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 _____	08/22/2019

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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 The standard Medicare Medicaid recertification survey started 08/19/19 and concluded on 08/22/19.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 625	1. Resident #100 record was reviewed	9/26/19

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

Electronically Signed | 09/21/2019

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F 625	Continued From page 1 facility failed to provide a bed-hold notice upon transfer to the hospital for 1 of 5 sampled residents (Resident #100) with a hospitalization. Failure to provide the facility's bed-hold policy does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: Review of Resident #100's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 08/07/19. The medical record lacked evidence the facility staff provided Resident #100 and/or their family member/legal representative written notice of the bed-hold policy upon transfer to the hospital. During an interview on 08/21/19 at 11:45 a.m., a social service staff member (#8) confirmed the facility failed to provide the bed-hold notice.	F 625	for notification of Bed Hold. The resident and/or legal representative was notified of the facility□s bed hold policy. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. All resident records were reviewed for notification of bed hold policy. Bed hold policy was updated. Transfer checklist was updated to include the bed hold policy notification upon transfer. Bed hold policy will automatically print off when transfer checklist is printed. Licensed nursing staff have been educated on September 19th, at the All Staff Meeting, September 16th or September 20th, and will be educated on September 25th, 2019 to provide bed hold policy upon transfer. 4. The Director of Social Services (or designee) will conduct a random audit of five (or number of residents transferred) weekly for four weeks, then biweekly for 2 months, then monthly for 9 months. These resident charts will be audited to ensure notification of bed hold policy was provided to the resident and/or representative and documented in record. The results of the monitoring will be reported to the QA committee quarterly by the Director of Social Service (or designee).	
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	F 657		9/26/19

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F 657	Continued From page 2 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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff reviewed and revised comprehensive care plan to reflect the residents' current status for 3 of 25 sampled residents (Resident #38, #72, and #102). Failure to review and revise the care plans to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care. Findings include:	F 657	1. Resident #38 care plan was reviewed and updated to include storing of cigarettes and lighter at the nurse□s station. Resident #102 has been discharged. Resident #72 has died. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. Policy and procedure for Care Planning was reviewed. Education will be provided to the licensed nursing staff on the process of how to update care plans in the electronic medical record. This education will be provided on September	

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F 657	Continued From page 3 Review of the facility policy titled "Care Planning" occurred on 08/22/19. This undated policy, stated, ". . . Care Plans are reviewed on a quarterly basis and PRN (as needed) for all residents . . ." - Review of Resident #72's medical record occurred on all days of survey. Based on the following observations, the current care plan failed to reflect the resident's present status. * Observations made on all days of survey showed Resident #72 in bed. When they provided cares and repositioned Resident #72 on August 19-22, 2019, multiple certified nurse aides (CNAs) stated the resident no longer attempts to self-transfer, and she no longer sits in a recliner. The current care plan stated, "If I slept in in the morning, allow me to stay up in a recliner in the evening. . . . Offer me the recliner between meals. . . . I am very restless at times and will wrap myself in blankets and roll about in bed or chair. . . . I need (pressure relieving cushion) to protect the skin while up in chair. . . . I rock back and forth in wheelchair and will scoot to foot pedals. . . . I do self transfer at times. . . . If I am restless, keep me up in wheelchair as tolerated. . . . I require staff assist of ambulation. . . ." A document titled "Physician's Certification for Medicare Hospice Benefit" dated 07/17/19 stated, "Bed bound, cannot sit independently . . . Sleeps 20/24 hours per day . . ." * Observations made all days of survey showed dolls in Resident #72's room, but staff never offered doll therapy to the resident when she hollered out throughout the survey. The current care plan stated, "I often holler out and chant. . . .	F 657	24th & 25th, 2019. All resident care plans will be reviewed and updated (as required) to reflect current status of resident. 4. The Neighborhood Nurse Manager (or designee) will review 3 care plans to ensure new or modified interventions (as required) have been addressed and documented regarding the resident□s care daily for two weeks, then three times per week for two weeks, then twice weekly for two months, then weekly for 10 months. The results of this monitoring will be reported to the QA committee on a quarterly basis by the Director of Nursing (or designee).	

