STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(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 and complaint survey started on June 27, 2016 and completed on June 30, 2016, the sample included four (4) residents for complete review, ten (10) residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to ensure competency of 1 of 1 staff nurse (#4) regarding the facility's emergency suction machine. Staff's lack of knowledge on setting up the suction machine in case of an emergency situation placed residents at risk for not receiving assistance during respiratory distress. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 1406-1407, states, ". . . Suctioning . . . When clients have difficulty handling their secretions or an artificial airway is in place, suctioning may be necessary to clear air passages . . . The nurse decides when suctioning is needed by assessing the client for signs of	F 281	F 281 SS=D 483.20(k)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 1) Nurse #4 received immediate 1:1 instruction on operation of suction machine and validated knowledge by providing a return demonstration. 3) The Nurse manager or designee provided education on operation of the suction machine to licensed nurses. Validation of nurses knowledge was completed though observation of return demonstration of nurses successfully performing suction process. A skills validation will be provided with orientation of newly hired nurses. 4) The Nurse manager/designee will	8/4/16

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

Electronically Signed | 07/20/2016

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F 281	Continued From page 1 respiratory distress or evidence that the client is unable to cough up and expectorate secretions. Dyspnea, bubbling or rattling breath sounds, poor skin color . . . or decreased oxygen saturation . . . levels . . . may indicate the need for suctioning. . . ." During interview on 06/28/16 at 5:00 p.m., a nurse (#4) stated he/she was not familiar with how to set up the emergency suction machine. The nurse then requested the assistance of another nurse (#5) who demonstrated how to set up the emergency suction machine to the nurse (#4). During an interview on 06/30/16 at 9:45 a.m., the administrative nurse (#6) stated she expected all nursing staff to have the ability to set up and utilize the emergency suction machine.	F 281	complete audits twice a week for four weeks, monthly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and recommendation. 5) Date of Compliance is August 4, 2016	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1). Based on record review and staff interview, the facility failed to provide the necessary care and services for 3 of 4 residents (Resident #14, #19, and #20) receiving hospice	F 309	F 0309 - 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1)	8/4/16

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F 309	Continued From page 2 services. Failure to provide access to the residents' hospice plan of care for all practitioners and staff involved in the residents' care limits coordination of care and services for the residents. Findings include: - Review of Resident #14's medical record occurred on 06/30/16. The record identified an admission to hospice services on 05/24/15, but failed to contain a copy of the hospice care plan. - Review of Resident #19's medical record occurred on 06/30/16. The record identified an admission to hospice services on 06/11/16, but failed to contain a copy of the hospice care plan. - Review of Resident #20's medical record occurred on 06/30/16. The record identified an admission to hospice services on 05/21/16, but failed to contain a copy of the hospice care plan. During an interview at 9:30 a.m. on 06/30/16, a social services staff member (#3) verified the facility does not have a copy of the hospice care plan on the residents' charts. 2) Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to reduce pressure on heels for 2 of 7 sampled residents (Resident #8 and #10) who required extensive assistance with bed mobility. Failure to consistently implement interventions for pressure relief (suspending/elevating the heels) may result	F 309	a) Resident #19 Expired. Resident□s #14 and #20 Care plans were reviewed and updated as needed to reflect changes. b) Residents receiving Hospice services have the potential to be affected by this practice. Care plans for these residents were reviewed and updated as needed to reflect changes. c) The DON or designee educated Social Services, Medical Records and Nurses on the need for a copy of Hospice care plans in the medical record for those receiving Hospice services. The DON, Administrator and Social Services met with Hospice to discuss and revise the process of obtaining new care plan updates for medical records. d) The Nursing Manager or designee will audit care plans of residents receiving Hospice weekly for four weeks, monthly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and recommendation. e) Date of Compliance is August 4, 2016 2) a) Residents #8 and #10's Care plans were reviewed, updated and preventative measures implemented as indicated. b) Residents with diabetic foot ulcers or	

