DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. BUILDING _____ B. WING _____	04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAKOTA ALPHA	1303 27TH STREET NW MANDAN, ND 58554

(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 04/13/15 and completed on 04/14/15, the sample included 2 residents for complete review, 5 residents for focused review, and 1 closed record for review. The sample included 1 additional closed record and 5 additional residents to verify specific concerns during the survey.	F 000	A review of the Fall Prevention policy and incidents reports including the Family/Significant Other Notification Protocol will be discussed at the Nurse's Meeting on May 7, 2015. All residents have the potential of being affected by the same deficient practice. The reportable event form was modified to explain where to look for the notification protocol in the residents chart. Nurses will be educated on the need to follow the protocol and how to successfully complete the reportable event. Nurses were also educated on how to find the residents family/significant other's notification preference when a fall occurs. All nurses including those who were unable to attend will sign off on the in-service minutes. A memo to travel nurses to review the Fall Prevention policy and Family/Significant Other Notification Protocol will be attached to the front of the nurse report book so travel nurses who do not attend our in-services are reminded to check the protocol.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: (Administrator) Mt. Brain Injury Services (X6) DATE: 5-1-2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to promptly notify the resident's legal representative/family for 1 of 5 sampled residents (Resident #3) experiencing falls. Failure to notify the resident's legal representative/family of fall incidents does not allow participation in the resident's care and is an infringement on the resident's rights. Findings include: Review of the facility policy titled "Fall prevention" occurred on 04/14/15. This policy, undated, stated, ". . . If a fall happens, the goal for the staff is to assess the resident for injury . . . After the resident is stable, the physician is notified if necessary and the family according to their notification preference . . . " -Review of Resident #3's medical record occurred on 04/13/15 and diagnoses included abnormality of gait and history of fall. An annual Minimum Data Set (MDS), dated 03/29/15, identified Resident #3 with falls since admission. Review of Resident #3's notification protocol titled "Family/Significant Other Notification Protocol" occurred on 04/14/15. The notification protocol stated, ". . . Please contact one designated family member or significant other immediately regardless of the time of day or night for all	F 157	The DON will review every completed reportable event to insure the protocol was properly followed and family/ significant other was notified according to preference starting on May 8, 2015 and will continue for the following 6 months (through October 2015). At the end of October, if no errors have been found, the checks will be discontinued. If errors are found, the checks will be continued for an additional 3 months and re-education will be done with the nurses who are repeating the errors. The DON will report the error rate to the Q.A. committee on a quarterly basis until compliance is reached. changed on all tags	5-08-15 ~~05/07/15~~ Por. Tc. E Admin 5-6-15

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F 157	Continued From page 2 incidents, even if in nursing judgment no significant injury has occurred . . ." Review of the facility's documents titled "Reportable Event" for Resident #3 showed the following: * 02/01/15 at 12:30 p.m., ". . . Not observed . . . possibly from over-reaching without seat belt on . . . Was Medical Personnel Notified? . . . Yes . . . Time: 12:35 pm [sic] . . . Accident . . . [name of resident] was sitting on the floor beside his wheelchair in the A wing outside of his room . . . [name of resident] was helped to his wheelchair . . . resident denied any pain/injury . . ." * 03/26/15 at 6:10 a.m., ". . . No injury noted. Will encourage [name of resident] to use call light when reaching for item out of reach to reduce fall risk and injury . . . Was medical personnel notified? . . . Yes . . . 6:15 am [sic] . . . [name of resident] had on his call light was sitting on the floor - said he was reaching for something + [plus] slipped out of bed- the bed was in the low position - denied hitting his head or getting hurt . . . " Both of these event reports did not indicate notification was made to resident's legal representative/family as requested by family. Review of the nursing progress notes occurred on 04/14/15. The nurses notes lacked documentation the facility notified the family of both incidents. During interview on 04/14/15 at 2:15 p.m. an administrative staff member (#1) and a supervisory nurse (#2) stated facility staff should follow the family's request for notification when an incident occurs as stated in the notification protocol.	F 157		

