STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/3/23 through 4/5/23. Bethesda of Beresford was found not in compliance with the following requirements: F700, F761, F801, and F812.	F 000		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and policy review, the provider failed to assess for the need for bed rails for one of five sampled residents (36). Findings include:	F 700	A physician order and bed rail assessment was completed on 4/7/23 for resident 36. All other residents' medical records were reviewed and revised to ensure a bed rail assessment was completed, signed consent, and a physician order were obtained prior to installation of any bed rails. DON, Administrator and interdisciplinary team reviewed and revised as necessary the policy and procedure for Bed Inspection and Bed Rail on 4/20/23. Administrator or designee will reeducate all nurses in charge of assessments, maintenance personnel responsible for installation and all other staff responsible for bed rail related tasks on 5/10/23. DON or designee will audit completed assessments, signed consent forms, and verification of a physician order for three residents weekly for four weeks and monthly for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review.	5/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/26/2023

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 700	Continued From page 1 1. Observation and interview on 4/3/23 at 4:30 p.m. with resident 36 in her room revealed she: *Was admitted about one month ago. *Had bilateral quarter bed rails on her bed. -She said the bed rails were on the bed when she was admitted. *Used the bed rails to reposition herself. 2. Interview on 4/5/23 at 10:23 a.m. with director of nursing B about bed rails revealed: *When a resident was discharged, she would submit a work order for maintenance to remove the bed rails in preparation for a new resident. *Before they would install bed rails, they would submit a request to the resident's physician to order a bed rail assessment. *If the bed rail assessment revealed the resident would benefit from bed rails, they would have completed the following steps: -Educated the resident and their representatives about bed rail use and safety. -Obtained signed consent forms for the use of bed rails. -Submitted a request for maintenance to install the bed rails. *She confirmed they had not obtained a physician's order, educated the resident, or had a signed consent form for resident 36 to use bed rails. *She had forgotten she had already added bed rails to resident 36's care plan. 3. Interview on 4/5/23 at 4:07 p.m. with administrator A regarding resident 36's bed rails revealed: *There was a breakdown in communication between the nursing and maintenance departments about which bed needed the bed	F 700		

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F 700	Continued From page 2 rails removed before resident 36 had moved into the facility. 4. Review of resident 36's medical record revealed: *She was admitted on 3/3/23. *There was no record of a bed rail assessment. *She had a Brief Interview for Mental Status score of 14, indicating she was cognitively intact. *Under the activities of daily living portion of her care plan, there was an intervention that read, "BED MOBILITY- 1 assist. I have bilateral 1/4 side rails for bed mobility." -The intervention was initiated on 4/3/23. 5. Review of the provider's 6/23/17 "Bed Inspection and Bed Rail" policy and procedure revealed: *Under the procedure section: -"1. Resident will be assessed upon admission, quarterly and [as needed] for need of side rails." -"2. Upon determination of need for side rails physician order will be obtained along with resident and/or family consent." -"3. Resident and/or family will have risks and benefits explained including the risk of significant injury if a fall occurs." -"4. Side rail assessment will be completed quarterly and [as needed]" -"5. Bed Rail safety assessment will be completed Annually per maintenance department to include each zone on attached assessment."	F 700		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761	The schedule IV controlled medications for resident 1, 5, 19, and 36 were removed from the single lock cart into the dual locked controlled substance compartment on 4/6/23. All other residents with schedule IV	5/20/23

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F 761	Continued From page 3 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Four of four sampled residents (1, 5, 19, and 36) scheduled IV controlled medications had been counted and secured under a double lock system. *One of one medication refrigerator had the proper interventions documented for out of range temperatures. Findings include: 1. Observation and interview on 4/5/23 2:30 p.m. with director of nursing (DON) B revealed: *Schedule IV controlled medications in two of two medication carts (100/400 and 200/300) included: -Alprazolam 0.5 milligram (mg) 17 tablets for	F 761	controlled medications were placed into the dual locked controlled substance compartment on 4/6/23. DON, Administrator and Interdisciplinary team reviewed and revised as necessary the policy and procedure for Controlled Substances to include Schedule IV medications are locked in the controlled substance compartment in the medication cart on 4/20/23. Medication Room Refrigerator Temperature policy and procedure was reviewed and revised on 4/20/23 to include proper fridge range temps and a process if temperatures fall out of the range. DON or designee will reeducate all staff responsible for ensuring Schedule IV medications are properly secure, fridge temperatures are within range and the process to follow if temperatures fall out of the range on 5/10/23. DON or designee will audit proper storage of controlled substances and fridge temperatures weekly for four weeks and monthly for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 761	Continued From page 4 resident 19. -Clonazapam 0.5 mg 4 tablets for resident 36. -Lorazepam 0.5 mg 31 tablets for resident 5. -Temazepam 30 mg 9 capsules resident 1. *DON B confirmed those scheduled IV controlled medications were not kept in the locked controlled substance compartment in the medication carts. Those medications had not been included in the nurses- controlled medication counts. Review of the provider's 3/3/15 Controlled Substances policy requirements for storage and documentation only applied to schedule II and other controlled substances. The policy had not listed what the other controlled substances had included. 2. Observation on 4/5/23 at 3:00 p.m. of the locked medication storage room revealed a medication refrigerator. It contained medications that included several types of insulin pens, suppositories, influenza vaccine, and tuberculin purified protein derivative. Interview on 4/5/23 at 3:10 p.m. with DON B revealed the temperature of the refrigerator was recorded on a daily basis. The refrigerator temperature should have been maintained between 36 and 46 degrees F. Review of the provider's Medication Room RefrigeratorTemperature Monitoring log revealed: *February 2023: 26 out of the 28 days the temperature had been recorded below 36 degrees F. There were no actions documented by staff if the temperature was out of range. *March 2023: 25 out of the 31 days the temperature had been recorded below 36	F 761		

