STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525516	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BADGER PRAIRIE HCC	1100 E VERONA AVE VERONA, WI 53593

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not allow all residents to make choices regarding aspects of their lives that are significant to them and did not allow 1 resident (R5) of 25 sampled residents to make a food choice during a meal. On 3/10/2020 at 12:20 PM, R5 requested another piece of meat for lunch. Nursing staff told her she wasn't allowed to have second helpings. R5 was admitted on [DATE] with [DIAGNOSES REDACTED]. R5's admission MDS (Minimum Data Set) on 11/23/19, measures her cognitive ability as severely impaired and is not interviewable. R5's care plan dated [DATE] documents as one of R5's delusional behaviors that she complains about staff denying her food. R5's care plan does not document restrictions on food. R5's physician orders [REDACTED]. R5's physician orders [REDACTED]. On 3/10/2020 at 12:20 PM, R5 was eating lunch. The lunch menu consisted of ham, sweet potato and cauliflower. R5 had finished eating her ham slice. R5 asked CNA G (Certified Nurse Assistant) if she could have more ham. CNA G said You know you don't get seconds! R5 made no response. On 3/10/2020 at 12:45 PM, Surveyor spoke with CNA G. Surveyor asked CNA G why R5 could not have another slice of ham. CNA G said I think it's because of her weight gain. On 3/10/2020 at 12:30 PM, R5 was sitting at the table with one half of sweet potato and cauliflower left. R5 asked CNA H if she could have a piece of ham. CNA H said no, you don't get seconds. R5 made no response. On 3/10/2020 at 12:50 PM, Surveyor spoke with CNA H. Surveyor asked CNA H why R5 could not have a piece of ham. CNA H said she wasn't sure, she just knew R5 could not have second helpings. On 3/11/2020 at 1:05 PM, Surveyor spoke with RD J (Registered Dietician). RD J said she was not aware of any food restrictions for R5. RD J said each resident should have what they want to eat and no resident should be denied a second helping of food. On 3/12/20 at 9:42 AM, Surveyor spoke to DON B (DON). DON B said residents can have additional food if their diet order does not have a restriction and it is in the resident goals of care.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not develop a comprehensive person-centered care plan for 3 sampled residents (R35, R86 and R65) of 25 reviewed for person centered care plans. R35 does not have a care plan for hospice services. R86 does not have a care plan for significant weight loss The facility failed to create an individualized, patient specific care plan that addressed R65's pain, pharmacological, and non-pharmacological interventions. This is evidenced by: The Facility's Policy and Procedure entitled Care Plans dated 1/28/20 documents, in part: 3. Include interventions/approaches/instructions needed to provide effective and resident centered care including but not limited to ADL (Activity of Daily Living) care needs, transfers, ambulation, communication, dietary .4. Address resident's health and safety concerns to prevent decline or injury including by not limited to .comfort care needs .3. Includes person-centered goals that are measurable objectives and timeframes to meet resident's medical, nursing and physical care needs as well as mental and psychosocial needs that are identified in the comprehensive assessment .4. Is developed with 7 days after completion of the comprehensive assessment and developed by an interdisciplinary team that includes but is not limited to: Attending Physician, RN (Registered Nurse)/CCC (Clinical Care Coordinator), CNA (Certified Nursing Assistant), Dietician, Social Worker . Example 1 The Facility and Hospice contract dated 2/14/17 documents, in part: .(i) Plan of Care means a written care plan established, maintained reviewed at minimum every 15 days .The Plan of Care shall reflect the participation of Hospice, Facility and the Hospice Patient and family to the extent possible. Specifically, the Plan of Care includes: (i) an identification of Hospice Services, including interventions for pain management and symptom relief, needed to meet such Hospice Patient's needs and the related needs of Hospice Patient's family; (ii) a detailed statement of the scope and frequency of such Hospice Services; (iii) measurable outcomes anticipated form implementing and coordinating the Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Hospice Patient; (v) medical supplies and appliances necessary to meet the