| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355044 | A. BUILDING _____ B. WING _____ | 10/03/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOUNTRAIL BETHEL HOME | 615 6TH ST SE STANLEY, ND 58784 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey started on 10/01/18 and concluded 10/03/18. | F 000 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) 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.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, staff interview and review of the Long -Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 12 sampled residents (Resident #8). Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status and identify and implement appropriate care approaches.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.5), dated October 2017, page | F 637 | Mountrail Bethel Home (MBH) will meet this requirement as evidenced by:<br><br>1) MDS Coordinator will change her practice and make sure to do a significant change on those residents that qualify so that the MDS accurately reflects the residents' status.<br><br>2) Any resident who has a significant change in status has the potential to be affected.<br><br>3) MDS Coordinator will be instructed on 10/30/18 on the importance of doing a significant change within 14 days on | 11/7/18 |

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

Electronically Signed | 10/22/2018

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| F 637 | Continued From page 1<br>2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . ."<br><br>Review of Resident #8's medical record occurred all days of the survey. A Annual Minimum Data Set (MDS), dated 05/10/18, identified the resident as requiring limited assistance with ambulation in room, continent of bowels, and had no behaviors. A quarterly MDS dated 08/10/18, identified the resident as requiring extensive assist with ambulation in room, occasionally incontinent of bowels, and had verbal and physical behaviors coded. The current care plan stated, " . . . Resident #8 is dependent on staff for most ADLs relating to her cognitive state, weakness, and other dx . . . . Staff will assist and ensure that Resident #8 is wearing a clean, dry product after any incontinent episode. . . . Monitor for decline in ability and increase in incontinence . . . ."<br><br>Observation on 10/02/18 at 8:34 a.m. showed a CNA (certified nurse aide) (#7) ambulated Resident #8 from the bathroom to the bed requiring extensive assistance with ambulation in room. | F 637 | resident #8 and any other resident who has had a significant change. This is going to be accomplished by changing the MDS collection form. Any identified residents with a change will be evaluated within two (2) weeks.<br><br>4) MDS Coordinator or designee will monitor resident #8 and any other resident for a significant change. Monitoring will be done monthly x 3 then quarterly for 1 year. Monitoring to begin on 10/31/2018. If concerns are identified, immediate corrective action will be implemented. MDS Coordinator will submit a report of the monitoring results to the QA Committee at each scheduled meeting.<br><br>5) 11/7/2018 | |

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| F 637 | Continued From page 2<br>Resident #8's medical record identified the following progress notes:<br>* 8/13/18 at 8:42 a.m. ". . . Resident #8 had a day of being both physical and verbal with staff . . . this is a decline from a previous assessment . . . ."<br>* 8/17/18 at 4:18 p.m. ". . . Resident #8 is occasionally incontinent of both bowel and bladder. . . ."<br>* 8/17/18 at 4:18 p.m. " . . . Resident #8 is dependent on staff for ADL [activities of daily living] cares. She needs extensive assist for all cares but eating. . . ."<br><br>During an interview on 10/03/18 at 9:40 a.m., an administrative nurse (#8) confirmed that a significant change assessment should have been completed for Resident #8. | F 637 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 4 of 11 sampled residents (Resident #4, #7, #9 and #30) observed during transfers. Failure to use a gait belt and to ensure safe mechanical lift | F 689 | MBH will meet this requirement as evidenced by:<br><br>1) Nursing staff will be instructed on 10/30/18 on the policy titled, "Mechanical Lift Policy and Procedure" and the policy titled, "Gait Belts for Transfer." Staff will | 11/7/18 |

