STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	06/03/2010

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COOPERSTOWN MEDICAL CTR NURSING HOME	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 06/01/10 and completed on 06/03/10, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review.	F 000		
F 323 SS=E	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: 1. Based on observation, record review, review of professional reference, and staff interview, the facility failed to utilize a gait belt appropriately for 2 of 5 sampled residents (Resident #1 and #2) observed during a gait belt transfer. Failure to utilize an assistive device (gait belt) appropriately has the potential to cause pain and injury to residents. Findings include: Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th ed., Pearson Education, Inc., New Jersey, page 1149, stated, "Assisting the Client to Ambulate: Purpose - To provide a safe condition for the client to walk with whatever support is needed . . . Use a transfer or walking belt if the client is	F 323	1. (a) Gait Belt Use: Staff were informed immediately upon State Survey Team exit that observations of inappropriate gait belt use were made. Education was provided on an individual basis to all staff present regarding correct procedure to follow. (b) Chemicals: Bleach and De-Scent products were removed from rooms 117 and 118 on 06/03/10 and placed in secured locations. 2. All residents have the potential to be affected by the deficient practice. 3. An All Staff Meeting is scheduled for 06/17/10 for all facility employees. Topics to be discussed are survey results and plan of correction education. All departments will be instructed on proper storage of chemicals at the meeting. A Mandatory Nursing Home Staff Inservice is scheduled for 06/23/10. Education and training will be provided to all Nursing Staff regarding appropriate gait belt usage and proper storing of chemicals. 4.	07/08/10

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

Admin / CEO | 6-18-10

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 323	Continued From page 1 slightly weak and unstable. Make sure the belt is pulled snugly around the client's waist and fastened securely. Grasp the belt at the client's back, and walk behind and slightly to one side of the client . . ." - Review of Resident #2's medical record occurred on all days of survey. Medical diagnosis included osteoarthritis, hearing loss, and visual loss. Observation on 06/01/10 at 3:55 p.m. showed Resident #2 seated in a wheelchair. A certified nursing assistant (CNA) (#10) applied a gait belt around the resident's waist. Two CNAs (#6 and #10), one on each side of the resident, assisted her to stand by lifting under her arms. The two CNAs failed to utilize the gait belt. Observation on 06/02/10 at 10:45 a.m. showed Resident #2 seated on the edge of the bed. The CNA (#8) applied a gait belt to the resident's waist. Two CNAs (#7 and #8) assisted Resident #2 to stand.The CNA (#8) lifted under the resident's left arm. Observation on 06/02/10 at 3:25 p.m. showed Resident #2 seated on the edge of the bed. The CNA (#9) applied a gait belt around the resident's waist and assisted her to stand. The CNA placed her left hand under the resident's left arm and her right hand on the gait belt. Observation showed Resident #2's left shoulder bowed upward during the lift. Observation on 06/03/10 at 8:10 a.m. showed Resident #2 seated in a wheelchair in her room. The CNA (#11) applied a gait belt around the resident's waist. The CNA placed her left hand	F 323	5. (a) Gait Belt Use: Gait belt usage will be monitored 3 x/week x 2 weeks, then weekly x 1 month by the facility Quality Assurance Coordinator to ensure gait belts are being applied and used correctly. Any problems will be addressed immediately with staff involved and also reported to the Director of Nursing. (b) Chemical Storage: Environmental rounds will be done weekly x 4 weeks, then monthly x 3 months by the facility Quality Assurance Coordinator or designee to ensure all chemicals are stored securely and out of resident reach. Problems identified will be corrected immediately and will be reported to the Director of Nursing. Results of all Quality Assurance monitoring will be reported at monthly Quality Assurance Meetings and recommendations for further monitoring beyond initial plan will be made by the Committee.	

