North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1036	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CARE CENTER	1116 9TH AVE LANGDON, ND 58249

(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) COMPLETE DATE
L1860	33-07-03.2-18,6 PHARMACEUTICAL SERVICES All medications must be administered by individuals authorized to do so in accordance with state laws and regulations governing such acts. Each dose administered must be properly recorded in the resident record. This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of facility job description, and staff interview, the facility failed to comply with the North Dakota Administrative Code (NDAC), Chapter 33-43-01 "Nurse Aide Training, Competency Evaluation, and Registry," for 1 of 1 Medication Aide (MA #2) observed administering insulin. Failure to ensure staff are properly trained to administer subcutaneous (an injection given just under the skin) insulin increases the risk for adverse consequences. Findings include: NDAC, Section 33-43-01-17 "Routes or types of medication administration" stated, ". . . Medication assistants I and II may administer medications by the following routes only when specifically delegated by a licensed nurse for a specific client: . . . Subcutaneous . . ." Section 33-43-01-16 "Specific delegation of medication administration" stated, ". . . 2. The individual on the department's nurse aide [registry] is taught by a licensed nurse for each specific client's medication administration which includes verbal and written instruction . . . 3. . . . is observed by a licensed nurse administering the medication to the specific client until competency is demonstrated. 4. . . . has been verified as competent by a licensed nurse . . ."	L1860	1. Resident #34 was identified as being affected by this practice. CMA□s are no longer administering insulin. 2. Two residents had the potential to be affected by this practice. 3. Nurses will be the only ones administering insulin in the facility. As of 7-10-24 CMA□s are no longer administering insulin. Policy was updated to reflect these changes. CMA were educated immediately on change to policy. 4. Monitoring is not needed as this action is no longer be performed.	8/20/24

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

Electronically Signed | 08/06/24

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L1860	Continued From page 1 Review of the facility policy titled "Certified Medication aide (CMA) II Policy" occurred on 07/09/24 and 07/10/24. This policy, revised April 2024, stated, ". . . Purpose/Objective: To allow nurse assistants who have completed the prescribe training and received registration through the ND Board of Nursing to assist licensed nursing staff in the delivery of specific medications for specific clients. . . . has demonstrated competency in the administration of routine, regularly scheduled medications . . ." Review of the facility policy titled "Administering Medications" occurred on 7/10/24. This policy, revised April 2024, stated, ". . . The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. . . ." Observation on 07/08/24 at 5:10 p.m., showed MA (#2) administered a subcutaneous insulin injection to Resident #34. Review of MA (#2's) competencies and skills validation record lacked both a competency validation for administering subcutaneous injections and the delegation from a licensed nurse to administer insulin to Resident #34. During an interview on 07/10/24 at 11:35 a.m., two administrative staff members (#1 and #4) confirmed the facility lacked documentation to show the MA (#2) received subcutaneous injection training and specific resident instruction by the nurse to administer insulin.	L1860		

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 07/08/24 and concluded 07/10/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		8/20/24

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, confidential interview, and staff interview, the facility failed to provide resident care for 2 of 11 sampled residents (Resident #8 and #14) requiring assistance with activities of daily living in a manner that promotes, maintains, or enhances their quality of life. Failure to cover a urinary catheter leg bag (Resident #8) and failure to clean and shave resident's face and change the soiled shirt (Resident #14) has the potential to affect the resident's psychosocial well being and personal dignity. Findings include: Review of the facility policy titled "Dignity" occurred on 07/10/24. This policy, revised February 2024, stated, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem. . . . Staff are expected to promote dignity and assist residents: for example: helping the resident to keep urinary catheter bags covered. . . ." Review of the facility policy titled "Activities of Daily Living (ADLs), Supporting" occurred on	F 550	1. Residents #8 and #14 were identified as being affected by this practice. The resident's care plans and task lists were updated to reflect their preferences. 2. All residents who are dependent on staff for hygiene could be affected. 3. Staff are responsible to ensuring dignified care per each resident's preference. Staff will be educated on 8-14-24. Audits will be performed by Resident Care Coordinator or designee weekly x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved. 4. Audits will be reviewed by the administrator or designee and brought to the QAPI for review and recommendation. 5. 8-20-24	

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F 550	Continued From page 2	F 550		

07/10/24. This policy, revised March 2024, stated, ". . . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. . . ."