needs of the Hospice Patient; and (vi) the IDT's (interdisciplinary team) documentation of the Hospice Patient's or representative's level of understanding, involvement and agreement with the Plan of Care. Hospice and Facility shall jointly develop and agree upon a coordinated Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Hospice Patient and his or her expressed desire for hospice care. The Plan of Care shall identify which provider is responsible for performing the respective function that have been agreed upon and included in the Plan of Care. R35 is a newer admission to the facility. R35 has the following Diagnosis: [REDACTED]. Per R35's medical record states she was admitted to the facility on Hospice Services. R35's medical record does not include a Hospice care plan. On 3/12/2020 at 12:55 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if R35 should have a hospice care plan, DON B said it should be under the Hospice tab in the chart. No care plan for R35 was located. Example 2 R86 is a long term resident of the facility who was recently hospitalized from [DATE] through 1/29/2020. R86 has the following Diagnosis: [REDACTED]. Per R86's weight record: 12/1/19= 154.4 12/9/19= 159.2 12/15/19= 155.8 12/22/19= 155.6 12/29/19= 157.4 1/5/20= 160.2 2/9/20= 138.6 2/16/20= 144.6 2/23/20= 140.2 R86's weight from January to February indicate a 21.6 pound/13.48% weight loss. R86's meal intake during survey was: 3/10/20- Breakfast=75%, Morning Snack= 0, Lunch= 0, Afternoon Snack= 0, Supper= 0 3/11/20- Breakfast= 0, Morning Snack=not recorded, Lunch= 0, Afternoon Snack= not recorded, D= 90% 3/12/20- Breakfast= 0 Per 86's Progress Notes: 2/12/20 nursing note documents, in part: .current weight 138.6, 140.2 on 2/2/20 and 160.2 on 1/5/20, lost weight since he returned from hospital, hospital stay= 1/13-1/29, email sent to Registered Dietician . 2/28/20 nutrition note documents, in part: .add magic cup supplement to lunch meal . 3/10/20 psychiatrist note documents, in part: .R86 not eating well, looked much thinner than I remember from prior hospitalization .became suspicious once began talking about eating . On 3/12/2020 at 10:46 AM, Surveyor interviewed RN Q. Surveyor asked RN Q if she could explain R86's eating and weight loss, RN Q explained around the end of January he was in the hospital and lately not eating, stating I can't afford this. Often R86 will wipe tables thinking he's working for his food. He won't always eat meals but will usually will accept a snack. R86 has always had a history of [REDACTED]. Surveyor asked RN Q if R86 had a care plan for weight loss, RN Q looked and then stated no. On 3/12/2020 at 12:22 PM, Surveyor interviewed RD J (Registered Dietician). Surveyor asked RD J what she could share with Surveyor about R86's weight loss, RD J explained that R86 always had an underlying paranoia regarding spitting in food or poisoning food. Surveyor asked RD J if R86 should have a care plan for weight loss, RD J stated I don't do care plans on everybody, maybe a stabilization one for R86 I could do. On 3/12/2020 at 1:06 PM, Surveyor interviewed RN S. Surveyor asked RN S if R86 should have a care plan for weight loss, RN S replied that the weight loss is related to his hospitalization , that the

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

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Dietician had been notified, the staff are monitoring his intake and his paranoia, and are continuing his diet as ordered. Example 3 R65 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R65's MDS dated [DATE] indicates the following: Section C - BIMS (Brief Interview of Mental Status) is 12 of 15 indicating R65 moderate impairment of cognition. Section J indicates that R65 has frequent pain that limits her activities, and rates pain at a 10 on a 0-10 scale. R65's signed physician orders [REDACTED].=10 mg PO weekly on Thursday Shift 2 (day shift) for RA ([MEDICAL CONDITION] Arthritis), [MEDICATION NAME] 0.6 mg PO QD (every day) for CPPD (Calcium [MEDICATION NAME] deposition). R65's MAR (Medication Administration Record) shows: Pain scale: y=yes, N= no QAM/PM (every morning, afternoon). On 3/10/2020 at 11:04 AM, Surveyor interviewed R65. Surveyor asked R65 if she was having pain. R65 stated that she has crippling arthritis and that she is having pain in her stomach; Surveyor observed R65 holding her left abdominal area and crying while speaking with R65. Surveyor reported pain to LPN N (Licensed Practical Nurse). On 3/11/2020 at 8:49 AM Surveyor interviewed CNA K (Certified Nursing