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F 323	Continued From page 2 under Resident #2's right arm, her right hand on the gait belt and lifted the resident. Observation showed Resident #2's right shoulder bowed up and the gait belt slid above the resident's breasts. - Review of Resident #1's medical record occurred on all days of survey. Medical diagnosis included a history of falls and macular degeneration. Observation on 06/02/10 at 8:45 a.m. showed Resident #1 seated in a recliner. A CNA (#8) applied a gait belt around the resident's waist and assisted her to stand by lifting under her right arm. The CNA failed to utilize the gait belt. During an interview on 06/03/10 at 10:35 a.m. with an administrative nurse (#12), the nurse stated she expected facility to utilize a gait belt and to use it appropriately. 2. Based on observation, staff interview, and review of product information labels, the facility failed to ensure an environment free of hazardous chemicals on 3 of 3 days of survey (June 01-03, 2010.) Failure to ensure the secured storage of hazardous chemicals placed vulnerable residents (e.g. wandering, confused) at risk for exposure to these chemicals. Findings include: An initial tour of the facility occurred on 06/01/10 at approximately 11:45 a.m. Observation in Room 117 revealed a cabinet located next to the toilet in a resident bathroom. This unlocked cabinet contained a one gallon jug of bleach. The product labeled stated, "Keep out of reach of children. . . . Causes severe but temporary eye injury. May	F 323		

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F 323	Continued From page 3 irritate skin. May cause nausea and vomiting if ingested. . . ." Observation in Room 118 revealed a spray bottle of "De-Scent" Odor Counteractant located in a basket next to a resident's toilet. The product labeled stated, "Keep out of reach of children. . . . CAUTION: May cause eye and skin irritation. If swallowed, may cause irritation, nausea, and stomach distress. . . ." Random observations on the afternoon of 06/02/10, and observations during the environmental tour on 06/03/10 at 10:00 a.m. revealed the bleach and odor counteractant in the same unsecured locations mentioned above. In an interview on 06/03/10 at 10:15 a.m., a nursing staff member (#3) stated the bleach and odor counteractant should not be in residents' rooms unsecured. The staff member stated she would remove the chemicals immediately.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced	F 328		

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F 328	Continued From page 4 by: Based on record review, review of facility policy, review of professional literature, and staff interview, the facility failed to clarify the physician's order regarding the amount of oxygen to administer and failed to check the resident's oxygen saturation prior to administration of prn (as needed) oxygen for 1 of 2 sampled residents (Resident #2). These oversights by facility staff could result in residents receiving oxygen unnecessarily or receiving the wrong amount of oxygen, which has the potential to cause the resident to stop breathing. Findings include: Review of the facility policy titled "Nursing Home and Swing Bed Standing Orders" occurred on 06/03/10. This policy, revised 05/03/10, stated, " . . . Emergency: 1. SOB (shortness of breath) . . . b. Check O2 (oxygen) saturations using pulse oximeter. c. Administer stat [immediate] oxygen at 2-3L/min [liters per minute] per nasal cannula . . . f. Notify the HCP [health care professional] . . ." Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th ed., Pearson Education, Inc., New Jersey, page 841, regarding medication orders stated, " . . . A prn, or as-needed order, permits the nurse to give a medication when, in the nurse's judgement, the client requires it . . . The nurse must use good judgment about when the medication is needed and when it can be safely administered . . . Essentials Parts of a Drug Order: . . . The dosage of the drug includes the amount . . . and in many instances the strength . . ." Review of Resident #2's medical record occurred	F 328	1. Resident #2's order for oxygen administration was clarified with parameters for flow rate on 06/08/10. 2. All resident's receiving PRN oxygen administration have the potential to be affected. 3. Charts/orders of all residents receiving PRN oxygen were reviewed on 06/08/10 to check to see if all included parameters for oxygen administration. All orders that were not written correctly were clarified with Healthcare Providers and corrected on 06/08/10. A Mandatory Nursing Department Inservice is scheduled for 06/23/10. Education will be provided to all nursing staff on the importance of clarifying orders for oxygen with Healthcare Providers if parameters are not given when orders are written. Education will also be provided on the importance of taking and recording oxygen saturations and documenting resident's symptoms to verify the need to administer the PRN oxygen. Education will be provided to Healthcare Providers at Medical Staff Meeting on 06/24/10 on the importance of always including parameters for oxygen flow when writing PRN oxygen orders. 4.	07/08/10