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| F 689 | Continued From page 3<br>transfers placed the residents at risk of accidents and injury.<br><br>Findings include:<br><br>Review of facility policy titled "Mechanical Lift Policy and Procedure" occurred on 10/03/2018. This policy, revised in 2015, stated, ". . . 2. Standing lift: a. Used for residents/patients who can bear weight. . . ."<br><br>- Review of Resident #4's medical record occurred on all days of the survey. An annual Minimum Data Set (MDS), dated 07/24/18, identified extensive assist of two for transfers and one fall with no injury. Diagnoses included dementia. Physician orders included contracture management as needed (PRN). The resident's current care plan stated, ". . . I transfer with assistance of two and a standing lift . . . . Staff will cue me for participation during transfers while using standing lift and assist x2 [times]. . . . " A physical therapy progress note, dated 07/26/18 at 1:24 p.m. stated, ". . . resident recently seen for annual MDS, it shows that resident transfers with a standing lift. Range of Motion [ROM] is limited in the right shoulder but is within functional limits in all other extremities. . . ."<br><br>During an observation on 10/02/18 at 8:55 a.m., two certified nurse aides (CNAs) (#6 and #7) transferred Resident #4 to and from the toilet using a sit-to-stand lift. Observation showed the resident held on with only her left hand, with knees bent at a 45-degree angle and grimaced during the transfer.<br><br>- Review of Resident #9's medical record | F 689 | be instructed to use the Hoyer Lift for resident #4 and #9 and all other residents who are unable to bear weight in a standing lift and also staff will be instructed to use gait belts on resident #7 and #30 and all other residents who are unable to stand up on their own. Resident #4 and #9 went to a Hoyer lift on 10/8/2018. Informed Nursing and CNAs and updated care plans.<br><br>2) Any resident requiring assistance to stand up or requiring the use of a mechanical standing lift has the potential to be affected.<br><br>3) The nursing staff and physical therapy staff will change their practice and make sure for those residents who need assistance standing up, a gait belt is used, and for those residents who require a mechanical lift for transfers, that the residents are able to hang on so that it will be a safe transfer.<br><br>4) The QA Coordinator or designee will monitor resident #4 and #9, and resident #7 and #30 and any other resident requiring a gait belt or a mechanical lift monthly x 3, then quarterly for one year. Monitoring to begin on 10/31/2018. If concerns are identified, immediate corrective action will be implemented. QA Coordinator will submit a report of the monitoring results to the QA Committee at each scheduled meeting.<br><br>5) 11/7/2018 | |

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| F 689 | Continued From page 4 | F 689 | | |

occurred on all days of the survey. A quarterly MDS, dated 08/28/18, identified extensive assist of two for transfers. The resident's current care plan stated, ". . . I need assistance of 2 with standing lift for transferring and toileting . . ." A progress note, dated 09/19/18 at 10:09 a.m. stated, ". . . resident has increased pain in R [right] shoulder with both transfers however, reporting less pain with hoyer [full body] lift. She is unable to reach R handle with R UE [upper extremity] during standing lift secondary to pain . . . resident will use hoyer lift primarily - if pain in R shoulder decreases, may use standing lift as able. . . ."

During an observation on 10/02/18 at 5:00 p.m., a CNA (#6) and an unidentified CNA transferred Resident #9 to and from the toilet using a sit-to-stand lift. The resident called out in pain and stated "hurry" throughout the transfer. Observation showed the resident failed to stand up straight, knees bent at approximately 45-degree angle, and held onto the lift with only her left hand.

During an interview on the morning of 10/03/18 an administrative nurse (#1) stated she expected staff to use the total body lift for residents unable to bear weight.

Review of the facility policy titled "Gait Belts For Transfer" occurred on 10/03/18. This policy, revised January 2007, stated, "Gait belts are provided to assist staff to safely transfer or ambulate residents."

- Observation on 10/01/18 at 3:20 p.m. showed two CNAs (#2 and #3) assisted Resident #7 from

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| F 689 | Continued From page 5<br>the bedside commode. During the transfer both CNAs placed their arm under Resident #7's axilla and assisted the resident to stand. The CNAs failed to use a gait belt during the transfer.<br><br>- Observation on 10/01/18 at 5:12 p.m. showed two CNAs (#4 and #5) assisted Resident #30 from the bed to a standing position. Both CNAs placed their arm under Resident #30's axilla to assist the resident to stand. The CNAs failed to use a gait belt to assist the resident.<br><br>During an interview on 10/03/18 at 10:35 a.m., an administrative nurse (#1) stated she expected staff to use a gait belt when assisting residents to stand. | F 689 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when | F 692 | | 11/7/18 |