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F 309	Continued From page 3 in skin breakdown. Findings include: Review of the facility policy titled "Heel Protection Guidelines" occurred on 06/30/16. The guidelines, revised 12/05/14, stated, ". . . Patients at risk for heel breakdown are identified and appropriate preventive measures taken as clinically indicated. . . . A pillow placed behind the back of the patient's lower legs is a good first option to float heels and reduce pressure on heels. . . ." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included diabetes, peripheral vascular disease, amputation of right big toe, and cellulitis of the second right toe. The resident's quarterly MDS, dated 04/02/16, identified extensive assistance for bed mobility. The current Kardex, stated, ". . . SKIN CARE . . . Friction reducing device . . . SUSPEND HEELS . . ." Observation showed Resident #10 laying on his bed with both heels resting directly on the mattress on: * 06/27/16 at 1:57 p.m. * 06/27/16 at 4:30 p.m. * 06/28/16 at 11:30 a.m. * 06/28/16 at 2:47 p.m. * 06/29/16 at 9:15 a.m. Observation on 06/29/16 at 9:25 a.m. showed a nurse (#7) changed a dressing to Resident #10's toe. After the dressing change, the nurse failed to suspend the resident's heels off the mattress.	F 309	an ulcer caused by peripheral vascular disease have the potential to be affected by this practice. These care plans were reviewed, updated and preventative measures implemented as indicated. c) The DON or designee educated nursing staff of the use of preventative measures for skin breakdown. Education occurred on 7/12/16, 07/22/16 and 07/27/16. d) The Nurse Manager or designee will audit for implementation of preventative measures three times weekly for four weeks, monthly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and recommendation. e) Date of Compliance is August 4, 2016	

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F 309	Continued From page 4 - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included a right above the knee amputation and peripheral vascular disease. The resident's admission Minimum Data Set (MDS), dated 05/02/16, identified extensive assistance for bed mobility. The current Kardex stated, ". . . SKIN CARE . . . encourage and/or assist to reposition frequently . . . SUSPEND HEELS . . ." Observation of Resident #8 showed the following: * 06/28/16 at 8:14 a.m.: A certified nursing assistant (CNA) (#8) provided perineal cares, repositioned the resident, and exited the room. The CNA (#8) failed to suspend her left heel. * 06/28/16 at 10:30 a.m.: Resident #8 resting in bed with her left heel resting directly on the mattress. * 06/28/16 at 10:46 a.m.: A CNA (#8) provided personal cares, repositioned the resident, and exited the room. The CNA (#8) failed to suspend Resident #8's left heel. * 06/28/16 at 12:29 p.m.: Resident #8 laying in bed with left heel resting directly on the mattress. * 06/29/16 at 8:09 a.m.: Resident #8 laying in bed with her left heel resting directly on the mattress. During an interview on 06/30/16 at 9:45 a.m., an administrative nurse (#6) stated she expected staff to suspend Resident #8 and #10's heels with pillows.	F 309		
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		8/4/16

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F 329	Continued From page 5 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, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 2 of 4 sampled residents (Resident #4 and #12) who received as needed (PRN) psychopharmacological medications. Failure to determine the necessity of a medication and to attempt non-pharmacological interventions prior to administration of PRN medications placed residents at risk of receiving unnecessary medications and suffering adverse consequences related to their use.	F 329	F 329 SS=D 483.25(l) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS 1) Resident□s #4 and #12 Care plans and task lists were reviewed and updated with non-pharmacological interventions. 2) Residents receiving PRN psychopharmacological medications have the potential to be affected by this practice. Care plans and task lists were reviewed and updated with non-pharmacological interventions.	