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F 328	Continued From page 5 on all days of survey. Medical diagnosis included congestive heart failure. A physician's order stated, "O2 [oxygen] per NC [nasal canula] to keep O2 sats [saturation] greater than 90%." Review of Resident #2's Medication Administration Records (MARs) showed an order for oxygen use PRN. Nursing staff are expected to initial on the date of it's administration. The vital sign flow sheets are utilized by facility staff to document the resident's oxygen saturation prior to the use of oxygen and the liter amount administered. Review of the MARs and vital sign flow sheets from January 2010 to May 2010 identified the following: * January: - Oxygen administered on the 1st - no documentation of the oxygen saturation or the liters per minute administered. - Oxygen administered on the 7th at 2L/NC (2 liters per nasal canula) and an oxygen saturation of 87%. * February: - Oxygen administered on the 6th, 7th, 13th, 14th, and 20th - no documentation of the oxygen saturation or the liters per minute administered. * March: - Oxygen administered on the 6th, 7th, 13th, 14th, 20th, 21st, and the 27th - no documentation of the oxygen saturation or the liters per minute administered. * April: - Oxygen administered on the 2nd, 10th, 24th, and the 25th - no documentation of the oxygen saturation or the liters per minute administered. * May: - Oxygen administered on the 1st - no documentation of the oxygen saturation or the liters per minute administered.	F 328	5. Charts of all residents receiving PRN oxygen administration will be monitored monthly x 3 months by the facility Quality Assurance Coordinator to ensure all orders are written correctly and are complete. Documentation done by nursing staff on all residents receiving PRN administration of oxygen will be monitored by the facility Quality Assurance Coordinator weekly x 4 and then monthly x 2 to ensure documentation is being provided to verify the resident's need for oxygen administration. Staff noted to have deficient practices will be notified of problems found. All problems identified will be reported to the Director of Nursing for follow-up. A summary of findings will be reported at the facility Quality Assurance Meeting monthly and recommendations for further monitoring will be given by the Committee.	

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F 328	Continued From page 6 -The vital sign flow sheet identified an oxygen saturation of 87% on the 4th and 2L/NC administered but the MAR failed to identify the oxygen usage. Review of Resident #2's nurse's notes for the above listed dates failed to identify any oxygen saturation checks or any other signs or symptoms, such as shortness of breath, that would be an indication for the administration of oxygen. An interview occurred on 06/02/10 at 4:30 p.m. with a licensed staff nurse (#4). The nurse stated nursing staff check Resident #2's oxygen saturation every night at bedtime. If the resident's saturation is below 90%, staff administer oxygen at 2L/NC and record the saturation on the vital sign flow sheet. The nurses stated, "She's been real good lately." An interview occurred on 06/02/10 at 4:45 p.m. with a licensed staff nurse (#5). The nurse stated nursing staff randomly check Resident #2's oxygen saturation and administer oxygen when needed at two to three liters per minute. Facility staff failed to clarify the physician's order for Resident #2 as to the amount of oxygen to administer as needed and failed to check and document the resident's oxygen saturation to determine the necessity of oxygen on 19 out of 20 occurrences.	F 328		
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	F 329		

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F 329	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on record review and review of professional reference, the facility failed to ensure a medication regimen free from unnecessary drugs for 2 of 4 residents (Resident #6 and #11) receiving an antipsychotic medication. Failure of the facility to monitor the need for these drugs and to attempt gradual dose reductions (unless contraindicated) may result in residents receiving unnecessary medications, experiencing adverse consequences, and failing to achieve their highest level of well-being. Findings include:	F 329	1. Orders were obtained for dose reductions of resident #6's and resident #11's Seroquel on 06/09/10. Monitoring is being done to see if the reductions are successful. 2. All residents receiving antipsychotics, hypnotics/sedatives, or psychopharmacological medications have the potential to be affected. A log to track which residents are on the above listed types of medications was initiated on 06/17/10. The log will allow staff to more easily track each resident to see when gradual dose reductions have been attempted (see Attachment A).	

