STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(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 04/03/17 and completed on 04/05/17, 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.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 9 sampled residents (Resident #1). Failure to determine the need for and complete a SCSA assessment in response to the resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include:	F 274	Resident #1 was reassessed for Comprehensive Assess after Significant Change. Guidelines revealed a Significant Change should have been completed on Resident #1. Resident #1 had experienced a decline consistently in 2 areas. An assessment reference date was immediately set up for 4/10/17. On 4/11/17 Resident #1 assessment was completed and transmitted. All residents who experience significant	4/28/17

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

Electronically Signed | 04/24/2017

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F 274	Continued From page 1 The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.14), dated October 2016, page 2-22 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." Page 2-23 stated, ". . . A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments . . ." Page 2-25 stated, ". . . A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL [activities of daily living] decline or improvement). . . . Decline in two or more of the following: Resident's decision-making changes; Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency . . . e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); Any decline in an ADL physical functioning area where a resident is newly coded	F 274	declines or improvements in two areas may have the potential to be affected. The MDS coordinator and MDS staff were immediately notified of need for significant change, review of guidelines completed. A licensed nurse meeting attended by licensed nurses and MDS staff was conducted on 4/19 & 4/20/17 by DON addressing the criteria for significant changes which included areas of decline and improvement. All nursing department staff in-service education provided on 4/19 & 4/20/17 an overview regarding the criteria for a significant change. A specific MDS meeting was held on 4/21/17 with Department Supervisors in which guidelines were reviewed regarding significant change The MDS coordinator will conduct weekly audits of all resident MDS' prior to MDS submission to ensure continued compliance under MDS Department QA checklist "Significant Change MDS Completed When Note Decline or Improvement in two (2) or more care areas." Areas of concern will be addressed at monthly QA meeting. MDS Coordinator/nurses utilized "Significant Change Guidelines" form to assess current residents to determine if decline or improvement warranted SCSA to be done. No SCSA were warranted. This form will be completed with each	

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F 274	Continued From page 2 as Extensive assistance, Total dependence, or Activity did not occur since last assessment; Resident's incontinence pattern changes or there was placement of an indwelling catheter . . ." Review of Resident #1's medical record occurred on all days of survey. Comparison of Resident #1's admission Minimum Data Set (MDS), dated 11/10/16, and his quarterly MDS, dated 01/31/17, identified the following areas of decline from November 2016 to January 2017: *11/10/16 MDS - C1310B Inattention coded as 0 (behavior not present); C1310D Altered level of consciousness coded as 0 (behavior not present); E0200A Physical behavior coded as 1 (behavior occurred 1 to 3 days); E0200B Verbal behavior coded as 2 (behavior occurred 4 to 6 days); E0200C Other behavioral symptoms coded as 0 (behavior not exhibited); E0800 Rejection of care coded as 0 (behavior not exhibited); E0900 Wandering coded as 0 (behavior not exhibited); H0300 Urinary continence coded as 1 (occasionally incontinent); and H0400 Bowel continence coded as 0 (always continent) *01/31/17 MDS - C1310B Inattention coded as 2 (behavior present, fluctuates); C1310D Altered level of consciousness coded as 2 (behavior fluctuates); E0200A Physical behavior coded as 3	F 274	MDS by the MDS Coordinator/nurse.	

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F 274	Continued From page 3 (behavior occurred daily); E0200B Verbal behavior coded as 3 (behavior occurred daily); E0200C Other behavioral symptoms coded as 2 (behavior occurred 4 to 6 days); E0800 Rejection of care coded as 1 (behavior occurred 1 to 3 days); E0900 Wandering coded as 2 (behavior occurred 4 to 6 days); H0300 Urinary continence coded as 2 (frequently incontinent); and H0400 Bowel continence coded as 2 (frequently incontinent) The decline in Resident #1's condition, from his admission MDS to the quarterly MDS, indicates the facility needed to complete a SCSA.	F 274		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification	F 278		4/28/17

