STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 08/18/14 and completed on 08/21/14, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F 157 1. Licensed Nursing Staff member who attended to Resident #8 was re-educated on the process of notification of Physician and the "Interact II Change in condition: When to report to the MD/NP/PA." 2. Any Resident in the facility has the potential to be affected. 3. Mandatory Nursing Meetings were held August 26th & 27th, 2014 and will be held on October 1st & 2nd, 2014 to re-educate staff on the circumstances that require notification of the Physician, legal representative or family member, and use of the "Interact II Change in condition: When to report to the MD/NP/PA." Prior to Survey the "Interact II Change in condition: When to report to the MD/NP/PA" information was laminated and placed at the Nurse's Station for quick access for staff.	10/3/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	09/25/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the physician in a timely manner for 1 of 5 sampled residents (Resident #8) with a current pressure ulcer. Failure to notify the physician in a timely manner may have caused a delay in treatment for the resident. Findings include: Review of the facility policy titled "Pressure Ulcer: Prevention, Assessment, and Care of" occurred on 08/21/14. This policy, dated 05/13, stated, ". . . 8. Pressure Ulcer Stages and appropriate dressings to be utilized: . . . b. Stage II . . . 1. Notify Nursing Manager and physician of change in condition of the resident. . . . c. Stage III . . . 1. Notify Nurse Manager and physician of change in condition of resident. . . . d. Stage IV . . . 2. Obtain specialized decubitus care orders from physician and initiate them promptly. . . ." Review of Resident #8's medical record occurred on August 19-21, 2014. Diagnoses included Stage IV pressure ulcer. Review of Resident #8's "Daily Skin Integrity Record" dated 07/25/14 first identified two Stage II pressure ulcers on the resident's coccyx. Staff applied collagen to the wound bed and a foam dressing per standing orders. Staff completed daily dressing changes and documentation. The	F 157	Policy and Procedure for "Physician Notification" was reviewed and revised. Resident #8 pressure ulcer was healed on September 25, 2014. 4. The Nurse Manager (or designee) will monitor Physician notification of Resident condition changes. Monitoring was initiated on September 2nd, 2014 and will include review of 24 hour report from electronic medical record and interview of staff for compliance of policy and procedure. Monitoring will be conducted weekly for one month, monthly for three months, then quarterly thereafter for one year. Results of monitoring will be immediately reported to the DON. If concerns are identified, immediate corrective action will be implemented. The DON will submit report of the monitoring results to the QA Committee monthly for three months then quarterly for one year. 5. October 3, 2014.	

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F 157	Continued From page 2 "Daily Skin Integrity Record" dated 07/29/14 stated, ". . . [Name of physician] has been updated on wound and waiting for reply. . . . [Name of physician] updated via fax. Wound nurse to be updated also. . . ." Review of Resident #8's 07/30/14 - 08/19/14 progress notes identified the following: * 07/30/14 at 12:37 p.m. - "Resident is noted to have a stage 3 pressure area to her coccyx. * 08/06/14 at 2:37 p.m. - "Follow up to 7/30/14 wound note. This wound is a reopening of a stage 4 pressure area and will now be listed as such." * 08/07/14 at 11:10 a.m. - "[Name of physician] reviewed wound recommendations r/t [related to] pressure area to residents coccyx. new dressing order: Cleanse wound per facility protocol, pat dry. Apply collagen to wound bed (cut to fit). Cover wound with bordered foam dressing. Change daily." Administrative staff were unable to provide the 07/29/14 fax updating the physician on Resident #8's pressure ulcer. Review of the facility's "MD/Nursing Communications" form identified facility staff faxed the wound nurse's recommendations on 08/06/14 to Resident #8's physician (12 days after the pressure ulcer was identified). Resident #8's physician ordered the wound care recommendations on 08/07/14. During an interview on 08/21/14 at 9:40 a.m., an administrative staff member (#3) stated she expects staff to update the physician at the time a pressure ulcer is found.	F 157		
F 278	483.20(g) - (j) ASSESSMENT	F 278		10/3/14