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F 329	Continued From page 6 Findings Include: Review of the facility policy titled "Behavior Practice Guideline" occurred on 06/30/16. This document, dated July 2015, stated, ". . . Medications can affect a patient's mental status and subsequently affect their behavior. Some of these behaviors may be considered as part of the therapeutic benefit of the medication, or as a negative consequence or response to the medication. . . . Select medications may be prescribed specifically targeting modification of patient behavioral symptoms. . . . antipsychotics . . . anxiolytics . . . Documentation: Patient behavioral symptoms are documented in the clinical record. . . . If a psychoactive medication is added or changed, the physician provides documentation of the risk and benefit of using the medication to the patient . . ." - Review of Resident #12's medical record occurred on June 29-30, 2016. Diagnoses included anxiety. The care plan stated, "Focus: Episodes of anxiety, use of antianxiety medication for dx [diagnosis] of anxiety . . . Interventions: Administer medication per physician orders Engage in relaxation techniques such as massage, breathing, guided imagery. Offer choices to enhance sense of control Remove to a quiet area and reassure . . ." Review of the medication administration record (MAR) showed Resident #12 received prn Xanax the following times: * March 2016: 46/46 doses administered without attempting non-pharmacological interventions * April 2016: 60/61 doses administered without attempting non-pharmacological interventions	F 329	3) The DON educated Nursing staff and Social Services on the utilization of non-pharmacological interventions in care plans, task lists and documenting attempts to use non-pharmacological interventions prior to administration of PRN psychopharmacological medications. Education occurred on 07/20/16 and 07/22/16. 4) The Nurse Manager or designee will complete audits on new PRN psychopharmacological medication orders and newly admitted residents with PRN psychopharmacological medication orders for non-pharmacological interventions in care plan and task lists five times weekly for four weeks, then three times weekly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and recommendation. 5) Date of Compliance is August 4, 2016	

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F 329	Continued From page 7 * May 2016: 68/69 doses administered without attempting non-pharmacological interventions * June 2016: 62/69 doses administered without attempting non-pharmacological interventions Failure to attempt non-pharmacological interventions prior to PRN medications may have resulted in the administration of unnecessary medications. - Review of Resident #4's medical record occurred June 27-30, 2016. Diagnoses included dementia with behavioral disturbance, major neurocognitive disorder with behavioral disturbance, mood disorder, and mental health problem. A quarterly Minimum Data Set (MDS), dated 04/09/16, identified severe cognitive impairment, physical and verbal behavioral symptoms directed towards others and rejection of care, all behaviors occurred one to three days of the seven-day assessment period. Resident #4's physician orders, dated 06/14/16, showed orders for olanzapine (an antipsychotic) five milligrams (mg), one tablet every 12 hours PRN, discontinued on 06/16/16. The original order, dated 01/27/16, stated, ". . . 1) Olanzapine 5mg oral now and every 12 hours prn severe agitation . . ." Review of information provided to the medical practitioner on 01/27/16, stated, "[Resident #4] is agitated. He has been 1:1 [one to one] for a long time. Agitation is on and off. Today the CNA [certified nurse aide] reported that he got up from his bed and walked. Did not want to sit down. Nurse got him back in chair. He keeps wanting to leave. 'I want to go home', he says this over and	F 329		

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F 329	Continued From page 8	F 329		

over. He is sitting by the door and wanting to leave. Nursing director wanted him to have PRN medication but they do not have anything to give him. They would like this."

A nurse's progress note, dated 01/27/16, stated, ". . . resident on one on one cares for behavior, resident got out of his w/c [wheelchair] in the room and ambulates self to the hallway, CNA advise [sic] him to go back and sit in his w/c and he refused, nurse notified and nurse went down and directed him to his w/c x3 [times three] and was compliance [sic], resident wanted to go out of facility, staff went with him to the lounge room by the main door and try to convince him to come back to his room but refused and stay [sic] there for 2 hours, staff gave prn Tylernol [sic] 500mg 2 tabs [tablets] for pain, and called [medical practitioner's name] for med [medication] for agitation. order was faxed for Olanzapine 5 mg oral now and prn every 12 hours . . . resident is calm now and in his room, will continue to monitor."

