North Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8025	A. BUILDING: _____ B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MEMORIAL HOME	610 S MAIN ST MC CLUSKY, ND 58463

(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) COMPLETE DATE
B 000	INITIAL COMMENTS For the unannounced licensure survey started on 05/18/15 and completed on 05/20/15, the sample included 5 residents for complete review and 1 closed record for review. In addition, the sample included 5 supplemental residents to verify specific concerns during the survey. Tier I findings were cited and attested as corrected at B923, B927, B1010, and B2000. Tier II citations included B910, B920, B928, B929, B1020, B1040, B1150, B1240, B1520, B1540, and B1800.	B 000		
B 910	33-03-24.1-09,1 GOVERNING BODY 1. The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws. This state licensing rule is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to comply with the North Dakota Administrative Code (NDAC), Chapter 33-43-01 "Nurse Aide Training, Competency Evaluation, and Registry," for 10 of 10 staff members (Certified Nurse Aide [CNA] A and B, Nurse Aide [NA] C, D, E, F, G, and H, and unlicensed staff member I and J) who administer medication to the residents. Failure to 1) delegate medication administration only to staff on the nurse aide registry; 2) provide proof of a licensed nurse's verbal instruction on each specific medication for each resident to each staff	B 910		

Health Resources Section
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Connie Werth — Administrator — 7/6/15

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B 910	Continued From page 1 member administering medication; 3) provide written instruction for each specific medication for each resident, including trade and generic name, route and frequency of administration, and when to contact the licensed nurse/health care practitioner; 4) ensure the licensed staff observed the staff member administering medication to specific residents until competency was demonstrated; 5) verify competency, including the six rights of medication administration and documentation of medication administered; and 6) update documentation of further training for each staff member related to changes in residents' medications may result in medication errors. Findings include: NDAC, Section 33-43-01-16 "Nurse Aide Training, Competency Evaluation, and Registry: Specific delegation of medication administration" states, "An individual on the department's [North Dakota Department of Health] nurse aide registry [includes CNAs and NAs] may accept the delegation of the delivery of specific medication for a specific client by a licensed nurse if the following steps are followed: . . . 2. The individual on the department's nurse aide [registry] is taught by a licensed nurse for each specific client's medication administration which includes verbal and written instruction for the specific client's individual medications, including: a. The medication trade name and generic name; b. The purpose of the medication; c. Signs and symptoms of common side effects, warnings, and precautions; d. Route and frequency of administration; and e. Instruction under which circumstances to contact the licensed nurse or licensed health care practitioner. 3. The individual . . . is observed by a licensed nurse administering	B 910		

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B 910	Continued From page 2	B 910		

the medication to the specific client until competency is demonstrated. 4. The individual . . . has been verified as competent by a licensed nurse through a variety of methods . . . in the following areas: a. Knows the six rights for each medication . . . b. Knows the name of the medication and common dosage; c. Knows the . . . side effects . . . d. Knows when to contact the licensed nurse; e. Can administer the medication properly to the client; and f. Documents medication administration . . . 5. Documentation that the individual . . . has received the training related to the receipt of specific delegation of medication administration for each client must be maintained and updated when further instruction is received as necessary to implement a change."

Review of the facility policy titled "Medication Administration Record" occurred on 05/19/15. This policy, dated 08/02/14, stated, ". . . When there is no nurse available, the licensed nurse may delegate medication administration to a nurse assistant who has completed a prescribed training program or through a specific delegation evaluation and found competent in medication administration. . . ."

Observation of the medication pass, at various times on May 18-19, 2015, identified a NA (C) and an unlicensed staff member (J) administering medications.

On 05/20/15, review of information with the administrator (#2) and/or the licensed nurse (#1) revealed the following:

* The facility schedule identified two CNAs (A and B), six NAs (C, D, E, F, G, and H), and two unlicensed staff members (I and J) administered medications to the residents. See B929.

