STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 07/23/18 and completed on 07/26/18, the sample included 30 residents for review and three (3) closed records for review.	F 000		
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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		8/15/18

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

Electronically Signed | 08/15/2018

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F 657	Continued From page 1 Based on observation, record review, review of facility policy and staff interview, the facility failed to review and revise the comprehensive care plan for 2 of 32 sampled residents (Resident #29 and #66). Failure to revise the care plan limited the ability of the staff to communicate care needs, ensure continuity of care for each resident and reduce/prevent the number of falls for Resident #29 and #66. Findings include: - Review of the medical record for Resident #29 identified diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, urinary incontinence, schizoaffective disorder and muscle weakness. The care plan revised on 11/03/17 indicated the resident was at risk for falls. There were no new interventions initiated since 06/06/17. The fall risk assessments, dated 03/26/18 and 06/27/18, identified the resident was a high risk for falls. Review of the "Fall Worksheet/Checklist" identified Resident #29 had fallen on 05/21/18, 05/24/18, 05/28/18, 07/02/18, a second fall on 07/02/18 and 07/22/18. There were no fall investigations completed. During an interview on 07/26/18 at 10:10 a.m. with the staff nurse (#15) she confirmed there were no new interventions initiated that addressed the resident's falls on 05/21/18, 05/24/18, 05/28/18, 07/02/18, a second fall on 07/02/18 and 07/22/18. She verified the resident was at risk for falls, but did not know what other interventions could be initiated to prevent further falls. The staff nurse (#15) verified the care	F 657	1. On 8/8/18 the nurse manager updated careplan for residents 29 and 66 and both are current with fall interventions. 2. All residents have the potential to be affected by this practice. 3. The facilities QA nurse educators held an in-service on Care plan updating 8/15/18. 4. QA will be completed by the Clinical support nurse, MDS Coordinator and monitored by QA nurse weekly for one month, monthly for 3 months and then quarterly till resolved. 5. 8/15/18	

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F 657	Continued From page 2	F 657		

plans were not updated to include recent falls or revised with new interventions since 06/06/17.

- Review of the medical record for Resident #66 identified diagnoses that included schizoaffective disorder, muscle weakness, mental disorder, obesity, diabetes, arthropathy and Parkinson's disease. The care plan, revised 09/14/17, indicated the resident was at risk for falls related to gait and balance problems. There were no new interventions on the care plan since 2017. The fall risk assessments, dated 03/07/18 and 06/07/18, indicated a high risk for falls.

Review of the "Fall Worksheet/Checklist" identified Resident #66 fell on 07/12/18 and 07/19/18. There were no fall investigations completed.

An interview with a staff nurse (#15) on 07/26/18 at 10:10 a.m. confirmed there were no new interventions initiated that addressed the resident's falls on 07/12/18 and 07/19/18. She verified the resident was at risk for falls, but did not know what other interventions could be initiated to prevent further falls. The staff nurse (#15) verified the care plans were not updated to include recent falls or revised with new interventions.

Review of the "Fall prevention" policy, dated 04/01/10, with the most recent revision on 06/2017, included the purpose was to strive to prevent falls from occurring by assessing for potential falls and assessing after falls for preventative interventions. The policy also included to review the care plan and revise if necessary with new interventions.

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F 657	Continued From page 3 An interview with a nursing coordinator (#4) on 07/26/18 at 2:20 p.m. verified the "Fall prevention" policy included the purpose was to strive to prevent falls from occurring by assessing for potential falls and assessing after falls for preventative interventions. The nursing coordinator verified the policy also included to review the care plan and revise if necessary with new interventions.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to complete skin assessments and treat pressure ulcers for 1 of 1 sampled resident (Resident #113) investigated for pressure ulcers. Failure to routinely assess, monitor and provide treatment may result in delayed healing of pressure ulcers. Findings include:	F 686	1. On 8/9/18 resident 113 QA was completed and is current on all weekly/monthly skin assessments. 2. All residents with skin issues have the potential to be affected by this practice. 3. The facilities QA nurse and Wound nurse held an-service on 8/15/18 in how	8/15/18

