STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 For the standard Medicare/Medicaid recertification survey started on August 4, 2014 and completed on August 7, 2014, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and facility policy, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 2 of 21 sampled residents (Resident #7 and #12) and 1 supplemental resident (Resident #25). Failure to knock on doors prior to entering residents' rooms (Resident #12 and #25) and provide privacy during cares (Resident #7) does not promote residents' dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Bath, Bed" occurred on 08/07/14. This policy, dated September 2011, stated, ". . . PROCEDURE: . . . 2. Provide privacy. . . ."	F 241	1. The primary CNA's (#2, #3 and #4) for residents #7, #12 and #25 were disciplined for not following facility policies and procedures. These policies and procedures were also reviewed with them. 2. All residents have the potential to be affected. 3. The "Bath, Bed" policy and also "Elim CNA Standard Cares" were reviewed. No changes were made to the "Bath, Bed" policy. An addition was added to the "Elim CNA Standard Cares" policy stating "Respect the dignity of all residents by assuring their privacy, i.e. pulling privacy curtains, knocking on door and waiting for a response or requesting permission before entering. If there is no response, staff may open the door partially to	

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

T Hagen — Administrator — 8-24-14

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 241	Continued From page 1 - During initial tour on 08/04/14 at 1:20 p.m., a CNA (#3) entered Resident #25's room without knocking. After entering the room, the CNA (#3) said "knock knock" when he saw the surveyor. - Observation on 08/05/14 at 8:20 a.m. showed a certified nursing assistant (CNA) (#2) assisted Resident #7 into a tub bath. An administrative nurse (#1) knocked on the spa room door and the CNA (#2) stated "come in." The administrative nurse (#1) entered the spa room and Resident #7 covered her upper body with her arms. CNA (#2) failed to close the privacy curtain. - Observation on 08/05/14 at 9:04 a.m. showed a CNA (#4) entered Resident #12's semi-private resident room in response to Resident 12's call light. Resident #12 and her roommate were in their beds. The CNA (#4) entered the room without knocking or requesting permission to enter the room.	F 241	ensure resident's safety." Similar wording was also added to the CNA Orientation Check list and the Annual Competency Checklist. All nursing staff will be educated at a meeting on September 3, 2014 regarding the updated "Elim CNA Standard Cares" policy and use of privacy curtains and knocking and the revised CNA Orientation Checklist and Annual Competency Checklist. 4. The Quality Assurance Coordinator will audit residents #7, #12 and #25 to assure that the addition to the "Elim CNA Standard Cares" is being followed. These residents will be audited weekly x 4 weeks, monthly x 3 months and quarterly thereafter. Random audits on an additional 3 residents a week will be conducted in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be taken. The Quality Assurance coordinator will report to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	9/10/14
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, resident group interview, and staff interview, the facility failed to ensure 1 of 15	F 246		

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F 246	Continued From page 2 sampled residents (Resident #12) who required extensive assistance for toileting and 3 supplemental residents (Resident A, B, and C), received assistance with activities of daily living (ADLs) when activating their call lights. Residents reported failure to provide assistance resulted in half hour to one hour wait times for toileting and resulted in Resident #12 waiting for one hour after activating her call light three times. Findings include: - During the group interview on 08/05/14 at 9:15 a.m. Resident A stated staff members turn off her call light and say they will be right back and return a half hour to an hour later. Resident A, Resident B, and Resident C stated they "quite often" wait a half hour for their call lights to be answered. - Review of Resident #12's medical record occurred on August 04-07, 2014. The resident's current diagnoses included history of a right hip fracture in the facility in March 2014. The quarterly Minimum Data Set (MDS), dated 06/09/14, identified the resident usually made herself understood and understood others, was cognitively intact, required extensive assistance of two persons for transfers, extensive assistance of one person for toileting, and was continent of bowel and bladder. Resident #12's medical record showed the physician advanced her weight bearing status from no weight bearing to weight bearing as tolerated on 06/02/14. The resident's current care plan identified she required assistance of one person for transfers. Observation on the morning of 08/05/14 showed	F 246	1. A visit by the Social Worker and Nursing Unit Manager will be conducted with resident #12 to review her current rising time. Facility staff will be updated regarding her wishes via care plan and Resident Profile. The facility holds Resident Town Hall meetings monthly for all residents, including A, B and C to attend and express any issues and/or concerns they may have. In the past 6 months no concerns regarding call lights were expressed by any residents. Residents will be reminded to bring up concerns such as call lights at the next Town Hall meeting on August 28, 2014. The "Call Light Monitoring" policy will be also reviewed. CNA's #4 and #6 were disciplined for not following the "Call Light Monitoring" policy and the policy was reviewed with them. 2. All residents have the potential to be affected. 3. The "Call Light Monitoring" policy was reviewed and revised. The "Gait Belt" policy was reviewed and revised. All nursing staff will be educated at a meeting on September 3, 2014 regarding the revised "Call Light Monitoring" and "Gait Belt"	

