STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on December 5, 2011 and completed on December 8, 2011 the sample included five (5) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000	**F-156** 1. No residents experienced a direct, negative outcome due to lack of posting required telephone numbers. 2. All residents have the potential to be affected by this.	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	3. This oversight was corrected immediately after surveyor brought it to the attention of staff. All addresses and phone numbers of all pertinent state agencies and client advocacy groups are now conspicuously posted on designated resident's rights bulletin board. LSW will monitor said bulletin board weekly to ensure the above-mentioned required information is posted. 4. A QA tool has been developed and implemented to monitor posting of required information. LSW will monitor weekly and log results on QA tool. Results will be presented and reviewed at quarterly QA meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy N. Burchill	CEO	1/5/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	5. 1-16-12	

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the names, addresses, and/or telephone numbers of pertinent State advocacy groups, State survey and certification agency, and the Medicaid fraud control unit on 4 of 4 days of survey. Failure to provide this information has the potential to limit facility resident's and families' access to these agencies.	F 156		

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F 156	Continued From page 3 Findings include: Observations of the facility's display board on December 5-8, 2011, failed to list contact information for the State Survey and Certification agency, Protection and Advocacy Project, and the Medicaid Fraud Control unit. After the environmental tour on the morning of 12/08/11, an administrative staff member (#4) and a social services staff member (#5) indicated the display board is usually up to date with information and were unsure what happened. The administrative staff member (#4) agreed the display board lacked some of the required information.	F 156		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the	F 274	1. A Significant Change in Status Assessment (SCSA) was completed for Resident #3 on 12-08-2011. Resident suffered no direct, negative outcome from inaccurate assessment. 2. All residents have the potential to be affected. 3. MDS Coordinator will review medical record and complete assessment for significant change if indicated, prior to completion and transmission of MDS. Computer software may alert need for significant	

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F 274	Continued From page 4 Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a Significant Change in Status Assessment (SCSA) after determining there had been a significant change in the resident's condition, for 1 of 17 sampled residents (Resident #3). Failure to conduct the SCSA limited the facility's ability to assess, care plan, and implement approaches regarding changes in Resident #3's status. Findings include: The Centers for Medicare and Medicaid Services (CMS), Long-Term Care Facility RAI User's Manual, version 3.0, revised October 2010, pages 2-20-23, states ". . . The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either improvement or decline. . . . Guidelines . . . Decline in two or more of the following: . . . Any decline in an ADL [activity of daily living] physical functioning area where a resident is newly coded as . . . Activity did not occur since last assessment . . . Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) . . ." Review of Resident #3's medical record occurred on December 05-08, 2011. The facility admitted the resident in May 2011. The resident's quarterly Minimum Data Set (MDS), dated 08/20/11, identified he walked in his room with extensive assistance of one or two persons, had no behavioral symptoms, and experienced a weight loss of more than five percent. The quarterly	F 274	change in status assessment. Interdisciplinary team will be educated at Medicare meeting on 1-05-2012 on importance of accurate MDS assessments. 4. A QA tool will be developed, implemented and completed by Quality Assurance Manager (QAM) or nurse manager to monitor a random sample of current MDS assessments to ensure significant change assessments are completed if indicated. This will be completed weekly x 1 month, monthly x 3 months and quarterly thereafter. 5. 1-16-12	

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F 274	Continued From page 5 MDS, dated 11/20/11, identified Resident #3 did not walk in his room during the assessment period, identified he had physical and verbal behaviors one to three days in the assessment period, and experienced a weight loss of five per cent or more in the last month or weight loss of ten per cent or more in the last six months. Resident #3's medical record identified fluctuating weights prior to the MDS, dated 08/20/11. Nurse's Notes identified facility staff stopped attempting to ambulate the resident on 10/19/11 due to his decline in status and lack of cooperation. The resident's care plan, dated 11/16/11, identified a weight loss of greater than five percent in the previous 30 days. During interview, on 12/08/11 at 8:40 a.m., a facility staff member (#6)responsible for completion of the MDS confirmed Resident #3's changes in status on 11/20/11 required the completion of a SCSA. Failure to complete the SCSA failed to trigger the Care Area Assessment process.	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278	1. No residents experienced a direct, negative outcome due to inaccuracy of MDS assessment. 2. All residents have the potential to be affected.	