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| F 692 | Continued From page 6<br>there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to offer fluids to 3 of 10 sampled residents (Resident #4, #5, and #8) who required staff assistance for fluid intake and at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTI's).<br><br>Findings include:<br><br>Review of facility policy titled "Hydration and Nutrition Policy and Procedure" occurred on 10/03/2018. ". . . POLICY: 1. The nutrition and hydration status of each resident is maintained as close to optimal levels as possible. . . . 6. Water must be available to residents at all times. . . ."<br><br>- Observation on 10/02/18 at 8:34 a.m. showed a CNA (#7) assisted Resident #8 to the bathroom and then to her bed. Observation showed a mug of water on the nightstand and not within the resident's reach. The CNA failed to offer fluids before leaving the room.<br><br>Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and hypertension. The current care plan stated, "Resident #8 is dependent on staff for most ADL's relating to her cognitive state, weakness . . . "<br><br>- Observation on 10/02/18 at 8:55 a.m. showed | F 692 | MBH will meet this requirement as evidenced by:<br><br>1) The QA Coordinator or nursing designee will monitor those staff who provide care to resident #4, #5, and #8, who need assistance with fluids, to ensure fluids are being offered consistently.<br><br>2) Any resident requiring assistance with fluids to maintain adequate hydration has the potential to be affected.<br><br>3)Nursing staff will be instructed on 10/30/18 on the policy titled, "Hydration and Nutrition Policy and Procedure." Staff will be instructed to offer fluids when providing cares to resident #4, #5, #8 and any other resident who needs assistance with fluids. On 10/8/2018 staff were instructed to offer fluids with dependent residents and to use gait belts with those residents who need help with mobility.<br><br>4) The QA Coordinator or nursing designee will monitor resident #4, #5, #8 and any other resident requiring assistance with fluids monthly x 3, then quarterly for 1 year. Monitoring to begin 10/31/2018. If concerns are identified, immediate corrective action will be implemented. QA Coordinator will submit | |

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| F 692 | Continued From page 7<br>two CNAs (#7 and #10) transferred Resident #4 to the bathroom and then to the bed with a stand lift. Observation showed a mug of water on the nightstand and not within the resident's reach. The CNAs failed to offer fluids before leaving the room.<br><br>Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, "DEHYDRATION: I am at risk for dehydration relating to my dependency on staff and limited mobility. I want to maintain an adequate hydration level. I want staff to offer and assist me with fluid intake frequently during the day and with cares at night. . . ." Physician orders included Furosemide (diuretic) Tablet Give 20 mg [milligrams] by mouth one time a day for edema/hypertension. . . ."<br><br>- Observation on 10/02/18 at 9:30 a.m. showed two certified nurse aides (CNAs) (#9 and #10) transferred Resident #5 from the wheelchair to bed with a hoyer (full body) mechanical lift. Observation showed a mug of water on the resident's nightstand and not within the resident's reach. The CNAs failed to offer fluids before leaving the room.<br><br>- Review of Resident #5's medical record occurred on all days of survey. The current care plan stated, "DEHYDRATION: I am at risk for dehydration due to immobility, cognitive impairment, and diagnosis of heart, kidney disease. . . I want to maintain adequate hydration and avoid any complications related to dehydration. I am dependent on staff for all ADL's [activities of daily living]. Please ensure water is provided to me frequently during the day | F 692 | a report of the monitoring results to the QA Committee at each scheduled meeting.<br><br>5) 11/7/2018 | |

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| F 692 | Continued From page 8<br>and with rounds at night. . . ."<br><br>During an interview on 10/03/18 at 11:16 a.m. an administrative nurse (#1) stated, "They [staff] should be offering fluids every time they finish with cares or take a resident out of their room. They should always be offering fluids." | F 692 | | |
| F 801 SS=D | Qualified Dietary Staff<br>CFR(s): 483.60(a)(1)(2)<br><br>§483.60(a) Staffing<br>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)<br><br>This includes:<br>§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-<br>(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.<br>(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. | F 801 | | 11/28/18 |

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| F 801 | Continued From page 9<br>(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 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.<br>(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.<br><br>§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 who-<br>(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:<br>(A) A certified dietary manager; or<br>(B) A certified food service manager; or<br>(C) Has similar national certification for food service management and safety from a national certifying body; or<br>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; and<br>(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service | F 801 | | |

