STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING _____ B. WING _____	10/31/2018

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GOOD SAMARITAN SOCIETY - PARK RIVER	301 SOUTH COUNTY ROAD 12B PARK RIVER, ND 58270

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 10/28/18 and concluded on 10/31/18.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, the facility failed to complete a status change assessment for 1 of 3 sampled residents (Resident #10) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care	F 644	1. Resident #10 updated Level I screening/change in status assessment was completed. Level II screening not required. 2. All residents with mental illness diagnoses and associating medications with these diagnoses have the potential to be affected. 3. A query was run to determine any current resident needing the Level I	12/1/18

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

Electronically Signed | 11/16/2018

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F 644	Continued From page 1 and services that are inconsistent with resident's needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening patients] to update the level I screen for determination of whether a first time or updated level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability and conditions related to intellectual disability [referred to in regulatory language as related to conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #10's medical record occurred on all days of the survey. The record showed an initial PASARR completed on 02/14/08 identified no mental illness. Review of Resident #10's medical record identified the following current diagnoses: general anxiety (dated 04/10/12, bipolar disorder (dated 11/06/14). The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnoses. During an interview on 10/30/18 at 3:31 p.m. a social services staff member (#5) confirmed Resident #10 should have had a Level I assessment completed after the new diagnoses.	F 644	screening/change in status assessment. The identified resident charts were reviewed and required screening/change in status assessments were completed. PASRR education was provided on 11/14/2018 by phone call with DDM Ascend. 4. Starting 11-27-2018 audits will be done according to the scheduled MDS assessments of the PASRR Level I screenings to assure screenings are current according to the residents mental health status and associating medications with these diagnoses. Audits will be one time monthly for three months and quarterly for 4 quarters then as deemed necessary by QAPI Committee. Responsible person will be licensed social worker or designee.	
F 656	Develop/Implement Comprehensive Care Plan	F 656		12/1/18

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F 656 SS=D	Continued From page 2 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 3 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to develop a comprehensive care plan for 3 of 15 sampled residents (Resident #34, #37, and #38). Failure to develop a care plan that includes the services to be provided to the resident may negatively impact the resident's quality of life. Findings include: - Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dementia and Alzheimer's disease. A quarterly Minimum Data Set (MDS), dated 07/25/18, identified moderately impaired cognition. Review of Resident #34's progress notes identified the following: * 7/15/2018, 2:09 p.m., "Resident was found wandering the parking lot. Brought back to her room safely in wheelchair. . . ." Review of Resident #34's current care plan stated, ". . . The resident has impaired cognitive function R/T [related to] Alzheimer's disease, depressive disorder, and other unspecified dementia E/B [evidenced by] poor short term memory, poor judgement, and reasoning skills. . . ." The care plan failed to address Resident #34's	F 656	1) The care plans for Resident #34, #37 and #38 were reviewed and revised. 2) All residents have the potential to be affected. 3) Residents with an identified risk for elopement, resident personal devices and diabetes diagnoses will have the risks and the appropriate goals and interventions care planned, and the care plan will be monitored and revised as applicable. Education will be provided to the Interdisciplinary Team on November 19th, 2018 by the Good Samaritan Rehab Skilled Consultant regarding care planning, monitoring effectiveness, and revising the care/care plan related to elopement, resident personal devices and diabetes diagnoses. 4) Starting November 20, 2018 Care plans for residents with incidents and changes of condition will be audited weekly X 3 weeks, monthly X 3 months, then as seemed necessary by the QAPI team. Audits will be reviewed at the QAPI meeting held the first Wednesday of every month. Responsible persons: Interdisciplinary Team, Director of Nursing and others as designated.	