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/16/14. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, and staff	F 278	Resident #8 has been discharged, so her MDS will not be corrected. All current residents' most recent MDS's were reviewed for documentation to support any delusions, hallucinations, physical or verbal behavioral symptoms, as well as rejection of care and wandering as documented in the MDS, Section E. Residents, who had no documented sources for checked symptoms in the above, had their MDS's modified and resent to CMS and the ND Department of Human Services. No billing adjustments were required. A nurse/CNA meeting is scheduled for May 7, 2015. CNA's and nurses will be educated that any behavior in Section E (hallucination, delusion, physical or verbal behavioral symptom, rejection of care, or wandering), must be reported to the nurse or social worker with information for them to provide supporting documentation. The social worker will check for the necessary charting for Section E on the MDS before coding it, and the social worker will report on the accuracy of this section to the Q.A. committee for the next 6 months of all residents who have MDS's done.	oE 05/07/15

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F 278	Continued From page 4 interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 1 of 2 closed records (Resident #8) coded as having behaviors. Failure to correctly code the MDS does not provide an accurate assessment of the residents' current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2014, Chapter 3, page E-5 stated, "E0200: Behavioral Symptom - Presence & [and] Frequency . . . Steps for Assessment: 1. Review the medical record for the 7-day look-back period. 2. Interview staff , across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period . . . 3. Observe the resident in a variety of situations during the 7-day look-back period. Coding Instructions . . . Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days . . ." Resident #8's closed medical record, reviewed on April 13-14, 2015, identified diagnoses including depression, anxiety, and personality disorder. A quarterly MDS, dated 03/12/15, identified the resident exhibited physical and verbal behaviors during the 7-day look-back period. Review of nurse's notes and social services notes for March 1-12, 2015 failed to identify the resident displayed physical or verbal behaviors during that time frame. During an interview on 04/14/15 at 2:20 p.m. an	F 278		

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F 278	Continued From page 5 administrative nurse (#2) provided provided no additional information indicating the resident exhibited verbal or physical behaviors during the 03/12/15 MDS look-back period.	F 278	A review of the protocol for tube feeding including clamping/kinking the tubing between medications/feedings to decrease the amount of free air will be discussed on May 7, 2015 during the All Staff Meeting. Nurses will be educated on the need to follow the protocol when feeding/administering medications to all residents receiving nasogastric treatments. All nurses including those who are unable to attend will sign off on the in-service minutes. A memo to travel nurses to review the tube feeding protocol will be attached to the front of the nurses report book so travel nurses who do not attend our in-services are reminded to check the protocol. The DON will "spot check" nurse's performing tube feedings/medication administration on random resident's who receive nasogastric treatments two times per week starting the first full week after the all staff meeting on May 7, 2015. The DON will make sure to address all residents with nasogastric treatments during checks. By May 31, 2015, 6 checks will be	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, professional reference review, and staff interview, the facility failed to provide the appropriate treatment and services for 2 of 3 sampled residents (Resident #2 and #11) observed receiving medications and/or bolus feedings via gastrostomy tube. Failure to limit the	F 322		

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F 322	Continued From page 6 amount of air in the stomach during feedings and medication administration may result in avoidable discomfort and stomach distention. Findings include: Review of the facility policy titled "PEG Tubes" occurred on 04/14/15. This undated policy stated, ". . . Feeding tube must be clamped in between medications and feeding to prevent any excess air from entering resident's stomach . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 871, states, ". . . Administering Medications by . . . Gastrostomy Tube . . . When administering the medication(s): Remove the plunger from the syringe and connect the syringe to a pinched or kinked tube. Rationale: Pinching or kinking the tube prevents excess air from entering the stomach and causing distention. . . ." - Review of Resident #2's medical record occurred on 04/13/15 and diagnoses included traumatic brain injury, dysphagia, and chronic diarrhea. The record identified the resident received nothing by mouth, except for sips of water, and received all medications and feedings via gastrostomy tube. Observation on 04/13/15 at 1:10 p.m. showed a nurse (#3) administered Resident #2's medications and a bolus feeding via gastrostomy tube. During the observation, the nurse (#3) failed to kink the tube in between each administration of medication, water flush, and feeding, allowing excess air to freely enter the gastrostomy tube	F 322	done. If spot checks result in no errors, the DON will reduce the number of "spot checks" to one per month for the following six months (through October 2015). At the end of October, if no errors have been found, the checks will be discontinued. If errors are found, the number of checks will be increased and re-education will be done with the nurses repeating the errors. The DON will report the error rate to the Q.A. committee on a quarterly basis for the remainder of the year or until compliance is reached.	05/07/15

