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	355079	A. BUILDING _____ B. WING _____	01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 01/17/17 and completed on 01/19/17, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--	F 280		2/23/17

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

Electronically Signed | 02/09/2017

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F 280	Continued From page 1 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 280		

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F 280	Continued From page 2 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 3 of 21 sampled residents (Resident #3, #4 and #6). Failure to revise the care plan limited the ability for staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "RAI [Resident Assessment Instrument] Process" occurred on 01/19/17. This policy, dated August 2015, stated, "Policy: The RAI process (MDS [Minimum Data Set], CAA [Care Area Assessment], and Care Planning) will be completed according to current state and federal regulations . . . Procedure: 1. The MDS will be used to collect basic physical, functional, and psychosocial data about the resident. 2. The CAA process will assist the interdisciplinary team in developing a comprehensive plan of care. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included a mood disorder due to known physiological condition with depressive features.	F 280	1. Corrective Action: It is the practice of the facility to maintain a comprehensive care plan. The care plan of resident #4 was updated to reflect I have a mood problem/depression related to diagnosis of mood disorder due to know psychological condition with depressive features, insomnia, altered living environment, loss of independence and pain with associated goal(s) and interventions on 1/19/2017. Education will include reminding nursing and case management staff to include care plan entries involving mood disorder and anxiety on the comprehensive care plan. The care plan of resident #6 was updated to reflect I am receiving end of life comfort care related to Hospice of the Red River Valley for cirrhosis of the liver with associated goal(s) and interventions on 1/19/2017. Education will include reminding nursing and case management staff to include care plan entries involving collaboration with Hospice of the Red River Valley on the comprehensive care plan. The care plan of resident #3 was updated to reflect I keep my padded gait belt on during waking hours as a means	

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F 280	Continued From page 3 Medications included buspirone [antianxiety] three times daily for "mood disorder" and Cymbalta [antidepressant] twice daily for "mood disorder." Resident #4's admission MDS, dated 12/28/16, indicated the behavior "rejection of care" occurred on 4 to 6 days of the 7-day lookback period and CAAs triggered included behavioral symptoms and psychotropic drug use. During an interview on 01/19/17 at 11:30 a.m., a nursing supervisor (#1) stated the facility did not care plan Resident #4 for psychotropic medications because he was admitted on them, and he had no mood problems. The facility failed to include on the care plan a problem related to Resident #4's behaviors and use of psychotropic medications. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included cirrhosis of the liver, with an order for admission to Hospice, dated 05/09/16. The chart contained a "Hospice Quick Reference Guide" to alert nursing facility staff to call Hospice before doing certain tasks, such as calling the physician or an ambulance, suctioning the resident, or regarding orders related to the terminal illness process, and when the resident is actively dying. Resident #6's current care plan included the following: * "Focus: I have nutritional problems . . . weight loss, and hx [history] of skin breakdown . . . Goal for comfort. . . . Interventions: . . . Alert nurse/dietitian if not consuming [supplements] on	F 280	of fall prevention on 1/25/2017. 2. Identify other residents: All residents including, but not limited to, those having a mood or anxiety disorder, those receiving collaborated care through Hospice of the Red River Valley and those who utilize a padded gait belt have the potential to be affected by this deficient practice. 3. Measure put in place: Nursing and case management staff will be educated to include care plan entries related to mood and anxiety in the comprehensive care plan. Nursing and case management staff will be educated to include care plan entries related to collaborated care with Hospice of the Red River Valley in the comprehensive care plan. Nursing staff will be educated to include care plan entries related to use of padded gait belts in the comprehensive care plan. Interdisciplinary Team meetings will be held regularly. These meetings will include discussions topics of new admissions, hospital returns, discharges. We will also discuss residents who have had a transfer of care, changes in condition, pain concerns, skin issues, infections, falls and other pertinent information. The individualized comprehensive care plan will be updated as necessary following these meetings. 4. Monitoring: A quality audit will be conducted for residents that have a mood or anxiety disorder. This audit was first conducted on 2/13/17. The audit will be conducted monthly for the first quarter	