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F 329	Continued From page 8 The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medication, within the first year the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. The Nursing 2009 Drug Handbook, 29th Edition, pp. 669-670, identified indications for Seroquel include Schizophrenia, Short-term treatment of acute manic episodes associated with bipolar I disorder, and Depression associated with bipolar disorder. The Handbook further states, ". . . NURSING CONSIDERATIONS . . . Alert: Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection. . . ." - Review of Resident #11's medical record occurred on June 3, 2010. Diagnoses included vascular dementia, depressive disorder, and unspecified psychosis. Current medications included Seroquel (an antipsychotic) 25 mg per day, initiated August 17, 2009.	F 329	3. A form was devised as a reference tool for "Gradual Dose Reduction/Tapering in the Nursing Home" (see Attachment B). This form will be utilized to educate the facility Healthcare Providers at a Medical Staff Meeting on 06/24/10. Nursing staff involved with monthly Psych Med Meetings will also be provided education regarding the reference tool. Facility Consultant Pharmacist will be educated on the reference tool on 06/22/10. Consultant Pharmacist, who is new to the facility, will be reminded to utilize the "Consulting Pharmacist's Drug Regimen Review Note Form" (see Attachment C) to notify Healthcare Provider and Director of Nursing of any irregularities found when completing monthly Resident Drug Regimen Reviews. The reference tool and log will be utilized at monthly Psych Med Meetings to help ensure that all residents due for reductions are addressed. 4.	07/08/10

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F 329	Continued From page 9 Resident #11's most recent Minimum Data Set (MDS), dated March 25, 2010, indicated the resident resisted cares on 4-6 days of a 7-day look-back period, and this behavior was not easily altered. The MDS identified no other behavioral symptoms. An MDS dated December 24, 2009, indicated the resident resisted cares on 1-3 days of a 7-day look-back period, and this behavior was not easily altered. The MDS identified no other behavioral symptoms. Review of physician progress notes revealed the following: * 08/27/09: ". . . Patient was recently started on Seroquel for sundowning and adverse agitated behaviors and seems to have settled down very well with that dose. . . . continue on . . . Seroquel . . . reassess in two months. . . ." * 10/28/09: ". . . With respect to her behaviors, Seroquel has been added, which has helped . . . Seroquel in the evening will be continued as that does seem to help functioning and behaviors during the evening hours. . . ." * 11/19/09: ". . . the Namenda was decreased and tapered off and discontinued and Zoloft restarted. The staff notes marked improvement in overall functioning. They feel that she is doing much better on this regimen. She will continue her Seroquel the same and Zoloft the same. . . ." * 12/31/09: ". . . Over time, we have discontinued her Namenda. Her Zoloft has been restarted and increased to 75 mg daily and she remains on 25 mg of Seroquel daily. The nursing staff notes that there is probably really no change in overall behavior, appetite, eating, etc., with the increased dose of Zoloft. * 01/21/10: ". . . The concern remains that [Resident #11] is refusing most of her meds most	F 329	5. A new "Quality Assurance Monitor Tool" (see Attachment D) was devised to assist in monitoring gradual dose reductions for all residents on antipsychotics, hypnotics/sedatives, or psychopharmacologic medications to ensure gradual dose reductions are completed as required. Each resident currently on any of the above listed types of medications will have a form completed by the facility Quality Assurance Coordinator by 06/25/10. Problems found will be reported immediately to the Director of Nursing for follow-up. All residents on the above listed medications will be reviewed monthly by the facility Quality Assurance Coordinator, or designee. This review will include checking monthly Consultant Pharmacist Review Notes to see if problems were addressed appropriately. Problems will be reported immediately to the Director of Nursing and Consultant Pharmacist for follow-up and all results will be reported monthly to the facility Quality Assurance Committee. Recommendations for further monitoring will be made by the Committee as needed.	