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F 322	Continued From page 7 and stomach. The nurse (#3) kinked the gastrostomy tube and capped the opening once she completed administration of the medications and bolus feeding. - Review of Resident #11's medical record occurred on 04/14/15 and diagnoses included cerebrovascular accident and dysphagia. The record identified the resident received nothing by mouth and received all medications and feedings via gastrostomy tube. Observation on 04/14/15 at 8:38 a.m. showed a nurse (#4) administered Resident #11's medications via gastrostomy tube. During the observation, the nurse (#4) failed to clamp the tube in between each administration of medication and water flush allowing excess air to freely enter the gastrostomy tube and stomach. The nurse (#4) clamped the gastrostomy tube and capped the opening once she completed administration. During an interview on the afternoon of 04/14/15, an administrative nurse (#2) stated staff should clamp or kink off gastrostomy tubes to avoid air entering the stomach.	F 322		
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.	F 323	Chemicals will be kept locked up where residents do not have access to them. Housekeeping and nursing staff will have access to the chemicals when needed and they will be placed back in the locked area when they are not being used. All residents at Dakota Alpha have the potential to be affected.	

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F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, review of material safety data sheets, and staff interview, the facility failed to maintain an environment free of hazardous chemicals in 1 of 2 laundry areas. Accessible hazardous chemicals placed cognitively impaired and wandering residents at risk for accidents/injury. Findings include: -Review of the material safety data sheets occurred on 04/14/15 and identified ". . . Clothesline Fresh Enzyme Spotter [S4] . . . causes mild eye irritation . . . may cause skin irritation . . . may be harmful if swallowed . . . inhalation of product mist may cause respiratory irritation . . . contains enzymes which may cause allergic respiratory reactions with symptoms of shortness of breath, wheezing and coughing . . . avoid contact with eyes, skin or clothing that is being worn . . . Do not swallow . . . Avoid breathing product mist . . . wash thoroughly after handling . . ." Observation on 04/14/15 at 1:15 p.m., during the environmental inspection showed the laundry sorting room door unlocked. The unlocked room contained a one quart spray bottle of Virex Tb disinfectant cleaner, identified by an administrative staff member (#1) as being the same product as Clothesline Fresh Enzyme Spotter, sitting on the sink countertop. During an interview on 04/14/15 at 2:15 p.m., an administrative staff member (#1) stated, staff are expected to keep all chemicals locked in a locked	F 323	The housekeeper will keep the chemical supplies locked up in the locked laundry area. The housekeeper will dispense one bottle at a time to the nursing staff and they will keep the cleaning solution locked in the health station when it is not in use. All staff will be reeducated on the need to keep chemicals locked up where residents do not have access to them at the all staff meeting on May 7th, 2015. Staff that are not in attendance will be required to review the meeting minutes and acknowledge that they are aware of information covered in the all staff meeting. The housekeeper will do random checks of the facility once a week for four weeks starting May 7th,2015, if compliance is reached the housekeeper will reduce spot checks to once per month for the remainder of 6 months. If compliance is not reached, staff will be reeducated and random spot checks will be continued for an additional 4 weeks. The housekeeper will report the findings of the spot checks to the QA committee at the quarterly QA committee meetings. Staff will be educated and compliance will be reached at the all staff meeting on May 7th, 2015. The random checks will be affective after the May 7th, 2015 all staff meeting.	05/07/15