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F 280	Continued From page 4 a routine basis. Obtain and monitor lab/diagnostic work as ordered. Follow up as appropriate." The facility failed to identify the Hospice team's involvement regarding nutritional concerns. * "Focus: I am at risk for dehydration or potential for unstable fluid status . . . Goal is for comfort. . . . Interventions: . . . Monitor/document/report to MD PRN [as needed] s/sx [signs/symptoms] of dehydration . . . Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as appropriate. . . ." The facility failed to identify the Hospice team's involvement regarding dehydration. * "Focus: ". . . potential for pain/actual pain or discomfort related to hx [history] of hip fracture, chronic infection, nausea, liver cirrhosis, ascites and end of life . . . Interventions: . . . Monitor/document for side effects of pain medication. Observe for constipation, . . . nausea; vomiting; dizziness and falls. Report occurrences to the physician. . . ." The facility failed to identify the Hospice team's involvement in pain/other symptom control. * "Focus: I have advanced care plan wishes . . . Interventions: . . . My preference for having someone present if I am actively dying is : Family as able. . . ." The facility failed to identify the Hospice team's involvement in the dying process. * "Focus: . . . potential to exhibit mood symptoms . . . Interventions: . . . Discuss with me and my family any concerns, fears, issues regarding health or other subjects as needed/requested." The facility failed to identify the Hospice team's involvement in addressing the resident's concerns or fears. The care plan failed to identity Hospice's	F 280	and quarterly thereafter. A quality audit will be conducted for residents that are receiving collaborated care with Hospice of the Red River Valley. This audit was first conducted on 2/13/17. The audit will be conducted monthly for the first quarter and quarterly thereafter. A quality audit will be conducted for residents that utilize a padded gait belt. This audit was first conducted on 2/2/17. The audit will be conducted monthly for the first quarter and quarterly thereafter. These audits will be completed by the Quality and Learning Coordinator and/or designee. The facility's Interdisciplinary Team will continue to meet to assure care plans are reflective of any resident's current status. If concerns are noted, immediate corrective action will be taken by the Quality and Learning Coordinator and/or designee. 5. The facility will be in substantial compliance by February 23, 2017.	

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F 280	Continued From page 5 involvement in Resident #6's care, along with specific Hospice responsibilities. - Review of Resident #3's medical record occurred on January 17-18, 2017. Diagnoses included Parkinson's disease and dementia. Observation on all days of survey identified a padded gait belt around Resident #3's waist when he was out of bed. The current care plan lacked the use of the padded gait belt. During an interview on 01/18/17 at 5:55 p.m., an administrative nurse (#2) stated staff implemented the padded gait belt for safety due to Resident #3's impulsive movements.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure staff reassessed the response to as needed (PRN) pain medications in a timely manner for 3 of 21 sampled residents (Resident #10, #11, and #18) identified with orders for PRN pain medications. Failure to timely reassess after administering a PRN pain medication limits the ability for staff to assess the effectiveness of the pain medication and may result in the resident experiencing	F 281	1. Corrective Action: It is the practice of the facility to reassess timely after administering PRN pain medication. Education was provided to nursing staff on timely reassessment after administration of PRN pain medications for Resident #10, Resident #11, and Resident #18 on 2/6/2017. 2. Identify other residents: All residents that have orders for a PRN pain medication have to potential to be	2/23/17