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F 657	Continued From page 4 Interventions . . . Doll Therapy . . . I can be verbally disruptive in common areas. . . . Interventions . . . Doll Therapy . . ." During an interview the morning of 08/22/19, a staff nurse (#10) reported staff no longer used Doll Therapy as Resident #72 no longer understood or showed comfort from the therapy. * Observations made all days of survey showed Resident #72 unable to verbally communicate with staff. The current care plan stated, "Use communication techniques which enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from resident, to ensure understanding . . . Ask yes/no questions if appropriate . . ." Interviews with multiple staff during survey indicated Resident #72 called out and moaned throughout the day and night. They indicated Resident #72 indicated pain through facial grimacing and muscle tension throughout her body. During an interview on the morning of 08/22/19, a CNA (#11) stated she had not been trained on how Resident #72 indicated pain. The CNA (#11) also stated Resident #72 smiled when staff brushed her hair. During an interview on the afternoon of 08/21/19, two administrative nurses (#12 and #13) agreed the current care plan did not reflect Resident #72's present status. - Review of Resident #38's medical record occurred on all days of survey. The current care plan stated, " . . . I smoke Cigarettes. I have had previous discussions with [Doctor] about stopping smoking. I have repeatedly refused to quit smoking, at times I get agitated when discussed	F 657		

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F 657	Continued From page 5 about quitting. . . . I can get to smoking area without assist . . . I go out to smoke as I choose- I will ask for assistance to get outside if I need it . . ." Resident #38's care plan failed to include where the resident stored his cigarettes and lighter. - Review of Resident #102's medical record occurred on all days of survey. The current care plan stated, " . . . I am a smoker. I have been advised facility is smoke-free. I plan to smoke while I am at the facility. I have been informed I cannot smoke on facility grounds. . . . I will not smoke on facility grounds. I will smoke on public sidewalk. Interventions are in place to promote my safety while smoking outside including a flag on wheelchair and alert button on person." Resident #102's care plan failed to include where the resident stored his cigarettes and lighter.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturers guidelines, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 2 of 4 residents (Resident #77 and #80) observed during insulin administration. Failure to offer food within 5-10 minutes of the administration of a rapid acting	F 658	F658-1 1. Staff providing care to resident #77 and #80 have been re-educated on manufacture guidelines of offering resident food within 5 to 10 minutes after administration of a rapid acting insulin. 2. Any resident receiving a rapid acting	9/26/19

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F 658	Continued From page 6 insulin and failure to date insulin pens with an open date may result in hypoglycemia (low blood sugar) and reduced medication efficacy. Findings include: Prescribing information for Novolog insulin, found at www.novo-pi.com/novolog.pdf, stated, ". . . NOVOLOG R is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus . . . Inject subcutaneously within 5-10 minutes before a meal . . . . Insulin FlexPens . . . Store the FlexPen® you are currently using out of the refrigerator at room temperature . . . for up to 28 days. The NovoLog® FlexPen® you are using should be thrown away after 28 days, even if it still has insulin left in it. . . ." Review of the facility policy titled "Medication Administration" occurred on 08/22/19. This undated policy, stated, ". . . Insulin is administrated as per manufacturer guidelines. . . . " - Observation on 08/20/19 at 5:01 p.m., showed Resident #80 received 10 units of Novolog insulin via an insulin pen. Resident #80 ambulated with a front wheeled walker to the dining room and received her supper tray at 5:29 p.m. (28 minutes after insulin administration). - Observation on 08/20/19 at 5:05 p.m., showed Resident #77 received 15 units of Novolog insulin via an insulin pen. Resident #77 wheeled herself to the dining room and received her supper tray at 5:40 p.m. (35 minutes after insulin administration)	F 658	insulin has the potential to be affected. 3. Licensed nursing staff have been educated to offer food or a 4 to 8-ounce glass of juice within 5 to 10 minutes of administration of a rapid acting insulin. This education was provided on September 16th, & 20th at nursing meetings, September 19th at the All Staff Meeting and will be on September 25th, 2019. 4. The Director of Nursing (or designee) will monitor residents who are receiving a rapid acting insulin to ensure staff are offering food or a 4 to 8-ounce glass of juice within 5 to 10 minutes of administration. This monitoring will be conducted for various meal times three times per week for 4 weeks, two times per week for 4 weeks, then 1 time per week for 4 weeks, then monthly for 9 months. The results of the monitoring will be reported to the QA committee quarterly by the Director of Nursing (or designee). F658-2 1. The two novolog pens, one Humalog pen, and one lantus pen on Harmony Neighborhood were removed and discarded. 2. Any resident receiving insulin has the potential to be affected. 3. An additional intervention has been added to the electronic medication administration record for daily check to assure insulin has the open date listed on the insulin pen. Licensed nursing staff have been educated on September 16th & 20th at nursing meetings, and on	

