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 _____	11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 11/04/19 and concluded on 11/07/19.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		12/12/19

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

Electronically Signed | 12/04/2019

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F 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and staff interview, the facility failed to notify the resident representative and physician for 1 of 1 sampled resident (Resident #3) after a change in condition. Failure to promptly notify the physician and/or resident representative of a change in condition may limit their ability to make informed decisions regarding medical care. Findings include: Review of facility policy titled "Contacting Family of Residents . . ." occurred on 11/07/19. This policy, revised 08/01/18, stated "To have a communication plan for contacting the primary contact when there are health care changes with a resident. . . . staff will contact the first contact person listed on file or by the way of the Advance Directive, on file."	F 580	MBH will meet this requirement as evidenced by: 1) Nursing staff will be instructed on 12-10-19 on the policy "Notification of Changes." For resident #3, a late entry will be entered by staff that they contacted family of change on 11-3-19. 2) Any resident having a change in condition or treatment has the potential to be affected. 3) The nursing staff will change their practice so the family and doctor of any resident having a change in condition or treatment is notified promptly. Staff were instructed on deficient practice noted on 11-12-19.	

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F 580	Continued From page 2 When asked, the facility did not provide a policy on notification of the resident's provider regarding a change in condition. Review of Resident #3's medical record occurred on all days of the survey. Review of consecutive nursing notes stated: *11/03/19 at 2:23 p.m. "Resident becomes very weak while sitting on the commode. Unresponsive and needing to be held upright, she is transferred back to bed. VS [vital signs] are taken, O2 [oxygen] sats [saturations] are low @ [at] 65% [percent] RA [room air]. Start oxygen therapy @2L [liters] per NC [nasal cannula] and monitor." *11/03/19 at 2:26 p.m. "Recheck O2 sats are 75% on 2L oxygen, increase O2 to 3L and monitor." *11/03/19 at 2:27 p.m. "Recheck O2 sats are 98% on 3L oxygen, decrease to 2L and monitor." *11/4/2019 at 9:01 a.m "Resting in bed this am with 02 on per nasal cannula 3 liters. 02 sats-100%. . . ." During an interview on 11/06/09 at 4:50 p.m., an administrative nurse (#10), stated the facility notified the provider when Resident #3 started PRN (as needed) oxygen, but she was not sure if the resident representative had been notified. The medical record failed to contain documentation that the provider and resident representative had been notified about Resident #3's change in condition. During an interview on 11/07/19 at 8:10 a.m., an administrative nurse (#3) stated facility staff are expected to notify the provider and family as	F 580	4) The QA Coordinator or designee will monitor resident #3 and any other resident who has a change monthly x 3, then quarterly x 1 year. Monitoring will begin 12-2-19. If concerns are identified, immediate corrective action will be implemented. QA Coordinator will submit a report of results to the QA Committee at each scheduled meeting. 5) 12/12/19	

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F 580	Continued From page 3 soon as possible with changes in resident staus. Refer to F695	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State	F 583		12/12/19

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F 583	Continued From page 4 law. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care for 1 of 8 sampled residents (Resident #11) observed in a manner/environment that maintained, enhanced, and respected the resident's dignity. Failure to knock on doors and wait for a reply, before entering a resident's room, does not preserve the resident's personal dignity or enhance quality of life and place them at risk of embarrassment or emotional harm. Findings include: Review of the facility policy titled "Confidentiality, Privacy, and Dignity" occurred on 11/07/19. This policy, revised June 2003, stated, ". . . All facility staff will protect and promote the right of confidentiality, dignity, and privacy of each resident/patient. . . . All staff will knock before entering a resident/patient's room and allow resident/patient's privacy when receiving treatment and caring for their personal needs. . . ." - Observation on 11/05/19 showed the following: * At 10:09 a.m. a certified nursing assistant (CNA) (#12) entered Resident #11's room without knocking. The resident, exposed from the waist down, sat on a beside commode. The CNA (#12) failed to knock/announce herself and wait for acknowledgment prior to entering the resident's room. * At approximately 10:20 a.m. staff provided perineal cares while Resident #11 stood in the stand lift exposed from the waist down. The CNA	F 583	MBH will meet this requirement as evidenced by: 1) Staff will be instructed by 12-12-19 on the policy "Confidentiality, Privacy, and Dignity." For resident #11, the privacy screen will be placed with each occurrence of personal cares provided daily. 2) Any resident requiring assistance with personal cares or ADL cares has the potential to be affected. 3) Staff will change their practice to assure privacy screen is used for resident #11 and any other resident receiving cares. Nurses were instructed on 11-12-19 and CNAs on 11-14-19 about the deficient practice and to correct it immediately following. 4) The QA Coordinator or designee will monitor and perform audits on resident #11 and any other resident receiving cares monthly x 3, then quarterly x 1 year. Monitoring will begin 12-2-19. If concerns are identified, immediate corrective action will be implemented. QA Coordinator will submit a report at each scheduled QA Committee meeting. 5) 12/12/19	