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F 686	Continued From page 4 Resident #113 was readmitted to the facility on 03/16/18. Diagnoses included dementia, stroke, muscle weakness and peripheral artery disease. The nursing admission assessment opened on 03/16/18, locked on 03/21/18 did not note any open skin. Review of Resident #113's care plan noted an entry for the Potential for Pressure Ulcers that was updated on 03/17/18. The care plan indicated that Resident #113 was admitted from the hospital with a Stage 3, a Stage 4 and an unstageable pressure ulcer. Approaches were to reposition Resident #113 every "2-3 hours," complete dressing changes per doctors' orders, float her heels (keep heels from touching the bed), weekly skin assessments and for hospice to provide services. An administrative nurse (#4) provided a copy of an in-service training, dated 05/18/18. Part of the training noted that a skin assessment that was to be done weekly was signed off as completed, but was not actually completed. A staff nurse (#20) signed that she was part of the training. Review of Resident #113's quarterly Minimum Data Set (MDS) assessment, dated 06/16/18, noted unhealed pressure ulcers, that the resident was at risk of developing a pressure ulcer and had one Stage 4 pressure ulcer and one unstageable pressure ulcer. Review of the Weekly/Monthly Skin Assessments noted that no assessment was completed between 04/14/18 and 05/01/18. The skin assessment, dated 04/14/18 and completed by a	F 686	to properly perform a skin assessment , Skin care policy was reviewed and updated. 4. QA will be completed by nurse managers, wound nurse and monitored by QA nurse weekly for one month, monthly for 3 months and quarterly till resolved. 5. 8/15/18	

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F 686	Continued From page 5 staff nurse (#20) noted no skin issues. Skin Notes documented that a wound to the right outer foot was discovered on 05/01/18 and measured 8.2 cm (centimeters) x 4.6 cm and was unstageable. There were no weekly skin assessments completed from 06/22/18 to 07/20/18. A Skin Note by a staff nurse (#17), dated 06/26/18, documented a new wound to the right inner foot which measured 0.4 cm x 1 cm and was a Stage 2. A physician's order to treat the right inner foot wound was started on 06/26/18. Review of the Medication Administration Record (MAR) for April 2018 revealed weekly skin assessments were signed out as completed on 04/20 and 04/27, but no skin assessment documents could be located. Review of the MAR for June 2018 revealed that a weekly skin check was signed out on 06/29, but could not be located. Review of the MAR for July 2018 revealed weekly skin checks signed out on 07/06 and 07/13, but could not be located. An administrative nurse (#4) confirmed on 07/25/18 at 10:00 a.m. they had not been completed . On 07/26/18 at 8:30 AM, an interview was completed with a staff nurse (#17). The staff nurse (#17) identified herself as the treatment nurse. She reported that Resident #113 had wounds to the inner and outer aspects of the right foot, the right heel and the back of the right ankle. Review of July 2018 treatment records for Resident #113 revealed no treatment order for a wound to the inner right foot. The staff nurse (#17) stated, "The inner wound may have healed. I was on vacation last week and the treatment could have been discontinued."	F 686		

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F 686	Continued From page 6 Further review of treatment records for June 2018 revealed no treatment order for the right inner foot. The staff nurse (#17) stated on 07/26/18 at 8:30 a.m. that she did not know why there was no documentation of a treatment to the inner foot as she had been doing treatments. The absence of treatment documentation was confirmed by an administrative nurse (#4) on 07/26/18 at 9:21 a.m.. On 07/26/18 at 8:32 a.m., an observation of wound care by a staff nurse (#17) was completed for Resident #113. An open wound was observed to the right inner ankle approximately 4 millimeters in diameter. As the staff nurse (#17) began to apply a dressing to the wound on the back of the right heel, she covered the right inner ankle wound, to which no treatment had been provided. The staff nurse (#17) was stopped by the Surveyor and asked if she saw the wound on the inner ankle. She stated "It must be open again" and noted the open wound. The staff nurse (#17) then applied a dressing to the right inner ankle wound. An interview was conducted with the staff nurse (#17) on 07/26/18 at 8:40 a.m. The staff nurse (#17) stated, "I measure the wounds once a week. The outer foot was in house (facility acquired). She broke that hip and the circulation is bad (to her right foot). The heel and back of the leg (wounds) came from the hospital. I found the inner right foot when I was doing her dressing change. The original order written in April was for hydrogel to all wounds. It didn't list the wounds separately."	F 686		

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F 686	Continued From page 7	F 686		