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F 246	Continued From page 3 Resident #12 lying in bed and the following sequence of events: *8:15 a.m. - Call light activated, the resident waiting for staff response, and stated she is hoping to get up for the day. *8:20 a.m. - A certified nursing assistant (CNA) (#4) entered the resident's room, turned off the call light, and said she would get some help. *8:50 a.m. - Resident #12 remained in bed. *9:00 a.m. - Resident #12 remained in bed. The resident reported she activated her call light again and a CNA (#6) responded, turned off the call light, said she would "check" on help, and did not return. Resident #12 activated her call light again. *9:04 a.m. - A CNA (#4) entered the room and indicated that if the resident's assigned CNA was busy, she would help. The CNA (#4) left the room, returned, and stated the resident's assigned CNA would be coming to help. *9:18 a.m. - A CNA (#3) entered the room and began to assist Resident #12 out of bed, to the bathroom for toileting, morning cares, and to get dressed. *9:45 a.m. - The CNA (#3) completed Resident #12's morning cares and transported the resident to the dining room for breakfast. During interview, on 08/05/14 at 8:40 a.m. and at 4:30 p.m., Resident #12 reported staff turn off her call light and she waits more than half an hour for assistance a "couple times a week, depends who's working" and it happens more on evenings and nights. During interview, on 08/06/14 at 7:40 a.m., at the completion of Resident #12's morning cares, a CNA (#7) reported the resident prefers to rise early and before her hip fracture was "independent, up at 6:00 a.m."	F 246	policies. All other departments will be notified via When-To-Work e-mail message. 4. The Quality Assurance Coordinator will audit resident #12 to assure the call light is being answered as per policy. This resident will be audited weekly x 4 weeks, monthly x 3 months and quarterly thereafter. Any residents bringing up concerns at the Resident Town Hall meetings regarding issues with their call lights not being answered as per policy will be audited in the same manner. If no residents express concerns random audits will be conducted on an additional 3 residents in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be taken. The Quality Assurance Coordinator will report to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	9/10/14

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F 246	Continued From page 4 During interview, on 08/07/14 at 9:30 a.m., a supervisory nursing staff member (#1) agreed Resident #12 should not have waited more than one hour for staff assistance. Failure to answer call lights and provide assistance in a timely manner may result in avoidable incontinence, loss of dignity, and a decreased quality of life.	F 246		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 1 of 4 sampled residents (Resident #6) observed during an EZ stand (sit-to-stand mechanical lift) transfer, and for 1 of 10 sampled residents (Resident #8) observed during a gait belt transfer. Failure to ensure proper use of an EZ stand lift and a gait belt may result in avoidable falls and injuries to residents. Findings include: Review of the facility policy titled "Gait Belts for	F 323	1. The care plan for Resident #6 did reflect that she was to be transferred using the EZ stand and 2 assist. CNA #14 was disciplined for not following resident's plan of care and re-education provided on the "Mechanical Stand" policy. CNA #4 was disciplined for not following "Gait Belts for Transfer" policy and re-education provided. 2. All residents currently using an EZ stand and/or gait belt have the potential to be effected. 3. The "EZ Stand" policy was reviewed and revised to include criteria for use of the stand vs the lift. The "Gait Belts for Transfer" policy was also reviewed and revised to include "NEVER lift a resident under their arms unless care planned to do so. This was also added to the "Elim CNA Standard Cares" policy,	

