STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275103	A. Building B. Wing	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Care and Rehabilitation	2400 Continental Dr Butte, MT 59701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 33796 Based on observation, interview, and record review, the facility failed to provide a warm and comfortable room for 4 (#s 2, 20, 21, and 24); and is was uncomfortably cold for 1 (#6) of 24 sampled residents. Findings include: Review of a written email to the facility administrator, provided by NF1, dated 12/13/21, showed resident #6 stated he thought his room had no heat, and his window would not shut properly. He stated there was a towel stuffed in the window to prevent the cold air from coming into his room. Resident #6 asked the CNA to leave his door open so heat from the hallway could circulate into his room. The CNA stated she could not leave his door open because of COVID-19 precautions. He stated he was uncomfortably cold. During an observation on 1/5/22 at 9:40 a.m., resident #6's window had been fixed, but the baseboard heater was no longer securely attached, and was halfway off (the wall) nearly on the floor. No heat was felt coming from the baseboard heater. During an interview on 1/5/22 at 9:50 a.m., staff member A stated she thought the baseboard heater had been fixed. She stated the facility did an audit on 12/17/21 and found resident #6's room was cold. Staff member D turned on the heat in the ceiling. Resident #6 was in the hospital, and unable to be interviewed regarding his cold room. Resident #24, who shares the room with resident #6, stated the room was cold, and he would put his head under the blanket to warm up his nose. 31923 During an interview on 1/3/22 at 12:12 p.m., resident #20 said, The room is usually cold. I tell them and they don't do nothing. I wrap up in blankets. During an interview on 1/3/22 at 12:30 p.m., resident #2 said, I went three months without heat. In this building the heat is either 85 degrees or you can't have heat. (continued on next page)

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.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/22 at 12:55 p.m., resident #21 said, They have problems with the heater. It's been pretty cold sometimes. They usually call [maintenance] to fix the boiler. Some of the rooms get really cold. During a phone interview on 1/3/22 at 1:59 p.m., NF1 said she had been in the building on 11/1/21, when both of the boilers were broken. She said the residents were in their coats and covered with blankets. The plumber was working on the heat and had been able to get one of the boilers working which improved the heat situation. She said, Last Monday they told me both the boilers were working. The facility had to order parts for the boiler. On another occasion I had to call and initiate a room change for resident #2.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 44769 Based on interview and record review, the facility failed to prevent the misappropriation of resident property; specifically, resident medications, including a controlled substance, for 1 (#22) of 1 sampled resident. This deficient practice had the potential to affect all residents who were prescribed a controlled substance. Findings include: A request for the facility investigation of the 10/9/21 drug diversion incident was requested on 1/3/21 at 11:55 a.m. During a phone interview on 1/3/22 at 3:10 p.m., NF2 stated she was informed there was narcotics missing from the medication cart, including oxycodone, lorazepam, and Lortab. During an interview on 1/3/22 at 4:00 p.m., staff member R stated on 10/9/21, she was working the second night of three nights in a row and went to give resident #22 his PRN oxycodone and could not find his oxycodone medication card. She stated the night before the medication card was three quarters full. Staff member R stated she checked to see if his physician order had been discontinued, and it had not been discontinued. She went through the narcotics book and found multiple discrepancies, and reported it to the DON. During an interview on 1/4/22 at 8:38 a.m., staff member F stated The controlled medication reconciliation was done at shift change. The oncoming nurse checked the medication cards, and the leaving nurse checked the medication off in the narcotic logbook. If the count was off, we double check it and if it was still off, we then would report it to the DON. It is possible a page could have been missed from the narcotic logbook, and the corresponding medication card could have been missed, and overlooked. During an interview on 1/4/22 at 9:17 a.m., staff member H stated if a medication card, and the corresponding page in the narcotic logbook was missing, the missing medication would probably be overlooked. Staff member H stated, I don't pay attention to the page numbers in the narcotic logbook. Staff member H stated she had not been instructed to check that all the pages were in the narcotics logbook. During an interview on 1/4/21 at 11:00 am staff member C stated she was involved at the end of the drug diversion investigation and can not find the investigation documentation. During a phone interview on 1/4/22 at 2:08 p.m., NF5 stated the facility verbally told the pharmacy about the potential drug diversion, and the pharmacy checked the facility medication carts quarterly. The pharmacy had not provided any education (to staff) after the drug diversion incident. The pharmacy had not documented the incident. NF5 said, I guess I should (document) in the future. Review of the facility's Individual Narcotic Logbook, labeled 11/6/21 #1, showed the double sided pages 105 and 106 were absent and no residual paper remained in the binding. Pages 113 and 114 were also missing and residual torn paper protruded from the binding. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Reported Incident findings on 10/14/21, showed, After investigation it was found that between the dates of 10/5 and 10/12 there were several cards of narcotics or other controlled meds that were displaced. The narcotic book was audited several times over the course of the investigation. The narcotic book showed signs of tampering with pages missing, pages crossed out, wasted meds with no signatures, and names and meds written over . The needed medications were replenished by the pharmacy and no harm or danger came to the resident. The pharmacy will perform an audit of our narcotic monitoring system and suggest changes as needed . Review of a facility document, Abuse Prevention Program, with a revised date of 12/2016, showed, . Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation . Review of the facility document, Controlled Substances, with a revised date of 12/2012, showed: . The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances . 9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. 10. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties, [sic] and give the Administrator a written report of such findings. 11. The Director of Nursing Services shall consult with the provider pharmacy and the Administrator to determine whether any further legal action is indicated . No investigation documentation for the 10/9/21 drug diversion incident was provided to the survey team prior to the end of the survey.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44769 Based on interview and record review, the facility failed to screen temporary contracted agency employees for a history of abuse, neglect, exploitation, or misappropriation of resident property. Findings include: A written request was made to the facility on [DATE] at 11:55 a.m. for the employee file for NF3, a contracted employee. During an interview on 1/5/22 at 8:07 a.m., staff member C stated, We don't have an employee file for NF3, it is in the contract with [staffing agency] and they will not give a copy of it to us. Review of the facility policy, Staff Screening, Operational Manual-Abuse & Neglect, with a revised date of 8/2020, showed: . The Facility will utilize reasonable and prudent criminal background screening and reference checks for prospective staff, contractors/consultants, registry/temporary staff, and volunteers, .II. If the Facility uses registry staff or permits students from affiliated academic programs to train on-site, the Facility will validate that these individuals undergo the same screening as is required of individuals employed directly by the Facility, .Through the contract, the Facility may require the staffing agency or academic institution to be responsible for screening registry staff and students. Such screening performed by third parties will meet the same requirements that the Facility uses for employees, . The Facility will request copies of documentation that supports such screening was conducted by the contracted entity. Review of the facility document, Abuse Prevention Program, with a revised date of 12/2016, showed: .Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation, .As part of the resident abuse prevention, the administration will; 2. Conduct employee background checks and will not knowingly employ or otherwise engage an individual who has: a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951 Based on interview and record review, the facility failed to report the findings of an investigation of an injury of unknown origin, for 1 (#13) of 1 sampled resident. Findings include: Review of the facility reported incident, dated 12/19/21, showed a staff member noticed resident #13 had bruising on her right lower eye lid. A head to toe skin assessment was completed, and resident #13 had bruising on the back of both hands, and small bruises on her thighs. Resident #13 was unable to tell the nurse what had happened due to dementia. Staff observed resident #13 knocking on closed doors, after the incident, and the resident had a history of wandering into other resident's rooms. A written request was made to the facility on [DATE] at 11:55 a.m., for all the investigation documentation regarding the incident on 12/19/21 for resident #13. During an interview on 1/4/22 at 10:32 a.m., staff member C stated she was looking for additional information on the 12/19/21 incident for resident #13. No documented findings of the investigation were provided to validate reporting requirements. During an interview on 1/5/22 at 7:50 a.m., staff member A stated NF2 was responsible for the investigation of resident #13's injuries and subsequent submission of the findings to the State Survey Agency. NF2 no longer worked at the facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951 Based on interview and record review, the facility failed to conduct a thorough investigation of an injury of unknown origin for 1 (#13) of 1 sampled resident; and failed to conduct a thorough investigation for an incident of drug diversion on 10/9/21 for 1 (#22) of 1 sampled resident. Findings include: 1. Review of the facility reported incident, dated 12/19/21, showed a staff member noticed resident #13 had bruising on her right lower eye lid. A head to toe skin assessment was completed and resident #13 had bruising on the back of both hands, and small bruises on her thighs. Resident #13 was unable to tell the nurse what had happened due to dementia. Review of resident #13's Quarterly MDS, with an ARD of 8/12/21, showed no score for her BIMS, which is severe cognitive impairment. Review of resident #13's physician's progress note, dated 12/22/21, showed resident #13 also had some right hip bruising and had no known recent falls. A written request was made to the facility on [DATE] at 11:55 a.m., for all the investigation documentation for resident #13, regarding the incident of unknown injuries, on 12/19/21. During an interview on 1/4/22 at 10:32 a.m., staff member C stated she was looking for additional information on the 12/19/21 incident for resident #13. No investigation documentation was provided by the end of the survey. Staff member A stated no documented interviews of staff, other residents, or additional information was completed following the incident involving resident #13 on 12/19/21. Review of the facility's policy titled, Abuse Prevention and Prohibition Program, last revised 8/2020, showed: - . VI. Investigation - A. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source . , - . D. iv. Interviews any witnesses to the alleged incident . , - . vii. Interviews Facility Staff members who have had contact with the resident during the period of the alleged incident. 44769 2. A written request was made to the facility on [DATE] at 11:55 a.m., for all the investigation documentation regarding a drug diversion incident involving resident #22's controlled medication on 10/9/21. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/22 at 3:30 p.m., staff member A stated she was looking for investigative information on the 10/9/21 drug diversion incident. During an interview on 1/4/22 at 11:00 a.m., staff member C stated she was involved at the end of the investigation for the 10/9/21 drug diversion incident for resident #22's medications, but could not find the documentation. No investigation documentation for the 10/9/21 drug diversion incident of resident #22's medications were provided to the survey team prior to the end of the survey.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33796 Based on interview and record review, the facility failed to prevent, identify, and follow Wound Clinic treatment orders for an Unstageable pressure injury on the right heel, resulting in a below-the-knee amputation; and failed to identify and treat necrotic pressure injuries on the sacrum, for 1 (#6) of 1 sampled resident. Findings include: 1. Review of resident #6's August 2021 TAR showed two weekly skin checks were missed on 8/11/21 and 8/18/21. Review of resident #6's Physician Note, dated 8/18/21, showed the resident had a heel wound (right) and would go to the Wound Clinic. Review of resident #6's Nursing Progress Notes, from 7/2021 through 9/2021, did not include information regarding the (right) heel wound, or how it was identified by the physician. During a phone interview on 1/5/22 at 12:44 p.m., NF2 stated the wound on resident #6's heel had started as a small blister. She stated she did not know if there were any pressure reducing interventions in place for resident #6, prior to the identification of the blister. Review of resident #6's Nursing Progress Notes and Weekly Skin Checks, from 7/2021 through 9/2021, did not identify a blister on resident #6's right heel. Review of resident #6's Wound Clinic note, dated 8/19/21, showed the (right) heel was black eschar. The wound clinic order showed to use betadine gauze and light kerlix. During an interview on 1/4/22 at 10:50 a.m., staff member H stated she did not know much about resident #6's heel pressure sore. She stated the heel was a tough spot to have a wound vac placed. She stated resident #6's bottom looked worse after he returned from the hospital on 11/19/21. During a phone interview on 1/5/22 at 9:54 a.m., NF4 stated the wound clinic chose to keep eschar in place using the betadine gauze. Review of resident #6's Nursing Progress Note, dated 8/22/21, showed the resident was seen at the wound clinic but had no dressing change orders, So will put xeroform covered with border dressing. Review of resident #6's Weekly Skin check, dated 8/25/21, showed right heel- 5.5 x 3 cm. No description of the wound was included. Review of resident #6's Wound Clinic note, dated 8/26/21, showed Pt did not have a betadine dressing on his heel to help dry this out and keep the wound stable. Instead he had a xeroform over his heel which made his stable eschar no longer stable. This was deroofed today and will now need a wound vac authorized by CCR SNF. Cleanse wound with normal saline and a thin layer of medihoney, then foam