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F 656	Continued From page 4 wandering and potential for elopement. - Review of Resident #37's medical record occurred on all days of survey. The current physician order stated, ". . . Continue cervical collar indefinitely. Nonunion of C2 [second cervical vertebra] fracture . . . Vista collar-on at all times except for bathing. . ." Observations during all days of survey showed Resident #37 wearing a cervical collar at all times. The care plan failed to address Resident #37's use of the cervical collar. - Review of Resident #38's medical record occurred on all days of survey. The current physician order stated, ". . . Blood sugar monitoring as needed. . . Blood sugar monitoring one time a day every THU [Thursday] . . . Call MD [medical doctor] if blood sugar <60 or >300 . . ." The current care plan stated, ". . . The resident has dx of Diabetes Mellitus [and] is insulin dependent . . . Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness and report abnormalities to Nurse . . ." The care plan lacked specific goals and interventions for Resident #38 diabetes cares. During an interview on 10/31/18 at 9:50 a.m., a supervisory staff member (#1) confirmed the care plan lacked interventions.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		12/1/18

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F 658	Continued From page 5 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, review of professional reference, and staff interview, the facility failed to follow professional standards of nursing practice for 3 of 15 sampled residents (Resident #32, #37, and #49). Failure to carry out a physician's order (Resident #32), complete neurological assessments after a fall with head injury (Resident #37), and administer medication as ordered (Resident #49) may result in adverse health effects. Findings include: PHYSICIAN'S ORDERS Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, Pearson, Boston, Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous not apparently erroneous, the nurse is responsible for carrying it out. . . ." - Review of Resident #32's medical record occurred on October 29-31, 2018. Diagnoses included depression, anxiety, psychotic disorder, and dementia. Current medications included Seroquel (an antipsychotic) 100 milligrams (mg) at bedtime. A psychiatrist's progress note, dated 03/01/18,	F 658	PHYSICANS ORDERS 1) Resident #32 will be scheduled on a calendar according to the psychiatrist□s next visit listed on the Progress Notes. Resident # 32 was seen in November 2018. 2) All residents being followed by the psychiatrist have the potential to be affected. 3) The Progress Notes for all residents receiving mental health services will be reviewed and a calendar schedule will be developed to ascertain accurate scheduling according to the psychiatrist□s progress notes. 4) Starting 11/27/2018 audits will be completed monthly X 6 months, then quarterly X 2 months, then as deemed necessary by the Quality Assurance Committee. Responsible persons include: RN Unit Managers or designee. NEUROLOGICAL STATUS 1) Resident # 37 was assessed by the	

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F 658	Continued From page 6 identified an order to increase Seroquel from 25 mg to 100 mg, and schedule a follow up appointment in three months. Record review identified Resident #32 did not see the psychiatrist until 08/08/18 (five months later). During an interview on the morning of 10/20/18 at 4:35 p.m., a supervisory nurse (#2) confirmed the psychiatrist should have seen Resident #32 in June, but the visit was missed. NEUROLOGICAL STATUS Review of the facility policy titled "Neurological Evaluation" occurred on 10/31/18. This policy, dated September 2016, stated, ". . . establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined . . . After the completion of initial neurological evaluation with vital signs, continue with evaluations every 30 minutes x 4, then every eight hours x 3 days or as directed by the provider . . ." Review of Resident #37's medical record occurred on all days of survey. A fall incident report, dated 12/31/17, stated, ". . . resident was getting up out of chair, tripped over his walker, fell against a wall and slid down to floor causing an abrasion to (L) [left] parietal area of head. . . ." Review of the progress notes showed the following: * 12/31/17 18:28 - ". . . s/p [status post] fall . . . called PA-C [provider] on call at first care and was ordered to send resident in for x-rays and evaluation. ambulance arrived and left at 1850 to	F 658	MD and a CT scan done. The policy and procedure for neurological checks will be followed for any other falls. 2) All residents experiencing head injuries have the potential to be affected. 3) Nurses will be educated on November 27, 2018 regarding the procedure for Neurological Evaluation. A form will be developed to include all neurological checks required. 4) Starting 11/27/2018 all records of head injuries will be audited for 2 X monthly for 2 months, then quarterly X 2 quarters, then as deemed necessary by the Quality Assurance Committee. Responsible persons include: Director of Nursing or designee. MEDICATION ADMINISTRATION 1) Immediate education was provided to staff #6 regarding medication administration procedures for Resident #49. Medication Administration Competency completed for staff #6 on Nov 13, 2018. 2) All residents receiving medications administered by licensed nurses have the potential to be affected.	

