STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035158	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society-Prescott Village	1030 Scott Drive Prescott, AZ 86301

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical record review, facility documents, and facility policy, the facility failed to ensure that two residents (#6 and #139) were not abused. Findings include - 1) Resident #6 was admitted on [DATE] with diagnoses of traumatic ischemia of muscle, and systemic Lupus Erythematosus. A significant change Minimum Data Set (MDS) dated [DATE] included that this resident was cognitively intact. A care plan initiated 8/23/2022 included that this resident had an Activities of Daily Living (ADL) self care performance deficit related to generalized weakness, osteoarthritis and rhabdomyolysis. This included that the resident has limited ADL function due to Bilateral Lower Extremity (BLE) weakness and that she needs assistance with toilet use and personal hygiene. A Reportable Event Record/Report included that at 9:00 AM on 4/25/2023, a Laundry Technician (staff #65) was walking by resident room and couldn't make out what resident had stated, but she heard Certified Nursing Assistant (CNA/staff #70) reply I am not going to keep wiping your ass just to get It on the right spot to resident #6. This document included that staff #70 was sent home pending the investigation and that this staff was terminated as a result of the Investigation. This document included that all staff will be re-educated on Resident Rights and Abuse and Neglect. An interview conducted with the laundry technician (staff #65) on 1/23/2024 at 2:12 PM, she said that she was walking by the resident's room and the CNA was yelling at her, I am not going to keep cleaning your ass!, i heard her say something but it was quiet and I immediately went to my supervisor. During an interview conducted on 1/24/2024 at 8:03 AM with resident #6 who said that it was a guy who was really rude and that she asked the male CNA to put barrier cream on her hemorrhoids as they were bothering her and that he said I don't want to touch you there However, refusal to perform care and derogatory statements are abusive. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #139 admitted on [DATE] with diagnoses of displaced fracture of the lateral malleolus of left fibula. A Discharge return not anticipated MDS dated [DATE] included that this resident was cognitively intact and did not have hallucinations or delusions. This document included that this resident required limited assistance for transfers and bed mobility and that walking in the room had only occurred 1 or 2 times in the look back period. A Reportable Event Record/Report dated 12/7/2022 included a witness statement from an Activities staff (staff #71) which included, As I was passing out The Daily Chronicle I entered the resident's room. Resident #139 was crying and obviously upset. She explained that she'd spilled her water, the nurse (RN/staff #72) came in and as she was wiping it up, told her she should Go to a mental hospital. The resident was very upset, shaking and crying. This document included that staff #72 was interviewed and stated that Is what she has been told to tell residents while on other agency contracts and didn't realize it was inappropriate. Staff #72 was removed from assignment and agency contract was terminated. A facility document dated 12/7/2022 included an interview with staff #72 who said that was what she was told to tell residents while on other agency contracts, that they could be sent to a mental institution or psychiatric facility for such behaviors and that she did not realize it was inappropriate. However, a reasonable person would conclude saying that residents would be sent to a mental institution or psychiatric facility constitutes a threat and is therefore abusive. An interview was conducted on 1/24/24 at 8:12 a.m. with a CNA (staff #14) who said that abuse is anything verbal, physical, and that she felt that neglect was part of abuse. I An interview was conducted on 1/24/2024 at 9:42 AM with a Registered Nurse (RN/staff #12) who said that abuse is anything that creates physical, mental, or emotional harm. This RN said that abuse can be verbal, physical, or financial. An interview was conducted on 1/24/2024 on 3:50 PM with the Administrator (staff #7) who said that her expectations for abuse was that they do not allow abuse in the facility and that staff are trained to report to their supervisor or her directly. She said that if there is any suspicion of abuse to report the abuse. She said for resident #6: staff notified her of the comment (CNA/staff #70) made and that an investigation was conducted and that staff #70 was terminated. She said that regarding resident #139: Staff notified her of a comment that was made as well. She said that could tell that the resident was upset so she terminated the contract of the agency staff who had caused the issue. A policy titled Abuse and Neglect - Rehab/Skilled, Therapy & Rehab dated 7/6/23 revealed that this document includes that the policy was that the resident has the right to be free from abuse and neglect. This document include the purpose of this policy was to ensure that residents are not subjected to abuse by anyone, including, but not limited to, location employees, consultants or volunteers, employees of other agencies serving the individual.