The current care plan stated, "Focus: Resistive/noncompliant with treatment/care (ambulation) related to: Cognitive Impairment s/p [status post] CVA [cerebral vascular accident] . . . Goal: Will comply with care routine/medical regimen . . . Interventions/Tasks: 'chat with [Resident #4's name] before attempting to change his soiled clothes. Remind him that getting help is ok . . . Allow for flexibility in ADL [activities of daily living] routine to accommodate mood, preferences, and customary [sic] routine . . . If resists care, leave (if safe to do so) and return later . . . Inform of ADL that is required ahead of time and give two options of times to be

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F 329	Continued From page 9	F 329		

done. Give choice and allow for flexibility in routines . . . Provide education about risks of not complying with therapeutic regimen . . . Provide non-care related conversation proactively before attempting ADL . . ."

The MAR showed Resident #4 received olanzapine on 13 occasions between 02/01/16 and 06/16/16. On 10 occasions staff identified the reason for administration as agitation, and three times staff failed to identify a reason for administering the medication. Listed for Resident #4's outcome after receiving the medication - calm seven times, relief two times, sleeping once, calm sleeping once, relief compliance once, and relief sleeping once. On two occasions in February nursing staff administered Tylenol and olanzapine at the same time, therefore staff were not able to determine if the Tylenol or the olanzapine provided Resident #4 with the desired outcome.

Progress notes identified the following reasons staff administered PRN olanzapine to Resident #4:

* 02/13/16 at 5:17 p.m., "resident got up and got dress, nurse saw resident propelling his w/c with moody face, nurse offered Seroquel [wrong medication named] prn to resident and he refused. . . . gave breakfast and he ate staff gave AM [morning] meds including Seroquel [administered olanzapine] prn for agitation after he calm down."
* 02/17/16 at 10:39 p.m., "resident was given Olanzapine 5mg for agitation at 0900 [9:00 a.m.] and it was effective, . . ."
* 02/26/16 at 4:26 p.m., "resident on one on one cares for behaviors, resident woke up and

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F 329	Continued From page 10 look agitated, nurse gave prn Olanzapine 5mg and he was calm and sleepy for 3 hours, no behaviors noted, will continue to monitor." * 03/05/16 at 10:38 a.m., "resident on one on one cares for behavior, gave Olanzapine 5mg twice for signs of agitation and had relief, resident was calm during the day, will continue to monitor." * 03/06/16 at 8:35 p.m., "resident on one on one cares for behavior, gave Olanzapine 5 mg at 0800 [8:00 a.m.] for signs of agitation and had relief, resident was calm during the day, will continue to monitor." * 03/15/16 at 8:38 p.m., "resident on one on one for behaviors, had small behaviors with staff, was given Olanzapine 5 mg and was effective slept for 3 hrs [hours] and was calm when he woke up, will continue to monitor." * 06/02/16 at 8:12 p.m., "resident on trial to discontinue one on one cares for behavior. no one on one cares for behavior this PM [evening] shift, resident propel self in hall way coming from south side toward his room and asking nurse 'which apartment do I have' staff took him to room door and he state 'my apartment has a kitchen and this does not have any kitchen', nurse use distraction and redirection to get his mind off situation, nurse offered a ride to his bedroom and he agreed, resident was taken to his room and he went to bed and slept, Olanzepine [sic] 5mg given prn as ordered for mild agitation, will continue to monitor." Nursing staff failed to document the behavior observed and/or the non-pharmacological interventions attempted prior to obtaining the prn order for olanzapine, before administering each dose of olanzapine, and/or outcome related to	F 329		

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F 329	Continued From page 11 the administration of the medication. Nursing staff administered the olanzapine outside the directions of the medical practitioner who ordered the medication for severe agitation not for the reasons identified by the nursing documentation.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 1 of 6 residents (Resident #21) observed during medication pass. Two errors occurred during staff administration of 26 medications, resulting in a seven percent error rate. Findings include: Review of the facility policy titled "MEDICATION ADMINISTRATION: MEDICATION PASS" occurred on 06/30/16. This policy, dated March 2010, stated, ". . . PROCEDURE . . . 4. Read transcribed physician order on MAR [medication administration record]: patient name, medication name, dosage, route and interval ordered, remove medication from cart, compare MAR with medication label for accuracy . . ." Observation of medication pass occurred on 06/28/16 at 7:55 a.m. A nurse (#1) dispensed several medications for Resident #21. The MAR	F 332	F 332 SS=D 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 1) Resident #21 was assessed for complications from the medication error and none were found. The nurse who was cited for the error is no longer associated with the facility. 2) Residents who receive medications have the potential to be affected by this practice. Licensed nurses were observed for accuracy of medication/treatment pass to prevent medication errors. 3) The DON or designee provided education to licensed nurses on medication administration and were observed administering medications. Education occurred on 07/18/16, 07/19/16, 07/21/16, and 07/22/16.	8/4/16