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F 278 SS=D	Continued From page 3 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), dated October 2013, and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the	F 278	F278: 1. Resident # 8's MDS dated for 01/08/2014 was corrected and resubmitted to North Dakota State Department of Human Services and CMS to identify that resident #8 had an indwelling catheter and a colostomy. Resident #8 MDS dated for 07/08/2014 was corrected and resubmitted to North Dakota State Department of Human Services and CMS to identify that Resident #8 had a colostomy. RN MDS Coordinator involved was re-educated on the above. 2. All Resident MDS's have the potential to be affected. 3. New policy and procedure "Conducting an Accurate Resident Assessment" was developed. Mandatory Nursing meetings were conducted on August 26th & 27th, 2014 and will be held on October 1st & 2nd, 2014 addressing the importance of identifying the indwelling catheter and colostomy and education of policy and procedure for "Conducting an Accurate Resident	

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F 278	Continued From page 4 residents' status for 1 of 1 sampled resident (Resident #8) with a colostomy and an indwelling catheter. Failure to accurately complete portions of the MDS does not allow each resident's assessment to reflect the resident's current status/needs. Findings include: The Long-Term Care Facility RAI User's Manual, page H-2, stated, ". . . Coding Instructions, Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days. H0100A, indwelling catheter . . . H0100C, ostomy (including urostomy, ileostomy, and colostomy) . . ." Review of Resident #8's medical record occurred on August 19-21, 2014. Diagnoses included neurogenic bladder and colostomy. The significant change MDS, dated 01/08/14, failed to identify Resident #8's indwelling catheter and colostomy and identified Resident #8's urinary continence as frequently incontinent. The quarterly MDS, dated 07/08/14, identified Resident #8 had an indwelling catheter and failed to identified Resident #8's colostomy. Resident #8's current care plan stated, ". . . Focus: I have an alteration in gastro-intestinal status colostomy r/t [related to] Disease process. . . . Interventions: Change colostomy bag and wafer on bath day and PRN [as needed]. . . . Focus: I have Indwelling foley Catheter . . . Interventions: CATHETER: I have 16 Foley Catheter. . . ." Observations during survey showed Resident #8	F 278	Assessment." Paper education on policy and procedure for Conducting an Accurate Resident Assessment was sent for Licensed Nursing Staff to review. Since the date of survey completion MDS Coordinators reviewed 10% of the completed MDS's for accuracy. 4. The MDS Coordinator will monitor accuracy of 100% of MDS's prior to submission. This monitoring was initiated on September 22nd, 2014 and will be conducted on a weekly basis. The MDS coordinator will report results to the DON on a weekly basis for one month, then monthly for three months, then quarterly for one year. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee monthly for three months, then quarterly for one year. 5. October 3, 2014.	

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F 278	Continued From page 5 had an indwelling catheter and a colostomy. During an interview on 08/20/14 at 9:30 a.m., a nursing staff member (#1) stated the facility incorrectly coded the MDSs.	F 278		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate treatment and services to maintain urinary continence for 1 of 1 sampled resident (Resident #7) not toileted according to the care plan. Failure to toilet Resident #7 resulted in avoidable incontinence and a loss of dignity. Findings include: Review of Resident #7's medical record occurred on August 19-21, 2014. Diagnoses included anxiety, dementia, and depression. The current care plan stated, ". . . I have an ADL [activities of daily living] Self Care Performance Deficit . . . Interventions . . . TOILETING SCHEDULE: Q2	F 315	F 315 1. Staff providing care to Resident #7 were re-educated on toileting program. Performance corrections were provided for staff members involved. 2. All Residents have the potential to be affected. 3. Mandatory Nursing meetings were held on August 26th & 27th, 2014 and will be held on October 1st & 2nd, 2014 to provide re-education on bowel and bladder assessments, implementation of toileting programs, providing care according to Resident care plan, when to perform re-assessment of Resident bowel and bladder, and review of the below policy and procedures. Policy and procedures reviewed include: 1) Bowel/Bladder Assessment forms. 2) Bladder Programs. 3) Bowel/Bladder Assessment.	10/3/14

