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 _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	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 06/13/16 and completed on 06/16/16, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225		7/21/16

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

Electronically Signed | 07/10/2016

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F 225	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure alleged violations of neglect were reported to the State Agency (SA) for 1 of 1 sampled resident (Resident #6) who fell from an EZ stand (sit to stand mechanical lift) during a transfer. Failure to identify this incident as possible neglect and report it to the SA placed all residents at risk for mistreatment and/or neglect. Findings include: Review of the facility policy titled "Abuse and Neglect Policy and Reporting Procedure" occurred on 06/16/16. This policy, revised in 2012, stated, ". . . INVESTIGATION: . . . 4. Prior to the initiation of any investigation of suspected abuse or neglect, a report will be made immediately by telephone or email to the Department of Health. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included	F 225	1. Resident #6 record reviewed by the Director of Nursing (DON) and Administrator on 7/1/16 and confirmed no rib fracture from x-ray report. DON provided education to CNA immediately on 1/8/16. 2. All residents have the potential to be affected. 3. The Abuse & Neglect Policy & Reporting Procedure was updated with staff to notify DON or Administrator if DON is unavailable, immediately of all newly diagnosed major injuries (including but not limited to fracture, dislocation, head trauma, subdural hematoma) so potential abuse can be assessed. An in-service was conducted by the DON and Administrator with nursing staff on 7/1/16 addressing circumstances that require reporting including appropriate timeframes as well as updated change in	

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F 225	Continued From page 2 Alzheimer's disease. Resident #6's progress notes identified the following: * 01/08/16 at 4:40 p.m. - "1615 [4:15 p.m.]-CNA [certified nursing assistant] was using EZ stand to get res [resident] off the toilet. Res was lowered to floor using EZ stand and staff assist. Res assessed and no injury noted. Using belt and 3 staff, res was stood and sat onto chair. HCP [health care provider] notified via fax and wife notified via telephone." Review of an incident report, dated 01/12/16, stated, "CNA transferring res off toilet [with] EZ lift & [and] loop from strap of belt came off, res lowered to floor. (black safety stop on lift but twisted). [no] initial injury. Sent to ER 1/10/16 - rib fx. Staff member was educated as res was set up to be 2 assist [with] EZ stand due to size." As part of an Informal Dispute Resolution request, received by the SA on 07/11/16, the facility submitted results from the chest x-ray performed on 01/10/16. This information was not available in the resident's paper chart at the time of the survey. Based on the chest x-ray report, Resident #6 did not sustain a rib fracture. During an interview on the afternoon of 01/16/16, an administrative staff member (#3) stated the immediate assessment of Resident #6 showed no injury so the facility did not report the incident to the SA. The facility failed to report the incident to the SA after the resident complained of pain and the facility sent the resident to the emergency room	F 225	policy. 4. 7/21/16 5. All situations that meet the definition of a reportable incident will be reported to the facility Quality Assurance Coordinator (QAC) by the department supervisor involved with the investigation. The QAC will monitor each situation to ensure appropriate notifications have been made. The Stand Up Committee will also discuss all events that arise on a daily basis to get an interdisciplinary decision on whether an incident that occurred meets the definition of a reportable incident. All incidents will be reported to the facility Quality Assurance Committee on a monthly basis. This process will continue indefinitely or until the Quality Assurance Committee deems necessary.	

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F 225	Continued From page 3 and received an initial diagnosis of a rib fracture by clinical exam.	F 225		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to prevent skin breakdown and the development of pressure ulcers for 2 of 6 sampled residents (Resident #3 and #9) who required extensive assistance with bed mobility. Failure to consistently implement interventions for pressure relief (i.e. repositioning) may result in skin breakdown and pressure ulcers. Findings include: Review of the facility policy titled "Routine Care Standards" occurred on 06/16/16. This policy, revised in 2001, stated, "PROCEDURE: . . . 15. Encourage resident to turn and reposition every two hours, assist as needed . . ." - Review of Resident #3's medical record	F 314	1. On 6/30/16 Resident #3 and #9 Braden assessments were reviewed. These residents both continue to be at risk for skin breakdown. Both of these resident□s care plans and care cards were reviewed and they continue on repositioning schedule per protocol. All staff educated on the importance of repositioning residents per policy. 2. Braden assessments were reviewed for all residents on 6/30/16 by the nursing management team. For those residents at risk, care plans were reviewed to ensure appropriate repositioning schedules per protocol. At this time two resident□s turning and repositioning schedules were able to be discontinued as they were no longer at risk. No residents needed to be added to the	7/21/16

