STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. BUILDING _____ B. WING _____	07/13/2023

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DAKOTA ALPHA	1303 27TH STREET NW MANDAN, ND 58554

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 07/10/23 and concluded 07/13/23.	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and family and staff interviews, the facility failed to provide resident representatives copies of the quarterly financial statements for 2 of 3 residents (Resident #4 and #17) reviewed for personal fund accounts. Failure to provide quarterly statements to the individuals designated by the residents to make financial decisions on their behalf prevented the representatives from verifying transactions and fund balances. Findings include: Review of the facility policy titled "Resident Spending Accounts" occurred on 07/13/23. This policy, revised 03/09/23, stated, ". . . Dakota	F 568	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 7/13/2023, education was provided to Administrative Assistant who completes the Quarterly personal funds reports. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with guardians and/or financial POAs have the potential to be affected, which is currently 70% of residents. 3. Action taken/systems put into place to	7/26/23

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

Electronically Signed | 08/02/2023

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F 568	Continued From page 1 Alpha can establish a Resident Spending Account that is separate from Dakota Alpha's operating accounts if the resident chooses. . . . Residents will be given an accounting of their funds held by the Administrative Assistant quarterly, and a copy is placed in their file. . . ." Family interviews identified the following: * 07/11/23 at 3:07 p.m., Resident #4's guardian indicated she had not received any quarterly financial statements. * 07/11/23 at 3:18 p.m., Resident #17's family member who manages her finances stated, "No, I haven't received one [quarterly statement]." During a staff interview on 07/12/23 at 9:52 a.m., a social services staff member (#8) indicated quarterly financial statements are sent to resident representatives upon request.	F 568	reduce the risk of future occurrence include: Procedure was created on 7/19/23 regarding Resident Personal Funds. Guidance was included in the procedure to send a personal funds statement to resident representatives, if the resident has a guardian and/or financial POA, on a quarterly basis. The 2nd Quarter financial statements were sent to residents and representatives on 7/26/23. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Social Services Director, or designee will complete random weekly audits for 6 weeks, then monthly for 4 months, and then ongoing as needed. Audits will be submitted to the Director of Nursing for review. Results will be reviewed in QAPI quarterly meeting for 6 months and finding no trends, will be reviewed again on an as needed basis.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		8/1/23

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F 584	Continued From page 2 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and clean environment for 2 of 3 sampled residents (Resident #8 and #15) and 2 supplemental residents (Resident #4 and #9) with personal fans. Failure to clean personal fans does not provide a safe/clean environment and has the potential to place the residents at risk for illness.	F 584	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 7/17/23 DON completed research and found resources for maintenance and routine cleaning of resident personal fans. On 7/19/23 DON met with the Director of Environmental Services and Maintenance	

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F 584	Continued From page 3 Findings include: Observations on 07/11/23 from 9:50 a.m. to 10:05 a.m., showed the following: * Resident #4 lying in bed with a tower fan (visible dust on the outside grate) blowing air directly toward the resident. * Resident #8 lying in bed with an oscillating stand fan (visible dust on the outside grate covering the fan blade) blowing air directly toward the resident. * Resident #9 lying in bed with a tower fan (visible dust on the outside grate) blowing air directly toward the resident. * Resident #15 lying in bed with a tower fan (visible dust on the outside grate) blowing air directly toward the resident. The facility failed to provide a policy related to the cleaning of residents' personal fans. During an interview on 07/13/23 at 12:56 p.m., an administrative staff member (#2) stated staff are expected to clean dirty equipment in residents' rooms.	F 584	personnel to discuss how to implement routine maintenance and cleaning of resident fans into department staff tasks. The current facility procedure “Cycle Cleaning” was also reviewed. The Director of Environmental Services updated the Housekeeping Departments cleaning checklist to include the cleaning of resident personal fans during routine room cleanings and also added a task for the fans to be cleaned quarterly by Maintenance. All personal resident fans were cleaned and inspected on 8/1/23 by maintenance. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents that have a personal fan have the potential to be affected, which is 15% of residents currently. 3. Action taken/systems put into place to reduce the risk of future occurrence include: All Environmental Services staff were educated regarding the updated facility procedure and checklists for routine cleaning and maintenance of resident personal fans. Cleaning personal fans was added to the TELS duties for maintenance and checklists for Housekeeping to clean routinely. 4. How the corrective action(s) will be monitored to ensure the practice will not recur:	