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F 278	Continued From page 6 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 3 of 17 sampled residents (Resident #6, #12, and #17). Failure to accurately code the MDS may affect the level of care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual (version 3), page E-18, states, ". . .Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction."	F 278	3. Interdisciplinary team will thoroughly review medical record during MDS look-back period to ensure accuracy of assessment. When residents are marked for behaviors, LSW will visit with staff to ascertain type and frequency of behaviors. Interdisciplinary team will be educated at Medicare meeting on 1-05-2012 on importance of accurate MDS assessments. 4. A QA tool will be developed, implemented and completed by Quality Assurance Manager (QAM), nurse manager or LSW to monitor a random sample of current MDS assessments to ensure resident level of care are accurately reflected prior to submission. This will be completed weekly x 1 month, monthly x 3 months and quarterly thereafter. 5. 1-16-12	

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F 278	Continued From page 7 - Review of Resident #12's medical record occurred on December 05-08, 2011. Review of an annual MDS, dated 04/11/11, identified Resident #12 required total assist of one person for locomotion on and off the unit, and walking in the corridor did not occur. Review of the behavioral section of the MDS indicated Resident #12 wandered one to three days during the assessment period. During an interview on 12/07/11 at 5:00 p.m., a social services staff member (#11) stated Resident #12 did not wander during the assessment period. The MDS was incorrectly coded for this resident. - Review of Resident #17's quarterly MDS, dated 09/20/11, identified Resident #17 wandered one to three days during the assessment period. Information provided by the facility upon entrance, identified Resident #17 as bedfast (in bed or recliner in own room 22 or more hours). Review of Resident #17's behavioral notes lacked information regarding wandering, and care conference notes stated the resident prefers to remain in her room. During the afternoon of 12/07/11, an administrative nursing staff member (#7) stated Resident #17 does not wander as she rarely comes out of her room. During an interview on the morning of 12/08/11, a social services staff member (#11) reported if the resident comes out of her room it is to find the nurse or to look out of the door of her room. The MDS did not accurately reflect this resident's behaviors.	F 278		

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F 278	Continued From page 8 - The Long-Term Care Facility RAI Manual (Version 3.0), page P-1 defines a fall as, "Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. . . . An intercepted fall occurs when the resident would have fallen if he or she had not caught himself/herself or had not been intercepted by another person - this is still considered a fall." Review of Resident #6's medical record occurred on December 05-08, 2011. The resident's quarterly MDS, dated 10/06/11, identified no falls since the prior assessment dated 07/06/11. Review of of progress notes, dated 08/13/11 at 3:45 p.m., identified the following: "Type of fall - witnessed - lowered to the floor. . . . The CNA [certified nurse aide] was able to hold onto the gait belt & lower the resident to the floor gently." During interview, on 12/08/11 at 8:45 a.m., a facility staff member (#6), responsible for completion of the MDS confirmed the 10/06/11 MDS, failed to identify Resident #6's fall on 08/13/11.	F 278		
F 363 SS=B	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363	1. Residents requesting or benefiting from small portions will be served correct portion sizes during meal service to meet nutritional needs. Cycle menu diet spreadsheets will have a "Small	

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F 363	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, review of menus and diet cards, and staff interview, the facility failed to ensure 2 of 3 sampled residents (Resident #11 and #16) and 3 supplemental residents (Resident #22, #23, and #24) received the correct portion sizes during meal service in 2 of 2 kitchenettes (A/B and C/D kitchenettes). Failure to ensure residents received correct portion sizes placed them at risk of inadequate nutrition as well as feeling "overwhelmed" by the amounts of food. Failure to identify small portion serving sizes on the diet menu limited the staff's ability to accurately provide the serving size requested or required. Findings include: - Review of the dietary menus for the week of December 04-10, 2011 identified a variety of diets. The menus lacked portion sizes for small portion diets. The meal items and portion sizes for the noon meal on 12/06/11 included chicken breast - four ounces, baked potato - three ounces, and creamed carrots - four ounces. - Observation of the noon meal service in the A/B kitchenette, on 12/06/11 at 11:55 a.m., identified a dietary staff member (#9) served the entree of chicken breast, baked potato, and creamed carrots or ground chicken, mashed potatoes, and creamed carrots. Diet cards for Resident #22 and #11 identified these residents were to receive "small portions" and Resident #22 was to receive ground meats.	F 363	Portions" diet category with serving sizes identified. Dietary staff will use correct scoop-disher sizes to portion food for small servings. 2. All residents have the potential to be affected. 3. a. Dietitian will determine that when residents request or benefit from "small portions" they will receive half of the regular serving size, unless indicated otherwise on diet spreadsheet. b. Dietitian will add a **Small Portions** category on the cycle menu diet spreadsheets. Portion sizes will be listed for each meal item offered at breakfast, lunch, and supper and	