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F 314	Continued From page 4 occurred on all days of survey. Diagnoses included Alzheimer's disease, a history of a pressure ulcer to the hip, and a current pressure ulcer to the sacrum. The resident's current Minimum Data Set (MDS), dated 04/03/16, identified extensive assistance from two or more people for bed mobility. A physician's order, dated 03/03/06, stated, "Reposition Q [every] 2 HR [hours] while in bed & Q 1 HR when up in chair & PRN [as needed]." Observation on 06/14/16 at 12:45 p.m. showed two certified nursing assistants (CNAs) (#4 and #9) used a full body mechanical lift to transfer Resident #3 into bed. The CNAs positioned the resident on her right side with her left knee flexed and a pillow between her knees. Observations throughout the afternoon showed Resident #3 remained in that position until 4:40 p.m. (nearly four hours later) when two CNAs (#7 and #8) assisted her out of bed with a full body mechanical lift. Throughout the observation, Resident #3 complained of pain, stating, "Oww, my leg," and rubbing her left knee and thigh. One CNA (#8) stated, "I know your knee hurts," and the other CNA (#9) stated, "She's in a lot of pain today." When the CNA (#8) moved Resident #3's left leg to remove the lift sling, the resident stated, "Oww! Easy!" and again rubbed her left knee/thigh. Observation on 06/15/16 at 12:25 p.m. showed two CNAs (#6 and #9) used a full body mechanical lift to transfer Resident #3 into bed and positioned the resident on her right side. Observations throughout the afternoon showed Resident #3 remained in that position until 4:04 p.m. (over three and a half hours later) when two	F 314	turning and repositioning schedule. 3. An in-service was conducted by the DON and Administrator with the direct care staff on 7/1/16, where the Skin Care Policy was reviewed. Staff were educated on the revised Routine Care Standards, and on the revised turning and repositioning charting sheet. Examples were provided on how to complete the turning and repositioning charting. 4. 7/21/16 5. The QAC nurse or designee will QA the resident□s turning and repositioning as well as the correlated charting. This monitoring will be done daily during Monday through Friday x 2 weeks, then weekly x 4 weeks, then monthly. If any problems are noted during QA monitoring, they will be reported to the DON immediately so corrective action can be taken, as needed. Results of all monitoring will be reported to the facility QA committee. The Committee will determine the need for continued monitoring.	

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F 314	Continued From page 5 CNAs (#10 and #11) assisted her out of bed with a full body mechanical lift. - Review of Resident #9's medical record occurred on June 15-16, 2016. Diagnoses included dementia. The significant change MDS, dated 05/31/16, identified extensive assistance required for bed mobility. Resident #9's care plan stated, "Problem: . . . Resident is at risk for skin breakdown R/T [related to] disease process . . . Approach: . . . Assist with bed mobility. Turn and reposition every 2 hours and every hour in chair as residents schedule allows and PRN . . " Observation on 06/15/16 showed Resident #9 in bed and positioned on her left side from 1:45 to 4:45 p.m. The CNA (#7) checked the resident's incontinence brief (dry) at 3:00 p.m. and positioned Resident #9 back on her left side. During an interview on the morning of 06/16/16, an administrative staff member (#3) stated the facility standard is repositioning every two hours in bed.	F 314		
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:	F 323		7/21/16