On 07/26/18 at 9:21 a.m., an interview was completed with an administrative nurse (#4). She stated, "There was a skin assessment opened by a staff nurse (#20) on 03/16/18 and it was locked on 03/21/18. There is no way to know when the assessment was done. In March we had the night nurse do the skin assessments (on new admissions). Now the nurse does the skin assessment when the resident is undressed for bed that night. There is no skin assessment completed when they first come in (at admission). The nurse manager does a head to toe assessment. It covers all the body systems except the skin. There is so much going on, we try to be less traumatizing to the resident and only undress them once. The staff nurse (#20) did the Weekly/Monthly Skin Assessment (form) on 03/17/18 and it only noted bruising. On the 18th (March 2018) the staff nurse (#17) completed the push tool." The push tool was identified as the electronic document created to monitor wounds. "A staff nurse (#19) started the push tool because she found a wound. A new push tool is started any time a new wound is found. The staff nurse (#19) didn't make any notes on finding a new wound. On the 18th (March 2018) there were push tools for wound evaluations for 2 wounds on the posterior right leg and one on the right heel and a weekly skin assessment was completed on 03/23 (18) by a staff nurse (#1). It noted that the right ankle had a dressing intact and was being monitored by the wound nurse." No weekly skin assessment was completed on 03/30/18. On 04/07/18 the next weekly assessment was completed by a staff nurse (#20). "She mentioned bruising on her right leg and shoulder and she said the resident had a pressure ulcer on the right leg that was covered

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F 686	Continued From page 8 with a dressing and an area on the right heel that was brown and decreasing in size. The three wounds to the leg were present on admission. The staff nurse (#20) noted a dressing on the 16th (March 2018 at the time of admission) but didn't remove it. The dressing was removed on the 18th when a staff nurse (#17) looked at Resident (#113). The dressing should have been removed when the staff nurse (#20) saw it on admission. She should have also started a push tool." The DON said that staff nurse (#20) went through a retraining on completing weekly wound assessments on 05/18/18. She noted that Resident #113 should have been getting weekly skin assessments.	F 686		
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, facility policy review, and staff interview, the facility failed to assess/investigate falls to determine the cause of the falls and implement new/alternative interventions to prevent falls/recurring falls for 2 of 6 sampled residents (Resident #29 and #66) who experienced falls. Findings include:	F 689	1. On 8/8/18 the nurse manager updated 29 and 66 care plans with current fall interventions to prevent further falls. 2. All residents at risk for falls have the potential to be affected by this practice. 3. The facility QA nurse educator□s held and in-service on fall interventions and prevention on 8/15/18.	8/15/18

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F 689	Continued From page 9 - Review of the medical record for Resident #29 identified diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, urinary incontinence, schizoaffective disorder and muscle weakness. The care plan, revised on 11/03/17, indicated the resident was at risk for falls. There were no new interventions initiated since 06/06/17. The fall risk assessments, dated 03/26/18 and 06/27/18, indicated the resident was at high risk for falls. Review of the "Fall Worksheet/Checklist" identified Resident #29 had fallen on 05/21/18, 05/24/18, 05/28/18, 07/02/18, a second fall on 07/02/18 and 07/22/18. There were no fall investigations completed. Resident #29 was observed in a reclining chair in the sitting area outside her room on 07/23/18 at 2:30 p.m. with her eyes closed. The resident was observed on 07/24/18 at 9:30 a.m. in bed with her eyes closed and a mat on the floor. The resident was observed on 07/25/18 at 10:00 a.m. and 2:00 p.m. in bed with her eyes closed. An interview with a staff nurse (#15) on 07/26/18 at 10:10 a.m. confirmed there were no new interventions initiated that addressed the resident's falls on 05/21/18, 05/24/18, 05/28/18, 07/02/18, a second fall on 07/02/18 and 07/22/18. She verified the resident was at risk for falls, but stated she did not know what other interventions could be initiated to prevent further falls. The staff nurse verified the care plans were not updated to include recent falls or revised with new interventions since 06/06/17. - Review of the medical record for Resident #66	F 689	4. QA will be completed by the Clinical support nurse, nurse manager and monitored by QA nurse weekly for one month, monthly for 3 months and then quarterly till resolved. 5. 8/15/18	

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F 689	Continued From page 10	F 689		

identified diagnoses that included schizoaffective disorder, muscle weakness, mental disorder, obesity, diabetes, arthropathy and Parkinson's disease. The care plan, revised 09/14/17 identified the resident was at risk for falls related to gait and balance problems. There were no new interventions on the care plan since 2017. The fall risk assessments, dated 03/07/18 and 06/07/18 indicated a high risk for falls.