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B 910	Continued From page 3 * Personnel records for all ten staff members responsible for medication administration lacked evidence of verbal instruction by a licensed nurse for each specific resident's medication administration. * The binder containing the licensed nurse's written instructions for each resident's medication included the name, use, and side effects of each medication for each resident. The written instructions lacked evidence of both the trade and generic names, the route and frequency of administration, and instructions under which circumstances to contact the licensed nurse/health care practitioner. * The facility's "Competency in Medication Administration" test lacked evidence the licensed nurse verified staff's competency in the six rights of medication administration and in documentation of medication administered. * The licensed nurse (#1) wrote changes to residents' medications on a white board hanging in the staff work room. The nurse stated she could not verify if all staff administering medication reviewed this information, nor were the changes documented in a permanent location. During an interview on 05/20/15 at 9:30 a.m., a licensed nurse (#1) explained the material covered with staff in specific delegation of medication administration, including each resident's medications with specific attention to inhalers, nebulizers, eye drops, liquid medications, MiraLax, bowel medications, narcotics, furosemide, and PRN (as needed) medications. Also instruction included time	B 910		

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B 910	Continued From page 4 frames to administer medications, infection control, when to notify the nurse, i.e. if a resident is lethargic, and the written medication instructions in the binder for each resident. The nurse stated the facility lacked an orientation checklist and she had not documented the instruction or observation of each resident's medications for each staff that administers medication. The nurse (#1) stated the unlicensed staff member (I) had not completed training for specific delegation of medication administration, even though she passed medications to residents since hired in February. The prior administrator had the staff member (I) train with a NA, versus the nurse. During an interview on 05/20/15 at 11:00 a.m., the current administrator (#2) stated the unlicensed staff members (I and J) would not be allowed to pass medications until registered as a NA and after completing the medication training with the nurse. Failure to comply with all the rules for specific delegation of medication administration, including restricting delegation to CNAs and NAs, provision of verbal and written instruction for each specific medication for each specific resident, and ensuring competency in all required areas may place residents at risk for adverse health effects and/or contribute to medication errors and/or jeopardize the safety of all residents who reside in the facility.	B 910		
B 920	33-03-24.1-09,2 GOVERNING BODY 2. The governing body is responsible for	B 920		

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B 920	Continued From page 5 approval and implementation of effective resident care and administrative policies and procedures for the operation of the facility. These policies and procedures must be in writing, signed, dated, reviewed annually, and revised as necessary, and shall address: This state licensing rule is not met as evidenced by: Based on observation, North Dakota Requirements for Food and Beverage Establishments, review of policy, and staff interview, the facility failed to develop and implement a policy and procedure for an approved method of sanitizing dishes, counters, and tabletops in 1 of 1 kitchen/dining room. Failure to develop a procedure for sanitizing dishes, counters, and tabletops may lead to staff confusion, inconsistent processes, lack of checking the sanitizer concentration levels, and an increased risk of foodborne illness for all residents. Findings include: North Dakota Requirements for Food and Beverage Establishments, approved 04/01/12, require in part the following: * 33-33-04-52. Manual warewashing - Sink compartment requirements. "1. A sink with at least three compartments shall be provided for manually washing, rinsing, and sanitizing equipment and utensils. . . ." Review of the facility policy titled "Kitchen and Food Area" occurred on 05/19/15. This policy, dated June 2014, stated, ". . . Appliance and work surfaces thoroughly cleaned following each meal."	B 920		