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F 323	Continued From page 5 Transfer" occurred on 08/07/14. This policy, dated 2011, stated, ". . . 4. To transfer: a. Assist resident to a standing position by grasping the secured belt at the waist. b. Pivot resident into chair or bed. . . ." - Review of Resident #6's medical record occurred on August 5-7, 2014. Diagnoses included generalized pain, osteoporosis, and Alzheimer's disease. The current care plan stated, ". . . TRANSFERS: Assist of 2 using the EZ-stand. . . ." Observation on 08/05/14 at 9:10 a.m. showed only one certified nursing assistant (CNA) (#14) transferred Resident #6 from her bed to the bathroom using an EZ-Stand lift. During the transfer, the sling around the resident's back slipped upward into her axillae, which caused her arms to bow outward and her shoulders to shrug upward. Observation also showed the resident's knees slightly bent. During the transfer, the resident stated, "Oww, oww, oww," and "I can't stand this." Resident #6 was again positioned in the lift as above during the transfer from the toilet to her wheelchair. ~~During an interview on 08/06/14 at 9:49 a.m., a~~ CNA (#13) stated Resident #6 needs two staff members for transfers with the EZ-Stand because "she doesn't hang on," so one staff member needs to ensure the resident hangs on during the transfer. During an interview, on 08/07/14 at 11:07 a.m., a supervisory nurse (#8) verified Resident #6 required two staff for transfers with the EZ stand. - Review of Resident #8's medical record	F 323	the CNA Orientation Checklist and the Annual Competency Checklist. All nursing staff will be educated at a meeting on September 3, 2014 regarding revised policies and checklists. All residents currently using the EZ stand will be screened to ensure resident safety. All residents are to use gait belts unless care planned otherwise. 4. The Quality Assurance Coordinator will audit resident #6 and #8 for proper transfers and to ensure facility policies are being followed. These residents will be audited weekly x 1 month, monthly x 3 months and quarterly thereafter. Random audits on an additional 3 residents will be conducted in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be taken. The Quality Assurance Coordinator will report to the Quality Assurance Committee at each scheduled meeting.	

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F 323	Continued From page 6 occurred on all days of survey. Diagnoses included dementia, anxiety, and generalized pain. The resident's current care plan stated, "... PROBLEM: Mobility ... APPROACH: ..., Assist of 1 to transfer ..." Observation on 08/05/14 at 5:05 p.m. showed two CNAs (#4 and #5) transferred Resident #8 from her recliner to her wheelchair. The CNA (#4) held onto the gaitbelt with one hand and lifted under Resident #8's left arm with her other hand. The staff member failed to properly utilize the gait belt to assist Resident #8.	F 323	5. See "Completion Date" column.	9/10/14
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1. The care plan and Resident Profile for Resident #8 were updated to include specifically how her anxiety is exhibited for her individually and individualized interventions to attempt prior to giving a PRN medication. 2. Any residents receiving PRN anti-anxiety medications have the potential to be affected. 3. The "Medication Administration-General" and "Psychotropic Drug Use" policies were reviewed and revised. Documentation on the EMAR was revised and staff will be required to enter a reason the medication was given as well as non-pharmacological interventions attempted and those results prior to	