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F 658	Continued From page 7 ER [emergency room]. . . ." * 12/31/17 20:45 ". . . called [hospital] for update, stated they had done a CT scan and found a fx of the C2 vertebrae and he is now in a neck collar. . . ." The facility completed neurological (neuro) on 12/31/17 at 17:17, 21:10, and 22:07 and continued onto 01/01/18 at 3:08 and 23:35. The facility failed to complete the evaluations every 30 minutes x 4, then every eight hours x 3 days after resident returned from the ER. During an interview on 10/31/18 at 9:60 a.m., a supervisory staff member (#1) would expect staff to complete neuro checks per policy. MEDICATION ADMINISTRATION Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, Pearson, Boston, Massachusetts, page 773, stated, ". . . 'Ten Rights' of Medication Administration . . . Right Dose . . ." - Review of Resident #49's medical record occurred on 10/30/18. The current physician orders included aspirin 325 mg daily. Observation on 10/30/18 at 11:40 a.m. showed a licensed nurse (#6) prepare Resident #49's medications. The nurse prepared aspirin 81 mg for the resident. This surveyor informed nurse she had prepared wrong dosage of medication per order. The nurse stated yes, she had prepared the wrong dose of aspirin, discarded the medication and prepared the correct medication and dosage for the resident. The	F 658	3) Licensed nurses will be educated on November 27, 2018 or prior to their next scheduled shift on GSS Medication Administration Policy and Procedure by Staff Development Coordinator. 4) Starting November 13, 2018 audits will be completed twice weekly X 2 weeks, then monthly X 2 months, then quarterly X 2 and as deemed necessary by the Quality Assurance Committee. Responsible persons include: Director of Nursing and Staff Development.	

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F 658	Continued From page 8 nurse failed to follow professional standards by not following one of the ten rights of medication administration.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, review of facility policy and operator's instruction manual, the facility failed to provide adequate assistance for 3 of 10 sampled residents (Resident #6, #34 and #38) observed during staff assisted transfers. Failure to ensure staff properly used assistive devices placed residents at risk for accidents with/without injury. Findings include: Review of the "EZ Smart Stand Operator's instructions" occurred on 10/30/18. The operator's instructions, stated, ". . . Patients should be able to bear some weight, have upper body strength and be able to follow simple commands. If a patient does not meet each of these three criteria, an EZ way total body lift must be used. . . ." - Review of Resident #6's medical record occurred all days of survey. Diagnoses included	F 689	1. Transfer on resident #6 evaluated using Sit-Stand-Walk assessment in PCC. Care Plan amended to use total lift with assist of two for all transfers. Resident #34 evaluated using same tool. Care plan amended to use total lift assist of two for all transfers. Resident #38 evaluated using same tool. Care plan updated for setup assist for transfers. 2. All residents requiring assist with transfer have potential to be affected. 3. All staff were re-educated by Staff Development Coordinator on 11/5/2018 at General Staff Meeting on communicating change of resident condition to nurses immediately for evaluation using Sit-Stand-Walk Data Assessment and GSS Safe Resident	12/1/18