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F 315	Continued From page 6 hrs [every 2 hours] . . ." Observation on 08/19/14 at 2:37 p.m. showed two certified nursing assistants (CNAs) (#6 and #8) brought Resident #7 to her room and assisted her out of the wheelchair using a sit-to-stand mechanical lift. One CNA then pulled down the resident's pants and incontinence brief, which was wet. Observation showed the CNA (#6) took a washcloth from the bathroom and attempted to perform perineal cares; however, the resident began voiding while suspended in the lift. The CNA then placed an incontinence brief between the resident's legs and stated, "Do you need the potty?" Observation showed the CNAs did not attempt to toilet Resident #7, and instead the resident voided on the incontinence brief. Observation also showed urine on the seat of the wheelchair cushion, the foot plate of the lift, and the resident's shoes. The CNA (#6) then completed perineal cares and placed a dry brief. The CNAs failed to toilet Resident #7 according to her care plan and instead allowed Resident #7 to be incontinent while in the lift. During an interview on the morning of 08/21/14, a supervisory nurse (#3) stated staff should toilet Resident #7 every 2 hours. Failure to toilet Resident #7 (instead of checking and changing her while in the lift) resulted in an incontinent void and a loss of dignity.	F 315	4) Bladder Scan BVI 3000: Use of. The above policy and procedures have been sent out for staff to review. Re-assessment of Resident #7 bowel and bladder will be conducted and if required care plan adjusted. 4. The Nurse Manager (or designee) will monitor compliance of Resident toileting program on a weekly basis for one month, then monthly for three months, then quarterly for one year. Results of monitoring will be immediately reported to the DON. If concerns are identified, immediate corrective action will be implemented. Quality Assurance monitoring was initiated on September 2, 2014. The DON will submit reports of the monitoring results to the QA Committee monthly for three months, then quarterly for one year. 5. October 3, 2014.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	F323 Concern #1: 1. Investigation of resident #2 was submitted to the North Dakota	10/3/14

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F 323	Continued From page 7 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: FALLS 1. Based on record review and staff interview, the facility failed to ensure necessary assistance and supervision to prevent accidents for 2 of 3 sampled residents (Resident #2 and #5) who experienced a fall with major injury. Failure to provide assistance with ambulation and bed mobility resulted in a hip fracture (Resident #5) and a head injury (Resident #2). Findings include: - Review of Resident #2's medical record occurred on August 19-21, 2014. Diagnoses included hemiplegia due to a stroke and dementia. The MDS in effect at the time of the fall, dated 02/25/14, identified extensive assistance from two or more people for bed mobility. Resident #2's care plan in effect at the time of the fall, dated 06/14/13, stated, ". . . I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Stroke, Dementia, Limited ROM [range of motion], Aggressive Behaviour [sic], Hemiplegia, Limited Mobility, Pain . . . BED MOBILITY: I require 2 staff participation to reposition and turn in bed. . . ." Nurses' notes stated the following:	F 323	Department of Health on May 15, 2014. Performance correction was completed with staff member involved, which included re-education of following resident care plan. Re-education was completed to all staff caring for Resident on May 10, 2014. All facility Nursing staff were re-educated on May 13, 14, & 15, 2014. To date there has been no response of results received back from the North Dakota Department of Health. Investigation of resident #5 was submitted to the North Dakota Department of Health on June 19th, 2014. Performance correction was completed with staff member involved, which included re-education of following resident care plan. All facility Nursing staff were re-educated during June 2014 Nursing Meeting. To date there has been no response received back from the North Dakota Department of Health. 2. Any resident has the potential to be affected. 3. Mandatory Nursing meetings were conducted on August 26th & 27th, 2014 and will be held on October 1st & 2nd, 2014 to re-educate	