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F 323	Continued From page 6 Based on record review and staff interview, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for 1 of 2 sampled residents (Resident #6) who required an EZ stand (sit to stand mechanical lift) for transfers. Failure to assure two staff members transferred Resident #6 with an EZ stand resulted in a fall. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The resident's Minimum Data Set (MDS), dated 12/10/15, identified extensive assistance from two or more people for bed mobility transfers. Resident #6's progress notes identified the following: * 01/08/16 at 4:40 p.m. - "1615 [4:15 p.m.]-CNA [certified nursing assistant] was using EZ stand to get res [resident] off the toilet. Res was lowered to floor using EZ stand and staff assist. Res assessed and no injury noted. Using belt and 3 staff, res was stood and sat onto chair. HCP [health care provider] notified via fax and wife notified via telephone." * 01/09/16 at 1:54 p.m. - "Bruise found to coccyx from fall on 1/8/16. Resident also c/o [complains of] soreness to L) [left] side under his arm. . . ." * 01/10/16 at 10:21 a.m. - "Resident c/o pain to L) ribs. Kept asking, 'Well can't you loosen it?'. Grimacing with coughing. Writer asked for pain level out of 10 and he stated 'Oh it's at a 20!' PRN [as needed] Tylenol was given. . . ." * 01/10/16 at 1:29 p.m. - Resident has had c/o pain to his left, mid back area. Tender to touch	F 323	1. On 6/30/16 reviewed resident #6□s care card and care plan and both were found to be current. 2. All residents have the potential to be affected. 3. An in-service was conducted by the DON and Administrator with the direct care staff on 7/1/16. The EZ Stand Lift Policy was updated to include that staff ensure the black safety stops are in place and secured correctly before use. The in-service addressed the importance of staff following care cards and care plans at all times. CNAs were also educated on the necessity of carrying their care cards with them at all times. A demonstration was provided during the in-service on the EZ stand lift, in regards to the black safety stop and the correct positioning before use with any resident transfer. 4. 7/21/16 5. The QAC nurse or designee will QA that the CNAs are carrying the resident care cards, and utilizing lifts per policy and as care planned. This monitoring will be done daily Monday through Friday x 2 weeks, then weekly x 4 weeks, then monthly. If any problems are noted during QA monitoring, they will be reported to the DON immediately so corrective action can be taken, as needed. Results of all monitoring will be reported to the facility QA committee. The Committee will determine the need	

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F 323	Continued From page 7 and c/o pain when coughing. States 'it's too tight get it off or loosen it up.' Writer thought he meant his shirts were tucked in too tight and were bothering him. When adjusting clothing resident noted to be tender to touch and c/o of pain. Resident was medicated with PRN at 1030 [am] with some relief obtained. states it's painful with movement. Will schedule appt [appointment] for Dr [doctor] Visit in the am [morning]." * 01/10/16 at 3:06 p.m. - "Resident c/o 12/10 L) rib pain . . ." * 01/10/16 at 4:49 p.m. - "Dr. [name] called about L) rib pain being 20/10. . . . Resident being transferred to CMC [name of hospital] ER [emergency room]." *01/10/16 at 6:00 p.m. - "Resident transferred back from CMC ER. Xray done; fx [fracture] to L) ribs . . ." Review of an incident report, dated 01/12/16, stated, "CNA transferring res off toilet [with] EZ lift & [and] loop from strap of belt came off, res lowered to floor. (black safety stop on lift but twisted). [no] initial injury. Sent to ER 1/10/16 - rib fx. Staff member was educated as res was set up to be 2 assist [with] EZ stand due to size." Review of the care plan utilized at the time of the incident stated, "Transfers per EZ stand," however the CNA care card identified Resident #6 required the assistance of two staff members and the EZ stand. As part of an Informal Dispute Resolution request, received by the SA on 07/11/16, the facility submitted results from the chest x-ray performed on 01/10/16. This information was not available in the resident's paper chart at the time	F 323	for continued monitoring.	