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F 323	Continued From page 9 cabinet or locked room. The administrative staff member stated there is no policy in place regarding chemical storage.	F 323	Maintenance cleaned/sanitized and replaced the water filters on the ice machine on May 1st, 2015. Maintenance will clean and change the water filters on the ice machine per the Housekeeping and Maintenance Policies and Procedures every 6 months (or 2 times per year). Maintenance will also sanitize the ice bucket per the Housekeeping and Maintenance Policies and Procedures on a quarterly basis (or 4 times per year). All residents that use the ice machine have the potential to be affected. Maintenance/Housekeeping were educated on the manufacturer's recommendations for cleaning and sanitizing the ice machine on May 1st, 2015. Maintenance developed a schedule for sanitizing and cleaning the ice machine per the Housekeeping and Maintenance Policies and Procedures. Maintenance will document the times the ice machine was cleaned and sanitized/ filters replaced on the ice machine cleaning and sanitization schedule. Maintenance will also report compliance of the ice machine cleaning/sanitization schedule to the QA committee for a period of one year at the quarterly QA committee meetings.	
F 371 SS=B	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 the manufacturer's guidelines, and staff interview, the facility failed to clean and sanitize 1 of 1 ice machine per manufacturer recommendations. Failure to clean and sanitize the ice machine has the potential to cause foodborne illness. Findings include: Review of the manufacturer's guideline for the facility's "Scotsman Ice System" occurred on 04/14/15. These guidelines, dated May 2001, pages 17-18, stated, ". . . Dispense Area Sanitation . . . The dispense area; spouts, sink, grill and splash panel will need periodic cleaning and maintenance . . . It is the user's responsibility to see that the unit is properly maintained . . . Maintenance and Cleaning should be scheduled	F 371		

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F 371	Continued From page 10 at a minimum of twice per year. Sanitizing of the ice storage bin should be scheduled for a minimum of 4 times a year . . ." Review of the facility policy titled "Housekeeping and Maintenance Policies and Procedures" occurred on 04/14/15. This policy, undated, stated, ". . . Maintenance . . . Quarterly . . . Ice machine bucket . . . Every Six Months . . . clean ice machine . . ." The facility's policy failed to reflect the manufacturers recommended cleaning schedule. During the environmental tour on 04/14/15 at 1:20 p.m., the maintenance staff member (#5) identified the ice machine is in the nourishment center near the nurse's station, and verified the facility does not routinely clean or sanitize the ice machine. During an interview on 04/14/15 at 1:35 p.m., the environmental staff member (#6) reported she washes the outside of the ice machine daily, but is unaware of any routine sanitization of the interior parts of the ice machine. During an interview on 04/14/15 at 2:15 p.m., an administrative staff member (#1) stated there is a policy in place that states the ice machine should be cleaned and sanitized, but is unaware of when the last time it was actually cleaned and sanitized.	F 371	Compliance was reached on May 1st, 2015, when the maintenance and housekeeping staff were educated and provided with a cleaning/sanitation schedule and the ice machine was cleaned and sanitized on May 1st, 2015.	05/07/15
F 431 SS=D	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	F 431		