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F 329	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 7 sampled residents (Resident #8) receiving an as needed (PRN) antianxiety medication. Failure to adequately assess the resident and attempt non-pharmacological interventions prior to administering an antianxiety medication placed Resident #8 at risk of receiving an unnecessary medication. Findings include: Review of the facility policy titled "Medication Administration- General" occurred on 08/07/14. This policy, dated December 2013, stated, ". . . ADMINISTRATION . . . 3. Prior to giving PRN Medications refer to the individual resident care plan for non-pharmacological interventions. . . . DOCUMENTATION . . . 5. When PRN medications are administered, the following documentation is provided: . . . c. Complaints or symptoms for which the medication was given. Be specific. When administering psychopharmacologic drugs (example, for anxiety, etc. [et cetera]), chart symptoms such as 'breathing rapidly' or 'excessive worrying.' . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. The record identified a physician's order, dated 05/14/14, for lorazepam	F 329	giving the medication. Interventions are individualized and identified on each resident's care plan. All residents currently receiving PRN anti-anxiety medications will be audited to ensure that the revised policies are being followed. All nursing staff will be educated at a meeting on September 3, 2014 regarding revisions to policy and how to operate the revised MAR documentation. 4. The Quality Assurance Coordinator will audit resident #8 for use of non-pharmacological interventions prior to giving PRN anti-anxiety medications. These interventions are resident specific and on the care plan and Resident Profile. This audit will also include follow-up documentation as to the effectiveness of either the interventions or medication. Other residents identified in the audit will also be audited randomly. These audits will be conducted weekly x 1 month, monthly x 3 months and quarterly thereafter. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be taken. The Quality Assurance	

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F 329	Continued From page 8 (Ativan) 0.5 milligram (mg) orally four times a day PRN for anxiety. Resident #8's current careplan stated, ". . . PROBLEM: Mood - dx [diagnoses] of anxiety, dementia. Resident reports feeling anxious at times . . . Resident will become anxious waiting for dau. [daughter] to come visit and will frequently ask about her. At times has increased anxiety when taking medications. . . . APPROACH: Offer meds [medications] one at a time on a spoon if having increased anxiety with med administration . . . Offer reassurance that dau. [daughter] is safe when resident becomes anxious while waiting for dau. [daughter] to visit. Dau. [daughter] will often let staff know if she is coming - if staff aware dau. [daughter] is coming, offer reassurance dau. [daughter] is on her way. Encourage resident to verbalize concerns. Provide support and encouragement as needed. Resident enjoys visiting and greeting staff when she is seated in the commons area. Strength: Dau. [daughter] visits often and is a source of support to resident. . . ." Review of Resident #8's May and June 2014 PRN medication administration record (MAR) identified staff administered Ativan as follows: * 05/24/14 at 4:52 p.m.: ". . . Reason: Other ...'. increased anxiety after [sic] . . . Result: Effective . . . sleeping . . ." * 06/02/14 at 5:57 p.m.: ". . . Reason: Other . . . anxiety . . . Result: Effective . . ." * 06/12/14 at 9:31 a.m.: ". . . Reason: Behavior issue . . . Increased anxiety and increased irritability . . . Result: Effective . . ." * 06/14/14 at 6:10 p.m.: ". . . Reason: Behavior issue . . . cryng [sic] attempting to strike . . . Result: Effective . . . Res. [resident] presents with	F 329	Coordinator will report results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	9/10/14

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F 329	Continued From page 9 a calm affect, sitting in commons this evening, now resting in bed comfortably . . ." * 06/17/14 at 10:03 a.m.: ". . . Reason: Behavior issue . . . increased anxiety, repetitive movements, yelling out . . . Result: Effective . . ." * 06/18/14 at 11:40 a.m.: ". . . Reason: Behavior issue . . . repetitive . . . Result: Effective . . ." Review of Resident #8's progress notes identified the following: * 06/17/14 at 10:19 a.m.: ". . . Resident noted to try and move the tables in the dinning [sic] room. Resident was offered toileting and stated that she was no longer hungry. This RN [registered nurse] placed resident at a table away from other residents where she could see outside. PRN Ativan administered. Resident was brought to her room and is sitting in her recliner at this time. She appears to be comfortable and is smiling and laughing at this time." On five of six occasions, nursing staff administered PRN Ativan prior to attempting non-pharmacological interventions. During an interview on 08/07/14 at 8:20 a.m., a supervisory nurse (#1) stated staff are expected to attempt non-pharmacological interventions prior to administration of PRN medications. During an interview on 08/07/14 at 9:57 a.m., a supervisory nurse (#8) stated staff are expected to document in progress notes the non-pharmacological interventions they attempted prior to administration of PRN medications. The record lacked evidence staff assessed Resident #8 to determine the possible cause of	F 329		