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F 323	Continued From page 8 of the survey. Based on the chest x-ray report, Resident #6 did not sustain a rib fracture. During an interview on the afternoon of 01/16/16, an administrative staff member (#3) stated she expected the CNA to follow Resident #6's care card related to transfers.	F 323		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to offer fluids or ensure fluids were accessible for 4 of 7 sampled residents (Resident #1, #3, #6, and #9) observed during cares. Failure to offer fluids and/or ensure fluids were accessible increased the risk of dehydration, constipation, and urinary tract infections (UTIs) for these residents. Findings include: Review of the facility policy titled "Routine Care Standards" occurred on 06/16/16. This policy, revised in 2001, stated, ". . . PROCEDURE: . . . 24. Offer and encourage 1500 mL [milliliters] of fluid every day unless otherwise directed . . . Encourage fluids with all cares. . . . 26. Keep water pitchers within reach if resident can drink independently. Offer a glass frequently. . . ." - Review of Resident #1's medical record	F 327	1. All staff were provided education on the importance of providing fluids with all cares and keeping water pitchers within reach for residents #1, #3, #6, and #9 as well as all residents in the facility at the in-service on 7/1/16. Resident's #1, #3, #6, and #9 are receiving their fluids. 2. All residents have the potential to be affected. 3. An in-service was conducted by DON and Administrator with the nursing staff on 7/1/16. During the in-service the revised Routine Care Standards were reviewed with staff. Education consisted of providing fluids and encouraging residents to drink with all cares and keeping water pitchers within reach if residents can drink independently.	7/21/16

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F 327	Continued From page 9 occurred on all days of survey. Diagnoses included a pelvic fracture (03/22/16), neurogenic bladder, and a history of UTIs. The quarterly Minimum Data Set (MDS), dated 05/24/16, identified Resident #1 required extensive assistance for transfers, independent with eating, and walking did not occur during the assessment period. The care plan stated, "Problem: Urinary Incontinence, History of chronic UTI . . . Approach: Encourage fluid intake . . ." Observation on 06/14/16 at 9:55 a.m. showed two certified nursing assistants (#4 and #5) utilized an EZ stand (sit to stand mechanical lift) and transferred Resident #1 from a wheelchair to a recliner. Observation showed a mug of water on a table next to the bed. The CNAs failed to offer the resident fluids and failed to place the mug of water within reach. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia. The significant change MDS, dated 03/24/16, identified Resident #6 required extensive assistance for transfers and walking did not occur during the assessment period. The care plan stated, ". . . Risk for dehydration r/t [related to] diuretic use and dementia . . . Approach: . . . Offer fluids of choice. Able to drink per self. Observation on 06/14/16 at 1:15 p.m. showed the CNA (#6) utilized an EZ stand and transferred Resident #6 from a wheelchair to a recliner. The CNA failed to offer fluids and no fluids were available in the room. - Review of Resident #9's medical record	F 327	4. 7/21/16 5. The QAC nurse or designee will do monitoring to see that residents are offered fluids with cares and/or that fluids are kept within reach based on resident□s ability to drink per self. This monitoring will be done daily Monday through Friday x 2 weeks, then weekly x 4 weeks, then monthly. If any problems are noted during QA monitoring, they will be reported to the DON immediately so corrective action can be taken, as needed. Results of all monitoring will be reported to the facility QA committee. The Committee will determine the need for continued monitoring.	

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F 327	Continued From page 10 occurred on June 15-16, 2016. Diagnoses included dementia. The significant change MDS, dated 05/31/16, identified Resident #9 required extensive assistance for bed mobility and transfers, supervision of one person for eating, and extensive assistance for walking. The care plan stated, "Problem: . . . Risk for dehydration r/t Alzheimers . . . Approach: . . . Offer fluids of choice. Able to drink per self. Observation on 06/15/16 from 1:45 p.m. to 4:45 p.m. showed Resident #9 in bed positioned on her left side. At 3:00 p.m., the CNA (#7) checked the resident's incontinence brief (dry) and positioned her back on her left side. The CNA failed to offer Resident #9 fluids and observation showed no fluids available in the room. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The resident's current care plan stated, ". . . Risk for dehydration r/t diuretic use. . . . Offer fluids of choice. Able to drink per self. . . ." Observations of Resident #3's personal cares occurred on 06/14/16 at 10:33 a.m., 06/14/16 at 12:45 p.m., and 06/15/16 at 4:04 p.m. Observations during these times showed staff failed to offer Resident #3 fluids.	F 327		
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	F 329		7/21/16