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F 323	Continued From page 8 *05/09/14 at 8:00 p.m.: ". . . CNA [certified nursing assistant] [name] approached Nurse [name] in hallway and summoned her to [Resident #2] room. Resident fell off the bed during PM [evening] care and sustained a laceration to back of head. Area to head is actively bleeding. Blood noted in corner of room on the floor. . . . Open skin noted. Unable to assess size due to matted hair. . . ." *05/09/14 at 8:05 p.m.: ". . . Call made to [hospital name] for transport for evaluation and treatment . . ." *05/09/14 at 11:45 p.m.: ". . . Resident arrived at bethel via wheelchair. . . . Dressing to site. 7 Staples in place. . . ." During an interview on the afternoon of 08/18/14, a supervisory nurse (#9) stated there were supposed to be 2 staff assisting Resident #2 while she was in bed, and the CNA did not follow the care plan. Failure to provide assistance with cares according to the care plan resulted in Resident #2's fall from bed with a head injury that required staples to repair. - Review of Resident #5's medical record occurred on August 19-21, 2014. Diagnoses included Alzheimer's disease and aftercare for healing a hip fracture. The MDS in effect at the time of the fall, dated 04/05/14, identified extensive assistance from two or more people for walking in corridors. Resident #5's care plan in effect at the time of the fall, dated 11/08/13, stated, ". . . Ambulate with walker assist of one with gait belt. . . . I am High risk for falls r/t [related to] Unaware of safety needs, Confusion, Psychoactive drug use, Wandering. Actual falls. .	F 323	staff on following of Resident care plan, providing appropriate assistance with ambulation and bed mobility. 4. The Nurse Manager (or designee) will monitor assistance provided to residents for ambulation and bed mobility as described in plan of care. Monitoring was initiated on September 2nd, 2014. Monitoring will be conducted weekly for one month, monthly for three months, then quarterly thereafter for one year. Results of monitoring will be immediately reported to the DON. If concerns are identified, immediate corrective action will be implemented. The DON will submit report of the monitoring results to the QA Committee monthly for three months, then quarterly for one year. 5. October 3, 2014. Concern #2: 1. No residents were identified within this section of F 323. Virex that was located at the Nurses station on Horizon Tower 3rd floor was immediately removed and placed	

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F 323	Continued From page 9 ." Nurses' notes stated the following: *06/13/14 at 10:00 a.m.: "this nurse saw CNA walking with resident to table. [The CNA was walked beside the resident without using a gait belt]. Resident stumbled CNA tried to reach unable to resident went down on right knee then to side then to back. . . after assessment done this nurse and two CNAs assisted the resident to sit up and applies [sic] a gait belt . . . my knees are bothering me icy hot applied and resident into wheelchair. . . Interventions: Stay at side for entire transfer." *06/13/14 at 1:00 p.m.: "resident no longer baring [sic] weight to right side needing two people to transfer called daughter and would like her checked out called dr [doctor] on call . . . ok to send to for evaluation." *06/13/14 at 8:00 p.m. (late entry): ". . . resident admitted with Right Hip fracture. Will have surgical repair in AM (morning) if no changes." During an interview on 08/20/14 at 2:30 p.m., a supervisory nurse (#10) stated according to Resident #5's care plan at the time of the fall, the resident should have been wearing a gait belt and a CNA assisting her. Failure to provide assistance with ambulation according to the care plan resulted in Resident #5's fall sustaining a broken hip that required surgical intervention. HAZARDOUS CHEMICALS 2. Based on observation, review of Material Data Safety Sheets (MSDS), and staff interview, the facility failed to ensure an environment free from	F 323	in a locked cabinet. Chemicals that were located in the Pine View Square were immediately removed and placed in a locked cabinet. 2. Any residents have the potential to be affected by unlocked chemicals. 3. Mandatory Nursing meetings were conducted on August 26th & 27th, 2014 and will be held on October 1st & 2nd, 2014 to re-educate staff on assuring chemicals are stored in locked cabinet/cupboard/closet. Lock was placed on cabinet located in the central bath area on Pine View Square. 4. The Nurse Manager (or designee) will monitor to assure chemicals are located in a locked cabinet. Monitoring was initiated on September 2, 2014. Monitoring will be conducted weekly for one month, monthly for three months, then quarterly thereafter for one year. Results of monitoring will be immediately reported to the DON. If concerns are identified, immediate corrective action will be implemented.	