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F 658	Continued From page 7 - Observation on 08/20/19 at 5:10 p.m. showed the medication cart in the Harmony Unit contained the following insulin pens with no open date: * Two Novolog Pens * One Humalog Pen * One Lantus Pen During an interview on 08/20/19 at 5:15 p.m. a licensed nurse (#3) confirmed the insulin pens required an open date and an expiration date so staff know when to discard the insulin pen.	F 658	September 19th at the all staff meeting and will be on September 25th, 2019 on the new intervention and to add this intervention to the electronic medication administration record when a resident is on insulin. All residents who are receiving insulin have had this intervention added to the electronic medication administration record. 4. The Director of Nursing (or designee) will monitor 50 percent of the insulin pens two times per week for 1 month, then weekly for 2 months, then monthly thereafter. The results of the monitoring will be reported to the QA committee quarterly by the Director of Nursing (or designee).	
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, and staff interview, the facility failed to provide adequate supervision necessary to prevent accidents for 3 of 10 sampled residents (Residents #25, #66, and #107) observed during a gait belt transfer. Failure to properly use a gait belt during transfers placed the residents at risk of an accident and/or injury.	F 689	1. Staff caring for resident #66, #25, and #107 were re-educated to utilize the gait belt to assist with transfers. 2. Any resident in the skilled nursing facility requiring assistance has the potential to be affected. 3. Policy and procedure for Gait Belt Use was reviewed and updated. Nursing staff	9/26/19

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F 689	Continued From page 8 Findings include: - Observation on 08/19/19 at 5:01 p.m. showed a licensed nurse (#4) and a certified nursing assistant (CNA) (#5) assisted Resident #66 to the toilet. During the transfer the licensed nurse (#4) lifted under the resident's axilla area and failed to use the gait belt around Resident #66's waist. - Observation on 08/20/19 at 11:36 a.m. showed a CNA (#2) assisted Resident #25 off the toilet with use of a gait belt. The CNA (#2) lifted under Resident #25's axilla and failed to use the gait belt. Review of Resident #25's medical record occurred on all days of survey. The current care plan stated, ". . . I am (Moderate) risk for falls . . . Use gait belt as able. . . ." - Observation on 08/20/19 at 5:01 p.m. showed a CNA (#9) assisted Resident #107 to stand. During the transfer the CNA (#9) lifted under the resident's axilla area and failed to use the gait belt around Resident #107's waist. During an interview on 08/21/19 at 4:25 p.m., a facility staff nurse (#1) confirmed staff are not to ever lift under the residents arms when transferring using a gait belt.	F 689	education was provided on September 16th and 20th at nursing meetings, September 19th at the all staff meeting, and will be on September 25th, 2019 on the application of gait belts, use of gait belts, location of gait belts (in each resident room, in the medication cart, and with individual employee), and to not lift under resident axilla unless resident choice. A video on the use of the gait belt has been uploaded on each of the neighborhood computers for staff to view. 4. The Director of Nursing (or designee) will monitor three resident transfers on the day shift and three resident transfers on the evening shift all of who require the use of a gait belt. This monitoring will be conducting three times per week for one month, then twice per week for one month, then weekly for one month, then monthly for 9 months. The results of the monitoring will be reported to the QA committee quarterly by the Director of Nursing (or designee).	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		9/26/19

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F 697	Continued From page 9 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services in a manner to maintain the highest practicable level of well-being for 2 of 2 residents (#72 and #374) observed expressing signs and symptoms of pain. Failure of staff to anticipate, identify, and act on the residents' pain place the residents at risk for continued pain and worsening health conditions. Findings include: Review of the facility policy titled "Pain Assessment (Screening)" occurred 08/22/19. This policy, dated May 2013, stated, "Bethel Lutheran Nursing & Rehabilitation Center attempts to reduce pain and suffering for all residents in our facility by identifying those residents who are experiencing pain by implementation of appropriate pain assessment and management protocols. . . . Each resident will be screened for pain identification within 24 hours of admission and within 24 hours of hospital return. . . ." - Observations of Resident #72 showed increased moaning, facial grimacing, and tense muscle tone with movement and turning on the following dates and times: * 08/19/19 at 3:23 p.m. - a staff nurse (#15) sat resident up in bed	F 697	1. Care plan for resident #374 was updated to include person centered interventions for when resident experiences pain. Resident #72, who was on hospice, has died. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. Nursing staff were provided education on September 16th & 20th at nursing meetings and September 19th at the all staff meeting and will be provided education on September 25th on non-pharmacological techniques to reduce pain, signs and symptoms of pain, and pain scales (numerical, faces, and PAINAD). Resident at risk for pain as identified on the section J of the MDS were reviewed and care plans updated as required. The Director of Nursing (or designee) has had and will continue to have a multidisciplinary pain committee every other week to review residents at risk for pain according to section J of the MDS. 4. The Director of Nursing (or designee) will audit thirty percent of residents who experience pain for effectiveness of treatment. The audits will be completed three times per week for 2 weeks, two times per week for 2 weeks, weekly for 2 months, then monthly for 9 months. Results of the monitoring will be reported	