Review of the "Fall Worksheet/Checklist" identified Resident #66 fell on 07/12/18 and 07/19/18. There were no fall investigations completed.

Resident #66 was observed on 07/23/18 at 2:40 p.m. in her room in her wheelchair, drowsy. The resident was observed on 07/23/18 at 5:00 p.m. in her wheelchair in the small dining room and she was more alert. She was observed on 07/24/18 at 12:30 p.m. in her wheelchair in the small dining room eating lunch and remained alert. The resident was observed on 07/24/18 at 4:30 p.m. in her wheelchair in her room. She was observed on 07/25/18 at 2:00 p.m. in the courtyard, in her wheelchair, participating in an activity with other residents and staff.

An interview with a staff nurse (#15) on 07/26/18 at 10:10 a.m. confirmed there were no new interventions initiated that addressed the resident's falls on 07/12/18 and 07/19/18. She verified the resident was at risk for falls, but stated she did not know what other interventions could be initiated to prevent further falls. The staff nurse verified the care plans were not updated to include recent falls or revised with new interventions.

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F 689	Continued From page 11	F 689		

Review of the "Fall prevention" policy dated 04/01/10, with the most recent revision 06/2017, included the purpose was to strive to prevent falls from occurring by assessing for potential falls and assessing after falls for preventative interventions. The policy also indicated the investigating was to include the immediate cause of the fall by reviewing medications for side effects, a pharmacy review, a consult with physical therapy and/or occupational therapy for reevaluation, assessment of pain control, assessment for significant change or infection and assessment of toileting schedule. The policy included the resident should be reassessed for alternative interventions. The policy also included to review the care plan and revise if necessary with new interventions.

An interview with an administrative nurse (#4) on 07/26/18 at 2:20 p.m. verified the "Fall prevention" policy included the purpose was to strive to prevent falls from occurring by assessing for potential falls and assessing after falls for preventative interventions. The policy also indicated the investigating was to include the immediate cause of the fall by reviewing medications for side effects, a pharmacy review, a consult with physical therapy and/or occupational therapy for reevaluation, assessment of pain control, assessment for significant change or infection and assessment of toileting schedule. The nursing coordinator verified there was no investigation completed that the surveyor would be able to review regarding the fall. She confirmed the policy included the resident should be reassessed for alternative interventions. The policy also included to review

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F 689	Continued From page 12 the care plan and revise if necessary with new interventions.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §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- §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; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to provide adequate nutrition resulting in avoidable weight loss for 1 of 5 sampled residents (Resident #48) reviewed for weight loss. Findings include: Review of Resident #48's medical record	F 692	1. Resident 48 will be given food alternative at meals and PRN at any time in the 24 hours in a day. Resident 48 will receive the right Texture of foods at all meals and PRN according to the tray card. Resident 48 will have accurate weights as new scales have been order for all area and interventions will be in place for resident with a 5% weight loss in one month.	8/15/18

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	355077	A. BUILDING _____ B. WING _____	07/26/2018

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F 692	Continued From page 13 identified diagnoses including: dementia, depression, ileostomy and anxiety. Review of the admission Minimum Data Set (MDS) assessment indicated the resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 8 out of 15. Review of Resident #48's care plan, revised on 07/26/18, identified a nutrition risk due to: schizoaffective disorder/traumatic brain disorder (TBI)/behavior disturbance/seizure disorder/depression/anxiety; hyperparathyroidism; ileostomy/mega colon/electrolyte imbalances; chronic pain; mechanically altered texture. Interventions included: Offer 8-ounce pop by nursing staff on Wednesday and Sunday at 1:30 p.m.. Offer cheese stick at lunch. Offer chocolate milk at brunch and dinner. Offer cottage cheese at dinner. Offer peanut butter bread at lunch; and bread at dinner. Offer regular diet, regular soft diced; thin liquid per medical doctor (MD) order. Offer yogurt at brunch and dinner. Review of Resident #48's weights and vital summary identified the following: *07/20/18: 149.8 pounds (8.9 % loss since admission) (4.7% loss x 1 month) *06/20/18: 157.2 pounds *05/18/18: 160.8 pounds *05/08/18: 164.4 pounds (admission) Review of Resident #48's physician orders identified: regular diet, regular soft diced texture, with a start date of 05/08/18. Review of the progress notes identified the following:	F 692	2. All residents with weight loss and special diets have the potential to be affected by this practice. 3. QA nurse educators had training on new scale on 8/13/18 with all bath aides. An all staff in-service held by QA nurse educator and Dietary Coordinator on 8/15/18. Following the tray card to ensure proper diets/textures are given to residents at meals. Also that we are open to serve our residents food 24 hours a day and alternatives can be given at meals or any snack. 4. QA will be completed by the Dietician, Dietary Coordinator and monitored by QA nurse weekly for one month, monthly for 3 months and then quarterly till resolved. 5. 8/15/18	