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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 329	Continued From page 10 her anxiety or implement the careplan approaches or other non-pharmacological interventions to address the anxiety prior to administering PRN Ativan. Failure to assess Resident #8 and attempt alternative interventions placed the resident at risk of receiving an unnecessary medication.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, review of professional literature, and staff interview, the facility failed to follow professional standards for medication administration for 1 of 3 sampled residents (Resident #1) who recieved medication without the appropriate timing between doses. Failure to administer medications with adequate time lapse between doses has the potential to cause increased sedation or inadequate pain relief. Findings include: Review of the facility policy titled "Medication-Pass Times" occurred on 08/06/14. This policy, dated 2012, stated, "Purpose: To dispense medication in a timely fashion while also complying with resident, family, and physician wishes. Procedure: . . . 3. Elim used a liberalized medication pass system as identified below: A.M. 07:00-10:00 Midday 11:00-14:00	F 333	1. The MAR for resident #1 has been updated to reflect the time range for medication administration between doses. 2. All residents have the potential to be affected. 3. The "Medication-Pass Times" policy was reviewed. Elim will continue to use the liberalized med pass, however, the time parameters have been changed for medications ordered TID and QID to provide an adequate time lapse between doses. The nurses are able to view the last time a medication was given and are to monitor that as well. All residents MAR's will be reviewed to ensure that those with medications ordered TID and/or QID are changed to reflect the revised policy. All nursing staff will be educated at a meeting on September 3, 2014 regarding the revised "Medication-Pass Times" policy and the need to check time	

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	355085	A. BUILDING _____ B. WING _____	08/07/2014

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F 333	Continued From page 11 P.M. 15:00-18:00 H.S. 19:00-23:00 . . . Three times daily medications will be given at A.M., Midday and P.M. . . ." Review of the Division of Health Facilities Position Paper titled "Medications Administration" dated 2005, stated, ". . . General Dosing Schedule: . . . TID between 6 to 8 hours apart . . ." Review of the website "www.drugs.com/dosage/ultram" stated, "Ultram Dosage generic name tramadol hydrochloride . . . Ultram 50 to 100 mg [milligrams] can be administered as needed for pain every 4 to 6 hours . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and generalized pain. Resident #1's physicians orders identified the resident on the following pain medications: * tramadol 50 mg three times a day and 25 mg every six hours as needed for pain * Aleve 220 mg one time a day and twice a day as needed for pain Resident #1's medication administration record (MAR) identified the resident received tamadol 50 mg three times a day scheduled for the following times: * A.M. 7:00 a.m.- 9:00 a.m. * Midday 12:00 p.m.- 2:00 p.m. * P.M. 5:00 p.m.- 7:00 p.m. Review of the medication administration record from 07/08/14 to 08/06/14 (29 days) identified on 13 occasions Resident #1 received the pain medication tramodol without appropriate timing	F 333	last given prior to administering a medication. 4. The Quality Assurance Coordinator will audit resident #1 to ensure medications ordered TID and/or QID have an appropriate time lapse between doses. These audits will be conducted weekly x 1 month, monthly x 3 months, and quarterly thereafter. Random audits of 3 residents per week will also be conducted in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will report results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion date" column.	9/10/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	Continued From page 12 between doses. The time between doses of the medication ranged from two hours eleven minutes to three hours forty seven minutes. During an interview on the afternoon on 08/06/14, an administrative nurse (#16) stated the nursing staff check the time stamp on the MAR for the time of the last dose of medication and give the next dose accordingly. During an interview on the afternoon on 08/07/14 two administrative nurses (#15 and #16) stated their consulting pharmacist reported tramadol required four hours of time lapse between each dose.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. All dietary staff were re-educated on 8/14/14 and 8/22/14 to compare sanitizer test strip to container; record the results on monthly sanitizer logs; sheet rock above dish machine replaced; walk- in cooler fan cleaned. 2. All residents have the potential to be effected.	9/10/14
	This REQUIREMENT is not met as evidenced by: Based on observation, review of chemical strip instructions, review of sanitizer logs, and staff interview, the facility failed to ensure staff followed proper procedures for testing the chemical concentration of the dishmachine sanitizer, failed to identify the correct concentration level for the sanitizer, and failed to		3. Sanitizer logs updated to include comparing test strip to container and recording ppm; checking wall/ceiling in kitchen weekly added to cleaning schedule; cleaning of walk-in cooler fan added to cleaning schedule.	9/10/14