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	355024	A. BUILDING _____ B. WING _____	C 06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(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 332	Continued From page 12 and physician's orders identified Docusate/Senna (Senna S) two tablets twice a day. The nurse (#1) administered Docusate Sodium (Colace) two tablets. After the staff member administered the medications, she returned to the medication cart. When asked to see the bottle of Senna S and Colace, the nurse (#21) confirmed she administered the wrong medication. When asked if Resident #21 had a prescription for eye drops, the staff member reviewed the MAR. The nurse (#21) did not see Pred Forte eye drops on the MAR until the surveyor showed her and the nurse stated, "oh, yeah." The staff member then administered the eye drops to Resident #21. The staff member failed to ensure the administration of all ordered medications according to the MAR, which resulted in two medication errors.	F 332	4) The DON or designee will complete random audits of medication administration three times weekly for four weeks, then weekly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and recommendation. 5) Date of Compliance is August 4, 2016	
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, review of professional reference, review of sanitizer concentration logs, and staff interview,	F 371	F 0371 - 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (LONG TERM CARE FACILITIES)	8/4/16

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F 371	Continued From page 13 the facility failed to ensure the correct concentration of sanitizing solution (used for tables, countertops, and pots and pans) in 1 of 1 kitchen. Failure to ensure sanitizing solutions did not exceed the recommended concentration has the potential to be harmful due to chemical residue left on surfaces. Findings include: Review of the 2013 Food and Drug Administration Food Code Annex, Public Health Reasons/Administrative Guidelines, page 539, states, "Chemical sanitizers are included with poisonous or toxic materials because they may be toxic if not used in accordance with requirements listed in the Code of Federal Regulations (CFR). Large concentrations of sanitizer in excess of the CFR requirements can be harmful because residues of the materials remain. . . ." Review of the facility's policy titled "MANUAL WARE WASHING" occurred on 06/27/16. This policy, revised July 2015, stated, ". . . GUIDELINES . . . The following are general guidelines for a three compartment sink using the quaternary ammonium compound Oasos [sic] from EcoLab as a sanitizer. SINK SET-UP . . . 5. Add Oasis 146 to give a concentration of 200-400 ppm [parts per million]. 6. Test the concentration with the QT-40 test strip designed for Oasis 146. . . . Adjust water or sanitizer if necessary. . . ." Review of the three compartment sink sanitizer concentration logs showed staff test the sanitizer concentration three times a day. The following	F 371	1)No Residents were identified that were affected by the deficient Practice. Dietary Staff were immediately trained on proper procedure for testing Sanitizer solution and confirming it is in proper range. 2)All Residents could be affected by too high of a Sanitizer level which may leave residual sanitizer on products if the PPM levels are not maintained according to policy 3)FSD provided Re-education to all Dietary Staff on proper procedure to cool the sanitized water to the test strip required temperature. Wall mounted test procedure chart was reviewed with all staff for reference if questions arose. Staff were also educated if Sanitizer falls outside of range as stated in the policy that notification of the FSD or Designee must occur immediately for a remedy. Initial education occurred on 06/30/16 and re-education occurred on 07/21/16. 4)FSD or Designee will audit Sanitizer testing logs daily x 4 weeks, weekly for 4 weeks and monthly for 4 months. All findings will be forwarded to the QA committee to be reviewed at the Monthly QA meetings 5)Compliance Date August 4, 2016	