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, interviews, and review of facility policies, the facility failed to ensure a resident's (#37) clinical record included the required information for transfer/discharge. The deficient practice could result in resident not receiving a safe and effective transition of care. Findings include: Resident #37 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), acute and subacute endocarditis (infection of tissue in the heart), and supraventricular tachycardia (irregular rapid heartbeat). A review of the admission Minimum Data Set (MDS), dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 07 out of 15, which indicated the resident had severe cognitive impairment. Per resident #37's clinical notes, the resident was discharged to Yavapai Regional Medical Center, via ambulance, on November 10, 2023 due to shortness of breath. Review of the clinical record revealed no evidence that a discharge summary had been completed. An interview was conducted on January 25, 2024 at 10:16 AM with the Director of Nursing (DON/Staff #5), who stated that a discharge summary should be done in a timely manner. The DON reviewed resident #37's clinical record and acknowledged there was no discharge summary on file and she expected it to be in the resident's clinical chart. An interview was conducted on January 25, 2024 at 10:45 AM with the facility Administrator (ADM/Staff #7) who stated she was not sure what the resident discharge policy was and she would need to check it to determine when a resident is to be provided with a discharge summary.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on record review, staff interviews, and the facility policy and procedures, the facility failed to ensure three residents were provided with a notification transfer/discharge in writing as soon as practicable. (#36, #3, and #37). Findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure, unspecified systolic congestion, and generalized anxiety. The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 13 indicating the resident was cognitively intact. The fall care plan dated September 3, 2022 revealed that the resident has had an actual fall with injury related to poor safety awareness, lacks insight, impulsive, cognitive impairment, impaired safety awareness, unsteady gait, risk taking behaviors, history of falls evidenced by not using the call-light for assistance, declined safety interventions. Review of the hospital transfer form dated November 14, 2022 revealed that the resident was transferred to the hospital because of a fall. A progress note datedNovember 14, 2022 revealed that the resident transferred to the hospital due to a fall. The resident's emergency contact was notified about the fall and transfer via a telephone call. Documentation of an email to the Administrator dated November 14, 2022 revealed that the resident sustained a pelvic fracture on November 13, 2022 after a fall in her room and was transferred to the hospital where she was admitted . Review of the clinical record did not reveal documentation of the resident being notified in a writing for the reason of the transfer. During an interview was conducted on January 25, 2024 at 11:18 AM with the (DON/staff #5) and the Administrator (staff #7), staff #7 stated that the resident was not given a written statement as to the reason why she was being transferred to the hospital because the facility doesn't do this. 48932 2) Based on clinical record review, staff interviews, and policy review, the facility failed to ensure residents #3 and #37 and/or the resident's representative was notified in writing of a transfer/discharge as soon as practicable. The deficient practice could result in residents having an unsafe discharge. Findings include: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #37 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), acute and subacute endocarditis (infection of tissue in the heart), and supraventricular tachycardia (irregular rapid heartbeat). A review of the admission Minimum Data Set (MDS), dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 07 out of 15, which indicated the resident had severe cognitive impairment. Per resident #37's clinical notes, the resident was discharged to Yavapai Regional Medical Center, via ambulance, on November 10, 2023 due to shortness of breath. There is no evidence in resident #37's chart that a notice of transfer/discharge was provided to the resident and/or their resident representative. An interview was conducted on January 25, 2024 at 10:11 AM with the Director of Nursing (DON/Staff #5) who indicated that social services was responsible for coordinating resident discharge paperwork that is not nursing related. The DON also indicated the facility's policy states that a written transfer/discharge notice should be given to the resident and their family. When reviewing resident #37's clinical record, the DON confirmed there was no indication that a written notice of transfer/discharge was provided to the resident or their family. An interview was conducted on January 25, 2024 at 10:29 AM with the facility Administrator (Staff #7) who indicated that in the event of an urgent transfer to an acute care facility, the facility nurse will then notify the resident representative about the transfer, verbally. This is then documented in a progress note. The ADM indicated that the facility does not provide a written transfer/discharge notice to residents and/or resident representatives when there is an emergency transfer/discharge. Review of facility policy titled, Discharge and Transfer - Rehab/Skilled, Therapy & Rehab, which was reviewed/revised on January 3, 2024, states if a resident is transferred to a hospital for an emergency, the transfer notice must be provided to the resident and/or their resident representative as soon as practicable.