Assistant). Surveyor asked CNA K if R65 complains of pain, CNA K stated that R65 sometimes complains of pain in her knees or foot. Surveyor asked CNA K how often R65 complains of pain, CNA K replied once in a while, not every day. Surveyor asked CNA K what do you do if R65 complains of pain, CNA K states that she asks R65 if she wants pain medication and then she tells the nurse. Surveyor asked CNA K if they use any non-pharmacological interventions for R65's pain, CNA K stated that they added padding to the EZ Stand Lift to help with R65's knee pain and that she can wear compression gloves for her hand pain. On 3/12/2020 at 9:04 AM Surveyor interviewed RN L (Registered Nurse). Surveyor asked RN L if R65 ever complains of pain, RN L stated that if R65 has pain, she will be able to tell you; I don't remember ever giving her any PRN (as needed) medications. Surveyor asked RN L if she performs a pain assessment on R65, RN L stated yes, it is done every shift. Surveyor asked if R65 has any non-pharmacological interventions that are effective for her, RN L states she gets scheduled Tylenol and has only used a PRN 2 times in the last 2 months. Surveyor asked RN L if she knows what R65's pain goal is, RN L stated I don't think she has a pain goal. On 3/12/2020 at 10:03 AM Surveyor observed cares. R65 did not demonstrate non-verbal signs of pain, nor did she report pain to staff while they were providing cares. On 3/12/2020 at 10:24 AM Surveyor interviewed R65. Surveyor asked R65 if she was having pain, R65 reported that she was having terrible pain in her back due to her wheelchair. Surveyor asked R65 if she could rate her pain on a 0-10 scale and R65 stated 10. Surveyor asked R65 if she had a pain goal, R65 became slightly agitated at this time, so the interview ended. On 3/12/2020 at 10:31 AM Surveyor called LPN N. Surveyor asked LPN N if she did a pain data collection on R65 when she reported pain on [DATE]20, LPN N stated that she asks R65 if she is having pain and then gives her the scheduled medication. Surveyor asked LPN N if she does data collection prior to administering PRN medications, LPN N stated that they ask about pain, chart where it is; since we know her so well, it would be a behavior so then we provide her with an alternative activity. Surveyor asked how would a staff member that is not familiar with R65 and her behaviors know if R65's complaints of pain is actual pain or a behavior, LPN N stated that they probably wouldn't know but could ask a CNA or another staff member. Surveyor asked LPN N if R65 complains of pain every day, LPN N stated no, the scheduled medications usually takes care of it, but she cries pretty much every day. Surveyor asked LPN N if crying and reports of pain listed as behaviors anywhere, LPN N stated no, the CNAs typically document on that. R65's behavior tracking from 2/12/2020 to 3/12/2020 does not indicate that staff is monitoring crying or complaints of pain as target behaviors. On 3/12/2020 at 1:55 PM Surveyor interviewed DON B, RN C, and RN M. Surveyor asked DON B and RN C what is the expectation for monitoring residents with chronic pain, RN C stated that they would have a pain scale that is individualized depending on their ability to answer questions, would be evaluated with the MDS, usually have a scheduled pain medication, and non-medication intervention. Surveyor asked RN M if she would expect a patient with chronic pain to have a care plan that addresses pain. RN M reviewed R65's care plan with Surveyor and stated yes, it's not in here. Surveyor asked RN M how would staff that is unfamiliar with R65's behaviors know if her complaints of pain is actual pain or behaviors, RN M and RN C stated that R65 does some moaning often and that staff are able to distinguish pain from behaviors. Surveyor asked if the moaning, crying, and reports of pain should be tracked in the behavior monitoring, RN M stated it's hard to determine if they are behaviors or pain. Surveyor shared R65's most recent MDS Section J with DON B and RN M which indicates R65 rated her pain at a 10, DON B stated the Social Worker fills out this section and she will call her to confirm. DON B reported back to Surveyor that the Social Worker stated the MDS was completed with the Social Work intern and that R65 often exaggerates her pain to new people. RN M states that R65 takes her scheduled medication routinely, she goes to the Rheumatologist routinely, and that her dose of [MEDICATION NAME] was increased on 1/14/2020. Doctor's notes from office visit on 1/14/2020 indicates in part that her hand joints are much improved with the addition of [MEDICATION NAME] .will increase dose of [MEDICATION NAME] to see if it can be more helpful in her toes. R65 is receiving pain medication however the facility failed to create an indivdualized care plan for R65's pain.