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F 329	Continued From page 10 of the time . . . Her psychotropic meds remain Zoloft 50 mg daily and Seroquel 25 mg daily, but here again, most of the time she misses those meds, as she does all of her other meds. . . ." * 02/22/10: ". . . [Resident #11] overall is about the same. The nursing staff is concerned primarily because of the fact that she rarely takes any of her medications . . . The nursing staff will try to continue to give her Seroquel, Zoloft. . . ." * 03/17/10: ". . . At this point in time, she is off most of her usual meds. Is still trying to get [sic] Seroquel and Zoloft. She does miss periodic dosages. . . . Nursing staff notes no real changes overall. She is stable. We will continue current dose of Seroquel and Zoloft for now. Reassess six months. . . ." The physician's notes failed to provide clinical rationale for the continued use of Seroquel or contraindications for a dose reduction attempt, even though the notes indicated frequent refusal of Seroquel by Resident #11 and little to no change in behaviors. - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included unspecified psychosis, depressive disorder, and hallucinations. Medications included Seroquel (an antipsychotic) 25 mg at bedtime, initiated on 09/14/09. Review of Resident #6's MDSs, dated 03/29/10, 12/28/09, and 09/28/09 identified sad, pained or worried facial expressions easily altered only on the MDS dated 12/28/10. The resident's current care plan stated, ". . . Res [resident] states dreams about snakes - worries he may injure others - staff have not obs [observed] any problems . . . may use chair check @ [at] nite	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 11 [night] if res requests . . . risk for elopement r/t [related to] psychosis . . ." Review of Resident #6's physician's orders identified the physician discontinued Seroquel on 05/25/09 and started it again at 12.5 mg twice a day on 09/14/09. On 10/28/09, the physician's order changed to Seroquel 25 mg at 9:00 p.m. The physician's notes failed to provide clinical rationale for the continued use of Seroquel or the contraindications for a dose reduction attempt for Resident #6 who has been on the same dose for over eight months.	F 329		
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 This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional literature review, and staff interview, the facility failed to properly cool potentially hazardous food during 1 of 1 observation (06/01/10) of cooling meat. Failure to follow safe food sanitation practices has the potential to result in food borne illness and can affect all residents who consume food prepared in the facility's kitchen.	F 371	1) No residents were directly affected by the deficient practice of cooling meats 2) All residents receiving meal service have the potential to be affected by the improper cooling of meats. 3) 6/1/10 - Initiated use of new form for cooling meats, which requires recording hourly internal temperatures and specifies time/temperature goals.(see Attachment D1) All time and temperature restraints have been met since 6/2/10 6/1/10-6/4/10 – Cooks were reminded of procedure for cooling meats. 6/10/10 - Cooks were formerly educated on the proper cooling of meats and reviewed the new policy and use of the new form. (see Attachment D2)	6/10/10

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	355039	A. BUILDING _____ B. WING _____	06/03/2010

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F 371	Continued From page 12 Findings include: The 2005 Food Code, published by the Food and Drug Administration, 3-501.14 Cooling, page 80, stated, " . . . A) Cooked Potentially Hazardous Food shall be cooled; (1) Within 2 hours from . . . (135 [degrees] F[Fahrenheit]) to . . . (70 [degrees] F); and (2) Within 6 hours from . . . (140 [degrees] F) to . . . (41 [degrees] F) or less . . . " The 2005 Food Code, published by the Food and Drug Administration, Public Health Reasons, page 388 stated, " . . . Safe cooling requires removing heat from food quickly enough to prevent microbial growth. Excessive time for cooling of potentially hazardous foods (time/temperature control for safety foods) has been consistently identified as one of the leading contributing factors to food borne illness. During slow cooling, potentially hazardous foods . . . are subject to the growth of a variety of pathogenic microorganisms. A longer time near ideal bacterial incubation temperatures, (70 degrees F - 125 degrees F), is to be avoided. If the food is not cooled in accordance with this Code requirement, pathogens may grow to sufficient numbers to cause food borne illness. . . ." Review of the facility's "Cook/Chill Monitor" procedure/temperature log occurred on 06/01/10 at 12:00 p.m. The procedure/temperature log stated, " When preparing foods in advance i.e. roasts, ground beef, etc. 1) Cook to appropriate internal temperature and record on form 2) Portion into small pieces (no larger than 6" X 6"[inches]) 3) Put into cool, shallow containers 4) Loosely cover and put in freezer for up to 1 hour, then transfer to walk-in cooler 5) Monitor &[and]	F 371	**4)** **5) The cook/chill monitor form will be completed according to policy as long as foods are prepared in advance and cooled to be reheated for later use within the facility. Cooks are to immediately notify management of any problems cooling meats to the proper temperatures within the recommended time restraints. The form will be reviewed by management on a monthly basis and implemented into the QA report monthly x3 months, then quarterly thereafter or as recommended by the QA team.**	6/16/10