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on staff interviews, clinical record review and facility policy, the facility failed to ensure that a care plan was revised for 2 residents (#15, #21) Findings include: 1) Resident #15 was admitted on [DATE] with diagnoses of hemiplegia and epilepsy. An Admission Minimum Data Set (MDS) dated [DATE] included that this resident was moderately cognitively impaired, required extensive 2 person assist for transferring. Review of the clinical record included that this resident had a fall on 7/4/23. However, review of the clinical record did not find any new interventions for this fall. 2) Resident #21 was admitted on [DATE] with diagnoses of vascular dementia and generalized anxiety disorder. A 5 day Minimum Data Set (MDS) dated [DATE] included that this resident was moderately cognitively impaired, required extensive 2 person assist for transferring. This MDS included that this resident had a fall in the last month. Review of the clinical record included that this resident had fallen on 9/27/22. A progress note dated included that the resident was hospitalized for status post fall with a head injury and that this resident had a subdural hematoma treated at the most recent hospital admission. However, review of the clinical record did not find a care plan for falls until 11/20/22 or interventions put in place to prevent a fall on or about 9/27/22. An interview was conducted on 01/24/24 9:42 AM with a Registered Nurse (RN/staff #12) who said that resident #21 has had falls in the past and her interventions are to answer call lights and make sure someone is with her when she tries to transfer. This staff said that this resident falls because she attempts to walk on her own and is not capable. He said he now thinks she is finally realizing she cannot transfer alone. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 1/24/24 at 2:57 PM with a Licensed Practical Nurse Clinical Care Leader (LPN/staff #6) who said that when a resident falls, the staff should assess for injury, implement neurological assessment, take vitals, notify the resident's family, the Director of Nursing, the Administrator, the Provider and complete an incident report and fall worksheet. This staff said that there should be a fall huddle and that the staff should update the care plan with interventions. This staff member reviewed resident #15's careplan and said that there was not an intervention put in place for falls until 8/21/23 and that the staff should be putting in an intervention right away. This staff reviewed resident #21's care plan for interventions put in place after the 9/27/22 fall and said I don't see anything for falls. This staff looked again and said No, it's not there. An interview was conducted on 1/24/24 at 3:50 PM with an Administrator (staff #7) who said that her expectation was that when residents have a fall, that staff alert the nurse and the nurse should assess the resident, take vitals, and if able to, they should transfer the resident , then complete a fall investigation, that staff do risk management including myself, the Physician/Medical Director and the resident's power of attorney. She said that for each fall there should be a new intervention which is dependant on what caused the fall. She said that for resident #15, on 7/4/23 fall interventions included bed mobility for strengthening and it was implemented 8/14/23. She said that interventions should be implemented as soon as possible and that this intervention should have been done sooner. She said that for resident #21, the care plan included that her transfer status might have changed, and that her Activities of Daily Living(ADL) were updated on the care plan on 10/1/22 to say limited ADL function. However, the issue with this resident's fall was not related to staff transferring the resident. A policy dated 4/26/23 titled Falls Resource Packet Rehab/Skilled revealed that thte staff are expected to identify fall risk factors and choose the most appropriate intervention(s) and make them specific to the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on clinical review, staff interviews, and facility policy and procedures, the facility failed to assess and administer pain medications according to accepted standards of clinical practice for three residents (#16 and #30). The deficient practice could result in residents being over or under medicated. Findings include: 1) Resident #16 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, chronic kidney disease, Type II Diabetes, and major depression. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 5 indicating the resident has a severe cognitive impairment. The order summary revealed an order dated April 26, 2023 for Acetaminophen tablet 325 mg give 650 mg by mouth every 4 hours as needed for pain. Acetaminophen not to exceed 3,000 mg per day. Contact provider/practitioner if a fever is present. Review of the Medication Administration Record (MAR) dated January 2024 revealed that Acetaminophen tablet 325 mg give 650 mg by mouth every 4 hours as needed for pain was administered on January 1 and 5, 2024 with a pain scale of 5. 2) Resident #30 was admitted to the facility on [DATE] with diagnoses that included Ankylosis right hip, chronic kidney disease, and chronic obstructive pulmonary disease. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. The pain care plan dated August 3, 2023 revealed that the resident is on pain medication therapy related to a history of left shoulder surgery and right hip surgery. Interventions included to monitor the resident's condition based on clinical practice and guidelines or clinical standards of practice related to the use of Lyrica, Norco, Oxycodone, and Voltaren gel and the resident's pain is rated using he numeric rating scale (0-10). The order summary revealed: On July 17, 2023, there was an order for Acetaminophen tablet 325 mg give 650 mg by mouth every 4 hours as needed for pain, acetaminophen not to exceed 3,000 mg per day. Additionally there was an order dated October 4, 2023, for Ibuprofen oral tablet, 200 mg give 600 mg by mouth every 6 hours as needed for pain. There also was an order dated November 8, 2023, for Oxycodone-Acetaminophen oral tablet 5-325 mg, give one tablet by mouth every 24 hours as needed for pain and may administer one additional dose prior to therapy. Notify the provider if the resident refuses to participate in therapy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication administration record (MAR) dated December 2023 revealed: Acetaminophen tablet 325 mg give 650 mg by mouth every 4 hours as needed for pain was not administered. Ibuprofen oral tablet 200 mg give 600 mg by mouth every 6 hours as needed for pain was administered 16 times with a pain scale ranging from 2 to 8. Oxycodone-Acetaminophen oral tablet 5-325 mg give one tablet by mouth every 24 hours as needed for pain was not administered. Review of the medication administration record (MAR) dated January 2024 revealed: Acetaminophen tablet 325 mg give 650 mg by mouth every 4 hours as needed for pain for a pain level of 3-5 was administered 1 time on January 6, 2024 for a low-grade fever. Ibuprofen oral tablet 200 mg give 600 mg by mouth every 6 hours as needed for pain was administered 9 times with a pain scale ranging from 4 to 7. Oxycodone-Acetaminophen oral tablet 5-325 mg give one tablet by mouth every 24 hours as needed for pain was administered 15 times with a pain scale range of 6 and 9. During an interview conducted on January 24, 2024 at 3:37 PM with the Clinical Care Coordinator (staff #38) who stated that the orders for a pain medication that is administered as needed (PRN) must include a pain scale. He stated that the reason for the pain scale is to determine if the specific pain medication is appropriate for the level of pain. During the interview, staff #38 reviewed the clinical record for residents #16 and #30 and stated that the orders for PRN pain medications did not include pain scales. During an interview conducted on January 24, 2024 at 4:00 PM with the Director of Nursing (DON/staff #5) who stated that PRN pain medications orders do not need a pain scale, but the risk of not having a pain scale is that a pain medication may be administered unnecessarily. The facility's policy Administration of PRN Medications, AL-[NAME] dated November 4, 2022 states that PRN prescriptions will be administered consistent with the parameters specified in the prescriber's prescription and with the procedures identified by the registered nurse for the administration and documentation of the PRN.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical record review, facility documents, and staff interviews, the facility failed to ensure that a pharmacy medication recommendation was reviewed and implemented. Findings include: Resident #15 was admitted on [DATE] with diagnoses of Major Depressive Disorder and epilepsy. A care plan dated 11/12/23 included that the resident is on anticonvulsant medication therapy related to seizures and included interventions to monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of divalproex. A physician's order dated 5/5/2023 included Divalproex Sodium (anticonvulsant/valproic acid) Oral Tablet Delayed Release 125 MG give 4 tablets by mouth three times a day for seizures related to epilepsy. A pharmacy Consultation Report dated October 18, 2023 included Please monitor a valproic acid trough concentration on the next convenient lab day, 1 week after any dosage changes, every 6 months thereafter, and as clinically indicated. However, review of the clinical record did not include a record of the valproic acid levels being drawn. An interview was conducted on 1/23/24 at 1:29 a.m. with the Director of Nursing (DON/staff #5) who said she was unable to locate when the lab had been drawn but that it was being drawn today. An interview was conducted on 01/24/24 01:37 p.m. with a Licensed Practical Nurse Clinical Care Leader (LPN/staff #6) who said that he did not know if there was a staff member who was officially responsible. He said that when he was responsible he would get emails from the pharmacy and he would notify the provider, get approval and finish them up but that he had that responsibility taken from him a few DON's ago. He said that this resident's Depakote level was probably missed during the leadership transitions. He reviewed the laboratory results records and said that he was not able to find that this resident had a Depakote level drawn since before October. A follow-up interview was conducted on 1/24/24 at 4:17 p.m. with the DON (staff #5) who said that pharmacy review should be completed timely. She said that the time frame that she expects is that once the pharmacy reviews are emailed that they are presented the next business day to Medical Director or the residents' Primary Care Provider and that once the pharmacy reviews have been sent to the provider, that the staff follow up with him the next day if the reviews have not been performed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy titled Physician/Practitioner Orders dated 3/29/23 included that the purpose of the policy was to provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders. This document included Orders are processed and transcribed into PCC immediately upon receipt of an order, that all orders must be noted by the licensed nurse who has processed the order and that consultant orders are included.