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F 697	Continued From page 10 * 08/20/19 at 8:17 a.m. - a certified nurse aide (CNA) (#16) sat resident up in bed * 08/20/19 at 10:54 a.m. - two CNAs (#17 and #18) performed perineal cares for the resident, turning her back and forth in bed * 08/21/19 in the morning - a CNA (#19) performed a bed bath for the resident, turning her back and forth in bed * 08/22/19 8:40 a.m. - a CNA (#20) turned the resident to check for a bowel movement and repositioned in bed Observations on all days of survey showed Resident #72 moaned and called out almost constantly. When staff provided cares and repositioned Resident #72 on August 19-22, 2019, multiple nurses and CNAs identified this as normal behavior for Resident #72. These staff reported facial grimacing and body tension as an indicator of pain for Resident #72. During an interview on the morning of 08/22/19, a CNA (#11) stated she had not been trained on how Resident #72 indicated pain. Review of Resident #72's medical record occurred all days of survey and included diagnoses of primary generalized osteoarthritis, Alzheimer's disease, generalized anxiety disorder, chronic pain syndrome, and pain in unspecified joint. The resident's most recent minimum data set (MDS), dated 06/29/19, included a staff assessment for pain. The assessment stated, "Indicators of Pain or Possible Pain in the last 5 days . . . Non-verbal sounds (crying, whining, gasping, moaning, or groaning) . . . Facial expressions (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) . . . Protective body	F 697	quarterly to the QA committee by the Director of Nursing (or designee).	

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	355070	A. BUILDING _____ B. WING _____	08/22/2019

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F 697	Continued From page 11	F 697		

movements or postures (bracing, guarding, rubbing or massaging a body par/area, clutching or holding a body part during movement) . . .Frequency . . . daily . . ." A document titled "Physician's Certification for Medicare Hospice Benefit" dated 07/17/19 stated, "Appears to have pain . . . Meets criteria for ongoing hospice cares . . ." A Hospice Clinician Note, dated 07/30/19, stated, "Educate Bethel nsg [nursing] home staff in use of pain scale . . ." A Hospice Clinician Note, dated 08/05/19, stated, "Care Plan . . . Supporting documentation for goals . . . Client's pain will be controlled to 2/10 thru period of care. . . . Education to Bethel nsg home staff the importance of assessment for pain first if client anxious, agitated or restless. . . . Client will have pharmacological measures like fentanyl patch and morphine and non-pharmacological interventions present in anticipation of mild pain (1-3). . . ." A Memo, dated 08/09/19, stated, ". . . client would grab her knees and legs and moan when moved or during turning and movement. . . ." A Routine Note by a hospice nurse, dated 08/12/19, stated, "Staff nurse reo/ports [sic] that 0.5 mg [milligrams] ativan [an antianxiety] tab is scheduled q [every] shift and ineffective as pt [patient] continues to cry out repetitively. . . . Becomes more agitated with position changes . . ." The note included a Non-Verbal Pain Assessment with the following identifiers of pain: Breathing Independent of Vocalization, Negative Vocalization, Facial Expression, Body Language, and consolability. Based on these criteria, the nurse scored Resident #72's pain as a 5 (moderate pain).