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F 584	Continued From page 4	F 584	The Director of Environmental Services, or designee will review the Cleaning Checklist and Direct Supply TELS to ensure residents personal fans are cleaned and free from dirt/dust. The Director of Environmental Services will complete random weekly audits for 6 weeks, then monthly for 4 months, and then ongoing as needed. Audits will be submitted to the Director of Nursing for review. Results will be reviewed in QAPI quarterly meeting for 6 months, and finding no trends, will be reviewed again on an as needed basis.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 3 of 4 residents (Residents #3, #6, and #16) observed during medication administration. Failure to properly prepare insulin pens (Residents #6 and #16), follow physician orders for blood glucose monitoring (Resident #16), and check gastric tube placement (Resident #3), may result in residents receiving inaccurate doses of insulin, adverse reactions due to high blood glucose levels, and medications not delivered to the stomach.	F 658	1. Immediate action(s) taken for the resident(s) found to have been affected include: A. Priming of insulin pens. Facility procedure was reviewed on 7/18/23 with CEO, DON, ADON and MDS Coordinator. Procedure is appropriate and no changes are warranted. B. Verifying placement of gastric tubes. Facility procedure was reviewed on 7/18/23 with CEO, DON, ADON and MDS Coordinator. Nursing management also met with facility Medical Director for	8/3/23

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F 658	Continued From page 5 Findings include: INSULIN PENS Review of the facility procedure titled "Insulin Pen" occurred on 07/13/23. This procedure, dated 06/06/23, stated, ". . . 11. . . . g. Attach safety needle: . . . iv. Twist open and remove outer cover from the pen needle. h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. . . ." Observation on 07/12/23 from 7:53 to 8:09 a.m. showed the nurse (#5) failed to remove the needle covers and held the pens horizontally while priming two insulin pens for Resident #16 and one insulin pen for Resident #6. During an interview on 07/13/23 at 1:00 p.m., an administrative staff member (#2) stated nurses are to hold insulin pens upright with the cover off when priming. MONITORING BLOOD GLUCOSE Review of the facility procedure titled "Blood Glucose Monitoring" occurred on 07/13/23. This procedure, reviewed/revised 12/01/22, stated, ". . . It is the procedure of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. . . . Collect blood sample . . . Read the digital display to receive blood glucose result. . . . Report critical test results to physician timely. . . . Document the procedure. . .	F 658	revision of order template recommendations. On 7/25/23, physician order template to verify placement of g-tube was revised to state: “Verify placement of feeding tube prior to administering intermittent feeding, flushes, or medications. Check enteral retention device is properly approximated to abdominal wall then check length of tube AND if residuals present, measure pH of gastric secretions. Gastric fluid usually has pH of 5 or less. Notify the physician of abnormal findings AND as needed.” The updated order was started for each resident that currently has a gastric tube at Dakota Alpha. C. Notifying physician of blood sugars out of parameters. On 7/17/23, the MDS Coordinator, RN edited resident’s insulin order so that blood sugars needed to be documented in the MAR along with the insulin administration for breakfast, lunch, and supper. Blood sugar documentation for bedtime remains in the TAR because resident does not receive any insulin at that time. High/Low blood sugar parameters updated in resident’s chart to reflect the physician order for prescribed parameters. With this change, an alert will be created in PointClickCare clinical chart if blood sugar is below 70 or above 400. On 7/18/23, supplemental documentation was added to the insulin order and blood	

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F 658	Continued From page 6 ." Review of the facility procedure titled "Provision of Physician Ordered Services" occurred on 07/13/23. This procedure, reviewed/revised 06/08/23, stated, ". . . Qualified nursing personnel will . . . review the diagnostic test . . . and communicate the results to the ordering Physician . . . per the ordering physician's orders. . . ." Review of Resident #16's medical record occurred on all days of survey. The current care plan identified, "[Resident #16] has Diabetes Mellitus Type II. He is at risk for diabetes related complications, Accuchecks as needed, Notify MD if needed . . ." The current physician's orders showed Resident #16 receives Lantus insulin, Novolog insulin, and Victoza for his diabetes. An order, dated 10/24/22, identified, "Accuchecks if symptomatic. Call MD [medical doctor] if < [less than] 50 [milligrams (mg) per deciliter (dL)] or > [greater than] 500." On 05/10/23, the physician changed the parameters to "< 50 or > 400." The blood glucose log identified Resident #16 had a blood glucose level of 502 mg/dL on 04/19/23 and 462 mg/dL on 05/17/23. A progress note, dated 04/21/23, identified, ". . . [Resident 16's] blood sugars have been before meals that [sic] last 3 days. 4/18: 362 before supper 4/19: 377, 502, 378, 4/20: 329, 368, not able to get one before supper 4/21: 314 this morning . . ."	F 658	sugar check at bedtime “Alert: Is BS less than 70 or more than 400? Call MD if so.” The nurse will have to enter a response to this question. On 7/19/23, new orders received to add sliding scale insulin with meals and at bedtime, orders were updated to have nurse document blood sugar prior to administration of insulin and supplemental documentation to answer if they needed to contact the physician continues. 2. Identification of other residents having the potential to be affected was accomplished by: A. The facility has determined that all residents who receive insulin have the potential to be affected, which is currently 15% of residents. B. The facility has determined that all residents who have a gastric tube have the potential to be affected, which is currently 15% of residents. C. The facility has determined that 2 residents have the potential to be affected due to having an order to notify the physician if blood sugar is outside of a prescribed range. 3. Action taken/systems put into place to reduce the risk of future occurrence include: A. Priming of insulin pens: Relias training module was assigned on 7/25/23 to facility RN/LPN staff, educating of correct way to prime insulin pens.	