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F 371	Continued From page 13 ensure a sanitary environment regarding cooler fans and non-cleanable surfaces in 1 of 1 kitchen. Failure to follow proper testing procedures and concentration levels of the dishmachine sanitizer and failure to maintain the kitchens free of dust, debris, and other environmental hazards has the potential to place residents, visitors, and staff at risk of food borne illness. Findings include: Observation during the initial dietary tour, on 08/04/14 at 1:20 p.m., showed a supervisory dietary staff member (#10) tested quaternary (quat) sanitizer located in a three-compartment sink. The staff member pulled out the strip and stated, "It's supposed to be a light green color," and showed the strip to the surveyor. Observation showed no color reference chart on the container which contained the strips, and the staff member did not compare the strips to a guide. Upon surveyor request, the staff member retrieved a new package of strips which contained a color reference chart. The staff member then compared the strip to the color chart, which showed a quat concentration of 200 parts per million (ppm). Although the concentration level of the quat was acceptable, the staff member did not initially compare the strip with the color reference chart. Observation showed a dietary staff member (#9) operating the dishwashing machine on 08/05/14 at 8:35 a.m. When asked to check the chemical concentration of the chlorine sanitizer, the staff member retrieved a chlorine test strip from a container, but did not take the container with her to the dishmachine. After the staff member tested the sanitizer water, she showed the surveyor the	F 371	4. Sanitizer logs and cleaning schedules to be audited weekly for one month; continue to monitor audits monthly. Staff will be observed with test strips. The audits are completed by Kathy Gullickson or Lisa Aipperspach. 5. See "Completion Date" column. Telephone call per Kathy Gullickson, Dietician/H.K. 9/15/14	9/10/14 9/10/14

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F 371	Continued From page 14 strip and said it was "ok." When asked how she knows what concentration it is, she stated "it should be light purple." The surveyor retrieved the chlorine strip container and asked the staff member what the concentration is expected to be. The staff member stated, "between 10 and 50 [ppm]." Review of the manufacturer's instructions on the chemical strip container stated ". . . dip strip into solution to be tested. . . and compare immediately with the color chart on label. . . ." The staff member then stated she shows the strip to the cook and the cook records it on a log. The staff member (#9) brought the strip to the cook (without taking the container) and the cook (#12) looked at the strip and recorded her initials on the log. The sanitizer log contained only initials, not the ppms of the sanitizer concentration. When asked about comparing the strip to the color reference on the container, the cook (#12) indicated staff know what the color should be. Failure to compare the chemical strip with the color indicator chart does not ensure an accurate reading of the chemical concentration. The main tour of the kitchen occurred on 08/05/14 at 3:15 p.m. with two administrative dietary staff members (#10 and #11). During an interview, an administrative dietary staff member (#10) stated the facility converted the dishmachine from a high temperature sanitizer to a chemical sanitizer in February 2014. When asked what the concentration of the chlorine sanitizer should be, the staff member (#10) stated they were instructed by the chemical company the concentration should be 10-50 ppm. The surveyor asked the staff members for the manufacturer's directions or documentation for this chemical concentration. The staff members stated they would look for this information. No	F 371		

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F 371	Continued From page 15 documentation was provided to the surveyor. Observation of a low sheet-rock/plasterboard-type ceiling directly above the dishware trays (exiting the dishwashing machine) showed several nicks and gouges. When the surveyor lightly touched these gouged areas, small grains of dust/debris fell onto the tray of dishware. Both dietary staff members (#10 and #11) agreed staff should repair or replace the ceiling. Observation in the walk-in cooler showed two compression fans in the ceiling with black dust/debris. During interview on 08/07/14 at 8:00 a.m. an administrative dietary manager (#11) stated a representative from the dishmachine chemical company came yesterday and checked the dishmachine. The representative informed them the chemical concentration should be 50 ppm chlorine.	F 371		