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F 278	Continued From page 4 (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: ITEM Z0400 (ATTESTATION STATEMENT) 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility staff failed to use the entire required days of observation when completing Minimum Data Sets (MDSs) for 8 of 9 sampled residents (Residents #1, #2, #3, #5, #6, #7, #8, and #9); and failed to complete resident interviews during the required look-back period for 1 of 9 sampled residents (Resident #5) and as identified in 1 of 1 closed record (Resident #10). Failure to collect assessment information for the entire required observation period and/or failure to complete resident interviews during the required look-back period, may result in incomplete and/or an inaccurate assessment of the resident. Findings include:	F 278	Resident's #1, #2, #3, #5, #6, #7, #8, #9, & #10 Section Z0400 CMS guidelines were immediately reviewed with the individuals who completed section. Guidelines revealed staff failed to use the entire required days of observation when completing Minimum Data Set; and failed to complete resident interviews during the required look-back period resulting inaccurate assessment. Staff members failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight). All residents have the potential to be affected. The MDS coordinator and MDS staff were immediately notified and educated on guidelines of Section Z0400. A licensed nurse meeting attended by licensed	

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F 278	Continued From page 5 The Long-Term Care Facility RAI User's Manual, revised October 2016, page A-31 stated, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . . The look-back period includes observations and events through the end of the day (midnight) of the ARD . . ." Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. The Long-Term Care Facility RAI User's Manual, revised October 2016, page C-19 stated the Staff Assessment of Mental Status has a 7-day look-back period; page D-12 stated the Staff Assessment for Resident Mood has a 14 day look-back period; and page J-17 stated the Staff Assessment for Pain has a 5-day look-back period. The Long-Term Care Facility RAI User's Manual,	F 278	nurses and MDS staff was conducted on 4/19 & 4/20/17 by DON addressing the importance & accuracy with need for accurate assessment of residents. All nursing department staff in-service education on 4/19 & 4/20/17 provided an overview regarding the importance of assessment accuracy/coordination. A specific MDS meeting was held on 4/21/17 with MDS nurse's and Department Supervisors in which guidelines were reviewed regarding use the entire required days of observation when completing Minimum Data Set; completion of resident interviews during the required look-back period resulting in accurate assessment, observation and collect MDS assessment information through the end of the day of the ARD (up until midnight). The MDS Coordinator will conduct weekly audits of all resident MDS prior to submission to ensure continued compliance under MDS Department QA checklist "MDS interviews section C,D,F,J,K,& Q." Areas of concern will be addressed at monthly QA meeting. Resident #2 was reassessed on 4/6/17 which included the review of CMS coding guidelines pertaining to coding application of ointments/medications other than to feet. Guidelines revealed Rup Rub Analgesics is not utilized to treat a skin condition. Resident #2 has been	

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F 278	Continued From page 6 revised October 2016, page D-4 stated, . . . "Look-back period for this item is 14 days . . . Conduct the interview preferably the day before or day of the ARD." . . . Page J-7 stated, ". . . the look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5-day look-back period; preferably on the day before, or the day of the ARD. . . ." The Centers for Medicare and Medicaid Services (CMS) identified the resident interviews for Cognition (Section C), Preferences (Section F), and Participation in Assessment and Goal Setting (Section Q) can be done any time during the 7-day look-back period; and item Z0400 should contain the actual date of the resident interview, when signed and dated by a facility staff member. - Review of Resident #1's medical record occurred April 3-5, 2017. A quarterly MDS, with an ARD of 01/31/17, identified a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three items (K0100 Swallowing Disorder, K0510 Nutritional Approaches, and K0710 Percent Intake by Artificial Route), as Z0400 showed a signature and date of 01/31/17 (the same date as the ARD). - Review of Resident #2's medical record occurred April 3-5, 2017. A 30-day Medicare MDS, with an ARD of 03/22/17, identified a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three	F 278	reassessed & corrections to prior MDS's have been implemented and submitted. A licensed nurse meeting attended by licensed nurses and MDS nurses was conducted on 4/19 & 4/20/17 by DON addressing the importance of accuracy with need for accurate assessment of residents current status and needs: including application of ointments/medications other than to feet used to treat a skin condition. All nursing department staff in-service education on 4/19 & 4/20/17 provided an overview regarding the importance of assessment accuracy/coordination focusing on ointments or medications used to treat a skin condition. A specific MDS meeting was held on 4/21/17 with MDS nurse's and Department Supervisors in which guidelines were reviewed regarding application of ointments/medications other than to feet. The MDS Coordinator will conduct weekly audits of all resident MDS prior to submission for three (3) consecutive months then quarterly thereafter to ensure continued compliance under MDS Department QA checklist "MDS does not accurately reflect individual resident's current status." Areas of concern will be addressed at monthly QA meeting.	