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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. 40581 Based on observations, staff interviews, facility process and procedures, the facility failed to ensure that dishes and utensils were cleaned under sanitary conditions. The deficient practice could result in residents becoming ill. Findings include: The initial walk through of the kitchen was conducted on January 22, 2024 at 10:37 AM with the senior cook (staff #76), who stated that he was in charge of the kitchen. Staff #76 stated that the temperature gauge on the dishwasher had not been working since December 31, 2023, but he had been using an external thermometer in a red plastic cover to manually temp the dishwasher to ensure that the dishwasher was 160 degrees during the washing and rinse cycle. -The first attempt to temp the dishwasher during the wash cycle resulted in a 118-degree reading. -The second attempt to temp the dishwasher during the wash cycle resulted in a 140-degree reading. -The third attempt to temp the dishwasher during the wash cycle resulted in a 203-degree reading. Staff #76 stated that he was responsible for temping the dishwasher from January 1, 2024 to January 22, 2024 and had completed the dishwasher temp log. He stated that he had not had a day off from January 1, 2024 to January 22, 2024 and had taken the temperature of the dishwasher himself. Staff #76 reviewed the dishwasher temperature log for January 2024 and acknowledged that he had not initialed the log from January 1, 2024 through January 22, 2024 and there were no temperature readings documented mornings, noon, or evenings for the wash or the rinse cycle. He stated that he had written on the right side of the log 160 degrees, checked with external thermometer and drawn a line from January 1, 2024 through January 22, 2024 indicating that he had checked the temperature on the dishwasher for all three meals. He also stated that there was a risk of bacteria and residents getting sick if the washing machine temperature was not 160 degrees or higher. Review of staff #76's time card revealed that staff #76 did not work the weekend of January 13, 2024 and January 20, 2024. An interview was conducted on January 25, 2024 at 8:25 AM with the Administrator (staff #7), who stated that the facility is getting a new dishwasher on January 25, 2024. She also stated that it is her expectation that the dishwasher temperature log is initialed by the staff who checked the temperature each meal. During the interview, staff #7 reviewed the time card for staff #76 and stated that he did not work the last two weekends, so he could not have checked the dishwasher temperature if he was not here. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035158	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society-Prescott Village	1030 Scott Drive Prescott, AZ 86301

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy Ware Washing - Mechanical and Manual - Food and Nutrition dated April 3, 2023 states to compare the federal regulation, state regulations and manufacture's guidelines and write the appropriate temperatures and chemical concentrations on the dish machine temperature log. Check compliance for wash cycles and rinse cycles each meal service. High temperature wash cycle is 150 to 165 degrees F. and the rinse cycle is 150 180 degrees F. Review of the dishwasher instruction manual revealed that the minimum water temperature for sanitizing during the wash cycle is 150 degrees F. and the rinse cycle is 180 degrees F. Based on observations, staff interviews, facility process and procedures, the facility failed to ensure that dishes and utensils were cleaned under sanitary conditions. The deficient practice could result in residents becoming ill.