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F 323	Continued From page 10 hazardous chemicals in 2 of 5 resident care areas (3rd floor Towers and Special Care Unit). Accessible hazardous chemicals place cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Observation on 08/20/14 at approximately 1:30 p.m. showed a spray bottle of Virex 256 One Step disinfectant cleaner and deodorant in an unlocked cupboard in the nurses' station. Observation showed the door to the nurses' station was open and unlocked and no staff members were present. Observation in the Special Care Unit on 08/20/14 at approximately 2:00 p.m. showed chemicals in an open and unlocked cabinet in the bath house. The door to the bath house was also open and unlocked with no staff present. The chemicals included: *Virex 256 One Step disinfectant cleaner and deodorant - 3 bottles *Diversey Good Sense odor counteractant - 1 spray bottle *Apollo Turbo Clean pre-disinfectant chelating detergent - 1 gallon *Ecolab Pantastic Concentrated Pot and Pan Cleaner detergent - 1 gallon MSDS's showed the following warnings: *Virex: "Danger. Corrosive. Causes skin and eye burns. Harmful or fatal if swallowed. Combustible liquid and vapor." *Apollo: "Mild irritation of sensitive skin and mucus membranes." *Ecolab: "May cause eye and skin irritation. Avoid contact with eyes, skin, and clothing."	F 323	The DON will submit report of the monitoring results to the QA Committee monthly for three months, then quarterly for one year. 5. October 3, 2014.	

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	355070	A. BUILDING _____ B. WING _____	08/21/2014

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F 323	Continued From page 11 During an interview on the morning of 08/21/14, a supervisory nurse (#3) stated staff should keep cleaning chemicals in locked cupboards/cabinets.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/29/13. Based on observation of food temperatures, group interview, review of Resident Council meeting minutes, staff interview, and surveyors' sampling of a scheduled hotdish meal tray, the facility failed to provide palatable food at the proper temperature for 7 of 7 residents (Resident A, B, C, D, E, F, and G) who attended the group interview and on 4 of 5 resident care units (Wheatland, Legacy, Harmony, and Towers). Failure to serve meals at the proper temperature and failure to address the residents' concerns regarding the palatability of the hotdishes served limited the facility's ability to ensure the residents received an appealing, tasteful diet, an enhanced dining experience, and may have placed the residents at risk of unintended weight loss. Findings include:	F 364	F 364 1. There were no specific residents identified in F364. Prior to survey temperatures were taken at point of service a minimum of two times per month and the cooks routinely tasted all prepared food prior to departure from kitchen. 2. All residents have the potential to be affected. 3. Mandatory dietary staff in-service was provided on August 22, 2014 which included re-education on preparation of steam tables, monitoring of food temperatures at start of service and at completion, appropriate temperature of food at service (120 degree F), and who to notify if temperature is not maintained. Cooks will continue to complete sample tasting at all meals.	9/25/14

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F 364	Continued From page 12 During the resident group interview, completed on 08/19/14 at 9:30 a.m., 7 of 7 residents reported hotdishes with bread or similar toppings do not always taste fully cooked. Residents in attendance also reported meal items are not always hot enough when served. A review of the Resident Council meeting minutes, dated 07/12/14, showed residents commented, ". . . the casseroles at times are dry. . . and the food temps on Wheatland and Harmony are not hot enough at times. . ." No follow-up information is included in the meeting minutes. - Random meal item temperature monitoring of test plates at the end of meal service identified the following: *08/19/14, 12:15 p.m., Wheatland - bratwurst - 108 degrees Fahrenheit (F) - broccoli - 100 degrees F 12:30 p.m., Legacy - broccoli - 120 degrees F 12:45 p.m., Harmony - bratwurst - 104 degrees F - broccoli - 105 degrees F Sample tasting of the bratwurst and broccoli by five surveyors identified the meal items were lukewarm to taste and not desirable temperatures. Dietary staff members provided documentation of meal item temperatures taken at the beginning of meal service which showed all meal items at acceptable temperatures. During interview, on 08/20/14 at 1:30 p.m., a dietary management staff member (#10) reported she expected facility staff should serve meal	F 364	Director of Food Services and Registered Dietician will continue to monitor test trays two times per week. Policy and Procedure "General Sanitation of Kitchen" was reviewed and updated on August 22, 2014. 4. The Director of Food Service (or designee) will monitor temperature of food before service and at completion to assure food maintains a temperature of 120 degree F or greater. Monitoring was initiated on August 22, 2014. Monitoring will be conducted three times per week. Results of monitoring will be immediately reported to the Director of Food Service. If concerns are identified, immediate corrective action will be implemented. The Director of Food Service will submit report of the monitoring results to the QA committee monthly for three months, then quarterly for one year. 5. September 25, 2014.	

