up. Staff will alert CDM if temperature goes below 160 degrees Fahrenheit. The CDM (Director of Dietary) will be responsible for the QI monitor on dishwasher temperatures. The CDM will test dishwashers weekly for one year to ensure the temperatures of the machines are in compliance. The results will be reported to the QAPI Committee at regularly scheduled meetings. If concerns are identified corrective action will be implemented.	

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F 371	Continued From page 15 dishwasher temperatures in the kitchenettes before use. The facility is responsible to ensure staff monitor/record dishwasher temperatures in the kitchenettes. Failure to use a dishwasher thermometer and maintain dishwasher surface temperatures at 160 F may result in a foodborne illness.	F 371		