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F 329	Continued From page 11 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, review of facility policy, and staff interview, the facility failed to attempt non-pharmacological interventions for 3 of 5 sampled residents (Resident #3, #5, and #8) before administering as needed (PRN) anti-anxiety medication. Failure to attempt non-pharmacological interventions before administering a PRN anti-anxiety medication may result in residents receiving unnecessary medications. Findings include: Review of the facility policy titled "Behavior Management" occurred on 06/16/16. This policy,	F 329	1. The documentation process for charting on non pharmacological interventions prior to giving medications on as needed (PRN) medications was reviewed for residents #3, #5, and #8 and staff was provided education on 7/1/16 on how to complete the documentation. 2. All residents receiving PRN psychotropic medications have the potential to be affected. 3. An in-service was conducted by DON and Administrator with the nursing staff on 7/1/16. The updated Behavior	

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F 329	Continued From page 12 revised May 2016, stated, "PURPOSE: To ensure that all resident behaviors are monitored, documented, and responded to appropriately. PROCEDURE: 1. The CNA [certified nursing assistant] charting in Matrix [a computer program] is completed each shift for every resident . . . 2. Monthly or sooner if indicated, this charting will be reviewed by the MDS [Minimum Data Set] Coordinator. After review, the MDS Coordinator will initiate the process of having staff document on Behavior Observation Forms for each behavior that tracking is deemed necessary for. The forms indicate what the behavior was, events pre-and post behavior, interventions, etc. . . ." Review of the "BEHAVIOR OBSERVATION FORM" occurred on 06/16/16. This form, revised in 2013, showed areas facility staff documented the behavior, non-pharmacological interventions attempted, PRN medication administered after other interventions failed, a description of the environment (quiet, noisy, crowded, etc.), and what happened before the behavior and after the behavior. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Medications included alprazolam (anti-anxiety) 0.25 mg every four hours PRN. The resident's current care plan identified, ". . . Resident may have mood problems d/t [due to] cognitive impairment. . . . Provide non-pharmacological interventions (I.E. 1:1 [one to one] visits, activities that are of interest, pictue [sic] books of pets and people, etc.) . . . Impaired cognition r/t [related to] dementia . . . Reassure resident when frustration	F 329	Management Policy was reviewed. The behavior sheets were reviewed and several examples were given of how to complete them. Education was given to staff on the importance of always attempting non-pharmacological interventions prior to giving medications, as well as the need to always document the interventions that were attempted prior giving a PRN. Staff were also made was aware of the location of where the behavior sheets are kept. The nurses were educated on completing a progress note with every behavior sheet they receive. The Travel Nurse Orientation checklist was reviewed and updated, as well as reviewing the travel CNA orientation checklist. 4. 7/21/16 5. The QAC nurse or designee will obtain a list from the electronic health record of any psychotropic PRNs given to residents. QA will consist of checking to see that non-pharmacological interventions were attempted, a behavior sheet completed, and a nurse□s progress note about the interventions attempted, whether they were effective, and if a PRN was given. This monitoring will be done daily Monday through Friday x 2 weeks, then weekly x 4 weeks, then monthly. If any problems are noted during QA monitoring, they will be reported to the DON immediately so corrective action can be taken, as needed. Results of all monitoring will be reported to the facility	