Physician's orders include:
* scheduled Lorazepam [an antianxiety] 2 MG/ML

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F 697	Continued From page 12 [milligrams/milliliter]- Give 0.5 ml by mouth two times a day (started 08/03/19) * scheduled Ibuprofen [pain medication] Suspension 100 MG/5ML- Give 10 ml by mouth every 8 hours (started 08/09/19) * scheduled Fentanyl Patch [pain medication] 72 Hour 75 MCG/HR [micrograms/hour]- Apply 1 patch transdermally [to skin] every 72 hours * Morphine Sulfate Solution [pain medication] 20 MG/ML- Give 0.75 ml by mouth every 30 minutes as needed (PRN) * scheduled Icy Hot Naturals Cream [for pain] 7.5% Menthol- Apply to knees/back topically [to skin] two times a day * scheduled What is your pain level? 0-10 two times a day Review of Resident #72's medication administration record (MAR) for August 1-20, 2019 indicated a pain level of greater than the stated goal of 2/10 (pain scale of 2 out of 10) for 16 of 20 days. 6 out of 16 of those days staff failed to administer the physician ordered PRN morphine which resulted in a missed opportunity for pain control. Facility staff failed to anticipate, monitor, and follow Hospice recommendations to control Resident #72's pain. - Observation on 08/20/19 showed two CNAs (#18 and #19) transferred Resident #374 from his wheelchair to bed with a hoyer lift with the resident calling out throughout the transfer. Once in bed, the CNAs positioned the resident on his right side without any positioning pillows. The resident moaned, called out "ouch," and tensed his muscles. The CNA (#19) stated the resident	F 697		

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F 697	Continued From page 13 verbalized pain by saying "ouch" during positioning. Review of Resident #374's medical record occurred all days of survey. The current care plan included pain as a focus area but lacked any interventions when he experienced pain. Facility staff failed to provide adequate treatment to control Resident #374's pain. During an interview on 08/21/19 at 3:20 p.m., two administrative nurses (#12 and #13) indicated staff failed to anticipate activities which caused Resident #72 pain and to provide adequate treatment by using all interventions available. An administrative nurse (#12) indicated she expected staff to use pillows for positioning to help alleviate Resident #374's pain and agreed the current care plan lacked interventions for pain.	F 697		
F 730 SS=D	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, the facility failed to ensure 2 of 3 employees (Employee #6 and #7) reviewed received an annual performance evaluation. Failure to complete performance evaluations on an annual basis	F 730	1. Employee #6 had 20.25 hours of education and competency check completed over the past 1 year. No required performance improvement plan required over the past 1 year. Employee	9/26/19

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F 730	Continued From page 14 does not ensure all staff have the skills and knowledge necessary to meet the needs of the residents. Findings include: Review of certified nursing assistant (CNA) employee files occurred on 08/22/19 and identified the following: * Employee #6's hired on 07/18/2016. The most recent performance evaluation was undated and not signed by the employee. The form identified a review period of 07/18/17 - 07/17/18. * Employee #7's hired on 10/11/2011. The most recent performance evaluation dated 04/02/18, identified a review period of 07/06/16 - 07/05/17.	F 730	#7 had 20.25 hours of education and competency check over the past 1 year. No required performance improvement plan required over the past 1 year. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. Policy and procedure for Competency has been updated to include competency checklist will serve as employee performance review. Employee concerns throughout the year will be handled through performance improvement plan. If employee does not complete competency checklist the month of their anniversary the employee will be taken off schedule and performance improvement plan will be initiated. 4. Staffing Development/Infection Control Nurse (or designee) will monitor monthly employee anniversary date and competency checklist completed. One hundred percent will be monitored. Results will be reported to the QA committee on a quarterly basis by the Staffing Development/Infection Control Nurse (or designee).	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.	F 804		9/26/19

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F 804	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and resident council interview, the facility failed to serve foods at palatable temperatures for 1 of 2 meals observed (Supper 08/19/19). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: - During an interview on the morning of 08/19/19 Resident B stated sometimes they run out of food, like hamburger buns and at times the food seems frozen. - During an interview on the morning of 08/19/19 Resident H stated the fruits and vegetable seems to be frozen. He/she also mentioned the soups are always lukewarm. - During an interview on 08/19/19 at 1:34 p.m. Resident I stated the food does not taste good and its cold. "Had cold carrots the other day, it wasn't like they were even warm, they were really cold." - During an interview on 08/20/19 at 8:20 a.m. Resident A stated, "the food is terrible, this morning I got oatmeal and no milk." - The surveyors received a supper test tray from the main kitchen on 08/19/19 at approximately 6:10 p.m. The test tray consisted of chili corn bread, shredded pork, corn, and soup. 5 of 5 surveyors confirmed the food failed to maintain a palatable temperature.	F 804	1. No residents were identified in this citation. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. New thermal containers were ordered to place warmed plate of food. Dietary and nursing staff have been/will be educated on the new thermal containers to be utilized for delivery of food to residents. Education for nursing staff has been completed on September 16th & 20th at nursing meetings and on September 19th during the all staff meeting and will be on September 25th, 2019. Dietary staff have been educated on September 19th at the all staff meeting and during dietary stand up meetings held on September 4th through the 6th, 19th, and 20th and on the 17th during the dietary meeting. The Director of Social Services (or designee) will have quality of food as a line item on the resident council meetings. Meal committee will be developed that will include residents/nursing staff/dietary staff/social service. This committee will meet every two weeks for 3 months, then monthly thereafter. Discussion at this committee will be reported to the resident council meeting. 4. The Director of Food Service (or designee) will monitor food temperatures at the point of resident on ten percent of the trays delivered. This monitoring will be conducted on a daily basis for 2 weeks, three times per week for 2 weeks,	