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F 583	Continued From page 5 (#5) knocked on the door, and entered the room. CNA #5 failed to announce him/herself and wait for acknowledgment before he/she entered the room. During an interview on the morning of 11/07/19, an administrative nurse (#3) stated she would expect staff to knock, announce themselves, and wait for acknowledgement prior to entering a resident's room.	F 583		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		12/12/19

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F 657	Continued From page 6 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to review/revise the comprehensive care plan to reflect the current status of 3 of 12 sampled residents (Resident #4, #11, and #13). Failure to review/revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Resident Care Planning" occurred on 11/07/19. This policy, revised 07/14/17, stated, ". . . The care plan will describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. . . . any revisions and/or additions will be done by Interdisciplinary Team . . ." - Review of Resident #4's medical record occurred on all days of survey. The record showed the resident required oxygen on 08/18/19 per facility standing orders and has continued oxygen use since. The current care plan failed to include a problem, goal, or interventions related to oxygen use. - Review of Resident #11's medical record occurred on all days of survey. The record indicated the resident received hourly checks related to frequent falls. Observations on 11/05/19 at 10:09 a.m., 4:34 p.m., and 5:39 p.m. showed use of gripper socks when resting in bed,	F 657	MBH will meet this requirement as evidenced by: 1) Nursing staff will be instructed on policy "High Risk Medications-Anticoagulants" and deficient practice on 12-10-19. Education will also be provided on policy "Resident Care Planning" and deficient practice. For resident #4, her care plan will be updated to reflect oxygen use. For resident #11, interventions for fall prevention will be added to care plan to reflect current plan. For resident #13, care plan will include anticoagulant use and appropriate interventions. For any other resident on anticoagulant, care plan will also be updated. 2) Any resident on an anticoagulant, fall precautions, or other noted changes in care are at potential risk to be affected. 3) Nursing staff will change their practice according to revised policy "Care Planning" and new policy on anticoagulant use. 4) QA Coordinator or designee will monitor resident #4, 11, 13 and any other resident on anticoagulant or change in cares monthly x 3, then quarterly x 1 year. Monitoring will begin on 12-2-19. Any concerns identified will have immediate	

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F 657	Continued From page 7 shoes worn during transfers, and bed placed in lowest position. The facility failed to add these interventions to the residents current care plan. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included atrial fibrillation and long term use of anticoagulant. Current physician orders included Warfarin Sodium (anticoagulant) 7.5 milligrams (mg) daily. The current care plan failed to include a problem, goal, or interventions related to the increased risk of bleeding and other side effects related to the use of an anticoagulant medication.	F 657	corrective actions implemented. QA Coordinator will submit report of findings to QA Committee at each scheduled meeting. 5) 12/12/19	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 2 of 2 sampled residents (Residents #3 and #4) receiving oxygen. Failure to obtain an order for the administration of oxygen and monitor the residents status has the potential for the residents to experience complications related to inadequate oxygen levels. Findings include:	F 695	MBH will meet this requirement as evidenced by: 1) Nursing staff will be instructed on revised policy "Oximeter Readings" and the new policy "Oxygen Therapy" on 12-10-19. Education will be provided on new oxygen implementation, monitoring and weaning process. For resident #3, she is no longer on oxygen so no additional changes are needed. For	12/12/19