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F 658	Continued From page 7 Review of the progress notes showed staff failed to document Resident #16's symptoms at the time of the 502 mg/dL and 462 mg/dL readings and failed to notify the physician in a timely manner when Resident #16's blood glucose readings fell outside the set parameters. During an interview on 07/11/23 at 3:45 p.m., an administrative nurse (#2) confirmed staff failed to document Resident #16's symptoms and failed to notify the physician in a timely manner when Resident #16's blood glucose readings fell outside the set parameters. GASTROSTOMY TUBE Review of the facility procedure titled "Verifying Placement of Feeding Tube" occurred on 07/12/23. This procedure, dated 06/22/23, stated, ". . . For gastrostomy tubes [surgical opening into the stomach through the abdominal wall], check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. . . . Measure the pH [a way to measure the acidity level] of the gastric secretions . . ." Review of Resident #3's medical record occurred on all days of survey. The physician orders, dated 09/22/21, stated, "Verify placement of feeding tube before beginning a feeding, flushing tube, or administering medications. three times a day Check that enteral retention device is properly approximated to abdominal wall before checking centimeter markings. Gastric fluid usually has a pH of 5 or less (See Verifying Placement of Feeding Tube policy and	F 658	Education will also be provided at the scheduled RN/LPN meeting on 8/3/23. B. Verifying placement of gastric tubes: Relias training module was assigned on 7/25/23 to facility RN/LPN staff, educating of correct way to verify gastrostomy tube placement. In addition, current Physician Order to verify placement was revised and started on 7/25/23, stating: “Verify placement of feeding tube prior to administering intermittent feeding, flushes, or medications. Check enteral retention device is properly approximated to abdominal wall then check length of tube AND if residuals present, measure pH of gastric secretions. Gastric fluid usually has pH of 5 or less. Notify the physician of abnormal findings AND as needed.” Education will also be provided at the scheduled RN/LPN meeting on 8/3/23. C. Notifying physician of blood sugars out of parameters: A new procedure titled “High Risk Medications” was created and assigned to RN/LPN staff to review on Relias training website. Education will also be provided at the scheduled RN/LPN meeting on 8/3/23. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: A. The Director of Nursing, or designee will audit to ensure RN/LPN staff are	

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F 658	Continued From page 8 procedure)" Observation on 07/11/23 at 10:00 a.m. showed the nurse (#6) administered medications and feeding via g-tube for Resident #3. The nurse failed to verify placement of the feeding tube. Observation on 07/12/23 at 9:55 a.m. showed the nurse (#5) administered medications and feeding via g-tube for Resident #3. The nurse failed to verify placement of the feeding tube. During an interview on 07/13/23 at 8:59 a.m., an administrative staff nurse (#2) confirmed when verifying placement of feeding tubes staff would be expected to check the measurement on the g-tube and check the pH of the gastric contents if it is present.	F 658	priming insulin pens correctly. The Director of Nursing, or designee will complete random weekly audits for 6 weeks, then monthly for 4 months, and then ongoing as needed. Audits will be submitted to the Director of Nursing for review. Results will be reviewed in QAPI quarterly meeting for 6 months, and finding no trends, will be reviewed again on an as needed basis. B. The Director of Nursing, or designee will audit to ensure RN/LPN staff are verifying placement of feeding tubes correctly per physician order. The Director of Nursing, or designee will complete random weekly audits for 6 weeks, then monthly for 4 months, and then ongoing as needed. Audits will be submitted to the Director of Nursing for review. Results will be reviewed in QAPI quarterly meeting for 6 months, and finding no trends, will be reviewed again on an as needed basis. C. The Director of Nursing, or designee will audit to ensure RN/LPN staff are notifying provider of blood sugars that are out of paraments per physician order by reviewing MAR and progress notes. The Director of Nursing, or designee will complete random weekly audits for 6 weeks, then monthly for 4 months, and then ongoing as needed. Audits will be submitted to the Director of Nursing for review. Results will be reviewed in QAPI quarterly meeting for 6 months, and finding no trends, will be reviewed again	