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F 329	Continued From page 13 or fear is present. (I.E. talk about residents past hx [history] as a nurse, how she took care of a presidents wife, living in New York, her sons). . . ." Resident #3's medication administration records (MARs) from March 13, 2016 through June 13, 2016 identified staff administered PRN alprazolam on 42 occasions. The record lacked evidence that staff attempted any non-pharmacological interventions prior to administering the PRN alprazolam. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Medications included lorazepam (anti-anxiety) 0.25 mg every four hours PRN. The resident's current care plan identified, ". . . Resident may have behavioral problems R/T dementia. . . . Give resident gum which is in treatment/med [medication] cart/nursing office cupboard when he is up and yelling out. . . . Redirect resident/reassure resident when he starts hollering out for family. (I.E. that his family is ok, start talking about farming, crop dusting, flying his plane, letting him know what time of day it is). . . . Resident may have mood problems d/t depression. Resident on hospice. . . . Provide non pharmacological interventions (I.E. talk about crop dusting and flying planes, working in the field, farming, etc.) . . ." Resident #5's MARs from March 13, 2016 through June 13, 2016 identified staff administered PRN lorazepam on five occasions. The record lacked evidence staff attempted any non-pharmacological interventions prior to	F 329	QA committee. The Committee will determine the need for continued monitoring.	

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F 329	Continued From page 14 administering the PRN lorazepam. - Review of Resident #8's medical record occurred on June 15-16, 2016. Diagnoses included dementia and anxiety. Medications included lorazepam 0.5 mg every 4 hours PRN. Resident #8's care plan identified the following problems: * "Behavioral Symptoms . . . Approach: . . . Offer non-pharmacological interventions related to resident interests (I.E. television, picture books, snacks, bathroom). . . ." * "Cognitive Loss/Dementia Risk for elopement . . . Approach . . . Prn medications as ordered. Attempt to redirect and provide safe environment if agitated. (I.E. television, 1:1, food, picture books). . . ." * "Cognitive Loss/Dementia Impaired cognition r/t [related to] Dementia . . . Approach . . . Reassure resident when frustration or fear is present (I.E. 1:1, picture books, talking about things of interest, just sitting and holding her hand, food, etc.). . . ." Resident #8's MAR identified facility staff administered lorazepam on 06/11/16 at 12:14 p.m. for anxiety and at 8:23 p.m. for, "wandering all over, going into other resident's rooms." Facility staff failed to attempt non-pharmacological interventions identified on Resident #8's care plan prior to the administration of PRN lorazepam. During an interview on 06/15/16 at 3:16 p.m., an administrative nurse (#12) stated staff are expected to attempt non-pharmacological interventions before using PRN medications, and	F 329		

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F 329	Continued From page 15 staff should document the interventions in the nurses' notes.	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, review of facility policy, and staff interview, the facility failed to properly store, prepare, and serve foods in a safe and sanitary manner for 1 of 1 kitchen. Failure to sanitize dishware and maintain a walk-in freezer has the potential to place residents at increased risk for food borne illness and affect the food quality for all who eat food prepared from the affected freezer. Findings include: Review of the facility policy titled "Nutrition Services" occurred on 06/14/16. This policy, dated February 2011, stated, ". . . 2. The dishwasher uses chemicals for cleaning, sanitizing and drying. a. The sanitizer level is checked three times per day to ensure that the proper amount is being distributed. . . ."	F 371	A) Dishwasher sanitizer 1. No residents were affected by the dishwasher not sanitizing properly. 2. All residents receiving meal service have the potential to be affected by the dishwasher not sanitizing properly. 3. On 6/13/16 when the surveyor was present, maintenance personnel repaired a tiny pin hole that wore in the tubing that caused the sanitizer to not to flow correctly. All dishes were rewashed prior to sending out of the dietary area. Facility process has been changed to include checking the sanitizer before the staff begin to wash the dishes and again when staff are done with dishes for that meal. The machine is periodically checked by the eco lab employee also to	7/21/16