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F 695	Continued From page 8 Review of the facility policy titled "OXYGEN THERAPY BY NASAL CANNULA OR FACE MASK PER PORTABLE TANK" occurred on 11/07/19. This policy, revised June 2006, stated, "Place sign 'OXYGEN IN USE' outside the room of the resident. . . . either mask or nasal cannula is used . . . adjust liter flow as ordered. . . . Record oxygen therapy on treatment and nurse notes. . . . Record: Liter flow . . . Time started . . . Pertinent observations . . . " Review of the facility policy titled "OXIMETER READINGS" occurred on 11/07/19. This policy, revised February 2006, stated, ". . . If a resident has an order to keep sats [saturation - level of oxygen in the blood] at a certain percent, an oximetry reading will be done every shift, unless otherwise ordered by the physician, and documented on the treatment record and/or medicare flow sheet. . . ." Review of the facility's standing physician orders, approved 06/18/19, identified the following: * "Oxygen per nasal cannula at 5 liters/[per] min [minute]. PRN [as needed] for acute respiratory distress. Titrate [measure and adjust] oxygen down to keep oxygen saturation > [greater than] 90% [percent]. Notify Provider. If unable to maintain sats above 90%, contact provider for advisement to increase oxygen or use a mask" * "Obtain O2 [oxygen] order if using prn O2 >30 days" - Observations on all days of survey showed Resident #3 receiving oxygen via nasal cannula with the oxygen concentrator running at two to three liters per minute, and no signage posted	F 695	resident #4, an order will be obtained for continuous oxygen an weaning parameters with frequency with failed attempts. Signage will be placed in appropriate places according to policy. Pulse oximeter readings will be obtained per policy and documented in medical records. 2) Any resident noted to have a change in status or acute illness has the potential to be affected. 3) Nursing staff will change their practice according to revised oxygen policy for those residents requiring oxygen. Standing orders will be revised to reflect new oxygen administration policy and scanned into each resident chart. 4) The QA Coordinator or designee will monitor resident #4 and any other residents requiring oxygen monthly x 3, then quarterly x 1 year. Monitoring will begin 12-2-19. Any concerns identified will have immediate corrective actions implemented. QA Coordinator will submit a report of the findings to the QA committee at each scheduled meeting. 5) 12/12/19	

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F 695	Continued From page 9 inside or outside of the resident's room identifying oxygen in use. Review of Resident #3's medical record occurred on all days of the survey. The nursing notes identified the following: * 11/03/2019 at 2:23 p.m., "Resident becomes very weak while sitting on the commode. Unresponsive and needing to be held upright, she is transferred back to bed. VS [vital signs] are taken, O2 sats are low @ [at] 65% RA [room air]. Start oxygen therapy @ 2L [liters] per NC and monitor." * 11/03/19 at 2:26 p.m., "Recheck O2 sats are 75% on 2L oxygen, increase O2 to 3L and monitor." A nursing note timed one minute later stated, "Recheck O2 sats are 98% on 3L oxygen, decrease to 2L and monitor." * 11/06/19 at 6:35 p.m., "During suppertime, resident head drooping down. Check oxygen level is 92-94% on 2L per NC. Increase oxygen to 3L, within a few minutes she picks her head up, starts asking for water and takes her meds [medications]. It appears she does much better on 3L, even tho [though] on 2L O2 sats are >[greater than] 90%." - Observation on all days of survey showed Resident #4 wearing continuous oxygen per nasal cannula and no signage posted inside or outside of the resident's room identifying oxygen in use. Review of Resident #4's medical record occurred on all days of survey. The record indicated oxygen was initiated on 08/18/19 per facility standing orders related to a diagnosis of bronchopneumonia. The record further indicated Resident #4 continued to require oxygen since	F 695		

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F 695	Continued From page 10 this date. Resident #4's medical record lacked a written physician's order for the initiation of/continued use of oxygen and lacked documentation regarding oxygen saturations and pertinent observations on the electronic medication administration record (eMAR). During an interview on 11/06/19 at 4:50 p.m., an administrative nurse (#10) reported the facility notified the provider when Resident #3 was started on PRN oxygen. Resident #3's medical record failed to reflect the facility notified the provider. During an interview on 11/07/19 at 8:10 a.m., an administrative nurse (#3) stated facilty nursing staff should notify the provider as soon as possible of resident change in status. The administrative nurse (#3) confirmed there should be an order in the resident's medical record, documentation showing when the order was implemented, and daily documentation on the eMAR regarding oxygen saturations and pertinent observations. During an interview on 11/07/19 at 8:14 a.m., an administrative nurse (#3) stated when oxygen is implemented per standing orders, a physician's order should be obtained and entered into the computer. Once entered, the order is visible in the resident's eMAR and the computer automatically triggers a notification for staff to obtain and document oxygen saturations on a daily basis. This conflicts with the facility's policy "OXIMETER READINGS" which states oximetry readings should be completed every shift.	F 695		