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F 371	Continued From page 13 record temperatures at 2 and 4 hours. *Foods need to be at or below 40 [degrees] F within 6 hours. . . ." An initial tour of the kitchen occurred with an administrative dietary staff member (#1) on 06/01/10 at 12:00 p.m. Observation showed a facility's "Cook/Chill Monitor" procedure/temperature log form posted on the door of the walk-in cooler. This form included an entry for the day of the tour. This entry identified the food item, pork loin roast, and an internal temperature, 171 degrees, measured at 9:00 a.m. (3 hours prior). No temperatures had been recorded for this item in the columns titled "2 hours later" or "4 hours later." Observation of the walk-in cooler showed a sheet pan on a wire shelf contained 4 cooling pork loin roasts loosely-covered with wax paper. The administrative dietary staff member (#1) identified a dietary staff member cooked a pork loin roast (thirteen pounds) and divided it into smaller pork loin roasts on the sheet pan for cooling. The administrative dietary staff member (#1) obtained a thermometer and measured the temperature of each pork loin roast as, 78, 78, 75, and 72 degrees F. The dietary staff member (#2) who prepared and cooled the pork loin roasts returned to the kitchen at 12:15 p.m. This staff member stated she should have measured the temperature of the roasts before serving the noon meal. The staff member identified she usually measured the temperature of cooling foods between two and two and a half hours and the temperatures are usually between 70 and 80 degrees. This staff member confirmed she placed the pork loin roasts directly into the walk-in cooler and failed to	F 371		

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F 371	Continued From page 14 initate cooling them in the freezer. This staff member obtained a thermometer and measured the temperature of two roasts as 78 and 70 degrees F. The staff member stated in two hours she would measure the temperature of the two other roasts for one more reading. She confirmed this temperature to be the usual temperature and lacked awareness of a required maximum two hours cooling temperature. When requested by this surveyor, a dietary staff member placed the sheet pan in a freezer and monitored the temperature of the pork loin roasts to ensure safe cooling. Observations confirmed, dietary staff reheated the pork loin roasts above 165 degrees F and maintained a holding temperature above 135 degrees F before service on 06/02/10. Review of the facility's "Cook/Chill Monitor" procedure/temperature log on the afternoon of 06/01/10 showed 4 of 5 entries during April and May for cooling food with temperature readings at 2 hours 80, 85, and 85 degrees F and at 2 hours and 50 minutes 75 degrees F. When interviewed on the morning of 06/03/10 an administrative dietary staff member stated she had interviewed dietary staff members and confirmed dietary staff had not been placing cooling meats in a freezer. This staff member agreed dietary staff should be following facility procedure and monitoring during the cooling of foods to ensure proper time and temperature parameters for food safety.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		

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F 428	Continued From page 15 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility's pharmacist failed to identify medication regimen irregularities for 2 of 4 residents (Resident #6 and #11) receiving an antipsychotic. Failure to recognize and report medication irregularities may result in residents receiving unnecessary medications, experiencing adverse consequences, and failing to achieve their highest level of well-being. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medication, within the first year the facility must	F 428	1. See Plan of Correction for F 329. 2. 3. 4. 5.	7/08/10

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F 428	Continued From page 16 attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. CMS outlined the "Medication Regimen Review" (MRR) as a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. - Review of Resident #11's medical record occurred on June 03, 2010. Diagnoses included vascular dementia, depressive disorder, and unspecified psychosis. Current medications included 25 milligrams (mg) of Seroquel (an antipsychotic) every day (initiated August 17, 2009). Review of Resident #11's "Monthly Pharmacists' Review" occurred on 06/03/10. The reviews, dated monthly from September 2009 to May 2010, showed the pharmacist conducted a review of medications each month. The record lacked evidence to indicate the pharmacist recommended a gradual dose reduction (GDR) in regard to the continued use of Resident #11's Seroquel. Physician's progress notes failed to identify a GDR attempt or provide clinical rationale as to why a GDR would be contraindicated. - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses	F 428		

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F 428	Continued From page 17 included unspecified psychosis, depressive disorder, and hallucinations. Medications included Seroquel (an antipsychotic) 25 mg, initiated on 09/14/09. Review of Resident #6's "Monthly Pharmacists' Review" occurred on 06/02/10. The reviews, dated monthly from September 2009 to May 2010, showed the pharmacist conducted a review of medications each month. The reviews failed to show any recommendations for a GDR of Resident #6's Seroquel.	F 428		