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F 692	Continued From page 14 *07/23/18: 15:37: Psychotropic note: "appetite is fair and has had weight loss and this is being addressed by dietary." *07/20/18: 13:49: Dietary note: "slow weight loss and minimal food intake noted. Offer cheese stick at lunch; cottage cheese at dinner; peanut butter bread at lunch; and bread at dinner." Observation on 07/23/18 throughout the evening meal showed Resident #48 received a turkey burger (plain and not diced) on a bun, creamed peas, and potatoes O'Brien. He asked for pizza, but the certified nurse aide (CNA) (#12) said "no pizza." At 5:27 p.m., the resident said he did not want the turkey burger or the pork that was on the menu. The staff stated he had to eat this. A CNA (#13) stated, "He wants something that's not on the menu." She told the resident he needed to talk to dietary. A CNA (#12) told the resident they needed to serve other people. The resident was observed trying to eat the potatoes. He ate the yogurt with fruit. At 5:33 p.m., the resident was observed asking for something else to eat with no response from staff. He then asked for cottage cheese, but no cottage cheese provided. At 5:39 p.m., the resident left the dining room. He had eaten the potatoes and a few bites of the peas. He ate all the yogurt with fruit. (No substitutes were offered to the resident.) Observation on 07/24/18 at 9:27 a.m. showed Resident #48 wheeling himself down the hallway away from the dining room. The resident was asked about breakfast and he said he didn't get to eat breakfast because he slept in that morning. The resident was asked if he was hungry and he said, "Yes." The dining room appeared blocked off with a portable wall. The staff member serving	F 692		

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F 692	Continued From page 15	F 692		

breakfast stated they did not technically have a breakfast cut off time, but did say the cut off time for breakfast was 9:00 a.m. Resident #48 was then given cereal, milk, juice and coffee.

Observation on 07/25/18 at 5:33 p.m. showed Resident #48 did not receive any cottage cheese with his meal. His tray card was reviewed on 07/26/18 at 8:13 a.m. For the evening meal: cottage cheese, chocolate milk, slice bread and ½ cup yogurt are to be provided.

A Certified Resident Aide (CRA) (#14) was interviewed on 07/26/18 at 8:13 a.m. and stated they could not deny the residents food. Most of the residents were in the dining room by 9:00 a.m., but some a little later.

A staff nurse (#18) was interviewed on 07/26/18 at 9:24 a.m. When asked about meals, she stated that the residents had the options on the menu and other foods such as soups, sandwiches, etc. At 3:26 p.m., she was interviewed again. She stated that resident choice was huge and that she had always offered other foods. The meals were at any time the residents were hungry as they were trying to break the older process and the options were there regardless of time.

A CNA (#13) was interviewed on 07/26/18 at 3:17 p.m. and stated they asked the residents ahead of time for their dinner choices. If they did not want what was on the menu, they could eat the alternate. When Resident #48 asked for other foods on 07/23/18, she stated she asked the dietary staff if there was something else he could get to eat, but the dietary staff never responded.