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that gastrostomy tube ([DEVICE]) placement was verified according to standards of practice before medication and feeding administration for 1 of 2 residents (R104) reviewed with a [DEVICE] out of a total sample of 25. R104's [DEVICE] placement was not verified before administration of medication, water and feeding solution. A [DEVICE] is a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications. This is evidenced by: The facility's Enteral Feeding and Medication Administration policy dated 10/19 states in part . Check placement of tube by checking mark on the tube prior to inserting feeding formula or medications. It is important to note this policy does not include aspirating the [DEVICE] to check for placement. The manufacturer's recommendations for R104's Mic-Key [DEVICE] states in part: . Verify Mic-Key Position and Patency . Aspirate gastric contents. The presence of gastric contents in the syringe confirms the correct Feeding Tube position within the stomach . R104 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R104's physician orders [REDACTED]. TID (three times daily) 7:00 AM, 12:00 (noon), 6:00 PM (May give PO (orally)/ GT ([DEVICE]) for neuropathic pain. -[MEDICATION NAME] 1.5 TID 7:00 AM, 11:30 AM, 6:00 PM, Administer 1 can (8 ounces) if resident misses a meal. Due to R104's Hypersomnia, R104 will sometimes sleep through a meal and will be provided a [DEVICE] feeding. On 3/10/20 at 12:30 PM Surveyor observed LPN D (Licensed Practical Nurse) flush R104's Mic-Key [DEVICE] with water, administer medication and [MEDICATION NAME] tube feeding without checking for placement of [DEVICE]. Surveyor observed R104's Mic-Key [DEVICE] port was flush to R104's abdomen. On 3/11/20 at 1:45 PM Surveyor interviewed LPN D about what she should do before administering R104's medication and feeding. LPN D stated we don't aspirate for placement because we don't have an order to aspirate for R104. LPN D stated her understanding was there was no need to check unless there was a specific order. On 3/11/20 at 2:12 PM Surveyor asked DON B (Director of Nursing) about facility policy for checking for [DEVICE] placement, DON B stated she needed to check the standard of practice and would get back to Surveyor. On 3/12/20 at 9:01 AM DON B reviewed facility policy for Enteral Feedings and Medication Administration with Surveyor noting policy states to check for mark on the [DEVICE]. Surveyor asked if this is the current Standard of Practice. DON B stated she would check on this. On 3/12/20 at 3:00 PM Surveyor interviewed RN C (Registered Nurse) about R104 [DEVICE] and checking for placement. RN C stated that R104 had a Mic-Key g- tube with a low profile button (port)and provided Surveyor with the manufacturer's recommendations. RN C stated that staff should be checking for placement by aspirating for gastric contents and were not.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** Based on interview and record review the facility did not ensure that the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist for 5 of 5 unnecessary medication review residents Resident (R33, R35, R44, R46, R52) of a total sample of 25. R33, R35, R44, R46 and R52 did not have drug regimen reviews monthly. This is evidenced by: The Facility's Policy and Procedure entitled Medication Regimen Review dated 2/25/2020 documents, in part:

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) .A licensed pharmacist will review the resident Medication regimen including the resident chart at least once a month .B. The consultant pharmacist will perform a monthly medication regimen review on each resident unless the resident condition/risk will indicate a more frequent schedule that is individualized and communicated between the facility clinical staff and the Pharmacy Consultant . Example 1 R33 admitted to the facility 10/9/14. R33 is missing monthly drug regimen reviews from the Consultant Pharmacist for (NAME)2019, October 2019 and February 2020. Example 2 R35 admitted to the facility 12/17/19. R35 is missing monthly drug regimen review from the Consultant Pharmacist for February 2020. Example 3 R44 admitted to the facility 6/17/19. R44 is missing monthly drug regimen review from the Consultant