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F 371	Continued From page 16 Initial tour on 06/13/16 at 12:35 p.m. with a dietary supervisor (#1) showed the following: * An unidentified dietary staff member using the the dishwashing machine. The dietary supervisor (#1) stated the dishwashing machine sanitizes the dishes with a chemical, and staff check the concentration level after each meal. When asked to check the chemical concentration, the dietary supervisor (#1) used a Chlorine test strip, which showed no change after contact with the water/chemical solution. The test strip remained white, indicating less than 10 parts per million (ppm). The unidentified dietary staff member stated she checked the concentration level after breakfast and it was 100 ppm. This staff member failed to record this reading on the dishwasher test log. The dietary supervisor (#1) stated the concentration level needs to be between 100-200 ppm. The dietary supervisor ran another cycle on the dish machine, and the test strip showed no change in color. The dietary supervisor manually primed the chemical solution and the chlorine strip showed a dark purple color indicating a reading of 200 ppm. The dietary supervisor ran another dishwashing machine cycle and the Chlorine strip once again did not change color. The dietary supervisor (#1) contacted the maintenance supervisor (#2) he located a hole in the chemical solution tubing and repaired the tubing. Review of the dishwasher log showed concentration levels checked three times a day with no low readings. * Ice frozen to the floor of the walk-in freezer in the kitchen. A large area of ice had accumulated on the fan due to water condensation dripping that also caused a chunk of ice on frozen pizzas.	F 371	ensure it is working properly. An in-service was provided for all dietary staff on July 1, 2016 to educate them on the new procedure for checking sanitizer levels. They were informed that levels of sanitizer need to register between 50 p.p.m.-200 p.p.m. according to information provided by Eco Lab personnel and listed on the chlorine test strips bottle. Facility policy has been updated to include the process changes. A new form has been implemented with additional lines to chart the extra times the machine is checked as well as instructions for staff with what to do if it is out of range. 4. 07/21/16 5. The dietary manager or designee will ensure that the sanitizer levels are being checked and responded to appropriately by monitoring the charting. This monitoring will be done daily Monday through Friday x 2 weeks, then weekly x 4 weeks, and then monthly. Results of all monitoring will be reported to the facility QA committee. The Committee will determine the need for continued monitoring. B) Freezer 1. No residents were affected by the water dripping in the freezer on to food. 2. All residents receiving meal service have the potential to be affected by the water dripping on to food in the freezer.	

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F 371	Continued From page 17 During an interview on the afternoon of 06/13/16, a dietary supervisor (#1) confirmed the dishmachine chemical concentration should be at 100 ppm and ice should not accumulate on food items.	F 371	3. On 6/13/16 food was removed and thrown away and a tray and container were set in the freezer to catch any drips and to ensure that any dripping would not reach food. An environmental checklist that will be done monthly was put into effect on 6/27/16 to ensure that the equipment is in proper working order, without excessive dripping and ice formation, and was posted in Nutrition Services. Items/areas will be rated using the following scale: G= Good condition, clean, working properly. F= Fair condition, working properly, needs to be cleaned and /or maintained P= Poor condition, not working properly, unable to meet safely and sanitation requirements. Management and /or maintenance will be notified of any item reported to be in less than good condition. All measures will be taken to improve the condition of the item or area. If the condition cannot be improved, the item or area will be replaced. On June 24, 2016 the maintenance man rerouted the drain pipe so it did not have a u shape in it, allowing the drain water to flow easier; also they blew out the drain pipe to get excess water out. See attached photos. An in-service was held on July 1st for all dietary staff to educate them on the new form and process for ensuring the freezer	

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F 371	Continued From page 18	F 371	is in good working condition. On July 7th Hanson Heating & Cooling came to investigate the dripping in the freezer. He determined it to be from normal condensation, he did recommend that indoor outdoor spray foam be applied around the compressor pipes that come into the freezer to decrease the amount of humidity coming in. This was completed by facility maintenance staff on July 8th. 4. 7/21/16 5. The dietary manager or designee will ensure that the freezer is not building up with ice and dripping condensation on food products by monitoring the charting and freezer. This QA monitoring will be done daily Monday through Friday x 2 weeks, then weekly x4 weeks, and then monthly. Results of all monitoring will be reported to the facility QA committee. The Committee will determine the need for continued monitoring.	