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F 364	Continued From page 13 items at a minimum of 140 degrees F. This staff member reported the facility staff did not monitor meal item temperatures at the end of meal service or at the point of service. - Review of the facility's menu for the week, August 18 - 22, 2014, identified Hamburger Tater Tot Casserole as the entree for the evening meal on 08/19/14. On 08/19/14 at 6:15 p.m., observation of a test plate of Tater Tot Casserole from the Towers Dining Room identified a temperature of 156 degrees F. Tasting of the casserole by five surveyors identified the tater tot topping did not taste fully cooked. During interview, on 08/20/14 at 1:30 p.m., a dietary management staff member (#10) reported the facility staff prepared the Tater Tot Casserole for each dining room in the same manner. The staff member (#10) was uncertain why the tater tot topping from the Towers Dining Room was not fully cooked.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F 371 Concern #1: 1. There were no residents identified in F 371. Fan was cleaned on August 21, 2014. 2. All fans have the potential to be affected. 3. Mandatory dietary staff in-service was provided on August 22, 2014 which included monitoring of fan	9/25/14

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F 371	Continued From page 14 Based on observation, review of facility policy and procedure, and staff interview, the facility failed to ensure preparation and service of food under sanitary conditions in 1 of 1 kitchen on 3 of 4 days of survey (August 18 - 20, 2014). Failure to keep a fan circulating air over clean dishes in the dishroom, free of dust and debris, and failure to ensure steam table pans and food storage containers were stored dried, placed all facility residents, staff, and visitors consuming food items prepared in the kitchen at risk of foodborne illness. Findings include: Review of an untitled facility policy and procedure occurred on 08/21/14. A dietary staff member (#10) provided this document on request on the morning on 08/21/14. The undated document stated "Policy: The staff shall maintain the sanitation of the kitchen and kitchenettes through compliance with a written, comprehensive cleaning schedule. Procedure: 1. Cleaning and sanitation tasks for the kitchen will be recorded. . . . 3. Tasks will be addressed as to frequency of cleaning. . . . 5. A cleaning schedule will be posted and employees will initial and date tasks when completed. . . ." Review of an undated "Food Services Cleaning Schedule" failed to identify the dishroom fan on the schedule. - During the initial tour of the facility kitchen, on 08/18/14 at 2:05 p.m., observation identified a fan circulating air above the dirty and clean dishes in the dishwashing room. Observation identified a heavy layer of dirt and debris accumulated on the	F 371	in the dishwashing room for debris and if debris was noted dietary staff are to submit a maintenance work order. Checklist for the dietary float staff was updated to include monitoring of the fan in the dishwashing room. 4. The Director of Food Service (or designee) will monitor fan in dishwashing room for debris daily. Monitoring was initiated on August 22, 2014. Monitoring will be conducted daily. Results of monitoring will be immediately reported to the Director of Food Service. If concerns are identified, immediate corrective action will be implemented. The Director of Food Service will submit report of the monitoring results to the QA committee monthly for three months, then quarterly for one year. 5. September 25, 2014.	