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B 920	Continued From page 6 - During an interview on 05/18/15 at 10:15 a.m., a cook/nurse aide (NA) (#3) described the dishwashing process using three sinks to prewash, wash, and rinse, before sanitizing in the dishwasher. The cook stated one teaspoon of white detergent (Lemon Scent Automatic Dishwashing Detergent) is added with each cycle. Observation showed a gallon bottle of bleach connected to the dish machine. On 05/18/15 at 12:33 p.m., a cook/NA (#3) checked the chlorine concentration of the dish machine when the water temperature reached 100 degrees Fahrenheit (F). The administrator (#2) stated the water temperature needs to reach 120 degrees F before a chlorine test can be done. The administrator (#2) stated the staff working in the kitchen are to check the chlorine level of the dish machine on the day and evening shifts, but a log is not kept. Following observation of the dishwashing process after the noon meal on 05/18/15, the surveyor requested the dish machine's manufacturer's instruction book from the administrator (#2). At 4:25 p.m., the administrator stated she left a message with [name of a chemical company] to request information on the proper sanitation procedure for the dish machine, as she was not able to locate the manufacturer's instruction book. During an interview on 05/19/15 at 10:18 a.m., the administrator stated a representative from [name of chemical company] returned her call and stated the facility should not use the "Cascade" type of detergent or bleach in the dish machine, but a different detergent, sanitizer, rinse aid, and delimer.	B 920		

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B 920	Continued From page 7 The facility failed to follow proper protocol for a three compartment sink, or determine what process was required for the use of the dishmachine. - On 05/19/15 at 8:39 a.m., observation showed a cook/NA (#5) used soapy water to clean the dining room tables, and then sprayed the tables with a solution of Sol-U-Mel to sanitize them. During an interview at 3:30 p.m., the administrator (#2) agreed Sol-U-Mel was not an approved sanitizer. The facility failed to provide a policy related to the proper procedure for dishwashing and sanitizing of tables and counters. See B1800.	B 920		
B 928	33-03-24.1-09,2,h GOVERNING BODY h. Personnel policies to include checking state registries and licensure boards prior to employment for findings of inappropriate conduct, employment, disciplinary actions, and termination. This state licensing rule is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/13/11. Based on personnel record review and staff interview, the facility failed to check the appropriate state registries and licensure boards prior to employment for 5 of 5 employees (employee D, G, I, J, and K) hired since the previous survey in 2011. Failure to develop and implement a policy to check state registries and	B 928		

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B 928	Continued From page 8 licensure boards for prior abuse allegations, findings of inappropriate conduct, disciplinary action, or termination placed facility residents at risk for abuse. Findings include: Review of facility personnel records occurred on the morning of 05/20/15 and lacked evidence the facility checked the state nurse aide registry or the nursing licensure board prior to employment for: * Employee D, caregiver, hired 04/15/14 * Employee G, caregiver, hired 05/07/14 * Employee I, caregiver, hired 02/14/15 * Employee J, caregiver, hired 05/11/15 * Employee K, nurse, hired 09/16/13 During an interview on the morning of 05/20/15, the administrator (#2) confirmed the employee files listed above lacked evidence the facility contacted state registries or licensing boards prior to their employment. The administrator was unable to locate a facility policy for contacting state registries or licensing boards.	B 928		
B 929	33-03-24.1-09,2,i GOVERNING BODY i. Personnel records to include job descriptions, verification of credentials where applicable, and records of training and education. This state licensing rule is not met as evidenced by: Based on observation, record review, review of North Dakota Administrative Code (NDAC), Chapter 33-43-01 "Nurse Aide Training, Competency Evaluation, and Registry," policy	B 929		

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B 929	Continued From page 9	B 929		

review, and staff interview, the facility failed to ensure 2 of 10 staff members (unlicensed staff member I and J) employed to administer medications to residents held appropriate licensure to perform this function. Failure to ensure staff members hold and maintain licensure required with training in specific delegation of medication administration may contribute to medication errors.

Findings include:

NDAC, Section 33-43-01-16 "Nurse Aide Training, Competency Evaluation, and Registry: Specific delegation of medication administration" states, "An individual on the department's [North Dakota Department of Health] nurse aide registry [i.e. certified nurse aides (CNAs), nurse aides (NAs), or medication aides (MAs)] may accept the delegation of the delivery of specific medication for a specific client by a licensed nurse . . ."

Review of the facility policy titled "Medication Administration Record" occurred on 05/19/15. This policy, dated 08/02/14, stated, ". . . When there is no nurse available, the licensed nurse may delegate medication administration to a nurse assistant . . . ."