Pharmacist for October 2019 and February 2020. Example 4 R46 admitted to the facility 9/12/12. R46 is missing monthly drug regimen review from the Consultant Pharmacist for October 2019 and February 2020. Example 5 R52 admitted to the facility 4/4/19. R52 is missing monthly drug regimen review from the Consultant Pharmacist for October 2019 and February 2020. On 3/12/2020 at 10:21 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor had requested pharmacy reviews for (NAME)2019, October 2019, and February 2020. DON B came back and stated our Pharmacist had a medical leave so there is no review for February 2020. Surveyor asked DON B how often should the pharmacy reviews be completed, DON B stated there should be one for every month, some are at the end of month before. On 3/12/2020 at 3:23 PM, Surveyor interviewed Consultant Pharmacist O. Surveyor asked Consultant Pharmacist O if she knew why there are not pharmacy reviews for R33, R35, R44, R46 and R52 for the months list, Consultant Pharmacist O replied that she was on a medical leave in February but is unsure about (NAME)and October or 2019. Surveyor asked Consultant Pharmacist O if anyone covers for her when she is unavailable, Consultant Pharmacist O stated no.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not include adequate monitoring for 2 of 5 unnecessary medication residents Resident (R33 and R35) reviewed of total sample of 25. R33 does not have adequate monitoring for his antipsychotic medication. R35 does not have an approved [DIAGNOSES REDACTED]. This is evidenced by: The Facility's Policy and Procedure entitled Mood and Behavior dated 8/27/19, documents, in part: .D. Mood and Behavioral symptoms are documented by staff in the resident chart via IPN (interdisciplinary progress note), Point of Care and when indicated individual targets are developed and documented for a resident . Antipsychotics are drugs that are used to treat symptoms of [MEDICAL CONDITION] such as delusions (for example, hearing voices), hallucinations, paranoia, or confused thoughts. These medications carry a black box warning which is designed to call attention to serious or life-threatening risks. Example 1 R33 is a long term care resident of the facility. R33 has the following Diagnosis: [REDACTED]. Per R33's Physician order [REDACTED]. R33's behavior documentation does not include any monitoring for delusions or agitation. On 3/12/2020 at 10:27 AM, Surveyor interviewed CNA P (Certified Nursing Assistant). Surveyor asked CNA P what behaviors they monitor for R33, CNA P said I'm unsure what they are, his regular CNA is off today. Surveyor asked CNA P if there was someone else working today that Surveyor could ask, CNA P said no the other girl that is working is a float and she won't know. On 3/12/2020 at 10:46 AM, Surveyor interviewed RN Q (Registered Nurse). Surveyor asked RN Q what behaviors they monitor for R33, RN Q said R33 can be accusatory of staff not doing stuff they should and can be obsessive regarding tasks, but he does not have a target behavior. On 3/12/2020 at 12:58 PM, Surveyor interviewed RN C. Surveyor asked RN C what behaviors the staff should be monitoring for R33, RN C stated he can have episodes of explosive verbal aggression, obsessive emotional/physical complaints if feels slighted or that he's receiving less attention. Surveyor asked RN C where the staff document on those behaviors, RN C looked in R33's record and could not see that those behaviors were being monitored anywhere. It is important to note that R33's indication for use on his Physician order [REDACTED]. Example 2 R35 is a newer admission to the facility. R35 has the following Diagnosis: [REDACTED]. Per R35's Physician order [REDACTED]. R35's CNA documentation documents the following: TB: How many times per shift did R35's husband call? and TB: Did staff have to intervene during phone calls? R35 does not have an approved psychiatric [DIAGNOSES REDACTED]. R35's behavior documentation does not include monitoring in relation to use of an antipsychotic medication. On 3/12/2020 at 10:33 AM, Surveyor interviewed CNA R (Certified Nursing Assistant). Surveyor asked CNA R what behaviors they monitor for R35, CNA R said the phone calls with her husband. Surveyor asked CNA R if she could explain what that meant, CNA R explained that R35 can be verbally aggressive and degrading towards him. On 3/12/2020 at 10:46 AM, Surveyor interviewed RN Q (Registered Nurse). Surveyor asked RN Q what behaviors they monitor for R35, RN Q said the phone calls with her husband related to her