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F 278	Continued From page 7	F 278		

items (K0100 Swallowing Disorder, K0510 Nutritional Approaches, and K0710 Percent Intake by Artificial Route), as Z0400 showed a signature and date of 03/22/17 (the same date as the ARD).

- Review of Resident #3's medical record occurred April 3-5, 2017. An annual MDS, with an ARD of 12/02/16, identified a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three items (K0100 Swallowing Disorder, K0510 Nutritional Approaches, and K0710 Percent Intake by Artificial Route), as Z0400 showed a signature and date of 12/02/16 (the same date as the ARD).

- Review of Resident #5's medical record occurred April 3-5, 2017. A significant change in status assessment (SCSA), with an ARD of 01/25/17, identified the following:

* no signature or date for completion of Section K.

* facility staff members failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on Sections A, B, C, D, E, G, H, I, J, L, M, N, O, P, S, V and Z, as Z0400 showed a signature and date of 01/25/17 (the same date as the ARD).

* a facility staff member failed to complete the resident interview for Preferences (Section F) and Particiation in Assessment and Goal Setting (Section Q) during the 7-day look-back period, as Z0400 showed a signature and date of 01/31/17 (6 days after the ARD).

- Review of Resident #6's medical record

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occurred April 3-5, 2017. A quarterly MDS, with an ARD of 03/18/17, identified a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three items (K0100 Swallowing Disorder, K0510 Nutritional Approaches, and K0710 Percent Intake by Artificial Route), as Z0400 showed a signature and date of 03/17/17 (one day before the ARD).

- Review of Resident #7's medical record occurred on 04/05/17. A quarterly MDS, with an ARD of 01/13/17 identified the following:

* a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three items (K0100 Swallowing Disorder, K0510 Nutritional Approaches, and K0710 Percent Intake by Artificial Route), as Z0400 showed a signature and date of 01/13/17 (the same date as the ARD).

* a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on the Staff Assessment of Mental Status, the Staff Assessment for Resident Mood; and the Staff Assessment for Pain, as Z0400 showed a signature and date of 01/12/17 (one day before the ARD).

- Review of Resident #8's medical record occurred on 04/05/17. A quarterly MDS, with an ARD of 01/06/17, identified a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three items (K0100 Swallowing Disorder, K0510 Nutritional Approaches, and K0710 Percent Intake by

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Artificial Route), as Z0400 showed a signature and date of 01/06/17 (the same date as the ARD).

- Review of Resident #9's medical record occurred on 04/05/17. A quarterly MDS, with an ARD of 12/22/16, identified a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three items (K0100 Swallowing Disorder, K0510 Nutritional Approaches, and K0710 Percent Intake by Artificial Route), as Z0400 showed a signature and date of 12/22/16 (the same date as the ARD).

- Review of Resident #10's medical record occurred April 4-5, 2017. An admission MDS, with an ARD of 01/12/17, identified the following:
* a facility staff member failed to complete the resident interview for Preferences (Section F) during the 7-day look-back period, as Z0400 showed a signature and date of 01/13/17 (1 day after the ARD).

During an interview on the morning of 04/05/17, an administrative nurse (#3) was unable to provide any additional information regarding the above-stated Z0400 signatures and dates.

SECTION M (SKIN CONDITIONS)

2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 9 sampled

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F 278	Continued From page 10 residents (Resident #2). Failure to accurately code skin and ulcer treatments does not allow the resident's assessments to reflect her current status/needs; and has the potential to affect the accurate development of a comprehensive care plan and the care provided to this resident. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.14), dated October 2016, page M-40 stated, ". . . M1200H Application of Ointments/Medications Other than to Feet . . . This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents). . . . This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream). . . ." - Review of Resident #2's medical record occurred on all days of survey. Current physician's orders included, "Rup Rub Analgesic Cream, apply topically to affected areas twice daily as needed for pain." Section M1200 of Resident #2's current MDS, dated 03/01/17, identified the use of ointments/medications for skin/ulcer treatments; however the record lacked evidence of ointments/medications used to treat a skin condition. During an interview on the morning of 04/05/17, an administrative nurse (#3) verified the analgesic cream was used for pain rather than to treat a skin condition.	F 278		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		4/28/17