On 05/18/15, observation of the suppertime medication pass showed an unlicensed staff member (J) set up and administered medications to the residents.

On the morning of 05/20/15, review of personnel files revealed two staff members (I and J) lacked evidence of a CNA or NA licence. During an interview, the administrator (#2) stated she planned to apply for NA registration today if possible for these staff members, and they would

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B 929	Continued From page 10 not be allowed to pass medications until registered as a NA and after completing the medication training with the nurse. The administrator provided the hire dates for the two staff members as 02/14/15 and 05/11/15 respectively. On 05/20/15 at 4:15 p.m., the administrator (#2) reviewed the schedules of the unlicensed staff members since hire and provided the number of shifts worked (including medication pass) as follows: staff member (I) worked 14 shifts and staff member (J) worked five shifts.	B 929		
B1020	33-03-24.1-10,2 FIRE SAFETY 2. Fire drills must be held monthly with a minimum of twelve per year, alternating with all workshifts. Residents and staff, as a group, shall either evacuate the building or relocate to an assembly point identified in the fire evacuation plan. At least once a year, a fire drill must be conducted during which all staff and residents evacuate the building. This state licensing rule is not met as evidenced by: Based on fire drill record review and facility notice to residents, the facility failed to alternate monthly fire drills on all work shifts for 2 of 4 night shifts (November 2014 and February 2015) in the past year. Failure to conduct fire drills on all shifts may result in an inappropriate response to a fire alarm, increase the risk of injury to residents and staff, and does not allow staff to assess residents' responses to an alarm during the night when residents are most vulnerable.	B1020		

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B1020	Continued From page 11 Findings include: Review of a facility notice, posted for residents regarding smoking and fire drills, occurred on 05/20/15. This undated notice stated, ". . . Fire Drills are required by law and are important safety precaution. It is essential when the signal is given that everyone obeys promptly and proceed to designed [sic] area's [sic] in the building by the prescribed routes. . . ." The facility failed to develop a policy related to rotation of fire drills on all shifts. Review of the facility fire drills, dated May 2014 - April 2015, occurred on 05/20/15. The facility identified the time of the 12/30/14 drill at 7:20 a.m. as occurring on the day shift. The four drills designated by the facility as occurring on the night shift included: * 08/05/14 at 6:55 a.m. * 11/22/14 at 7:30 a.m. * 02/26/15 at 8:00 a.m. * 05/12/14 at 6:45 a.m. The facility conducted the November and February fire drills after the day shift started.	B1020		
B1040	33-03-24.1-10,4 FIRE SAFETY 4. Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill including the escape path used and evidence of simulation of a call to the fire department. This state licensing rule is not met as evidenced	B1040		

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B1040	Continued From page 12 by: Based on fire drill record review and staff interview, the facility failed to maintain a complete written record of the fire drills conducted during 12 of 12 months (May 2014 - April 2015) in the past year. Failure to include a brief description of the fire drill, including the escape path used, duration of the drill, and/or resident's participation/absence does not allow the facility to assess and monitor the effectiveness of the drills and make changes as necessary. Findings include: Review of the facility fire drill reports, dated May 2014 - April 2015, occurred on 05/20/15. The fire drill report form included the following questions: "Date, Time, Shift, [who] Initiated the drill, Was the fire department notified, Was smoke detected [sic] used, Did duty personal participate, All required doors closed, Emergency back-up lights checked, Exit lights checked, Fire Extinguishers checked, and ALL Residents accounted for?" A separate sheet included the residents who participated and the staff present for the drill. The facility failed to include a brief description of the fire drill, including the escape path used, and the duration of the drill on all 12 fire drill reports. The facility failed to include the names of residents who participated in the drill or their absence for the drill on 10/21/14. During an interview on the morning of 05/20/15, the administrator (#2) agreed all the fire drills lacked the escape paths and duration of the drill, and the names of residents who participated in the October 2014 drill.	B1040		