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F 371	Continued From page 15 protective grid of the fan. During observation of the dishwashing process, on 08/19/14 at 12:45 p.m., observation of the fan in the dishwasher room occurred as identified on 08/18/14. At this time, the fan was turned off and the fan blades also showed a heavy accumulation of dirt and debris. During interview, on 08/19/14 at 12:45 p.m., a dietary management staff member (#10) reported the fan is cleaned "every two weeks." On request, the staff member (#10) checked the fan cleaning schedule and reported the fan was scheduled to be cleaned "yesterday," 08/18/14. During the general tour of the facility kitchen, on 08/20/14 at 1:30 p.m., observation showed a heavy accumulation of dirt and debris remained on the fan and the fan continued to circulate air over the dirty and clean dishes in the dishroom. During interview, on 08/20/14 at 1:30 p.m., a dietary management staff member (#10), reported she notified the responsible department on 08/19/14 and agreed the fan should have been cleaned on 08/19/14. - During the general tour of the facility kitchen, on 08/20/14 at 1:30 p.m., observation identified the following: *on a storage rack, approximately 10 steam table pans stored stacked, wet *on a storage rack, approximately eight clear plastic food storage containers stored stacked, wet During interview, on 08/20/14 at 1:30 p.m., a dietary management staff member (#10) confirmed the steam table pans and food storage containers should be allowed to dry before being	F 371	Concern #2: 1. There were no residents identified in F 371. 2. All washed dishes have the potential to be affected. 3. Mandatory dietary staff in-service for re-education of staff was provided on August 22, 2014 which included process of allowing clean dishes to air dry prior to storage. Policy and Procedure for "General Sanitation of Kitchen" was reviewed and updated on August 22, 2014. 4. The Director of Food Service (or designee) will monitor three times per week to assure clean dishes are left to air dry until the dishes are completely dry. Monitoring was initiated on August 22, 2014. Results of monitoring will be immediately reported to the Director of Food Service. If concerns are identified, immediate corrective action will be implemented. The Director of Food Service will submit report of the monitoring results to the QA committee monthly for three months, then quarterly for one year. 5. September 25, 2014.	

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F 371	Continued From page 16 stacked.	F 371	F 456 1. No residents were identified in F 456. Licensed Nursing Staff member #4 was re-educated on location of suction machines on each Neighborhood that she provides care to residents. 2. Any resident has the potential to be affected. 3. Mandatory Nursing meetings were held on August 26th & 27th, 2014 and will be held on October 1st & 2nd, 2014 to provide re-education on location of suction machines on each of the neighborhoods. Policy and procedure ("Suction Machine") was developed to identify the location of the suction machines, which has been provided as paper education for staff to read. Orientation checklist for Licensed Nursing Staff was updated to include review of the location of suction machine on each neighborhood. At change of shift for Licensed Nursing staff, the suction machine will be checked. 4. The Nurse Manager (or designee) will monitor random Licensed Nurse for knowledge of location of suction machine on a weekly basis for one month, then monthly for three months, then quarterly for one year. Results of monitoring will be immediately reported to the DON. If concerns are identified, immediate corrective action will be implemented. Quality Assurance monitoring was initiated on September 2, 2014. The DON will submit report of the monitoring results to the QA Committee monthly for three months, then quarterly for one year. 5. October 3, 2014.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment on 1 of 5 nursing units (Pine View) when staff could not identify the location of a suction machine on the unit. Failure to locate a suction machine in a timely matter may lead to injury or death of a resident requiring suction. Findings included: Request for observation of the suction machine on Pine View occurred on 08/20/14 at 5:04 p.m. with a licensed nurse (#4). This nurse looked through two cabinets and did not locate the suction machine. The licensed nurse (#4) stated she would call her supervisor on another unit. After dialing three different telephone numbers, the licensed nurse (#4) stated someone is on their way. At 5:12 p.m. a licensed nurse (#5) arrived on the unit and located the suction machine in the dining room. During an interview on 08/21/14 at 9:25 a.m., an administrative nurse (#3) stated she expects licensed staff to know the location of the suction machine.	F 456		10/3/14