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F 761	Continued From page 5 degrees F. There were no actions documented by staff if the temperature was out of range. *April 1st through the 4th, 2023: 3 out of the 4 days the refrigerator temperature had been recorded below 36 degrees F. There were no actions documented by staff if the temperature was out of range. Interview on 4/5/23 at 4:00 p.m. with DON B revealed: *She received the medication room refrigerator temperature logs after the end of each month. *She had not reviewed those logs to ensure the temperatures had stayed in the correct range or if there had been any documentation of corrective action taken by staff. *Staff had not informed her the refrigerator temperatures had been out of the correct range. *They had no policy for the medication refrigerator temperatures.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified	F 801	Administrator or designee will enroll two staff members into the ~~Serv-Save-program~~ FSM course* by 5/20/23. On-going efforts to recruit for the open dietary manager include, but not limited to, increasing starting wage for the position, expanding advertisements for the position, or promoting a highly qualified staff member within the facility. All residents have the potential to be affected by this deficient practice. DON, Administrator and interdisciplinary team reviewed and revised as necessary the policy and procedure for Qualified Dietary Staff. Administrator or designee will audit the efforts of the vacancy of the position and review on-going recruitment efforts weekly for four weeks and monthly for two more months.	5/23/23 5/20/23*

*edited 5/1/2023
BWA mg

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F 801	Continued From page 6 nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food	F 801	Administrator or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 801	Continued From page 7 service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on Interview, and job description review, the provider failed to employ a qualified nutritional professional to serve as the dietary manager. Findings include: 1. Interview on 4/3/23 at 3:00 p.m. with Cook F. during the initial kitchen tour revealed: *They currently had no dietary manager. *The administrator had been filling the position until someone could be hired. *It had been many months since they had a dietary manager on staff. Interview on 4/4/23 at 4:16 p.m. with	F 801		

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F 801	Continued From page 8 administrator A revealed: *The last dietary manager had left in early October 2022. -She had worked as the CDM a few months, left for maternity leave, and put in her notice when she returned after her maternity leave ended. *They had recruited for the open dietary manager position but were not successful in getting someone hired. *She confirmed awareness that she had been required to have education and training if she served in the dietary manager position. *She had not enrolled in or started a dietary manager training program. *She was not Serv Safe certified. *None of the cooks or dietary staff had been Serv Safe certified. *A registered dietician (RD) was contracted to complete nutritional assessments and take care of any dietary needs of the residents. *The RD came to the facility at least every two weeks. Review of the provider's dietary manager job description revealed: *Qualifications: -Dietary manager's certificate. *If not certified upon hire, must enroll in a course within 90 days of hire. Review of the provider's administrator job description revealed: *Recommends and develops policies and procedures for aspects of the care center according to state and federal regulations.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	All residents have the potential to be affected by this deficient practice.	5/23/23 5/20/23 *

*edited 5/1/23

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F 812	Continued From page 9 §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, interview and policy review, the provider failed to: *Ensure appropriate glove use during the meal preparation and food service by one of one cook (F) during one of one observed meal service. *Maintain the cleanliness of the exhaust fans in one of one walk-in cooler. 1. Observation on 4/3/23 at 4:15 p.m. through 5:15 p.m. during food preparation and meal service with cook F revealed: *She washed her hands with soap and water, dried them, and put on a pair of gloves. *Foods were taken out of the oven and placed on the steam table for the meal service. *Grilled cheese had been on the menu. *There had been a stack of buttered slices of bread on a wooden cutting board on the food	F 812	Cook F will be reeducated on proper glove usage and hand hygiene on 5/10/23. All other cooks responsible for food preparation regarding glove usage and hand hygiene will be reeducated on 5/10/23. The walk-in cooler exhaust fans were cleaned of all dust and debris from the cover on 4/24/2023. All other exhaust fans covers in the kitchen were cleaned from any dust and debris on 4/24/2023. Kitchen Cleaning checklist was updated on 4/24/2023 to ensure all exhaust fan covers get cleaned monthly. Administrator or designee will audit the cooks for proper glove usage and hand hygiene weekly for four weeks and monthly for two more months. Administrator or designee will audit the exhaust fans to ensure cleanliness weekly for four weeks and monthly for two more months. Administrator or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 812	Continued From page 10	F 812		