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B1150	Continued From page 13	B1150		
B1150	33-03-24.1-11,5 EDUCATION PROGRAMS 5. The staff responsible for activities shall attend a minimum of two activity-related educational programs per year. This state licensing rule is not met as evidenced by: Based on review of employee education records and staff interview, the facility failed to ensure 1 of 1 activity staff member (#2) responsible for providing activities attended at least two activity-related educational programs in the past year. Failure to ensure staff members receive continued activity-related education may result in residents not receiving purposeful and individualized activities and may have a negative impact on their quality of life. Findings include: Review of employee education records for the months of April 2014 through May 2015 occurred on 05/20/15. The education records lacked evidence the activity staff member (#2) received two activity-related education programs in the past year. During an interview on 05/20/15 at 11:10 a.m., the administrator (#2) stated she has been the only activity staff person for the last one and one-half years and received no activity-related educational programs during that time.	B1150		
B1240	33-03-24.1-12,4 RESIDENT ASSESSMENTS/CARE PLANS 4. The care plan must be updated as	B1240		

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SHERIDAN MEMORIAL HOME	610 S MAIN ST MC CLUSKY, ND 58463

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B1240	Continued From page 14 needed, but no less than quarterly. This state licensing rule is not met as evidenced by: Based on observation, record review, policy review, staff interview, and resident interview, the facility failed to update the care plan for 5 of 5 sampled residents (Resident #1, #2, #3, #4, and #5). Failure to update the care plan limits staff understanding of residents' needs and does not allow for continuity of care. Findings include: Review of the facility policy titled "Care Plans" occurred on 05/19/15. This policy, dated June 2014, stated, ". . . each resident will have a care plan developed for them . . . that reflects the resident's needs and strengths. . . . updated as needed . . . and kept current . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and history of urinary tract infection (UTI). The resident roster, provided by the facility the morning of 05/18/15, identified Resident #1 as incontinent. Resident #1's care plan failed to include incontinence and approaches to minimize incontinence. During an interview on the afternoon of 05/20/15, a licensed nurse (#1) stated the resident wore an incontinence product, and agreed staff failed to include incontinence on the care plan. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included hypertension and dementia. Medications	B1240		

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included furosemide (diuretic) twice daily, oxybutynin (overactive bladder) daily, Senna (bowel stimulant) daily, and alprazolam (antianxiety) daily and as needed (PRN). The resident roster and additional information, provided by the facility the morning of 05/18/15, identified Resident #2 as incontinent, exhibited behaviors, and had recent falls.

Resident #2's progress notes, dated 09/16/14 through 05/20/15, identified two UTIs, erratic behavior which improved once UTIs treated, falls, lower extremity edema with use of Ace wraps, confusion, hallucinations, and encouragement to use incontinence pads after taking furosemide to protect clothing from accidents. The quarterly "Fall Assessment" forms identified nine falls occurred during the four quarters ending 04/23/15, with the resident stating her "legs give out."

Resident #2's current care plan stated, "Problem: Psychotropic/Psychoactive Drugs . . . Approach: . . . Observe for changes in behaviors . . . Problem: Resident has a history of dementia . . . Approach: Assess effectiveness of interventions and treatments . . . Problem: Falls: Resident at risk for falls . . . Approach: . . . walker . . ." The care plan failed to describe what behaviors the resident displayed, what interventions and treatments were planned for dementia, or that the resident actually fell (not just a risk for falls).

Observation throughout the survey showed Resident #2 ambulated in the facility with a front wheel walker. The resident was observed on multiple occasions stopping at Resident #3's table in the dining room to visit and once sitting next to him on the edge of his bed with her arm around his back and Resident #3 patting

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Resident #2's leg by her knee. The two residents visited with each other and staff coming in and out of the room.

During an interview on 05/20/15 at 5:35 p.m., a licensed nurse (#1) and administrator (#2) stated Resident #2 and #3 have an intimate relationship, and they have not care planned this issue.