dressing. Please authorize wound vac for his next wound clinic appt on 9/9/21. Review of resident #6's August 2021 TAR showed this order was not implemented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/5/22 at 9:10 a.m., staff member H stated NF2 was responsible for wound care, but was no longer working at the facility. She stated wound clinic orders got missed because the paper work was given to staff member Q for scheduling the next appointments. She also stated the nurses in the facility had not been provided training on the use of the wound vac. Review of resident #6's Nursing Progress Note, dated 8/26/21 showed, No orders received from wound clinic thus far. New dressing applied to lower right leg. Review of resident #6's Weekly Skin Check, dated 9/1/21, showed the area to the right heel was debrided last week at wound clinic. No description of the wound was included in the skin check. Review of resident #6's Nursing Progress Note, dated 9/9/21, showed the Resident returned with wound vac to right heel, awaiting order from wound clinic. Review of resident #6's Wound Clinic note, dated 9/9/21, showed orders for black foam, skin prep, apply negative pressure wound therapy to right heel. Review of resident #6's September 2021 TAR, dated 9/11/21, showed an order for Dressing change: Black foam with skin prep at 125 mmHG setting continuous. The order did not include 'wound vac.' The wound vac was initiated on 9/14/21, and not 9/11/21. Review of resident #6's Nursing Progress Note, dated 10/9/21, showed the resident was found to not have the wound vac applied. The resident stated he had removed it several days ago and was told not to reapply it by the wound clinic. He did agree to a dressing change with an alginate/sterile dressing. Review of resident #6's TAR, dated 10/9/21, did not reflect this dressing change. Review of resident #6's Wound Clinic note, dated 10/14/21, showed the wound vac was to be discontinued. The new order was for lodafoam, and was sent to the facility with the patient. Review of resident #6's Nursing Progress note, dated 10/14/21, showed the resident returned from wound clinic with a new dressing on right heel, no new orders received yet. Review of resident #6's Physician orders, dated 10/18/21, showed, Cleanse wound with NS, lodafoam inserted to wound, apply ABD and kerlix. Review of resident #6's October 2021 TAR showed the wound vac and dressing change were not discontinued, and nursing staff continued to sign the TAR showing the treatment was being completed until 10/30/21. The new dressing change from 10/18/21 was not carried over to the November 2021 TAR. Review of resident #6's November 2021 TAR showed a dressing change order dated 11/22/21; Change every other day, clean with NS, apply ABD, wrap with kerlix. The order did not specify what the dressing change should include, as in the lodafoam. It did not include the site of the wound. The TAR showed only one skin check was completed that month. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #6's Weekly Skin Check, dated 10/20/21, showed the heel pressure injury was bigger at 6. 5 x 3.5 x 1 cm depth, with yellow slough in the middle. The Skin Check did not include the pressure ulcer Stage (severity classification). Review of resident #6's Nursing Progress Notes, dated 10/23/21, showed the wound dressing was changed and the wound had a 'strong smell of rotting flesh/ammonia.' Review of resident #6's wound clinic note, dated 10/25/21, showed, Dressing on patients heel was not appropriate. He had xerofoam and silicone bordered foam that was heavily saturated with significant odor present. Will switch order to betadine gauze, this will need to be done daily. Review of resident #6's Physician orders, October 2021 TAR, and Nursing Progress Notes, showed the order change from the wound clinic on 10/25/21 was not implemented. Review of resident #6's Nursing Progress Note, dated 11/8/21, showed the resident's wound was necrotic, foul smelling and pus flowing. The provider requested a picture of the wound, and believed the extremity needed to be amputated. Review of resident #6's Nursing Progress Note, dated 11/9/21, showed the resident was admitted to the hospital for a right below-the-knee amputation. Review of resident #6's care plan did not include the right heel pressure injury, the use of the wound vac for treatment, dressing changes, or the interventions for the resident to wear a green off-loading boot, and to prevent the heel from getting wet in the shower. 