- Review of #8's medical record occurred on all days of survey. The current care plan stated, ". . . I require assist of one for most ADL's . . ."

Observations throughout the day on 07/08/24 showed Resident #8's urinary catheter leg bag (containing urine) exposed below the resident's pant leg and uncovered.

Observations on 07/09/24 at 12:09 p.m. and 5:20 p.m., and on 07/10/24 at 7:53 a.m. showed Resident #8 seated at the dining room table with the urinary catheter leg bag (containing urine) exposed below the resident's pant leg and uncovered.

During an interview on 07/10/24 at 11:21 a.m., and administrative nurse (#1) stated staff are expected to cover resident's urine catheter leg bag at all times.

-Review of Resident #14's medical record occurred on all days of survey. The current care plan stated, ". . . I require assist. of 1 for all ADL's. I have an ADL self-care performance deficit r/t [related to] cognition/mobility. . . . PERSONAL HYGIENE/ORAL CARE: I am an assist of one. . . . DRESSING: I am an assist of one."

An interview occurred 07/08/24 at 5:12 p.m. with

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F 550	Continued From page 3 Individual A. This individual stated Resident #14 is frequently unshaven and has a dirty face and clothing. Observations on 07/08/24 at 11:15 to 11:53 a.m.showed Resident #14 seated in a wheelchair in the front lobby or the dining room wtih an unshaven face, a soiled shirt, and food debris on his face. Observations on 07/09/24 from 8:34 a.m. to 12:12 p.m. showed Resident #14 seated in a wheelchair in the front lobby or in the dining room with an unshaven face, a soiled shirt, and food debris on his face. At 1:12 p.m., a progress note stated Resident #14 allowed a certified nurse aide (CNA) to wash his face but refused to have his shirt changed. Resident #14 remained unshaven and in the same soiled shirt the rest of the observation day. Observation on 07/10/24 at 9:00 a.m. showed Resident #14 seated in a wheelchair in the front lobby with his shirt and face soiled with food. The above observations showed facility staff had multiple encounters with Resident #14, but failed to change his soiled shirt, shave and wash his face. During an interview on 07/10/24 at 11:19 a.m., an administrative nurse (#1) confirmed Resident #14 frequently has a soiled shirt or dirty face and staff are expected staff to change his shirt and wash his face.	F 550		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		8/20/24

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F 658	Continued From page 4 §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: 1. Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled residents (Resident #15) reviewed with orders for specific parameters for blood glucose levels. Failure to notify the physician of high blood glucose levels as ordered placed the resident at risk for delayed treatment and adverse health events. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, "Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. . ." Review of the facility policy titled "Physician, Physician Assistant, Nurse Practitioner or Clincal Nurse Specialist Lab Notification" occurred on 07/10/24. This policy, revised 03/11/24, stated, ". . . The physician . . . will determine parameters for 'immediate' and 'non-immediate' lab results. . . Notification parameters for 'immediate' lab results will be included in lab order. . . Immediate notifications. . . Call physician. . . with lab result and resident current condition. . ." Review of Resident #15's medical record	F 658	1. Resident #15 and #34 was identified as being affected by this practice. Notification was sent to provider regarding out of range blood sugar for resident #15. Resident #34 did not have his insulin prepped or administered properly. Certified Medication Aids will no longer be administering insulin. 2. All diabetic residents have the potential to have blood sugars out of range. Residents #15 and #34 are the only ones who have insulin administered. 3. CMA's will no longer be administering insulin and were educated on this on 7-10-24, as this tag was specifically due to CMA administration of insulin. Nurses on the floor were educated on 7-10-24 that they would be the only ones to administer the insulin going forward. They will be reminded about the administration of insulin at the upcoming meeting on 8-14-24. The audits for blood sugars for affected residents will be performed weekly by the Resident Care Coordinator or designee x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved.	