being verbally aggressive toward him. On 3/12/2020 at 12:55 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if all residents on [MEDICAL CONDITION] medications should have individualized behavior tracking, DON B said yes they should. On 3/12/2020 at 12:58 PM, Surveyor interviewed RN C. Surveyor asked RN C what [DIAGNOSES REDACTED]. Surveyor asked RN C if there is supportive documentation regarding this in R35's medical record, RN C stated she would look further into it. On 3/12/2020 at 1:06 PM, Surveyor interviewed RN S. Surveyor asked RN S what behaviors staff should be monitoring for R35, RN S said R35 can be verbally agitated and have aggressive behavior, interactions with her husband. Surveyor asked RN S if there was any reason they couldn't add the specific behaviors they are concerned with to the behavior tracking log, RN S said I don't see why not. Surveyor received no additional information from the facility.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. This has the potential to affect all 109 residents. The facility did not ensure the main kitchen's dishwasher was reaching the appropriate temperature. Dietary staff was observed touching resident food after touching multiple other objects. Findings include: Example 1 The facility's main kitchen uses a high temperature dishwashing machine for prefatory pots and pans. The facility monitors the internal temperature of the dishwasher with test strips once per day. The test strips have a dark blue band on the end and the strips read, Pass when blue bar turns orange, 180F. Additionally, kitchen staff document the external digital readout of the dishwasher temperature twice daily. The facility's main kitchen does not have a policy or procedure regarding dishwasher temperatures and testing. On 3/10/20 at 9:44 AM, Surveyor observed dishwashing being conducted in the facility's main kitchen. Surveyor reviewed the temperature log and found historical daily test strips for the month of February and March. Only 10 test strips between February 1 and (NAME)10 had completely turned orange in accordance with the test strip manufacturer guidelines, indicating the dishwasher had reached the appropriate temperature on 10 days. In addition, the external digital gauge documentation shows, in February and (NAME)of 2020, the wash temperature failed to reach 150 degrees Fahrenheit on 3 occasions and the rinse temperature failed to reach 180 degrees Fahrenheit 25 times. On 3/10/20 at 9:50 AM, Surveyor interviewed DM E (Dietary Manager) regarding the dishwasher temperature monitoring. DM E stated she had not been contacted by any staff in regards to the dishwasher not operating correctly. DM E stated that staff probably did not allow the dishwasher to warm up before testing the temperature and documenting the external digital gauge. DM E also stated that if staff get an unacceptable reading from the dishwasher gauge or test strip, they are expected to attempt a second time and if the reading is still not either 150 degrees Fahrenheit wash temperature and/or 180 degrees Fahrenheit rinse temperature, a supervisor should be notified immediately. Example 2 On 3/10/10 at 12:20 PM Surveyor observed FSH F (Food Service Helper) serving lunch for residents on the F unit. Surveyor observed FSH F pick up baked sweet potatoes with his gloved hands, set the potato on the serving plate, pick up a knife to cut the sweet potato, then pick up a slice of baked ham with the same gloves and place the ham on the serving plate and cut the slice of ham. FSH F was wearing the same gloves and was observed touching the handles of multiple serving utensils, trays cards, beverge containers, bread bag, the refrigerator door handle, packets of butter and serving plates. FSH F served multiple residents food after touching multiple objects as indicated above on unit without changing his gloves and touching food with gloved hands. On 3/10/20 Surveyor interviewed FSH F about observations of FSH F touching the resident's food with his gloved hands and touching other items during food service. FSH F stated that he should not have touched the ham or sweet potatoes with his gloved hands and should have used utensils to serve the ham and potatoes. On 3/12/20 at 2:58 PM Surveyor interviewed DM E (Dietary Manager) about staff touching resident's food with gloves hands when

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) serving meals. DM E stated that there was not a specific policy for this, but that staff should have used utensils for contact with resident food, not gloved hands.