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F 281	Continued From page 6 unrelieved pain. Findings include: "Nursing 2013 Drug Handbook," 33rd Edition, Wolters and Kluwer, Pennsylvania, stated the following: * Page 68: " . . . acetaminophen [Tylenol] . . . Analgesic . . . peak [highest level of pain relief at] 1/2 - 2 hr [hour] . . ." * Page 1027: " . . . oxycodone . . . opioid analgesic . . . peak 1 hr . . ." * Page 1354: " . . . Tramadol . . . Analgesic . . . peak 2 hr . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice." 9th ed., Pearson Education Inc., New Jersey, page 1227- 1229, stated," . . . NONOPIOID ANALGESICS/NSAIDS [nonsteroidal anti-inflammatory drugs] FOR MILD PAIN - *Acetaminophen (Tylenol . . .) . . . OPIOID ANALGESICS FOR MODERATE PAIN - *Tramadol . . . OPIOID ANALGESICS FOR SEVERE PAIN . . . *Oxycodone . . . NURSING RESPONSIBILITIES *Assess pain prior to and 60 minutes after administration . . . Evaluate the effectiveness of pain control measures used through ongoing assessment . . ." Review of facility policy titled "Medication Administration by Medication Aide" occurred on 01/19/17. This policy, revised October 2016, stated, " . . . OBJECTIVE: To increase nurse availability to do assessments and coordinate plan of care. . . . PROCEDURE: . . . The nurse is to complete any follow up necessary in a timely manner. . . ."	F 281	affected by this deficient practice. Residents were identified through a report from our EHR who are receiving PRN pain medications. 3. Measure put in place: Nursing staff will be educated on the importance of timely reassessment after administering PRN pain medication. 4. Monitoring: A quality audit will be conducted to assure there is timely follow up after administering PRN pain medications. This audit will be conducted weekly for one month, then monthly for 2 months, then quarterly thereafter. This audit will be completed by the Quality and Learning Coordinator and/or designee. This audit was first conducted the week of February 6, 2017. If concerns are noted, immediate corrective action will be taken by the Quality and Learning Coordinator and/or designee. 5. The facility will be in substantial compliance by February 23, 2017.	

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F 281	Continued From page 7 - Review of Resident #10's medical record occurred on January 17 -18, 2017. Diagnoses included pressure ulcer on left lateral ankle, fracture of left fibula, and arthritis. An admission Minimum Data Set (MDS), dated 12/14/16, identified presence of occasional pain rated 6 on a scale from 0 to 10 (0 is no pain and 10 is the worst pain imaginable). The current care plan stated, "Focus . . . I have actual pain related to: Disease process, Fracture, Wound . . . Interventions . . . Evaluate the effectiveness of pain interventions PRN . . ." PRN medication included: * Ultram Tablet 50 milligrams (mg) (TraMADOL) give 1 tablet by mouth as needed for Moderate pain. Take at bedtime as needed. Review of the electronic medication record (eMAR) and progress notes for December 1 - 12, 2016 showed Ultram administered 3 times with reassessment on 3 occasions occurring 3 to 14 hours later. * Ultram Tablet 50 mg (TraMADOL) give 1 tablet by mouth every 6 hours as needed for pain. Review of the eMAR and progress notes for December 13 - 31, 2016 showed Ultram administered 9 times with reassessment on 3 occasions occurring 3 to 8 hours later. - Review of Resident #11's medical record occurred on January 17 -18, 2017. Diagnoses included neuralgia, osteoarthritis, left hip pain, fracture of first lumbar vertebra, and pelvic and perineal pain. A quarterly MDS, dated 12/07/16, identified presence of frequent pain rated 2 on a scale from 0 to 10.	F 281		

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F 281	Continued From page 8 PRN medication included: * Acetaminophen 650 mg oral pill or rectal suppository every 4 hours as needed for aching/fever. Review of the eMAR and progress notes for March 1 - 31, 2016 showed acetaminophen administered 2 times with reassessment on 1 occasion occuring over 4 1/2 hours later. * Percocet Tablet 5 - 325 mg Give 1 tablet by mouth every 4 hours as needed for Pain. Review of the eMAR and progress notes for March 1 - 31, 2016, showed Percocet administered 25 times with reassessment on 10 occasions occuring 2 to 7 hours later. - Review of Resident #18's medical record occurred on January 19, 2017. Diagnoses included hip fracture and degenerative changes to bilateral shoulders. PRN medication included: * Acetaminophen 650 mg oral pill or rectal suppository every 4 hours as needed for aching/fever. Review of the eMAR and progress notes for December 16 - 31, 2016, showed acetaminophen administered 1 time with reassessment occuring 7 hours later. During an interview on 01/19/17 at 10:30 a.m., an administrative nurse (#8) confirmed staff are required to follow up within 1 hour regarding the effectivness of the analgesic administered.	F 281		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local	F 371		2/23/17