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F 363	Continued From page 10 Observation identified staff member (#9) provided the following for these residents' meal service: Resident #11 - a chicken breast cut in half, a full baked potato, approximately half of a four ounce scoop of carrots. Resident #22 - approximately half of a four ounce scoop, each, of mashed potatoes, carrots, and ground chicken. Observation of the remainder of the meal service showed the dietary staff member (#9) served approximately half of a four ounce scoop for all small portions as identified on the residents' diet cards. During interview, at the conclusion of the meal service, at approximately 12:20 p.m., the dietary staff member (#9) reported she used approximately half of the four ounce scoop for all small portion serving sizes. - Observation of the noon meal service in the C/D kitchenette, on 12/06/11 at 12:25 p.m., identified a dietary staff member (#10) served the entree of chicken breast, baked potato, and creamed carrots or ground chicken, mashed potatoes, and creamed carrots. Diet cards for Resident #16, #23, and #24 identified these residents were to receive "small portions." Observation identified staff member (#10) provided the following for all three residents' meal service: - a chicken breast cut in half, a baked potato cut in half, and approximately half of a four ounce scoop of carrots. Observation of the remainder of the meal service showed the dietary staff member (#10) served approximately half of a four ounce scoop for all	F 363	appropriate scoop-disher sizes will be listed. c. Adequate scoop-dishers in sizes needed for small portions will be stocked and available for use in all 3 kitchens during meal service. d. At department meeting to be held 1-5-12, dietary staff will be educated on reading the cycle menu diet spreadsheets for portion sizes and scoop-disher sizes and how to use the proper size of scoop-dishers when portioning food for meal service. Dietary staff will be taught to use the correct size scoop-disher to portion food for small portions during	

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F 363	Continued From page 11 small portions identified on the residents' diet cards. During interview, at 12:40 p.m., the dietary staff member (#10) reported she used approximately half of the four ounce scoop for all small portion serving sizes. The staff member (#10) reported some residents may be "overwhelmed" by a full serving of food and the small portion servings may reduce this feeling. During interview, on 12/07/11 at 11:30 a.m., a dietary management staff member (#1) and a dietary supervisory staff member (#8) confirmed the dietary staff in the kitchenettes should use two ounce scoops for small portions. These staff members provided no information regarding the lack of small portion sizes on the facility's menus.	F 363	meal service and for pre-portioning menu items, such as some desserts. e. Cycle menu diet spreadsheets are already updated and in place. Additional scoop-dishers needed for three kitchens have been ordered. 4. The Dietary Director or the Dietary Supervisor will monitor meal service once a week for 4 weeks. Items to be monitored: correct cycle menu diet spreadsheets being used, correct scoop-disher sizes being used to portion food in 3 kitchens, and correct residents who have small portions indicated on their diet cards are receiving the correct small portions on their plate. After 4 weeks, monitoring will continue on a monthly basis. Results will be recorded on a QA form, reported to the QAM, and presented at the quarterly QA meeting. If any of the previously listed items are found to be out of	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to store, distribute, and serve food under sanitary conditions regarding inadequate dishwashing temperatures for 1 of 1 kitchen, improper storage of wet dishes on 2 of 3	F 371		

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F 371	Continued From page 12 days of observation (December 07 and 08, 2011), and soiled air circulating fans in dishwashing areas on 3 of 3 days of observation (December 05, 07, and 08, 2011). Inadequate dishwashing temperatures for a period of 33 of 42 days placed all residents, staff, and visitors consuming food and beverage items from facility washed dishes or utensils at risk of foodborne illness. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding proper sanitation to prevent the outbreak of foodborne illness which states residents risk serious complications from foodborne illness as a result of their compromised health status. Food handling equipment may become contaminated by improper sanitation. A potential cause of foodborne outbreaks is improper washing and sanitizing of contaminated equipment. Dishwashing machines, operated according to manufacturer's specifications, may wash, rinse, and sanitize dishes and utensils using heat sanitization at 150-165 degrees Fahrenheit (F) wash and 180 degrees (F) final rinse. Review of the facility policy and procedure "Storage of Foods" occurred on 12/08/11. This document, dated 11/11/10, stated ". . . CANNED GOODS: . . . 6. When re-stacking canned goods, always put old stock on front of shelves so it will be used first. 7. Canned goods should be inspected frequently for swells and leaks. . . ." Review of the facility policy and procedure "Steps in Dishwashing" occurred on 12/08/11. This	F 371	compliance, the small portions plate will be re-served using the correct scoop-dishers and portions, and dietary staff retrained 5. 1/16/12. **F 371** 1. The facility is now achieving and maintaining proper dishwashing temperatures, is keeping circulating fans and vents free of lint and debris, is avoiding improper storage of dishes, and is performing regular stock rotation to avoid out-of-date food items left on the shelf and dispose of rusted canned goods. 2. All residents have the potential to be affected. 3. a. A food and par level list will be created for items that need to be stocked in the neighborhood kitchenettes. All dietary staff will be educated on Jan 5, 2012 on how to read food packages for "use by"	