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F 804	Continued From page 16 - The surveyors received a supper test tray from Towers unit on 08/19/19 at approximately 6:30 p.m. The test tray consisted of cornbread casserole, corn, and soup. 5 of 5 surveyors confirmed the food failed to maintain a palatable temperature. During the Resident Council interview on the morning on 08/20/19, Residents C, D, E, F, and G stated the food is cold and it takes a long time to deliver meal trays. The residents also stated staff failed to address dietary concerns and no changes are made. Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 804	two times per week for 1 month, weekly for 1 month, then monthly for 9 months. Results of this monitoring will be reported to the QA committee quarterly by the Director of Food Services (or designee).	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		9/26/19

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F 812	Continued From page 17 §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, resident interview, and staff interview, the facility failed to ensure proper food handling at 2 of 2 meals observed (08/19/19 and 08/21/19) in 1 of 7 dining room (Legacy Dining Room). Failure to follow proper food handling and food service safety may result in contamination of food and foodborne illnesses. Findings include: * Observation on 08/19/19 at 5:38 p.m. in Legacy Dining Room showed a dietary staff member (#14) wore gloves while she plated food for meal service. The dietary staff member (#14) touched her face and glasses, pulled up her pants, used the telephone, opened drawers, the fridge and the microwave, and handled tickets from resident tables while she wore the same pair of gloves. She then handled ready to eat foods for residents as she wore the same gloves. The dietary staff member (#14) failed to change her contaminated gloves during meal service. * Observations at the supper meal on 08/19/19 and 08/21/19 in Legacy Dining Room showed multiple staff failed to assist with or offer any hand hygiene to residents before meals. Both meals included finger foods (a sandwich, toast, and a wrap). During an interview on the evening of 08/21/19, Resident #74 reported staff never assisted or	F 812	F812-1 1. No residents were identified in this citation. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. Dietary staff member was re-educated on proper glove use, maintaining the gloves clean, use of ancillary devices such as tongs/paper/etc., and when to change gloves/wash hands. Dietary staff were re-educated on the above at the all staff meeting held on September 19th, during dietary stand up meetings held on September 4th through the 6th, 19th, 20th, and on the 17th during the dietary meeting. 4. Director of Food Services (or designee) will monitor glove usage/hand washing during varying meal service three times per week for 8 weeks, two times per week for 4 weeks, weekly for 4 weeks, then monthly for 8 months. Results of the monitoring will be reported to the QA committee quarterly by the Director of Food Services (or designee). F812-2 1. Staff caring for Resident #74 were re-educated on offering resident hand hygiene prior to meal. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. Nursing staff have been re-educated	

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F 812	Continued From page 18 offered hand hygiene prior to meals in the Legacy Dining Room. During an interview on the afternoon of 08/21/19, an administrative nurse (#1) stated she expected dietary staff to change contaminated gloves prior to handling ready to eat foods and to assist with and offer hand hygiene to residents prior to meal time.	F 812	on offering residents hand hygiene prior to meal on September 16th and 20th at nursing meetings and on September 19th at the all staff meeting and will be on September 25th, 2019. Premoistened hand wipes are available in the neighborhood dining rooms. 4. The Staff Development/Infection Control Nurse (or designee) will monitor thirty percent of the residents at varying meals the offering of hand hygiene prior to meal service. Monitoring will be conducted three times per week for 2 months, weekly for one month, biweekly for one month, then monthly for 8 months. Results of the monitoring will be reported to the QA committee quarterly by the Staff Development/Infection Control Nurse (or designee).	