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F 431	Continued From page 11 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 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: ACCESS TO MEDICATION STORAGE: 1. Based on observation, review of facility policy, and staff interview, the facility failed to ensure only authorized personnel had access to keys for 2 of 2 medication storage areas (medication cabinets and medication cart). Failure to ensure	F 431	A review of the protocol on keeping the medication cabinet or cart locked at all times will be discussed on May 7, 2015 during the All Staff Meeting. Nurses will be educated on the need to follow the protocol when accessing medication storage, and ensuring only authorized personnel have access to keys. All nurses including those who are unable to attend will sign off on the in-service minutes. A memo to travel nurses to review the medication administration protocol will be attached to the front of the nurses report book so travel nurses who do not attend our in-services are reminded to check the protocol. All residents have the potential of being affected by the same deficient practice. The DON will randomly "spot check" nurse's accessing the medication storage cabinets two times per week starting the first full week after the all staff meeting on May 7, 2015. The DON will ensure that only authorized personnel have access to keys and all medication storage cabinets are locked when personnel are not present. By May 31, 2015, 6 checks will be done. If spot checks result in no errors, the DON will reduce the number of "spot checks" to one per month for the following six months (through October 2015).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. BUILDING _____ B. WING _____	04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 12 only authorized personnel had access to the keys may result in unauthorized staff gaining access to medications. Findings include: Review of the facility policy "MEDICATION ADMINISTRATION" occurred on 04/14/15. The undated policy stated, "Follow the steps outlined below before each medication pass. . . .12. Keep the med [medication] cabinet or cart locked at all times. The keys must be in the nurse's possession at all times." Observation on 04/14/15 at 7:20 a.m. showed a licensed nurse (#4) in the nurses' station preparing medications for an unidentified resident. Observation showed the medication cabinet doors standing open and keys in the lock. The nurse left the room to administer the medications and a Certified Nursing Assistant (CNA) (#7) entered the room and remained for approximately five minutes while the nurse was absent. Over the next 30 minutes, the nurse went in and out of the room to administer medications for Resident #6, #13, and #14 while the cupboard doors remained open with the keys in the lock. During an interview on 04/14/15 at 9:45 a.m. an administrative nurse (#2) stated the keys observed at 7:20 a.m. included keys for the medication cabinets and the medication cart, including the narcotic drawer on the cart. When informed of the above observation, the nurse stated, "They know better than that." LABELING INSULIN PENS 2. Based on observation, review of facility policy,	F 431	At the end of October, if no errors have been found, the checks will be discontinued. If errors are found, the number of checks will be increased and re-education will be done with the nurses repeating the errors. The DON will report the error rate to the Q.A. committee on a quarterly basis for the remainder of the year or until compliance is reached. A review of the protocol on initialing and dating insulin pens/bottles when opened will be discussed on May 7, 2015 during the All Staff Meeting. Nurses and CMA's will be educated on the need to follow the protocol when opening insulin pens/bottles to ensure that both initials and date are written. All nurses including those who are unable to attend will sign off on the in-service minutes. A memo to travel nurses to review the protocol will be attached to the front of the nurses report book so travel nurses who do not attend our in-services are reminded to check. All residents have the potential of being affected by the same deficient practice. The DON will randomly "spot check" the insulin pen/bottle to ensure that it is labeled per protocol two times per week starting the first full week after the all staff meeting on May 7, 2015. The DON will ensure that both initials and the date	

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F 431	Continued From page 13 and staff interview, the facility failed to date an insulin pen for 1 of 1 insulin-dependent resident in the facility (Resident #12). Failure to identify an open date on insulin may result in use beyond 28 days and affect the potency and efficacy of the medication. Findings include: Review of the facility policy titled "Medications" occurred on 04/14/15. This undated policy stated, ". . . Insulin: Insulin pens/bottles must be marked with the date the item was opened and initials of staff who opened the pen/bottle at that time . . ." Observation of the medication storage area occurred on the morning of 04/14/15 with a nurse (#4). Observation identified a NovoLog FlexPen undated and in use for Resident #12. During an interview on the afternoon of 04/14/15, an administrative nurse (#2) stated the nurses should date and initial insulin pens after the first use.	F 431	when opened are written on the pen/bottle per protocol. By May 31, 2015, 6 checks will be done. If spot checks result in no errors, the DON will reduce the number of "spot checks" to one per month for the following six months (through October 2015). At the end of October, if no errors have been found, the checks will be discontinued. If errors are found, the number of checks will be increased and re-education will be done with the nurses repeating the errors. The DON will report the error rate to the Q.A. committee on a quarterly basis for the remainder of the year or until compliance is reached.	OE 05/07/15