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F 371	Continued From page 14	F 371		

times the sanitizer tested above 400 ppm:
* January 2016: 47 out of 93 times with no follow-up
* February 2016: 29 out of 87 times with no follow-up
* March 2016: 27 out of 93 times with no follow-up
* April 2016: 24 out of 90 times with no follow-up
* May 2016: 15 out of 93 times with no follow-up
* June 2016: 25 out of 80 times with no follow-up

Review of the red sanitizer bucket concentration logs showed the staff test the sanitizer concentration three times a day. The following times the sanitizer tested above 400 ppm:
* January 2016: 58 out of 93 times with no follow-up
* February 2016: 28 out of 87 times with no follow-up
* March 2016: 15 out of 93 times with no follow-up
* April 2016: 12 out of 90 times with no follow-up
* May 2016: 37 out of 93 times with no follow-up
* June 2016: 28 out of 80 times with no follow-up
The dietary manager (#2) stated the sanitizer concentration should measure between 200-400 ppm and staff should report out of range measurements to her.

During an interview on 06/27/16 at 1:45 p.m., the dietary manager (#2) stated she reviews the sanitizer concentration logs to ensure they are complete, but does not look at the ppm.

Observation on 06/27/16 at approximately 2:00 p.m., showed the dietary manager (#2) filled the third sink of the three compartment sink with sanitizer premixed with hot water. She tested the

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F 371	Continued From page 15 concentration of the sanitizer by immersing a test strip in the solution for approximately 10 seconds. The test strip measured 500 ppm. The dietary manager (#2) stated she contacted Ecolab and they said if the temperature of the water is too high it can cause a higher reading on the test strip. The dietary manager (#2) stated Ecolab will be at the facility on 06/28/16. Observation on 06/27/16 at 2:36 p.m. showed "Oasis 146 Multi-Quat Sanitizer" laminated information posted above the three compartment sink, it stated, "Testing solution should be at room temperature - 65 [degrees] F [Fahrenheit] - 75 [degrees] F." The dietary manager (#2) stated she took the temperature of the sanitizer in the third sink of the three compartment sink at 2:30 p.m. and it showed 131 degrees. She also checked the sanitizer concentration and it still tested at 500 ppm. During an interview on 06/27/16 at 4:33 p.m., the dietary manager (#2) stated the quat sanitizer is used on dining room tables, kitchen counters, and to sanitize pots and pans.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		8/4/16

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F 431	Continued From page 16 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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, policy review, and staff interview, the facility failed to properly store and label medications in 1 of 1 medication room (South Unit). Failure to discard expired medications increased the risk of residents receiving outdated medications with reduced efficacy. Findings include: Review of the facility policy titled, "STORAGE OF MEDICATIONS" occurred on 06/30/16. This	F 431	F 431 SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1) No residents identified. Expired medications were immediately removed and destroyed. 2) Residents receiving medications have the potential to be affected by this practice. Medication/treatment storage areas are being routinely audited for	

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F 431	Continued From page 17 policy, undated, stated, ". . . M. Outdated, contaminated, or deteriorated medications . . . are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from pharmacy . . ." On 06/28/16 at 4:54 p.m., observation in the South Unit medication room with a staff nurse (#4) identified expired dates on twelve medications: * One vitamin C bottle expired April 2016 * Three Vitamin D bottles expired May 2016 * Three Glutose 15 tubes expired October 2015 * Three Glutose 15 tubes expired November 2015 * One iron supplement tablet bottle expired May 2016 * One aspirin 325 milligram (mg) bottle expired April 2016 During an interview on 06/30/16 at 9:45 a.m., an administrative nurse (#6) stated the facility process is to destroy expired medications.	F 431	expired medications. 3) The DON or designee educated licensed nurses on removal of expired medications from medication/treatment supply areas. Initial Education occurred on 06/30/16 and re-education on 07/22/16. 4) The Unit manager or designee will complete audits of the medication carts, medication room, supply areas and treatment carts of expired biologicals/medications weekly. 5) Date of Compliance is August 4, 2016	
F9999	FINAL OBSERVATIONS Based on observation, record review, resident, family, and staff interviews, the complaint investigated in conjuction with the standard Medicare/Medicaid survey was unsubstantiated.	F9999		