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F 371	Continued From page 9 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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of temperature logs, and staff interview, the facility failed to serve, prepare, and store food in a safe and sanitary manner for 1 of 1 kitchen. Failure to ensure food is served at the appropriate temperatures; drinking glasses are stored correctly; the correct sanitation strips are used to measure the amount of sanitizer in a cleaning bucket and 3-compartment sink; and the cleanliness of the dietary department increased the risk of food born illness and contamination and may affect all residents who consume food stored, prepared, or served in the kitchen.	F 371	1. Corrective Action: It is the practice of the facility to ensure food is served at the appropriate temperatures; drinking glasses are stored correctly; the correct sanitation strips are used to measure the amount of sanitizer in cleaning buckets and 3-compartment sink; and the maintain cleanliness of the dietary department. The facility recognized that no residents were affected by this deficient practice. 2. Identify other residents: This practice may affect all residents who consume	

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F 371	Continued From page 10 Findings include: Review of the facility policy titled "PROTOCOL AND PROCEDURE" occurred on 01/19/17. This policy, revised January 2017, stated, "SUBJECT: Temperatures of Steam table, . . . PROTOCOL: To ensure proper temperatures for food safety and sanitation. PROCEDURE: Steam table will be maintained at or above the following temperatures: Beginning of service: Meat 165 [degrees Fahrenheit (F)] Potatoes and Vegetables 145 [degrees F]. End of service: Meat 150 [degrees F] potatoes and vegetables 145 [degrees F]. Temperatures will be monitored at the beginning of food service and at the end of service for each meal each day. Person responsible for monitoring temperatures will be the cook. Information is recorded in book [sic]. . . . The cook is to alert the Dietary Manager to temperatures that do not meet the standard. In the absence of problems, the Dietary Manager will review the logged temps [temperatures] as needed. . . ." Review of the facility policy titled "PROTOCOL AND PROCEDURE" occurred on 01/19/17. This policy, dated 2014, stated, "SUBJECT: SANITATION/PHYSICAL ENVIRONMENT. OBJECTIVE: To prevent food born illness/contamination. Protocol: The physical environment must be cleaned and in good repair. . . ." - Observation of the dietary department occurred on 01/17/17 at 12:50 p.m. with the dietary manager (#3) and showed a red sanitation bucket on the counter. The manager stated it	F 371	food stored, prepared or served by the kitchen. 3 Measure put in place: The incorrect sanitizer test strips have been removed from the kitchen. The cleaning schedule will be updated to include the plate warmer rack, the sugar, flour and rice storage containers and the trash cans. A tray or counter liner will be used to allow for moisture drainage from beverage glasses, coffee cups, water pitchers and soup bowls. Beverage glasses will be stored in a single layer. The policy for recording of food temperatures will be revised. The temperature log will be revised to reflect the revised temperature policy. Education will be provided to the dietary staff on use of the correct sanitizer test strips, use of the cleaning schedule, use of tray liners, single layer storage of glasses and the revised policy and log for the recording of food temperatures. Education will be provided by the dietician and/or designee. 4. Monitoring: Audits will be conducted for the cleanliness of trash can lids, the rice, sugar and flour storage containers and the plate warmer rack; use of the correct sanitizer test strips, use of tray liners for storage of beverage glasses, water pitchers, coffee cups and bowls; single layer storage of beverage glasses; the food temperature logs completion and rewashing of any bowls removed from the dishwasher with discolored water. An audit will be completed to assure cleanliness of the trash can lids, flour, sugar and rice	