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| F 801 | Continued From page 10<br>managers or dietary managers, and<br>(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, the facility failed to ensure the dietary manager received the necessary education to obtain the required qualifications to hold the dietary manager position for 1 of 1 dietary manager (#11). Failure to ensure qualified staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services has the potential to result in foodborne illness to residents, staff and visitors.<br><br>During an interview on 10/01/18 at 11:39 a.m., a dietary manager (#11) stated, "I have started the process of getting my CDM [certified dietary manager]."<br><br>Upon request, on 10/01/18, the facility failed to provide evidence of staff member (#11) completing the required education of CDM, certified food service manager, or a national certification for food service management and safety from a national certifying body.<br><br>The facility failed to provide the necessary training in food and nutrition services to carry out daily operation duties. | F 801 | MBH will meet this requirement as evidenced by:<br><br>1) The Dietary Manager will be instructed on 10/30/18 on the importance of receiving the necessary education to hold the Dietary Manager position.<br><br>2) Any Dietary Manager that does not have the correct education has the potential to be affected.<br><br>3) The current Dietary Manager is enrolled in the Safe Serve Manager Course and Exam on November 27, 2018 in Devil's Lake, ND. The Dietary Manager has been enrolled in the CDM course online since July 17, 2018.<br><br>4) The Consultant Dietician or designee will monitor the Dietary Manager quarterly x 1 year to ensure that progress in being made in the CDM course along with obtaining the CDM certification. Monitoring to begin 10/31/2018. If concerns are identified, immediate corrective action will be implemented. Consultant Dietician will submit a report of the monitoring results to the QA Committee at each scheduled meeting.<br><br>5) 11/28/2018 | |

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| | 355044 | A. BUILDING _____ B. WING _____ | 10/03/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOUNTRAIL BETHEL HOME | 615 6TH ST SE STANLEY, ND 58784 |

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| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of the Food and Drug Administration (FDA) Food Code 2013, review of manufacturer's instructions, review of facility policy, 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 the cleanliness of food preparation/ storage areas and proper temperatures/procedures for food storage and cooling has the potential to result in foodborne illness to residents, staff, and visitors.<br><br>Findings include: | F 812 | MBH will meet this requirement as evidenced by:<br><br>1) The Dietary Department will change their practice and will make sure: temperatures are checked twice a day on all refrigerators/ coolers; hair nets will be worn at all times; no food will be eaten by staff in the Kitchen area; expiration dates will be checked on all items and expired items will be discarded; staff will know the correct way to test and utilize Oasis 146 quat solution; we will no longer keep leftovers. Four new refrigerators were | 11/7/18 |

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| F 812 | Continued From page 12<br>FOOD STORAGE/TEMPERATURE<br><br>Review of the facility policy titled, "Policy for the Preparation, Distribution, and Storage of Food" occurred on 10/03/18. This undated policy, stated, ". . . Freezer and cooler temps [temperatures] will be monitored twice daily by recording of temperatures from the thermometers in each unit . . . Coolers will be maintained between 32 and 40 degrees F [Fahrenheit]. Any variation from these temps must be reported to dietary supervisor or maintenance man immediately. . . . All equipment shall be cleaned and maintained according to written policy. . . ."<br><br>The FDA Food Code 2013, page 91-94, stated, ". . . Time/Temperature Control for Food Safety shall be maintained . . . At 5 degrees C [Celsius] (41 degrees F) . . . "<br><br>An initial kitchen tour occurred on 10/01/18 at 11:14 p.m. with a dietary staff member (#11). Observation showed the walk-in cooler temperature at 46 degrees F and a pipe coming from the box fan located on the ceiling of the walk-in cooler covered by a large amount of ice. Review of the "Appliance Temperature chart" indicated walk-in cooler temperatures out of range for 23 out of 30 days in September 2018.<br><br>During the initial tour temperatures of random food included:<br>* Homemade tarter sauce - 45.6 F<br>* Cherry vanilla yogurt - 44.4 F<br>* Ranch dressing - 44.1 F<br>* Cheese block - 45.8 F<br>* Whole eggs - 47.3 F | F 812 | ordered and installed on 10/1/2018. A new walk-in cooler was ordered on 8/7/2018; installation is to start on 10/26/2018.<br><br>2) Anyone who eats at our facility, both staff and residents, have the potential to be affected by a food borne illness.<br><br>3) Dietary Manager and Dietary staff will be instructed on 10/30/2018 by the Dietician on the policies titled, "Policy for the Preparation, Distribution, and Storage of Foods" and will review the daily cleaning task list. Staff will be instructed on the importance of checking temperatures for the freezer and cooler twice a day, that hair nets must be worn by all personnel at all times, that staff cannot eat in the Kitchen food preparation/serving area, that we must check all items' expiration dates and discard those that are expired, how to properly test and utilize the correct concentration of Oasis 146 quat solution, and also staff will be informed that we will no longer save leftover foods.<br><br>4) The Dietary Manager will monitor checking temperatures, wearing of hair nets, that staff are not eating in the Kitchen area, that expiration dates are being checked and expired items discarded,that the quat solution is tested and utilized correctly, and that no left overs are being saved. Monitoring of above items will be done monthly x 3, then quarterly x 1 year. Monitoring will | |