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F 323	Continued From page 11 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. 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 supervision and assistive devices necessary to prevent accidents for 4 of 7 sampled residents (Resident #3, #7, #8, and #9) observed transported in a wheelchair. Failure to provide wheelchair foot rests for residents during transport may result in injury and/or falls. Findings include:	F 323	Nursing department staff education completed promptly with each shift report regarding free of accident hazards/supervision/devices. Specific education provided re: resident #3, #7, #8, & #9 as well as all residents. Residents immediately assessed and footrests implemented accordingly. All staff were educated on 4/19 & 4/20/17	

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	355038	A. BUILDING _____ B. WING _____	04/05/2017

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F 323	Continued From page 12 Review of the facility policy titled "Transporting Residents in Wheelchairs" occurred on 04/05/17. This policy, dated February 1995, stated, ". . . During the trip, the escort should: . . . Check the chair frequently to make sure that wheels are free and that the resident's feet are secure on the footrests. . . ." - Review of Resident #8's medical record occured on 04/05/17. Diagnoses included Alzheimer's disease, dementia, and osteoarthritis. The current care plan stated, ". . . I am weak and can't . . . be up by myself . . . foot pedals utilized when unable to elevate feet while pushed . . . w/c utilized for all long distances. . . ." Observation on 04/03/17 at 5:25 p.m. showed an unidentified staff member transported Resident #8 down the hall without foot rests. The resident's feet made an audible noise as they brushed on the floor during the transport. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The current care plan identified, ". . . Right now I utilize my w/c [wheelchair] for primary transport . . ." Observation on the afternoon of 04/04/17 showed a certified nursing assistant (CNA) (#1) transported Resident #3 from her room to the TV area in a wheelchair without foot rests. The resident's feet made an audible noise as they brushed on the floor during the transport. - Review of Resident #7's medical record occurred on 04/05/17. Diagnoses included	F 323	regarding the importance of preventing accidents focusing in on wheelchair transport. Licensed Nurses also educated regarding the importance of this standard on 4/19 & 4/20/17 at licensed nurse meeting. Both meetings were conducted by the Director of Nursing. QA spot checks were implemented immediately for random checks to ensure standard is followed. Random spot checks will continue daily until 5/8/17 conducted by charge nurse. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to QA committee. The QA director will conduct weekly audits to ensure compliance x4, then monthly under the Safety Department QA checklist labeled "Safe w/c transport." Areas of concern will be addressed at monthly QA meeting.	

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F 323	Continued From page 13	F 323		

Alzheimer's disease. The current care plan identified, ". . W/C for mobility . . ."

Observation on the morning of 04/04/17 showed a CNA (#2) transported Resident #7 down the hallway in a wheelchair without foot rests. Resident #7's legs were crossed, and observation showed the resident's heel bounced along the floor during the transport.

- Review of Resident #9's medical record occurred on 04/04/17. Diagnoses included Alzheimer's disease. The current care plan stated, ". . . W/C for mobility . . . May use footrests on W/C when needed . . ."

Observation on the morning of 04/04/17 showed an unidentified staff member transported Resident #9 down the hallway in a wheelchair without foot rests. The resident's feet made an audible noise as they brushed on the floor during the transport.

- Review of Resident #8's medical record occured on 04/05/17. Diagnoses included Alzheimer's disease, dementia, and osteoarthritis. The current care plan stated, ". . . I am weak and can't . . . be up by myself . . . foot pedals utilized when unable to elevate feet while pushed . . . w/c utilized for all long distances. . . ."

Observation on 04/03/17 at 5:25 p.m. showed an unidentified staff member transported Resident #8 down the hall without foot rests. The resident's feet made an audible noise as they brushed on the floor during the transport.