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F 371	Continued From page 11 contained a sanitation solution and staff used it to clean counters. When asked, the manager measured the concentration of the sanitizer with a test strip, compared it to the color chart on a bottle of test strips, and stated it measured 50 parts per million (ppm). When asked what it should measure, the manager (#3) stated 200 to 400 ppm. Additional observations at this time included: * Three trash can lids soiled with food and debris * Food debris in the plate warmer rack and on a shelf below a food preparation counter * Water pitchers and soup bowls stored upside down with water moisture present * Beverage glasses, coffee cups, and soup bowls just out of the dishwasher, turned right-side-up, containing discolored water. An unidentified staff member emptied the discolored water and stacked the dishes along with clean dishes * Beverage glasses stacked and stored upside down with water moisture present * Dust and food debris on the lids of the flour, sugar, and rice storage containers - Observation on 01/18/17 at 11:20 a.m. with the dietary manager (#3) showed a three compartment sink in the kitchen. A dietary aide (#10) stated the third sink contained sanitizer. When asked, the dietary aide tested the sanitizer in the sink with a test strip, compared it to a color chart on a test strip bottle, and found it didn't measure at all. The dietary aide stated the sink had just been filled. Observation showed one bottle of test strips (QAC QR) and one wheel of test strips (Hydrion QT-40). The dietary manager (#3) stated the dietary staff use both types of strips to measure the ppm of the sanitizer.	F 371	storage containers and plate warmer rack. This audit will be conducted weekly for 4 weeks, monthly for the next 3 months and as directed by the QAPI Committee. Audits will be conducted by the dietitian and/or designee. An audit will be completed to assure kitchen staff are using the correct sanitizer test strips. This audit will be conducted weekly for 4 weeks, monthly for the next 3 months and as directed by the QAPI Committee. Audits will be conducted by the dietitian and/or designee. An audit will be completed to assure tray liners are being used for storage of beverage glasses, water pitchers, coffee cups and bowls. This audit will be conducted weekly for 4 weeks, monthly for the next 3 months and as directed by the QAPI Committee. An audit will be completed to assure a tray or counter liner is being used to allow for moisture drainage from beverage glasses, coffee cups, water pitchers and soup bowls. This audit will be conducted weekly for 4 weeks, monthly for the next 3 months and as directed by the QAPI Committee. Audits will be conducted by the dietitian and/or designee. An audit will be completed to assure beverage glasses are being stored in a single layer. This audit will be conducted weekly for 4 weeks, monthly for the next 3 months and as directed by the QAPI Committee. Audits will be conducted by the dietitian and/or designee. An audit will be conducted to assure foods are foods are being served at the appropriate temperatures. This audit will be	

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F 371	Continued From page 12 Observation showed a chart provided by Ecolab (supplier of sanitizer) affixed to the wall above the three compartment sink. The chart stated, "Oasis 146 Multi Quat Sanitizer" (a type of sanitizer) and identified the Hydrion QT-40 test strips (wheel) for use with the sanitizer. The dietary staff failed to use the correct test strips (wheel) to measure the sanitizer and when the correct strips were used, the staff members compared the color the the color chart of the bottle, not the wheel. - Observation of the dishwasher process occurred on 01/18/17 at 2:30 p.m.. A dietary aide (#11) stated if glasses and other dishes are turned right-side-up during the wash, they are run through the dishwasher again. - Observation of food service occurred on 01/18/17 at 4:20 p.m. and showed a temperature food log on the door of the refrigerator. Review of this form showed a column for each day of the week, Sunday through Saturday, and an area to document the temperature of each hot food item for breakfast and dinner (14 weekly meals). The log failed to show the temperatures of food items presently served. When asked if the temperatures were obtained prior to serving, a dietary cook (#9) stated, "I forgot." Review of the temperature logs, dated November 27, 2016 through January 18, 2017 showed dietary staff failed to document the temperature of the food items as follows: *Week of November 27: 9 of 14 meals *Week of December 04: 8 of 14 meals *Week of December 11: 10 of 14 meals *Week of December 18: no log provided *Week of December 25: 9 of 14 meals	F 371	conducted weekly for 4 weeks, monthly for the next 3 months and as directed by the QAPI Committee. Audits will be conducted by the dietitian and/or designee. An audit will be conducted to assure any bowls that come of the dishwasher with discolored water are being re-washed. This audit will be conducted weekly for 4 weeks, monthly for the next 3 months and as directed by the QAPI Committee. Audits will be conducted by the dietitian and/or designee. All of the above audits will start the week of February 20th, 2017. If concern are noted immediate corrective action will take place by the dietician and/or designee. 5. The facility will be in substantial compliance by February 23, 2017.	