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F 658	Continued From page 9	F 658	on an as needed basis.	
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #19) diagnosed with post-traumatic stress disorder (PTSD) received appropriate treatment and services to meet his assessed needs. Failure to provide appropriate person-centered and individualized treatment and services may result in Resident #19's inability to attain his highest practicable mental and psychosocial wellbeing. Findings include: The facility failed to provide a copy of their policy addressing trauma and/or post-traumatic stress disorder (PTSD). Review of Resident #19's medical record occurred on all days of survey. The quarterly Minimum Data Set, dated 06/11/23, identified a diagnosis of PTSD. Current medications included	F 742	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 7/17/23, DON researched and found resources for trauma informed care and treatment/services which were passed on to the IDT. On 7/18/23, IDT met and developed a Trauma Informed Care policy/procedure, reviewed trauma screenings/questionnaires and discussed care plan options. A trauma screening assessment tool (Brief Trauma Questionnaire) has been added to our assessments on 7/19/23. A History of Trauma care plan was initiated for resident #19 on 7/31/23. The Brief Trauma Questionnaire was completed with resident #19 on 8/1/23. 2. Identification of other residents having the potential to be affected was	8/2/23

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F 742	Continued From page 10 antianxiety, antidepressant, and antipsychotics. During an interview on 07/12/23 at 3:30 p.m., an administrative nurse (#2) stated, "We do not have a PTSD assessment. We do have the PHQ-9 assessment [Patient Health Questionnaire 9 - Mental Health Screening for depression]." A "Bio-Psychosocial History," dated 05/11/23, identified a history of sexual abuse and past thoughts/plan to self-harm . . . [Resident #19] reports although he is addressing his issue in counseling, it continues to be an unresolved issue for him, and he believes it always will be. . . ." The current care plan failed to address Resident #19's emotional/psychosocial needs related to his trauma/PTSD diagnosis, and failed to include any clinically appropriate and person-centered interventions used to avoid re-traumatization. During an interview on 07/13/23 at 2:30 p.m., an administrative nurse (#2) confirmed Resident #19's care plan failed to address his emotional/psychosocial needs related to his trauma/PTSD diagnosis. The facility failed to: * Ensure Resident #19's assessment identified expressions or indications of distress, identified triggers that may cause re-traumatization, and addressed his preferences, * Develop and implement approaches to care that were both clinically appropriate and person-centered, and * Develop an individualized care plan that addressed Resident #19's assessed	F 742	accomplished by: The facility has determined that all residents have the potential to be affected. 3. Action taken/systems put into place to reduce the risk of future occurrence include: Social Services Director added questions to the Bio-Psychosocial History interview that is completed upon admission to screen for potential trauma. If Resident responds positively to these questions, a Brief Trauma Questionnaire will be completed to assess for need for care planning interventions. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Social Services Director, or designee will audit to ensure admitted Residents are being screened for trauma, and if trauma is present, appropriate care plans are initiated. The Social Services Director, or designee will complete random weekly audits for 6 weeks, then monthly for 4 months, and then ongoing as needed. Audits will be submitted to the Director of Nursing for review. Results will be reviewed in QAPI quarterly meeting for 6 months, and finding no trends, will be reviewed again on an as needed basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. BUILDING _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 742	Continued From page 11 emotional/psychosocial needs related to his trauma/PTSD diagnosis.	F 742		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he	F 801		7/21/23

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F 801	Continued From page 12 or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for	F 801		

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F 801	Continued From page 13 food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure 1 of 1 nutrition and food services supervisor (#1) obtained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure staff have the qualifications to carry out the functions of food and nutrition services has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: During an interview on 07/13/23 at 12:36 p.m., the nutrition and food services supervisor (#1) confirmed they have not completed the necessary courses required for the director of food and nutrition services. The facility failed to ensure the supervisor (#1) completed the required education for a certified dietary manager, certified food service manager, or a national certification for food service management and safety from a national certifying body.	F 801	1. Immediate action(s) taken for the resident(s) found to have been affected include: Facility Dietary Manager completed the Certified Food Manager (CFM) course on 7/21/23 and completed ServSafe Certification on 7/28/23. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Action taken/systems put into place to reduce the risk of future occurrence include: On 7/25/23 the Dietary Manager and Director of Nursing reviewed regulations related to F801 and created a procedure titled “Dietary Services-Staffing” to ensure the facility employs staff with the appropriate competencies and skill sets to carry out the functions of the Dietary Department. 4. How the corrective action(s) will be monitored to ensure the practice will not recur:	

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F 801	Continued From page 14	F 801	The Dietary Manager completed the Certified Food Manager (CFM) course on 7/21/23, therefore no further auditing is warranted.	