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| F 812 | Continued From page 13<br>The dietary staff member (#11) discarded all the foods requiring refrigeration from the walk-in cooler after the identified out of range temperatures (greater than 41 F). Continuation of the initial kitchen tour showed 5 opened, expired juice/water thickener containers in the dining room refrigerator. The dietary staff member (#11) discarded the items.<br><br>Review of the "Daily Cleaning Task List" indicated kitchen staff signed the check list off 27 out of the 30 days in September 2018 for the walk-in cooler regarding throw dates, clean spills, and remove expired leftovers. The facility failed to provide a policy regarding sanitation of the walk-in cooler per request.<br><br>A final kitchen tour on 10/02/18 at 3:00 p.m. showed one mighty shake and a carton of 2 percent (%) milk expired in the kitchen nourishment refrigerator. The dietary staff member (#11) discarded the items.<br><br>COOLING PROCESS/LEFTOVERS<br><br>Review of the facility policy titled, "Policy for the Preparation, Distribution, and Storage of Food" occurred on 10/03/18. This undated policy, stated, ". . . Leftover foods will be stored in shallow, covered pans immediately, must be labeled and dated, and utilized within 72 hours. . . ."<br><br>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 | F 812 | start on 10/31/2018. If concerns are identified, immediate corrective action will be implemented. Dietary Manager will submit a report of the monitoring results to the QA Committee at each scheduled meeting. | |

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| F 812 | Continued From page 14<br>cooled within 4 hours to 5 degrees C (41 degrees F) or less . . . "<br><br>During an interview on the afternoon of 10/01/18, a dietary staff member (#11) stated the facility only keeps cooked vegetables and does not follow a cooling process or track the leftover vegetables. Observation during the interview showed kitchen staff had placed leftover carrots from the lunch meal in the refrigerator. The dietary staff member (#11) discarded the carrots.<br><br>Observation on 10/01/18 at 3:44 p.m. showed leftovers in the walk-in freezer including:<br>* Pork roast with gravy, dated 08/09/18, without the lid on tightly with visible freezer burn<br>* Swedish meatballs dated 08/18/18<br>* A beef dish dated 09/19/18<br><br>The dietary staff member (#12) discarded the above items.<br><br>SANITIZATION<br><br>Review of manufacturer's instructions for Ecolab Oasis 146 Multi-Quaternary (Quat) Sanitizer identified a concentration range of 150 parts per million (ppm) to 400 ppm active quat required for effective sanitizing.<br><br>Observation in the kitchen on 10/02/18 at 3:00 p.m. showed a bucket of Oasis 146 quat solution on the counter. Observation showed the test strip available to test the solution were specific to testing chlorine-based solutions. A unidentified dietary staff member provided the correct Hydrion QT 10 strips and tested the bucket. When dipped in the quat solution, the strip failed to produce a | F 812 | | |

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| F 812 | Continued From page 15<br>change of color. The dietary staff member (#11) discarded and filled the bucket with new solution. This surveyor tested and found the solution within the proper range.<br><br>During an interview on 10/02/18 at 3:00 p.m., a dietary staff member (#11) failed to know the proper concentration for the quat solution or correct test strips used.<br><br>Review of the facility policy titled, "Policy for the Preparation, Distribution, and Storage of Food" occurred on 10/03/18. This undated policy, stated, ". . . hair restraint shall be worn by all personnel . . ."<br><br>Observations showed dietary staff member (#11) failed to wear a hair restraint on multiple occasions while going in and out of the kitchen on 10/01/18.<br><br>Observation on 10/02/18 at 6:15 p.m. showed a unidentified staff member eating soup in the kitchen food preparation/serving area during resident meal service. | F 812 | | |