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F 692	Continued From page 16 She stated this resident had come back to the dining room again and ate some more of the peas. A dietary supervisor (#2) was interviewed on 07/26/18 at 1:35 p.m. He stated they had other food options if the resident did not want what was on the menu. He stated residents could eat 24 hours a day. They had other foods and are supposed to offer other foods. Two registered dietitians (RD) (#21 and #22) and the certified dietary coordinator RD (#3) were interviewed on 07/26/18 at 2:13 p.m. They stated they were initiating a new menu cycle for improved food choices and were not aware of residents being denied foods. They had other food options the residents could eat if they didn't want to menu choices and stated it was a team effort to change the process. Review of the Nursing Responsibilities policy, revised 02/2016, stated "offering suitable substitutes as needed (prn) honoring resident's preferences." Review of the Menu Planning and Nutritional Adequacy and Substitution policy, revised 06/2016, stated "a third alternative of soup and sandwich will also be available."	F 692		
F 812 SS=F	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,	F 812		8/15/18

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F 812	Continued From page 17 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, record review, review of facility policy, and staff interview, the facility failed to prepare and serve food in accordance with professional standards for food service safety in 9 of 9 kitchens and 2 of 8 dining rooms. The facility failed to ensure proper food temperatures throughout meal service; ensure proper dish handling; and prevent contamination of ready-to-eat foods. Findings include: Food Temperatures The 1st floor main dining room was observed on 07/25/18 at 5:54 p.m. A Nutrition Assistant (#9) was observed serving the evening meal. At the end of service, she took food temperatures of all the food items on the steam table, when requested, with the temperature of the ground chicken at 120 degrees.	F 812	1. All staff will use proper sinks and handwashing techniques when working with food. Food preparation done by dietary dept. will be done in a sanitary way of using utensils and not hands. Food temperatures will be done with each heat wells and two cold items to ensure all food is maintain the correct temperature for safety and customer satisfaction. 2. All residents have the potential to be affected by this practice. 3. The facility QA nurse educator and Dietary Coordinator held an in-service on 8/15/18 for food sanitation , handwashing and food temp on 8/15/18. 6. QA will be completed by the Dietician, Kitchen Supervisor and Dietary	

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F 812	Continued From page 18 Review of the internal food temperatures of food logs revealed, "Be sure to record the temperatures of both a cold item and a hot item before and after meals service daily. It is highly suggested to temp milk or another dairy product for record of a cold item and to temp the main entrée for record of a hot item every day." Review of the internal food temperatures of food logs for 1st main kitchen Brunch revealed: May 2018: missing documentation for the whole month June 2018: missing documentation for the whole month July 2018: missing documentation July 1-8; 10-11; 13-17 Review of the internal food temperatures of food logs for 1st main kitchen Dinner revealed: May 2018: missing documentation for the whole month June 2018: missing documentation for the whole month July 2018: missing documentation July 1-8; 10-17 Review of the internal food temperatures of food logs for the 1st north kitchen Brunch revealed: June 2018: missing documentation June 24-25; 29-30 July 2018: missing documentation July 1; On July 9: The before (B) temperature was 130 degrees and after (A) temperature was 120 degrees; missing documentation July 10-11; 22-25 Review of the internal food temperatures of food logs for the 1st north kitchen Dinner revealed:	F 812	Coordinator and monitored by QA nurse weekly for one month, monthly for 3 months and then quarterly till resolved. 4. 8/15/18	

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F 812	Continued From page 19 May 2018: missing documentation May 25-27; 29 June 2018: missing documentation June 16-19; 22; 25-26; 29-30 July 2018: missing documentation July 1; 7-8; 10-11; 13-25 Review of the internal food temperatures of food logs for the Sunshine kitchen Brunch revealed: May 2018: missing documentation May 29 July 2018: missing documentation July 5 and 25 Review of the internal food temperatures of food logs for the Sunshine kitchen Dinner revealed: May 2018: missing documentation May 29 June 2018: missing documentation June 26 July 2018: missing documentation July 5 Review of the internal food temperature of food logs for the SCU kitchen Brunch revealed: May 2018: missing documentation May 2, 8 and 22 June 2018: missing documentation June 5 and 23-24 July 2018: missing documentation July 6 and 12; On July 17: The B temperature was 128 and the A temperature was 129; On July 25: The B temperature was 130 and the A temperature was 120 Review of the internal food temperatures of food logs of the SCU kitchen Dinner revealed: May 2018: missing documentation May 1-2, 8 and 22 June 2018: missing documentation June 17, 23-24 July 2018: missing documentation July 2, 6, 11-12 and 15-16	F 812		