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F 689	Continued From page 9 dementia and Parkinson's disease, dementia without behavior disturbance and unspecified superficial injury of right forearm. A quarterly Minimum Data Set (MDS), dated 07/29/18, identified extensive assist of two staff members for transfers, extensive assist of one staff member for toileting, two falls without injury and severely impaired cognition. Resident #6's current care plan stated, ". . . TRANSFER: Resident transfers with TL-M [total lift medium] mesh high back sling out of bed with assist of 2. . . Continue to transfer with SS-M [sit to stand medium] with assist of one for seated transfers. The resident has a need for restorative intervention due to limited physical mobility R/T [related to] decreased strength . . . The resident has had an actual fall with S/P [status post] fx [fracture] left hip and left hip fracture- serious injury R/T Parkinson's disease E/B [evidenced by] need for assist with transfers and gait. History of falls and at risk for falls, Poor balance. The resident has impaired cognitive function/dementia or impaired thought processes. . . E/B forgetfulness, confusion, disorientation, and poor safety awareness. . . ." Review of Resident #6's medical record identified the following progress notes: * 10/24/2018 15:13 - "Resident lost consciousness on the stand lift while toileting this afternoon, husband aware. Did not fall off lift, safely transferred to her recliner chair. Notification sent to MD [medical doctor] . . ." * 10/26/2018 13:18 - "While resident was in stand lift, she let go with her hands being held up by only the lift pad. Resident shouted, "oh my God help me . . ."	F 689	Handling Policy was reviewed. Nursing department staff were re-educated on Nov. 8, 2018 by Kim Betts, E-Z Way Representative,on the use of Stand Aid, Total Lifts and Hygiene Slings. Safe Resident Handling policy was review with Resident #6 family on 11/8/2018 by Staff Development Coordinator. 4. Starting November 13, 2018 audits of observations of resident transfers and record review will be completed randomly 3-5 times weekly for 1 week, then weekly for four weeks, then monthly times 3 months, then as deemed necessary by the QAPI Committee. Responsible person: Rehab Coordinator and others as designated.	

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F 689	Continued From page 10 Review of Resident #6's medical record identified the following falls involving the mechanical lift: * 07/16/18 at 1:10 p.m., "Staff relate they were assisting resident to bathroom and when assisting her out she let go of the bars, leaned forward, and buckled her knees. Staff able to assist her into recliner. After being readjusted staff were able to stand her back up with assist of 2 present and use of butt strap. Resident was hollering out at staff during incident and following she was swing [sic] out at them . . . . no injuries observed." * 10/20/18 at 10:32 a.m., "On lift in BR [bathroom]. CNA [certified nurse aide] stepped away and resident slipped arm out of sling, buckle still in place and found sitting on foot plate of stand lift . . . bruise to right front and rear knee and skin tear to right elbow." Observation on 10/29/18 at 8:35 a.m. showed two certified nurse aides (CNAs) (#4 and #7) transfered Resident #6 from the bed to the wheelchair using a full body lift. The same two CNAs transferred Resident #6 from her wheelchair to the bathroom using the EZ stand lift. Staff utilized the seat strap after a third unidentified CNA presented to the room and showed CNAs (#7 and #4) how to use it. During the transfer the harness sling slid up the resident's back to the axilla area and the resident leaned forward causing the resident's elbows to bow outward above the shoulders. Observation on the late morning of 10/29/18 showed two CNAs (#4 and #7) transferred Resident #6 from the recliner to the bathroom using the EZ stand lift, utilizing the harness sling and seat strap. During the transfer the harness sling slid up the	F 689		

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F 689	Continued From page 11	F 689		

resident's back to the axilla area and the resident leaned forward causing the resident's elbows to bow outward above the shoulders.

Observation on 10/29/18 at 12:54 p.m. showed two CNAs (#4 and #8) transferred Resident #6 from wheelchair to bathroom using the EZ stand lift with the harness sling and seat strap. The resident failed to hold onto the lift handles and appeared limp. As staff tranfered Resident #6 from the toilet to the recliner, the one CNA (#8) attempted to hold onto the resident's bottom to prevent the resident from falling to the floor. The CNA (#8) stated, "This is not safe at all."

- Review of Resident #34's medical record occurred all days of survey. Diagnoses included dementia. A quarterly MDS, dated 07/25/18, identified extensive assist with transfers and toileting, moderately impaired cognition and two falls with no injuries.

Resident #34's care plan stated, ". . .The resident has impaired cognition function R/T Alzheimer's Disease. . . and other unspecified dementia E/B poor short term memory, poor judgement and reasoning skills. . .The resident has an ADL self care performance deficit R/T diabetes E/B edema to lower extremities. TRANSFER: Resident uses TL-M for transfers in and out of bed. May attempt self transfers. TOILET USE: Resident may toilet with SS-L [sit-to-stand large] assist of 2. History of self transfers. . . ."