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F 695	Continued From page 11 The facility failed to obtain written physician orders for Resident #3 and #4 after oxygen was initiated/utilized greater than 30 days, to obtain and document oxygen saturation levels every shift, and to post signage inside/outside the resident's room indicating oxygen in use for Resident #3 and #4 as per facility policy.	F 695		
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of employee files and review of facility Employee Handbook, the facility failed to ensure 2 of 3 employees (Employee #1 and #2) reviewed, received an annual performance evaluation. Failure to complete performance evaluations on an annual basis does not ensure all staff have the skills and knowledge necessary to meet the needs of the residents. Findings include: Review of the facility Employee Handbook occurred on 11/06/19. The Employee Handbook, revised July 2019, stated, "Performance Evaluation: Your Department Manager will evalutate your performance annually on your anniversary date. . . ."	F 730	MBH will meet this requirement as evidenced by: 1) CNA Supervisor and HR Director will be educated on the importance of completing annual reviews according to the Employee Handbook. Evaluations of employee #1 and #2 will be completed by department manager. 2) Any staff working for MBH has the potential to be affected. 3) The HR Director will change the evaluation process and assure evaluations are done for each employee according to the Employee Handbook. The department managers will change	12/12/19

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	355044	A. BUILDING _____ B. WING _____	11/07/2019

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

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F 730	Continued From page 12 Review of certified nursing assistant (CNA) employee files occurred on 11/06/19 and identified the following: * Employee #1 hired on 10/09/16. The most recent performance evaluation dated 08/16/18. * Employee #2 hired on 08/07/17. The most recent performance evaluation dated 08/17/18.	F 730	their practice to follow the Employee Handbook regarding evaluations. 4) The HR Director or designee will monitor staff #1 and #2 until evaluations are complete. All staff will be monitored by HR Director monthly x 3 and quarterly x 1 year. Monitoring will begin 1-1-20. If concerns are noted, immediate corrective action will be implemented. HR Director will submit a report of monitoring results to QA Coordinator and QA Committee at each scheduled meeting. 5) 12/12/19	
F 801 SS=D	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	F 801		12/12/19

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F 801	Continued From page 13 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 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 who- (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: (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	F 801		

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F 801	Continued From page 14 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 (ii) In States that have established standards for 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: THIS IS A REPEAT DEFICIENCY FOR THE STANDARD SURVEY CONDUCTED ON 10/03/18 Based on staff interview, the facility failed to ensure the dietary manager received the necessary education to obtain the required qualifications to hold the position of director of food and nutrition for 1 of 1 dietary manager (#13). Failure to ensure qualified staff have 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 and/or adverse consequences to residents, staff, and visitors. Findings include: During an interview on 11/05/19 3:07 p.m., a dietary manager (#13) stated she has not yet completed the certified dietary manager's (CDM) course. The facility failed to provide evidence staff	F 801	MBH will meet this requirement as evidenced by: 1) The Dietary Manager will be instructed on the importance of receiving necessary education to hold the Dietary Manager position. 2) Any Dietary Manager that does not have the correct education has the potential to be affected. 3) The current Dietary Manager has completed all coursework and tests for the CDM course. Once she receives final grading, she is eligible and will schedule the national exam. 4) The Consultant Dietician or designee will monitor the Dietary Manager monthly x 3 to ensure CDM certification is obtained. If concerns are identified, immediate corrective action will be implemented. Consultant Dietician will	

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F 801	Continued From page 15 member (#13) completed the required education of either a CDM, certified food service manager, or a national certification for food service management and safety from a national certifying body.	F 801	submit a report of monitoring results to the QA Committee until CDM certification is complete. 5) 12/12/2019	