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F 812	Continued From page 20 Review of the internal food temperatures of food logs of the Cottage kitchen Brunch revealed: May 2018: On May 3: The A temperature was 140 and the B temperature was 120; missing documentation May 8 and 27 June 2018: missing documentation June 16 July 2018: missing documentation July 6 and 12 Review of the internal food temperatures of food logs of the Cottage kitchen Dinner revealed: May 2018: missing documentation May 8, 22 and 27 July 2018: missing documentation July 6 and 12. Review of the internal food temperatures of food logs of the 2nd floor kitchen Brunch revealed: May 2018: missing documentation May 11 and 25 June 2018: missing documentation June 11, 16 and 18 July 2018: missing documentation July 13-15, 20 and 23 Review of the internal food temperatures of food logs of the 2nd floor kitchen Dinner revealed: May 2018: missing documentation May 3-4, 8, 10-11, 18, 25, 28 and 31 June 2018: missing documentation June 7 and 11 July 2018: missing documentation July 5-6, 10, 13-17, 20 and 23 Review of the internal food temperatures of food logs of the 3rd floor kitchen Brunch revealed: May 2018: missing documentation May 3-4, 12-13, 16-18, 25, 27 and 30-31 June 2018: missing documentation June 1-5, 10, 18-22, 26 and 29	F 812		

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F 812	Continued From page 21 July 2018: missing documentation July 2-3, 5, 11-15 and 17-23 Review of the internal food temperatures of food logs of the 3rd floor kitchen Dinner revealed: May 2018: missing documentation May 4-5, 11-13, 16-18, 21 and 25-31 June 2018: missing documentation June 1-5, 8, 10 and 14 July 2018: missing documentation July 3; On July 14: The A temperature was 140 and the B temperature was 120; missing documentation July 18-21 Review of the Sanitation in Food Preparation-Handling Uncooked Food and Cooking of Food policy, revised 05/2016, revealed "Avoid holding foods in danger zone 41-135 degrees to prevent bacterial growth." During an interview on 07/26/18 at 1:35 p.m., a dietary staff member (#2) stated they only took the temperature of one main course hot item and one milk during meal service. The temperatures are taken at the beginning of the meal and at the end of the meal and they have done that for years. He stated in the kitchen, the staff take the temperature of one vegetable item in the same steamer and do not take the temperatures of all the food items, but would usually check the meat. When asked about training, he stated he did the yearly training required for all staff and if anything changed, he would talk to the certified dietary coordinator/registered dietitian (#3). Three registered dietitian's (#3, #21 and #22) were interviewed on 07/26/18 at 2:13 p.m. They stated they had monthly dietary meetings,	F 812		

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F 812	Continued From page 22 reviewed charting and how to document the temperatures along with the "danger zone" for foods as they needed to "make sure it's not in the danger zone." Improper Dish Handling Observation in the SCU (Geri-psych) dining room on 07/23/18 at 5:15 p.m. showed a nutrition assistant grabbing a glass with her fingers touching the lip surface of the glass. She placed the glass of Arginaid onto a tray for a resident. Observation in the SCU (Geri-psych) dining room on 07/26/18 at 12:25 p.m. showed a nutrition assistant (#6) placed a glass onto a resident's tray. His fingers touched the lip surface of the beverage. The kitchen supervisor (#2) was interviewed on 07/26/18 at 1:35 p.m. and confirmed the glasses needed to be held from the bottom of the cup. He could not remember the last time training had been provided. Contamination of Ready-to-Eat Foods Observation of the main kitchen on 07/26/18 at 10:24 a.m. showed a Cook (#11) mixing what appeared to be coleslaw in a large metal bowl. She was observed wearing gloves. She reached to the bottom of the bowl with both hands to mix the coleslaw together with the dressing. Her forearms touched the coleslaw multiple times during the observation. After she was finished, she washed her hands in a sink that was not a designated hand washing sink.	F 812		

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F 812	Continued From page 23 Review of the Sanitation in Food Preparation-Handling Uncooked Food and Cooking of Food, revised 05/2016, stated "Wear plastic gloves or use tongs, scoops, etc. whenever handling food." The kitchen supervisor (#2) was interviewed on 7/26/18 at 1:35 p.m. and stated that when he blended the mixture, he used a utensil. He confirmed that the staff member used a sink not designated for hand washing.	F 812		