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F 658	Continued From page 5 occurred on all days of survey. Diagnoses included Type 2 Diabetes Mellitus. A physician's order, dated 10/11/22, stated, "Notify provider if blood glucose [sugar] is above 400 or below 70." Review of Resident #15's blood glucose levels from 05/10/24 through 07/10/24 showed the following: * 05/23/24: 445.0 mg/dL [milligrams per deciliter]. * 05/28/24: 436.0 mg/dL The medical record lacked documentation the facility notified Resident #15's provider of the elevated blood glucose levels. During an interview on 07/10/24 at 12:30 p.m., an administrative nurse (#1) confirmed the staff failed to notify the provider of Resident #15's elevated blood glucose levels. 2. Based on observation and review of facility policy, the facility failed to follow professional standards of practice for 1 of 1 supplemental resident (Resident #34) observed for insulin preparation and administration. Failure to prime the insulin pen and administer the insulin over the required length of time may result in the resident receiving an inaccurate dose. Findings include: Review of the facility policy titled "Insulin Administration" occurred on 07/10/24. This policy, dated 06/14/24, stated, "Purpose: To provide guidelines for the safe administration of insulin to residents with diabetes. . . . Steps in the	F 658	4. Audits will be reviewed by the administrator or designee and brought to the QAPI for review and recommendation.	

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F 658	Continued From page 6 procedure for (insulin pen) administration . . . Prime the insulin pen. Priming means removing air bubbles from the needle. . . . You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear. . . . Depress the plunger and remove the needle after approximately five (5) seconds." Observation on 07/08/24 at 5:20 p.m. showed a medication aide (MA) (#2) prepared Resident #34's Novolog insulin pen for administration. The MA (#2), without priming the insulin pen, dialed the insulin pen to the prescribed units, inserted the needle into the resident's abdomen, depressed the plunger and removed the needle without waiting the required length of time. During an interview on 07/10/24 at 11:35 a.m., an administrative staff member (#1) confirmed she expected staff to follow the policy for priming insulin pens and administering insulin.	F 658		
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, review of	F 689	1. Resident #33 was identified as being	8/20/24

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F 689	Continued From page 7 professional reference, and staff interviews, the facility failed to provide supervision to prevent accidents for 1 of 2 sampled residents (Resident #33) observed during a gait belt transfer. Failure to provide supervision of certified nurse aides (CNAs) by a licensed nurse regarding resident transfer assistance may result in unnecessary pain, falls and/or injury for residents. Findings included: Review of the North Dakota Administration Code (NDAC) online at www.ndlegis.gov/information/acdata/pdf/33-43-01.pdf stated, ". . . 33-43-01-12. Supervision and delegation of nursing interventions. An individual on the department's nurse aide registry [CNA] may perform nursing interventions which have been delegated by a licensed nurse. An individual on the departments nurse aide registry as delegated and supervised by a licensed nurse . . ." Review of Resident #33's medical record occurred on all days of survey and included diagnoses of weakness and dementia. The current care plan stated, ". . . TRANSFER: Resident is transfer of 1-2 depending on pt [patient] tolerance. If resident is shakier, will assist of 2 PRN [as needed]. . . ." A physical therapy note, dated 06/05/24, stated, "Transfer of 1-2 depending on pt tolerance. If [Resident #13] is more shaky, use assist of 2 as needed. PT [physical therapy] observed transfer attempt with assist of 1 today and was safer with assist of 2. . . ."	F 689	affected by this practice. Resident's care plan was updated to transfer with two staff members at all times. 2. Residents needing assistance with transfers have the potential to be affected. 3. Staff are responsible for checking the care plans to ensure safe transfers. Nursing staff will be educated on or before 8-20-24. Audits will be performed by Resident Care Coordinator or designee weekly x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved. 4. Audits will be reviewed by the administrator or designee and brought to QAPI for review and recommendation.	