2. Review of resident #6's Wound Clinic note, dated 10/7/21, showed the resident had an 8 x 8 Deep Tissue Injury on his sacrum, and would need an off loading cushion to protect this from worsening. Review of resident #6's Weekly Skin Check, dated 10/20/21, did not show the resident had a pressure injury to his sacrum. Review of resident #6's Wound Clinic note, dated 10/25/21, showed the resident now had a Stage II wound on his sacrum. Today his [seat cushion] in his chair is completely flat. Review of resident #6's Weekly Skin Check, dated 10/27/21, noted an '8 x 8 wound with yellow slough' to the sacrum. Review of resident #6's After Visit Summary from the hospital discharge, dated 11/19/21, showed dressing to sacrum - medihoney to necrotic areas. Review of resident #6's November 2021 TAR did not include the physician treatment order. Review of resident #6's Weekly Skin Checks showed no skin checks were provided/documented by the facility after 10/27/21. Review of resident #6's November 2021 TAR did not include sacrum wound care until 11/22/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #6's December 2021 TAR showed an order for Wounds on L and R ischium, change every other day, foam dressings. The wound dressing change was to occur every Monday, Wednesday, and Friday. The dressing changes were not completed seven days out of the month of December. During an interview on 1/4/21 at 1:30 p.m., NF1 stated resident #6 had complained he was not getting turned every two hours. Sometimes he stated it was 12 hours of no repositioning. NF1 stated on 11/29/21 she had requested the facility keep a log of resident #6's turning schedule with initials from staff, and refusals from the resident. NF2 had told NF1 the resident refused to be turned. The turning schedule was found in resident #6's room and showed a log that was initiated on 12/13/21. One position change was initialed on 12/13/21, nine out of 12 position changes were initialed on 12/14/21; one position change was initialed on 12/15/21. Days 16 through the 23rd were all incomplete. The turning log did not continue past the 23rd of December, 2021. Review of resident #6's care plan, dated 11/26/21, showed the resident was readmitted to the facility from the hospital with pressure areas to the buttocks. It did not include the Stages of the pressure areas (severity classification), or descriptions. Review of resident #6's Wound Clinic notes, dated 10/7/21 and 10/25/21, showed the buttocks/sacral pressure ulcer had originated on 10/7/21. Review of resident #6's Nursing Progress Note, dated 12/31/21, showed the resident was sent to the hospital with possible aspiration pneumonia, and could not be interviewed.

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	275103	A. Building B. Wing	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Care and Rehabilitation	2400 Continental Dr Butte, MT 59701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 33796 Based on observation, interview, and record review, the dietary department failed to hire and train competent staff to carry out the duties with professional standards for meal service for all residents by not following the menu, not using recipes, and having no spreadsheets to identify altered textures and specialized diets. Findings include: Review of the Hire and Termination dates of the dietary personnel showed from 11/16/21 to 12/14/21, eight employees quit without notice, including the Dietary Supervisor. During an interview on 1/3/22 at 1:35 p.m., NF1 stated the dietary staff had 'walked out' around December 7th, 2021. She stated the residents had told her the facility was buying fast food because there was no staff to cook the meals, and food was not being ordered. Review of a hand-written note from staff member A showed fast food was provided six times to the residents from 11/25/21 through 12/12/21. During a lunch observation on 1/3/22 at 11:50 a.m., the meal served was chicken strips, potatoes, and mixed vegetables. The designated menu for 1/3/22 showed the residents should have been served chili, a salad, and a cornbread muffin. Staff member S stated the kitchen did not have the ingredients to serve the designated meal, so she changed it. The ground chicken strips which were served were observed to be dry and crumbly. No sauce was provided for the residents who had ground chicken strips, which could increase the risk of the resident choking. Review of a hand-written menu showed the dinner meal on 1/3/22 should have been a ham and hash bake with corn. Staff member S stated she had written out menus for the week, based on the ingredients in the kitchen. The hand-written menus did not include a signature from the Registered Dietitian to show the substitutions made were nutritionally adequate. The facility menu had called for Polish sausage, potatoes, and sauerkraut. During an interview on 1/3/22 at 12:45 p.m., staff member K stated it was his first day as the dietary manager, and his goal was to get familiar with the electronic systems. He did not know where the spreadsheets were for the meals, and was not sure what they were. The spreadsheets showed the dietary staff what residents should receive for altered texture and specialized diets. He stated he would ask staff member A about the spreadsheets. He did not know if the dietary staff had taken the ServSafe class. During interview on 1/4/22 at 7:40 a.m., staff members L and M stated they had not received training on the spreadsheets, and were not sure what they were. Staff member M stated that staff member S would show or tell them what to do, because she had worked at the facility in 2021. Staff member S had returned to work in the dietary department on 12/13/21. Staff members L and M stated they were not familiar with the ServSafe certification course for sanitation (safety). (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 1/4/22 at 7:40 a.m., staff member L was preparing 'Confetti Eggs' for breakfast. She stated she did not have a recipe for the eggs, so she 'Googled' it. The recipe called for red, green, and yellow peppers. She