During an interview on 04/05/17 at 11:29 a.m., a

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F 323	Continued From page 14 supervisory nurse (#3) agreed staff should use foot rests if the resident cannot lift his/her feet off the floor.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		4/28/17

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F 329	Continued From page 15 (2) Residents who use psychotropic 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 staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 1 of 2 sampled residents (Resident #4) who received as needed (PRN) anti-anxiety medications. Failure to provide non-pharmacological interventions prior to administration of an anti-anxiety medication placed residents at risk of receiving unnecessary medications, experiencing adverse consequences related to their use, and ineffective anxiety relief. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnoses included psychological disorder, mood disorder, delusional disorders, and a history of a traumatic brain injury. Physician orders included PRN alprazolam 0.5 milligrams (mg) by mouth as needed twice daily for agitation or aggression. Review of Resident #4's medication administration records from January 1 through March 31, 2017, the Behavior/Intervention/Outcome Roster, and the nursing progress notes identified the following: * On 11 occasions staff administered PRN alprazolam. Staff failed to provide non-pharmacological interventions on 5 of the 11 occasions.	F 329	Nursing department staff education completed promptly with each shift report regarding medication regimen that is free from unnecessary drugs for resident #4 who received as needed (PRN) anti-anxiety medications, in absence of non-pharmacological interventions prior to administration of an anti-anxiety. All residents receiving PRN anti-anxiety medications have the potential to be affected. A licensed nurse meeting was conducted on 4/19 & 4/20/17 by DON addressing the importance of documentation of non-pharmacological interventions prior to administration of an antianxiety medication. All staff in-service education on 4/19 & 4/20/17 provided with an overview regarding non-pharmacological interventions. Our eMAR is now programmed to flag to chart non-pharmacological interventions prior to administration of an anti-anxiety. CNA's educated re: need to document behaviors/interventions/etc. The QA Director will conduct weekly audits x3months of all residents receiving	

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F 329	Continued From page 16 During an interview of 04/04/17 at 11:25 a.m., a nurse manager (#3) stated staff should provide and document non-pharmacological interventions before administering the PRN anti-anxiety medication.	F 329	PRN anti-anxiety medications, then quarterly thereafter to ensure continued compliance under Pharmacy Department QA checklist "Non-Pharmacological Interventions prior to Administering PRN Psychotropics." Areas of concern will be addresssed at monthly QA meeting.	
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371		4/28/17

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F 371	Continued From page 17 by: Based on observation, review of facility documents, and staff interview, the facility failed to ensure appropriate sanitization in food preparation/service areas in 1 of 1 facility kitchen. Failure of facility staff to ensure quaternary (quat, a chemical sanitizer) solutions remained at a proper concentration level to sanitize may result in inadequate sanitization and place residents at risk for food-borne illness. Findings include: Review of an untitled document provided by the dietary manager (#4) occurred on the morning 04/05/17. This document, undated, stated, "Standard of Practice is followed for sanitizing counters, sinks, tables and other food contact surfaces. This includes using warm water in order for sanitizing solution to be effective according to testing strips. Each new bucket of sanitizing solution is tested using test strips for QT-10. Once water becomes cool, soiled, cloudy, etc. a new bucket of sanitizing solution is created." Observation during the kitchen tour on 04/03/17 at 2:50 p.m. showed a red bucket, with a mixture of water and quat sanitizer, in the kitchen sink. When asked to test the concentration of the sanitizer solution in the red bucket, a dietary staff member used a quat test strip and the reading showed 100 ppm (parts per million), detecting an ineffective concentration. The dietary staff member stated the concentration level should be between 200-400 ppm to be effective. During an interview on the morning of 04/05/17,	F 371	All residents have the potential to be affected. Dietary dept staff members were educated by CDM 4/19, 4/20 and 4/27/17 regarding policy/procedure for preparing and maintaining proper sanitizing solution concentration levels and regarding documentation of testing sanitizing solution. CDM will conduct weekly audits to ensure compliance with new policy x4, then quarterly under Dietary Dept QA checklist labeled 'Quat Sanitizing Solution @ Sanitizing level'. Areas of concern will be addressed at monthly QA meeting.	

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F 371	Continued From page 18 the dietary manager (#4) provided a monitoring sheet showing staff test the quat sanitizing solutions and document the results once a day, immediately after mixing the water and quat sanitizer. When asked to provide a policy/procedure on the use and monitoring of the quat sanitizing solution, the dietary manger identified the facility did not have a policy/procedure. Failure to ensure the quat sanitizer solutions remained at a proper concentration level to sanitize may result in unsanitary dietary conditions and place residents at risk for food-borne illness.	F 371		