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F 689	Continued From page 8 Observation on 07/08/24 at 4:01 p.m. showed Resident #33 seated in the wheelchair. A CNA (#8) placed the gait belt on Resident #33, placed a front wheeled walker (FWW) in front of the resident and assisted the resident to a standing position. As the resident attempted to stand, she was shaky, unsteady, and leaned backwards as she placed her left hand on the FWW and her right hand on the wall. The CNA (#8) continued to assist the resident to ambulate to the bathroom. During an interview on 07/10/24 at 12:35 p.m., when asked if Resident #33 is transferred with one or two assist, a CNA (#8) stated, "I always just use one assist because that's what they told me to do." Observation on 07/10/24 at 11:28 a.m., showed a CNA (#7) attempted to assist Resident #33 from the bed to the wheelchair. The resident refused to get out of the bed. When asked how the CNA (#7) would have transferred the resident out of bed the CNA stated, "She's a pivot transfer with one person." When asked if the CNA ever used two staff to transfer the resident, the CNA stated, "She [Resident #33] had a fall a few months ago and then we started to use two staff sometimes. It depends on the kind of day she (Resident #33) is having. I can decide if I should use one or two assist to transfer her." During an interview on 07/10/24 at 1:26 p.m., an administrative nurse (#1) stated she expected the nurse to assess Resident #33 to make the decision if the resident needed to be transferred with two staff.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		8/20/24

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F 690	Continued From page 9 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a	F 690	1. Resident #33 was identified by being	

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F 690	Continued From page 10 professional reference, and staff interview, the facility failed to provide appropriate toileting for 1 of 6 sampled residents (Resident #33) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, "Fecal and Urinary Incontinence: Moisture from incontinence promotes skin maceration [tissue softened by prolonged wetting or soaking] and makes the epidermis [skin] more easily eroded and susceptible to injury. Digestive enzymes in feces, urea in urine . . . also contribute to skin excoriation [area of loss of the superficial layers of the skin] . . . Any accumulation of secretions . . . is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. . . ." Page 1221 stated, "Managing Urinary Incontinence . . . Habit training, also referred to as timed or prompted voiding and scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . . ." Review of Resident #33's medical record occurred on all days of survey and included a diagnosis of dementia. The care plan stated, ". . . TOILET USE: The resident is an assist of 1 . . ."	F 690	affected by this practice. Slips were left in areas that would be found if resident would be toileted every 2-3 hours. 2. All residents who need assistance with toileting have the potential to be affected. 3. Staff will be educated on or before 8-20-24 and charting will be reviewed to check that care provided is charted. Audits will be performed by Resident Care Coordinator or designee weekly x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved. 4. Audits will be reviewed by the administrator or designee and brought to QAPI for review and recommendation.	

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	355050	A. BUILDING _____ B. WING _____	07/10/2024

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F 690	Continued From page 11 Observation on 07/08/24 at 4:01 p.m. showed a certified nurse aide (CNA) (#8) assisted Resident #33 to the bathroom. The resident's saturated incontinent product leaked urine through the resident's jeans. Observation on 07/10/24 at 11:29 a.m. showed a CNA (#7) changed resident #33's incontinent product and showed it saturated with urine. Review of Resident #33's toileting record, dated June 9th through July 9th, 2024, identified 56 occasions where staff failed to assist the resident with toileting every three hours. The log showed gaps of approximately 3.5 to 12 hours between staff assistance with toileting. During an interview on 07/10/24 at 1:26 p.m., an administrative staff member (#1) stated she expected staff to assist residents with toileting every 2-3 hours.	F 690		
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. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy,	F 804	1. Residents either who selected or	8/20/24