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	355082	A. BUILDING _____ B. WING _____	12/08/2011

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F 371	Continued From page 13 document, dated 11/11/10, stated ". . . 3. Inspection . . . d. Allow dishes to air dry before storing - ESPECIALLY plastic trays . . ." - During the initial dietary tour, on 12/05/11 at 10:35 a.m., a dietary management staff member (#1) and a dietary supervisory staff member (#8) reported the facility kitchen dishwasher uses hot water sanitization. Activities on 12/07/11, regarding the kitchen dishwasher, occurred as follows: *9:10 a.m. - Observation of the dishwashing process in the facility's kitchen showed the temperatures on the dishwasher display panel "134" degrees F wash and "151" degrees F final rinse. A panel on the dishwasher identified minimum temperatures of "150 degrees F" for the wash cycle and "180 degrees F" for the rinse cycle. During interview at this time, the dietary staff member (#13) operating the dishwasher reported she observed the low temperatures the previous day and submitted a work order to the facility maintenance department at that time. At the surveyor's request, the staff member (#13) provided the dishwasher temperature log book for December 2011. Review of the log book showed no entries for December 01, 02, 04. Remaining entries showed the following in degrees F: *12/03/11 - wash, 161; rinse, 123. *12/05/11 - wash, 148; rinse, 160. *12/06/11 - wash, 134; rinse, 156. *12/07/11 - wash, 133, rinse, 153. *9:30 a.m. - The surveyor notified the dietary management staff member (#1) and the dietary supervisory staff member (#8) of the low	F 371	dates, how to use the food lists and par levels to maintain stock and avoid excess stock in neighborhood kitchens, how to properly restock using "FIFO" (First In – First Out), and how to properly discard out-of-date items or food packages and cans that are rusty, dented, leaky, and/or swollen. The 6:00-2:30 dietary aides assigned to their respective neighborhood kitchenettes will be responsible on a daily basis to check par levels, restock as needed, and check "use by" dates as items are being re-shelved using the FIFO method. b. A schedule for cleaning air-circulating fans in the three dishwashing areas will be created and followed. Each fan will be taken apart and the grids and blades will be cleaned free of lint and debris twice a month by the 6-2:30 dietary aide and janitor. All dietary staff will be educated on Jan 5, 2012 on how to clean a fan.	

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F 371	Continued From page 14 dishwashing temperatures. These staff members reported they were not aware of the low temperatures and agreed the temperatures were not adequate for sanitization. The staff members (#1) and (#8) requested that a maintenance management staff member (#14) come to the kitchen. *9:45 a.m. - A maintenance management staff member (#14) adjusted the wash temperature to 135 degrees F and the final rinse temperature to 188 degrees F. During interview at this time, staff member (#14) reported he received the work order the previous day, 12/06/11, regarding the low dishwasher temperatures. He reported he did not receive any previous work orders regarding low dishwasher temperatures. *9:55 a.m. - Following the adjustments by staff member (#14), the dietary management staff member (#1) and the dietary supervisory staff member (#8) agreed the kitchen dishwasher temperatures were inadequate for sanitization and other arrangements would be necessary for sanitizing all dishes and utensils until the dishwasher was repaired. These staff members (#1) and (#8) reported the dishwashers on the A/B and C/D kitchenettes also used hot water sanitization. Observation of the dishwashers on those units at that time showed minimum temperature requirements of "150 degrees F" for the wash cycle and "180 degrees F" for the rinse cycle. Review of the temperature logs for each kitchenette showed the temperatures to be at or above the minimum temperatures. Review of the kitchen dishwasher temperature logs showed the wash and rinse temperatures	F 371	c. The main kitchen dishwashing machine booster heater was replaced on 12-21-11 and is now consistently maintaining proper dishwashing temperatures. Procedures for starting the machine and allowing the water temperature to heat up before dishes are washed have been put in place. On 12-7-11 and 12-15-11, dietary staff were educated on this procedure, and who to alert in a timely manner if proper temperatures cannot be achieved, and alternate plans for washing dishes. Dietary management or designee is checking dishwashing temperatures on a daily basis. Increased recordkeeping and monitoring has been put in place to assure proper washing and rinsing temperatures are maintained. Dishwashing temperature record sheets will be revised to require ten random wash and rinse readings during the three post-meal dishwashing times. The 6-2:30 dietary aides and the 9:30 Heritage Centre aide are responsible for noting,	