preparation table.
*A plastic container with slices of cheese was next to the cutting board.
*She began to assemble the grilled cheese and placed them on the hot cooktop grill.
*The cheese container was returned to the cooler.
*At 4:39 p.m. she walked over to a kitchen drawer and opened it with her gloved hands to retrieve a serving tool.
-She went to the cooktop grill, removed one of the grilled cheese sandwiches and placed it on the cutting board.
-With the same gloved hands touched the top of the sandwich with the palm of her gloved right hand, cut it in half and placed the halves into a serving container using her gloved hands.
-She removed and discarded her gloves and placed new gloves on her hands without washing or sanitizing her hands.
*At 4:53 p.m. she walked to the cooler and retrieved the plastic container with slices of cheese with her gloved hands.
-With the same gloved hands took two buttered slices of bread, a slice of cheese out of the plastic container, assembled the sandwich, and placed it onto the cooktop grill.
*During the meal service she used serving utensils for placing food onto plates for the residents.
*At 5:03 p.m. she went to the cooler with her gloved hands and got a plastic container of shredded cheese and placed it next to the service counter.
*With those same gloved hands she was observed placing foods into small dishes for soup or side dishes.
-When food had spilled onto the surface of the dish, she took her gloved right index finger and

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F 812	Continued From page 11	F 812		

moved the spilled food back into the serving container.
-She was observed to used her gloved right index finger to move food back into a serving dish on 3 more occasions during the meal service.

Interview on 4/3/23 at 5:20 p.m. with cook F revealed:
*She agreed she had missed opportunities for hand hygiene and glove changes during meal preparation and the food service.
*Her education and training was up to date on proper hand hygiene and glove usage.

Review of the provider's March 2023 revised Glove Use policy revealed:
*"Hands are to be washed thoroughly before putting gloves on and after taking gloves off.
*Gloves are to be changed:
-Before handling ready to eat foods.
-When coming in contact with something that is contaminated such as opening a trash can or touching a door knob or faucets."

2. Observation and interview on 4/3/23 at 3:18 p.m. with Cook F revealed:
*The walk-in cooler exhaust fans had tendrils of a dark, thick, fuzzy layer of debris that was blowing out from the fan covers.
*She had not been sure who had been responsible to ensure the fans were cleaned but thought maintenance was.

Observation on 4/4/23 at 5:10 p.m. of the walk-in cooler exhaust fans revealed they were in the same condition as above.

Interview on 4/4/23 at 4:37 p.m. with administrator A revealed:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 12 *Her expectation would have been for the staff to follow proper procedures for hand hygiene and glove use while working in the kitchen. *Cook F had received training on hand hygiene and glove use and had not followed the provider's policy. *She should have included the walk-in cooler exhaust fans on a cleaning list.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	806 W CEDAR BERESFORD, SD 57004

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 4/3/23 through 4/5/23. Bethesda of Beresford was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/26/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10595	A. BUILDING: _____ B. WING _____	04/05/2023

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BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/3/23 through 4/5/23. Bethesda of Beresford was found not in compliance with the following requirement: S296.	S 000		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the	S 296	Administrator or designee will enroll two staff members into the Serv Safe program by 5/20/23. On-going efforts to recruit for the open dietary manager include, but not limited to, increasing starting wage for the position, expanding advertisements for the position, or promoting a highly qualified staff member within the facility. All residents have the potential to be affected by this deficient practice. DON, Administrator and interdisciplinary team reviewed and revised as necessary the policy and procedure for Qualified Dietary Staff. Administrator or designee will audit the efforts of the vacancy of the position and review on-going recruitment efforts weekly for four weeks and monthly for two more months. Administrator or designee will present the audit findings at the monthly QAPI meetings for review. ✓	5/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 4/26/2023

* serv safe food manager
5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10595	A. BUILDING: _____ B. WING _____	04/05/2023

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S 296	Continued From page 1 residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Based on interviews, and job description review, the provider failed to ensure the acting dietary manager and at least one cook had been Serv Safe certified. Findings include: 1. Interview on 4/3/23 at 3:00 p.m. with Cook F. during initial kitchen tour revealed: *They currently had no dietary manager. *The administrator had been filling the position until someone could be hired. *It had been many months since they had a dietary manager on staff. *She had not been Serv Safe certified and was not aware of any dietary staff that had been certified. Interview on 4/4/23 at 4:16 p.m. with administrator A revealed: *The last certified dietary manager (CDM) had left in early October 2022. -She had worked as the CDM a few months, left for maternity leave, and put in her notice when she returned after her maternity leave ended. *They had recruited for the open dietary manager position but were not successful in getting someone hired. *She confirmed awareness that she had been required to have education and training if she served in the dietary manager position. *She had not enrolled in or started a dietary manager training program. *She was not Serv Safe certified. *None of the cooks or dietary staff had been Serv Safe certified.	S 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 296	Continued From page 2 Review of the provider's administrator job description revealed: *Recommends and develops policies and procedures for aspects of the care center according to state and federal regulations.	S 296		