The facility failed to develop a care plan and/or interventions for Resident #2's problems related to incontinence/UTIs, lower extremity edema/Ace wraps, behaviors, and relationship with another resident. The facility failed to include the actual history (hx) of falls or identify that the resident's "legs give out" in the Falls care plan.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included hx of cerebral vascular accident (CVA) with right leg weakness and pulmonary fibrosis. Medications included furosemide daily. A physician order, dated 08/21/14, initiated oxygen at 2 liters (L) with activity. The resident roster and additional information, provided by the facility the morning of 05/18/15, identified Resident #3 as incontinent, utilized oxygen, and had recent falls.

Resident #3's progress notes, dated 11/07/14 through 05/20/15 identified falls and oxygen use. The quarterly "Fall Assessment" forms identified three falls occurred during the four quarters ending 03/12/15, and utilized a walker since 04/10/14.

Resident #3's current care plan stated, "Problem: Falls: Resident at risk for falls related to [left] sided weakness . . . Approach: . . . Encourage use of proper assistive devices [cane is circled]. The care plan failed to note the resident actually

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B1240	Continued From page 17	B1240		

fell (not just a risk for falls), incorrectly identified the assistive device the resident used as a cane, and noted left-side weakness which conflicted with the diagnosis of right-sided weakness.

Observation throughout the survey showed Resident #3 ambulated in the facility with a four-wheel walker, utilized oxygen, and wore hearing aids.

During an interview on 05/20/15 at 5:15 p.m., a licensed nurse (#1) stated Resident #3 wore an incontinent brief due to accidents from waiting too long to use the toilet.

The facility failed to develop a care plan and/or interventions for Resident #3's problems related to incontinence, oxygen use, need for hearing aids, and relationship with another resident. The facility failed to include the actual history (hx) of falls in the Falls care plan.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included sleep apnea, diabetes mellitus, lumbar compression fracture, and history of falls.

Observation throughout the survey showed a CPAP (continuous positive airway pressure) machine and a reacher (assistive device to pick up items from a distance) in Resident #4's room.

During an interview on 05/18/15 at 2:06 p.m., Resident #4 stated he checks his own blood sugar level every other day and writes the results on a calendar in his room. Observation showed the calendar with blood sugar results on his table.

The facility failed to develop a care plan and/or interventions for Resident #4's problems related

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B1240	Continued From page 18 to sleep apnea/use of CPAP, diabetes/checking own blood sugar, and use of a reacher. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD) with oxygen dependence, and recent cancer. Current physician orders included "Port [implanted intravenous (IV) access site] flush q [every] 30 days, oxygen 1-4 L NC [nasal cannula] continuous . . . chloraseptic spray [at] bedside . . . ProAir 2 puffs q 4 [hours] PRN SOB [shortness of breath] - at bedside . . ." The resident roster provided by the facility, the morning of 05/18/15, identified Resident #5 utilized oxygen and self-administered medication (SAM). Observation throughout the survey showed Resident #5 ambulated independently in the facility without an assistive device, utilized oxygen, and had a Proventil (ProAir) inhaler in his room. During an interview on 05/20/15 at 2:10 p.m., a licensed nurse (#1) stated Resident #5 has a ProAir inhaler and chloraseptic spray in his room that he administered himself. The nurse stated she failed to assess the resident for SAM, and verified the clinic nurse flushed his port every 30 days. The nurse added she typically updates the care plan with the quarterly assessment or with changes. The facility failed to develop a care plan and/or interventions for Resident #5's problems related to oxygen use, port for IV access, and SAM.	B1240		
B1520	33-03-24.1-15,2 PHARMACY/MED ADM SERVICES	B1520		