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F 371	Continued From page 13 *Week of January 02: 7 of 14 meals *Week of January 08: 11 of 14 meals *Week of January 15: 7 of 8 meals During an interview on 01/18/17 at 4:45 p.m., the dietary manager (#3) stated dietary staff are expected to document the temperatures of each food item before the meal is served.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals.	F 431		2/23/17

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F 431	Continued From page 14 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (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. (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, review of facility policy, review of professional reference, and staff interview, the facility failed to store medications under proper temperature controls in 1 of 4 medication refrigerators (Oaklane). Failure to maintain the refrigerator temperature within an acceptable range has the potential to affect the potency and efficacy of the medication. Findings include: Review of the facility policy titled "Temperatures/cleanliness for unit medication	F 431	1. Corrective Action: It is the practice of the facility to maintain temperatures of 36-46 degrees Fahrenheit in the refrigerators that are used for storage of medications. The medications that were being stored in the Oak Lane medication refrigerator were removed and placed in the Friendship Lane medication refrigerator. The medications remained in the Friendship Lane refrigerator until the Oak Lane refrigerator reached the acceptable temperature range of 36-46 degrees Fahrenheit.	

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F 431	Continued From page 15 refrigerators" occurred on 01/19/17. This policy, revised February 2015, stated, "Policy: Temperatures of the medication refrigerators will be within 36-46 degrees at all times. . . . Temperatures of the medication refrigerators in the Communication Center should be checked weekly. . . ." The "Nursing 2015 Drug Handbook," 35th edition, Wolters and Kluwer, Pennsylvania, pages 759-760, stated, Novolog . . . Store drug between 36 degrees and 46 degrees F [Fahrenheit] . . . Don't Freeze. . . ." Observation of the medication storage areas on Oaklane occurred on 01/19/17 at 10:10 a.m. with nurses (#5 and #6). The medication refrigerator, located in the Communication Center (nurse's station) on Oaklane, measured 32 degrees F. The refrigerator contained five vials of lorazepam and 22 insulin pens (Novolog and Lantus). During an interview on the morning of 01/19/17, an administrative nurse (#7) stated the medication refrigerators should not measure below 36 degrees F. The facility failed to maintain refrigerator temperatures between 36-46 degrees F. This practice has the potential for the medications to freeze and lose their efficacy and/or potency.	F 431	2. Identify other areas/residents: All medication refrigerators in the facility have the potential to be affected by this deficient practice. All residents who receive insulin have the potential to be affected by this deficient practice. A report will be generated through the facility's EHR to recognize all residents that receive insulin. 3. Measure put in place: The temperatures of all medication refrigerators are checked on a daily basis and recorded on a log. The facility's policy was updated to reflect this. The policy was updated on 2/8/17. The Oak Lane refrigerator identified in the deficient practice was replaced on 2/8/17. Nursing staff will be educated on the importance of checking refrigerator temps daily and logging and to follow facility policy in the event the temperature is not between 36-46 degrees Fahrenheit. 4. Monitoring: A quality audit will be conducted to assure all medication refrigerators are between 36-46 degrees Fahrenheit. This audit will be conducted weekly for one month, then monthly for two months, then quarterly thereafter. This first audit will be conducted the week of February 6th, 2017. This audit will be completed by the Quality and Learning Coordinator and/or designee. A quality audit will be conducted to identify whether any residents that receive insulin have had a hypo- or hyperglycemic episode that may have been related to the storage of insulin. The audit will be conducted weekly for 4 weeks, then monthly for 2	

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F 431	Continued From page 16	F 431	months, then quarterly thereafter. The first audit will take place on 2/16/17. This audit will be conducted by the Quality and Learning Coordinator and/or designee. If concerns are noted, immediate corrective action will be taken by the Quality and Learning Coordinator and/or designee. 5. The facility will be in substantial compliance by February 23, 2017.	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441		2/23/17

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F 441	Continued From page 17 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced	F 441		