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F 371	Continued From page 15 below the minimum requirements for 33 of 42 days beginning on 10/27/11 and continuing through 12/07/11. Review of the facility's Infection Control Log failed to identify multiple residents with episodes of nausea, vomiting, or other indications of possible foodborne illness. *10:25 a.m. - The dietary management staff member (#1), the dietary supervisory staff member (#8), and an administrative management staff member (#4) reported the following actions: *All items washed in the kitchen dishwasher were removed from service. *Disposable dishware used for the noon meal. *Items washed in the kitchenettes would continue to be used. *Staff educated immediately regarding these actions. *Repair persons called and would be on-site that day. *12:40 p.m. - The dietary management staff member (#1), provided the following information: *Kitchen dishwasher repaired at 11:30 a.m. *Additional dishwasher repair and replacement would be evaluated that afternoon. *Dishwasher cycles after the repair were within an acceptable range. *All dishware removed from service was washed at the proper temperatures. *Mandatory dietary staff education scheduled that afternoon. *Dietary management staff would monitor dishwashing temperatures. On 12/08/11 at 9:45 a.m., the dietary management staff member (#1) and the dietary supervisory staff member (#8) provided the	F 371	recording the temperatures and, alerting management and/or maintenance if there are problems. All dietary staff will be educated on 1-05-12 on how to fill out the new temperature sheets. d. Bowls, plates, and serving trays are now dry before being stacked and stored, due to dishwashing machine achieving and maintaining proper hot water temperatures since noon on 12-7-11. Also, chemical rinse agent was adjusted by maintenance staff under the direction of Ecolab rep. on 12-7-11. Dietary staff were retrained on 12-7-11 and 12-15-11 to allow adequate drying time. Additionally, on 1-5-12 all dietary staff will be trained on proper racking of dirty dishes to best achieve quick drying. e. Debris specks left on clean dishes will be avoided by careful examination done by dietary aide on clean end of the dishwashing machine as dishes come through. If dishes have debris left on them, they will be removed, sent back to the dirty end, pre-washed by hand	

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F 371	Continued From page 16 surveyor a copy of the meeting agenda and attendance roster for the mandatory dietary meeting completed on 12/07/11 at 3:30 p.m. The agenda items included the low temperatures identified on 12/07/11, potential for foodborne illness, procedure for dishwashing cycles, proper temperatures, contacting staff members (#1), (#8), or maintenance staff immediately if temperatures are not adequate, and responsible parties for recording of temperatures. Observation on 12/08/11 at 9:45 a.m., identified the kitchen dishwasher temperatures at or above the minimum temperatures of 150 degrees F wash and 180 degrees F final rinse. Review of the temperature log for the kitchen dishwasher for the period from 12/07/11 at 11:30 a.m. to 12/08/11 at 9:45 a.m., showed temperatures for each dishwashing cycle at or above the minimum requirements. Failure to ensure kitchen dishwashing temperatures were adequate for sanitization placed all residents, staff, and visitors at risk of foodborne illness. Failure to inform appropriate staff and failure to monitor temperature logs extended the period of risk for 33 of 42 days. - During the initial dietary tour, on 12/05/11 at 10:35 a.m., observation identified an air circulating fan, with accumulated lint and debris on the fan grid, on the floor in the dishwasher room, directing air towards the clean dishes. - Observation of the dishwashing process, on 12/07/11 at 9:10 a.m., identified a dietary staff member (#15) removed clean items from the dishwashing racks and stacked them for future	F 371	and sent through dishwashing machine again. If debris specks continue to appear, employee and management will try to determine reason. Dishwashing will stop, the dishwashing machine will be drained, the interior sides and arms spray rinsed, and the strainer basket removed and spray rinsed. The dishwashing machine with be reassembled and restarted. The process will be repeated as needed. On 1-5-12 all dietary staff will be trained on how to catch debris specked dishes before they are stored away, rewash them, and clean the dishwashing machine. 4. The dietary director or the dietary supervisor will monitor for stacked wet dishes and serving trays, debris specks on dishes, lint and debris on air-circulating fans, and out of date food items once a week for 4 weeks. After 4 weeks, monitoring will continue on a monthly basis. Results will be recorded on a newly developed and implemented QA form, reported to the QAM, and presented at the quarterly QA meeting. Dishwashing temperature	