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B1520	Continued From page 19 2. The facility shall provide a secure area for medication storage consistent with chapter 61-03-02. a. A specific system must be identified for the accountability of keys issued for locked drug storage areas. b. Residents who are responsible for their own medication administration must be provided a secure storage place for their medications. This state licensing rule is not met as evidenced by: Based on observation, record review, policy review, staff interview, and review of the North Dakota Administrative Code (NDAC), Chapter 61-03-02 "Consulting Pharmacist Regulations for Long-Term Care Facilities (Skilled, Intermediate, and Basic Care)," the facility failed to ensure 4 of 5 sampled residents' (Resident #1, #2, #4, and #5) and one supplemental resident's (Resident #8) controlled medications were stored and accounted for in accordance with acceptable professional standards of practice. Failure to develop and implement policies to secure and account for controlled medications may result in unauthorized access to these medications. Findings include: NDAC, Section 61-03-02-03 "Consulting Pharmacist Regulations: Physical requirements of provider pharmacy licensed on premises or other pharmacy" states, ". . . 4. Storage . . . b. When	B1520		

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B1520	Continued From page 20 drugs to be dispensed are stored in a long-term facility drug room, the consulting pharmacist shall verify that space will be available at each unit for storage, safeguarding, and preparation of medication doses for administration and shall include provision of at least the following: . . . (2) A container or compartment which is capable of securing controlled substances with a lock or other safeguard system shall be permanently attached to storage carts or medication rooms [double locked]. . . . 7. Controlled drug accountability. The consulting pharmacist shall establish and implement effective procedures and assure that adequate records be maintained regarding use and accountability of controlled substances [includes narcotics and non-narcotics] . . . " Review of the facility policy titled "Medication Management" occurred on 05/19/15. This policy, dated 06/20/14, stated, ". . . General recommendations for safe medication management: Store all medications . . . in a locked storage area. . . ." The policy failed to address the security requirements and accountability of controlled substances. Review of the Drug Enforcement Administration (DEA) website www.dea.gov/druginfo/ds.shtml occurred on 05/18/15. "DEA/Drug Scheduling," stated, ". . . Schedule II: Schedule II drugs . . . are defined as drugs with a high potential for abuse . . . with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Some examples of Schedule II drugs are: Combination products with less than 15 milligrams of hydrocodone per dosage unit . . ." An attached "Controlled Substances" list, dated 02/02/15, showed hydrocodone as a Schedule II narcotic,	B1520		

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B1520	Continued From page 21 Tylenol with codeine a Schedule III narcotic, and Xanax a Schedule IV controlled medication. On 05/18/15 at 4:30 p.m., observation of the facility's medication room occurred with a licensed nurse (#1). Observation showed the medication room lacked a system to double lock schedule II controlled medications. The nurse stated the facility has never double locked narcotics and does not count controlled medications. The nurse stated several residents are on narcotics and/or antianxiety medications. Medical record review on all days of survey identified Resident #1, # 2, and #8's medications included hydrocodone with acetaminophen; Resident #1, #2, and #5's medications included Xanax; and Resident #4's medications included Tylenol with codeine. On 05/19/15 at 09:40 a.m., observation showed a nurse aide (NA) (#3) removed one hydrocodone/acetaminophen 5/325 milligrams (mg) from Resident #2's medication card, placed it in a medication cup, and set it on a tray marked with the resident's name. The NA stated she planned to administer the medication at noon. (See B1540). The NA then placed the tray back in the medication cupboard and locked it. The NA failed to double lock the hydrocodone/acetaminophen or account for the remaining narcotics in the medication card.	B1520		
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be:	B1540		

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B1540	Continued From page 22 a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This state licensing rule is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to administer medications according to standards of practice during 3 of 3 shifts (05/18/15 day and evening shifts and 05/19/15 day shift) observed with a medication pass. Failure to administer medications within one hour of preparing them has the potential to cause medication errors. Findings include: Review of the facility policy titled "Medication Administration Record" occurred on 05/20/15. This policy, dated 08/02/14, stated, "Medication Administration Record (MAR) shall be initialed under the appropriate time and day by the person administrating [sic] the medication. The person responsible for putting medication in the cup shall be responsible for administering medication to the resident. . . . Policy: . . . The person administering the medication to be given to the resident puts the medication in a cup in the med [medication] tray where the resident name is located then initial the MAR. Lock up medication. . . . When a prescription medication has been ordered, it is important the medication be given within one hour before or after the designated time. . . ."	B1540		