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F 441	Continued From page 18 by: HAND HYGIENE 1. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed infection control practices for 1 of 2 sampled residents (Resident #13) observed during colostomy cares. Failure to perform hand hygiene in accordance with facility policy may result in the spread of infections within the facility. Findings include: Review of the facility policy "Hand Hygiene" occurred on 01/19/17. The policy, revised in November 2009, stated, ". . . POLICY: Employees will perform hand hygiene following current CDC [Centers for Disease Control] guidelines. PROCEDURE: 1) Hand hygiene is performed: . . . e) After contact with body fluids or excretions . . . h) After removing gloves. . . " Observation on 01/18/17 at 5:50 p.m. and showed a licensed nurse (#2) assisted Resident #13 with colostomy cares with the resident seated on the toilet. Both the nurse (#2) and Resident #13 wore gloves. Observation showed the colostomy bag approximately half filled with soft stool. The nurse (#2) unclamped the colostomy bag and Resident #13 emptied the contents into the toilet. Observation showed the nurse cleansed around the opening of the bag, replaced the clamp, and cleansed the resident's thighs with perineal wipes. While Resident #13 washed her hands, the nurse (#2) removed her gloves and, without performing hand hygiene, donned new gloves, bagged the garbage,	F 441	1. Corrective Action: It is the practice of the facility to maintain proper hand hygiene after the removal of gloves. Education will be provided to nursing staff caring for Resident #13. Education will include review of facility policy and procedure related to hand hygiene after removal of gloves and prior to exiting the resident□s room. It is also the practice of the facility to ensure proper cleaning and sanitizing of the ice dispensers used for residents. The ice machine located in the resident dining room was cleaned by Dakota Refrigeration on 1/26/2017. 2. Identify other residents/areas: All residents in the facility have the potential to be affected by this deficient practice. The two ice machines used for residents have the potential to be affected by this deficient practice. 3. Measure put in place: Education will be provided to all nursing staff on the importance of following facility policy and procedure related to hand hygiene. Dakota Refrigeration and/or the facility will clean and sanitize the ice machine quarterly. 4. Monitoring: A quality audit will be conducted to assure nurses are completing hand hygiene after the removal of gloves. This audit will be conducted weekly for 4 weeks, monthly for 2 months and quarterly thereafter. The first audit will conducted during the week February 13th, 2017. This audit will be conducted by the Quality and Learning Coordinator and/or designee. A quality	

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F 441	Continued From page 19 removed her gloves, exited the room, disposed of the garbage in the soiled utility room, then washed her hands. During an interview on 01/19/17 at 11:15 a.m. an administrative nurse (#1) stated staff assisting with colostomy cares should perform hand hygiene after removal of gloves and prior to exiting the resident's room. Failure to follow facility policy by not performing hand hygiene after removal of gloves worn during colostomy cares and before exiting the resident's room may result in the spread of infection. ICE DISPENSER 2. Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to ensure proper maintenance of 1 of 1 ice dispenser used for residents. Failure to ensure proper cleaning and santizing to prevent the development of mold occurred on a regular basis has the potential to affect the health of residents consuming the ice from the dispenser. Findings include: Review of the manufacturer's instructions for the ice dispenser titled "CLEANING AND SANITIZING" occurred on 01/19/17. The instructions, dated June 1994, stated, ". . . Maintenance and Cleaning should be scheduled at a minimum of twice per year. . . ." Observation of the dietary department occurred on 01/17/17 at 12:50 p.m. with the dietary manager (#3) and identified an ice dispenser	F 441	audit will be conducted quarterly to assure proper cleaning of the ice machine. This audit was first completed on 1/26/2017. This audit will be completed by the Quality and Learning Coordinator and/or designee. If concerns are noted with these audits, immediate corrective action will be taken by the Quality and Learning Coordinator and/or designee. 5. The facility will be in substantial compliance by February 23, 2017.	

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F 441	Continued From page 20 used for residents in the kitchen. The manager stated the dietary staff empty the ice machine every Saturday and clean the inside of the ice bin but do not sanitize and de-mineralize the ice dispenser. Observation of the environment occurred on 01/19/17 at 8:00 a.m. with the environment manager (#4). The manager stated the dietary department is responsible for cleaning and sanitizing the ice dispenser.	F 441		