stated she only had green peppers. She stated she was making biscuits instead of toast, because the kitchen did not have a toaster. She stated she took food temperatures on the trayline 'when she remembered.' She stated meal service should start at 7:30 a.m., but she was a 'little behind' and breakfast would be served late. During a breakfast observation and interview on 1/4/22, the meal was not delivered until 8:48 a.m., which was 35 minutes late. Staff member L stated she was getting used to reading the diet slips, so trayline took longer. She stated she had 'messed up' trays when she did not read the diet slips. It was observed the residents on C wing were not provided jelly or butter for their biscuits. During an observation and interview on 1/4/22 at 11:50 a.m., staff member L stated the chicken for lunch was still frozen, so she changed the menu to Swedish meatballs and bowtie pasta. The meatballs appeared to be dry, brown, and overcooked. Staff member L put the bowtie noodles in cream of mushroom soup along-side the meatballs. When asked why she did not mix the meatballs into the soup and noodles, as to help moisten the meatballs, she stated she was told not to mix meat into other foods by staff member S. Review of a written anonymous complaint, dated 12/10/21, showed the residents had been served raw chicken for lunch on 11/18/21. The raw chicken was returned to the kitchen, and a replacement was not provided. During an interview on 1/5/22 at 9:55 a.m., staff member A stated the meal on 11/18/21 was a chicken fried steak that had been served frozen, and not raw chicken. Review of the dietary schedule for December 2021 showed no staff were on the schedule from December 1st through the 15th. During an interview on 1/4/22 at 1:45 p.m., staff member A stated she had been cooking and doing dishes 'on and off' in the kitchen, since she started on 11/15/21. She stated two dietary supervisors walked out in December, and she took charge of some of the duties. She stated she was not able to provide the oversight required for the dietary department to function well. She stated, I know it is bad in the dietary department.

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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. 33796 Based on observation and interview, the facility dietary department failed to maintain a clean and sanitary work area and to designate how and when cleaning of the kitchen/equipment would occur; failed to prepare, store, and serve food from a sanitary kitchen and using sanitary and safe food handling practices; and staff lacked necessary training for safe food/sanitary practices. The kitchen served all residents. Findings include: During an observation on 1/3/22 at 11:50 a.m., the following was found: The hand washing sink was dirty with dark dirt-like stains throughout the sink. It appeared to have not been cleaned for several days. The garbage can in the dish washing room was covered with food spills on the outside of the can. The bottom shelves in the dish washing room were covered in water spots. The oven handles were sticky and greasy. An unidentified meat was thawing in a bucket of cold water. During an interview on 1/3/22 at 4:08 p.m., staff members O and P stated they did not know that meat should be thawed under running cold water, if it could not be thawed in the cooler. The glasses of milk for the residents dinner was poured, and sitting in a non-functioning cooler, but it would not be served for six hours. The can opener's base was filled with a dry and sticky substance. The blade contained food debris. The air conditioning unit was covered with greasy dust. During an observation on 1/3/22 at 12:00 p.m., the milk glasses, which had been sitting in the non-functioning cooler, showed a temperature of 46.8 degrees. The red sanitation bucket sitting on a shelf next to the sink, was tested for the appropriate amount of sanitation solution using the facility test strips. The test strips showed there was no sanitation solution in the bucket. A cleaning schedule was requested on 1/5/22, and staff member A stated there was no cleaning schedule for the dietary department. During an observation on 1/3/22 at 3:15 p.m., hot dogs were being thawed in a bucket of cold water, the cold water was not running. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and observation on 1/4/22 at 7:40 a.m., staff member M stated the kitchen did not have an ice machine, so milk and juice were not being iced for service to the residents, and were not holding a cold temperature. The milk was poured and sitting in a cooler that did not function. The milk was to be served for the lunch meal at 12:00 p.m. During an observation and interview on 1/4/22 at 4:40 p.m., the red sanitization bucket, previously observed, was empty and turned over. No other sanitizing buckets were observed. Staff member M stated she did not know where the test strips were for testing the sanitizer water, and she had not received any training on sanitation when she started her position at the facility. She stated the facility said to her 'sink or swim' when she was hired. During a test tray on 1/4/22 at 12:53 p.m., the food was lukewarm, and all menu items temperature tested were 101.9 to 105 degrees. The milk temperature was 49.2 degrees.