Review of Resident #34's record identified the following progress notes:
* 6/9/18 11:22 a.m. - "Resident was assisted to the bathroom with assist of the stand lift, when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING _____ B. WING _____	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	301 SOUTH COUNTY ROAD 12B PARK RIVER, ND 58270

(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 689	Continued From page 12	F 689		

coming out of the bathroom she became weak on the lift and was lowered to the floor for her safety. Assisted from floor with total lift, no injury noted. . . ."

Fall report 06/09/18 9:40 a.m., (for above progress note) stated, "Res [resident] was on lift when she lost her strength and was lowered to the floor . . . ."

Observation on 10/29/18 at 1:36 p.m. showed a CNA (#10) transferred Resident #34 from the bath chair to the wheelchair using the EZ stand lift. During the transfer the harness sling slid up the residents back to the axilla area and the resident leaned forward causing the resident's elbow to bow outward above the shoulders with the resident's buttocks positioned below the wheelchair seat. During the transfer Resident #34 displayed signs of pain and/or fear.

Review of the policy titled, "Gait (Transfer) Belt" occurred on 10/31/18. This policy, dated October 2017, stated, " . . Gait belts are use with assisted ambulation unless medically contraindicate . . . explain that it is a device used for stability and/or support for a short time during the actual transfer or ambulation . . . Do not use the pants/slacks belt as a gait (transfer) belt . . ."

- Review of Resident #38's medical record occurred on all days of survey. The resident's current care plan identified, ". . . AMBULATION: Resident may ambulate with SBA [stand by assistance] of 1, gait belt and FWW [front wheel walker] . . . transfers with SBA of 1 with gait belt. . . ."

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	355089	A. BUILDING _____ B. WING _____	10/31/2018

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F 689	Continued From page 13 Observation on 10/29/18 at 10:35 a.m. showed a CNAs (#4) provided stand by assistance while Resident #38 transferred his/herself on and off the toilet. The CNA transferred Resident #38 to the common area and provided stand by assistance while the resident transferred his/herself to the recliner. The staff failed to use a gait belt and FWW during the transfers.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the Food and Drug Administration (FDA) Food Code 2013, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen (Main kitchen). Failure to ensure proper	F 812	1. Disposed of all leftovers that were not properly temped during the cooling process. 2. All residents have the potential to be	12/1/18

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F 812	Continued From page 14 temperatures/procedures for food storage and cooling has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: The FDA Food Code 2013, page 90-91, stated, ". . . Cooling . . . Cooked Time/Temperature Control for Safety Food shall be cooled . . . Within 2 hours from 57 degrees C (135 degrees F) to 21 degrees C (70 degrees F) and . . . Shall be cooled within 4 hours to 5 degrees C (41 degrees F) or less . . . " Observation on 10/30/18 at 8:30 a.m. showed the following leftovers in deep containers in the fridge including: * Mashed potatoes dated 10/30/18 * Chicken noodle soup dated 10/30/18 * Beef barely soup dated 10/30/18 The dietary staff member (#3) stated the facility does not have a process for cooling foods and staff do not check the temperatures of the cooling foods. The dietary staff member (#3) discarded the above items.	F 812	affected. 3. All cooks were educated on GSS Cooling and Reheating Food Policy and Procedure by Director of Food and Nutrition. As per policy, cooks will now do the following as per P&P: Leftover food will be transferred to a shallow pan, and placed uncovered in the cooler. Temperatures will be taken after 2 hours (must be < 70 F), and again after 4 hours (must be below 41 F), and recorded on the Cooling Temperature Log (GSS form #449). Once cooling process is completed, leftover food will be covered, labeled and dated. 4. Starting November 13, 2018 audits reviewing temperatures recorded on Cooling Temperature Log form and observation for the proper use of shallow pans will be completed daily for 2 weeks, then 2 times per month for 3 months, then as deemed necessary by the QAPI Committee. Immediate re-education to staff involved will occur if deviation from P&P is identified. Audits will be reviewed at the QAPI meeting held the first Wednesday of every month. Responsible persons include: Responsible person: Food & Nutrition Supervisor or others as designated.	