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F 804	Continued From page 12 and resident and staff interviews, the facility failed to serve foods at palatable temperatures on 2 of 3 days of survey (July 8-9, 2024). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled "Food Temperatures" occurred on 07/10/24. This policy, dated 07/13/23, stated, ". . . Foods will be served at the appropriate temperatures to ensure good flavor and to prevent food borne illnesses. . . . All hot food items will be served to the resident at the temperature of at least 140 degrees." During an interview on 07/08/24, Resident A stated, "The food is always cold." Observation of the noon meal occurred on 07/08/24 at 12:25 p.m. in dining room 1-3 and showed a cook (#5) dished the final resident tray. A temperature of the three-bean vegetable showed a reading of 72.5 degrees Fahrenheit (F). Observation of the evening meal occurred on 07/09/24 at 5:35 p.m. in dining room 1-3. The surveyors asked for a meal tray after all the residents had received their meals. Temperatures were obtained and showed the following: *Macaroni and Cheese at 132 degrees F *Mashed Potatoes at 139 degrees F *Green Peas at 95 degrees F During an interview on 07/10/24 at 11:45 a.m., an administrative staff member (#4) agreed she	F 804	where given the standard meal were affected by this practice. Food will have the temperature taken in the kitchen as well as on the line before it is served to residents. 2. All residents have the potential to be affected. 3. The cooks are responsible to make sure the temperatures are appropriate before serving food. One cook was educated on 7-9-24 and the other cook was educated on 7-19-24. Food will be heated or reheated if not up to temperature before serving. If food is unable to be reheated for any reason then food will replaced with properly prepared food that is heated to the correct temperature. All heat sources (steam table, oven) will be checked to make sure that they are functioning properly as well. Audits will be performed by the Dietary Manager or designee weekly x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved. 4. Audits will be reviewed by the administrator or designee and brought to QAPI for review and recommendation.	

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F 804	Continued From page 13 expected staff to serve food to residents at an acceptable temperature.	F 804		
F 812 SS=E	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. §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, review of facility policy, and staff interview, the facility failed to store food in a sanitary manner in 1 of 1 main kitchen. Failure to apply an identifying label to food and add an open date has the potential to affect food quality/preparation and may result in the spread of foodborne illness to residents, staff, and visitors. Findings include:	F 812	1. No residents were identified as being affected by this practice. 2. No residents would be affected by this because foods which have been found not dated or labeled must be thrown per our policy. 3. Most dietary staff are responsible for food storage. The policy reflected the correct information related to food	8/20/24

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F 812	Continued From page 14 Review of the facility policy titled "Storage and Cooking of Food" occurred on 07/10/24. This policy, dated July 2023, stated, ". . . Food Storage . . . Foods which have been opened or prepared will be placed in an enclosed container, dated and labeled. If food is ever found undated these will be thrown without exception. . . ." Observation of the main kitchen occurred on 07/08/24 at 11:20 a.m. with a dietary manager (#6) and showed the following: Walk-in Refrigerator: *Four individually dished containers identified as taco sauce by a dietary staff member with no identifying label or prepared date. *One brick of a white substance identified as "cream cheese but not sure," by a dietary staff member with an unidentifiable date and no identifying label. *Two disposable bowls of a pudding like dessert and a crumble type dessert covered with unsealed plastic wrap with no identifying label or date. *One 1/2 full gallon size zip top plastic bag of sliced strawberries with no identifying label or date. *Three 1/2 full bags of shredded cheese with no open date. *One 1/4 full open jar of peach preserves with no open date. *A tray holding an onion, apples, and oranges with one orange soft and showing dark spots. *A tray with four containers of fruit juice sitting in spilled juice, with dark, sticky spots. Walk-in Freezer: *Three 1/2 full bags of frozen potato tots and	F 812	storage. Most staff were educated on 7-17-24. The remaining staff will be educated by 8-20-24. Audits will be performed by Dietary Manager or designee weekly x 4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved. 4. Audits will be reviewed by the administrator or designee and brought to QAPI for review and recommendation.	

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F 812	Continued From page 15 french fries with no open dates. *A zip top plastic bag with what dietary staff identified as "omelet patties," with no identifying label or open date. *An open bag of sausage patties and an open bag of sausage links inside their respective boxes which showed an open date of the box, but not the individual bags. Walk In Cooler: *One box of oranges, one of the oranges soft and black. Dry Storage: *Four open bags of pudding mix within a zip top plastic bag, with no open date. *One open bag of croutons wrapped in plastic wrap with no open date. During an interview on 07/10/24 at 11:45 a.m., an administrative staff member (#4) confirmed she expected staff to label and date food items when opened and throw away food items if not identifiabe.	F 812		