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F 371	Continued From page 17 use. These items included the following: *Wet bowls with debris on them. *Wet serving trays. *Wet divided plates with debris on them. The dietary management staff member (#1) and the dietary supervisory staff member (#8) present at this time agreed staff should not store wet or soiled dishes. - During the facility dietary tour, on 12/08/11 at 9:45 a.m., observation identified the following: *Kitchen - The floor fan with lint and debris in the dishwasher room as identified during the initial tour on 12/05/11. - Four stacks, total of approximately 25 bowls, stacked wet. - One stack, approximately 10 serving cups, stacked wet. - Three steam table pans stacked inverted, nested, and wet. *A/B kitchenette - A floor fan to circulate air in the dishwashing room, with lint and debris on the fan grid. *C/D kitchenette - A floor fan to circulate air in the dishwashing room, with lint and debris on the fan grid. - One 7.25 ounce can, Cream of Mushroom Soup with a use by date of 09/24/10. The bottom of the can was rusty. The dietary management staff member (#1) and the dietary supervisory staff member (#8) present at this time agreed staff should not store dishes wet or soiled. These staff members also agreed the fans should be cleaned and the soup should not be available for service.	F 371	records will be monitored daily by dietary director, dietary supervisor, or designee. Results will be recorded on a QA form, reported to the QAM quarterly, and presented at the quarterly QA meeting. If any of the previous listed items are found to be out of compliance, appropriate measures will be taken to immediately correct, and the dietary staff retrained 5. 1/16/12.	
F 373 SS=C	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	F 373		

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F 373	Continued From page 18 A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration.	F 373	1. No residents experienced a direct, negative outcome due to resident assessment for use of paid feeding assistants being completed by speech/language pathologist or licensed dietician. 2. All residents who require assistance with eating have the potential to be affected. 3. All assessments of residents for appropriateness of being bed by paid feeding assistants will now be completed by a licensed nurse. All current residents have had paid feeding assistant assessments updated and completed by licensed nurse. 4. A QA tool will be developed, implemented and completed by QAM or nurse manager to monitor a random sample of completed paid feeding assistant assessments to assure regulatory compliance. This will be	

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F 373	Continued From page 19 Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review and staff interview, the facility failed to ensure the charge nurse assessed the resident's ability to be fed by a paid feeding assistant (PFA) for 11 of 17 sampled residents (Resident #1, #3, #5, #6, #7, #11, #12, #14, #15, #16, and #17). Failure to ensure a PFA feeds only residents without complicated feeding problems places resident at risk for choking and aspiration. Findings include: Review of the facility policy/procedure titled "Paid Feeding Assistant" occurred on 12/08/11. This policy, dated January 2011, stated, "Policy: Paid Feeding Assistants will only feed residents who have no complicated feeding problems. Complicated feeding problems include, but are	F 373	completed weekly x 1 month, monthly x 3 months and quarterly thereafter. 5. 1-16-12	

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F 373	Continued From page 20 not limited to, difficulty swallowing, recurrent lung aspiration, and tube or parenteral intravenous feedings. Paid Feeding Assistants may also be referred to as Mealtime Assistants. Purpose: To assure that residents are assisted with eating by appropriate staff. . . Procedure: . . . 4. Assessments will include input from the Speech Therapist, Licensed Dietician, Nurse Managers, or Nurses and resident status will be reviewed quarterly or with any significant change in status. . . ." During an interview on 12/08/11 at 8:50 a.m., an administrative staff member (#7) stated the facility completes the form "Paid Feeding Assistant Assessment" for all residents on admission. The staff member (#7) stated the speech therapist completes the initial assessment and the dietician completes the quarterly and significant change paid feeding assistant assessments. Review of the "Paid Feeding Assistant Assessment" form for Resident #1, #3, #5, #6, #7, #11, #12, #14, #15, #16, and #17 showed the licensed dietitian completed their most recent assessments and not a licensed nurse as directed by regulation.	F 373		