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B1540	Continued From page 23 On 05/18/15 from 12:01-12:11 p.m., observation showed a nurse aide (NA) (#3) had a tray with slots to hold med cups and cards labeled with residents' names. The tray held four med cups containing pills along with the residents' name cards, in a row labeled 12 noon, and several med cups in a row labeled 2:00 p.m. The Medication Administration Record (MAR) contained the initial of the NA's first name, and as the NA administered each cup of medications to Resident #2, #7, #10, and #11, she signed the corresponding MAR with the initial of her last name. The NA then replaced the tray into the locked medication cupboard. The NA (#3) stated she sets up all the medications for the day at 6:00 a.m. when she arrives. She stated her shift ended at 3:00 p.m., and the next staff member will set up the supper and evening meds at the time she arrives. At 2:00 p.m., the NA (#3) retrieved the tray with the above medication from the locked med cupboard and administered Resident #2's medication, approximately eight hours after she set them up. On 05/18/15 at 3:55-4:14 p.m., a resident assistant (#4) set up the medications for 12 residents due at 5:00 p.m., 6:00 p.m., and 7:00 p.m. She placed the filled med cups in the tray slots along with the corresponding resident name cards and put the tray in the locked med cupboard. At 5:05 p.m., observation showed the resident assistant (#4) administered Resident #7's medication due at 5:00 p.m., and administered the rest of the medications on the tray to the other residents starting at 5:59 p.m., approximately two hours after she set them up. On 05/19/15 at 7:55 a.m., observation showed a NA (#3) began to administer medications to 12	B1540		

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B1540	Continued From page 24 residents in the dining room from a tray holding 12 pre-dished cups of medication. The NA stated she set up the medications at 6:00 a.m. when her shift started, as she always does, but waited to set up the noon and 2:00 p.m. medications today so the surveyor could observe set-up. At 9:00 a.m., observation showed the NA (#3) administered six morning medications in a med cup from the med tray to Resident #5 in the resident's room with breakfast. Staff administered these medications two to three hours after set-up. On 05/19/15 at 9:37 a.m., observation showed a NA (#3) pre-dished medications for four residents due at noon, and three due at 2:00 p.m. The NA then placed the tray back in the med cupboard and locked it. Observation at 12:08-12:17 p.m. showed the NA administered the pre-dished medication to Resident #2, #7, #10, and #11, more than two hours after she set them up. Observation showed the staff members administered medications from pre-dished medication cups to the residents approximately 1 to 8 hours after they prepared the medications. Failure to set-up and administer medications within one hour of scheduled time increased the risk of a medication error. Storage of medications in open med cups increased the risk of contamination, loss, theft, and mixing with other residents' medications.	B1540		
B1800	33-03-24.1-18 DIETARY SERVICES 33-03-24.1-18. Dietary services. The facility must meet the dietary needs of the residents and provide dietary services in conformance with the North Dakota sanitary requirements for food	B1800		

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B1800	Continued From page 25 establishments. Dietary services must include: This state licensing rule is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/13/11. Based on observation, policy review, dish machine operational requirements, and staff interview, the facility failed to provide dietary services in conformance with the North Dakota Requirements for Food and Beverage Establishments in 3 of 4 food storage, preparation, or service areas (kitchen, dining room, and storage room). Failure to develop a procedure on washing/sanitation of dishware and food/nonfood contact surfaces, ensure staff are instructed on and consistently follow a recommended procedure, use approved cleaning and sanitizing products, ensure proper concentration of sanitizing chemicals, monitor the temperature of all refrigerators and freezers, label all potentially hazardous food with an open and/or expiration date, discard all expired food in a timely manner, ensure defrosting of freezers, ensure equipment kept clean, and dispose of utensils with uncleanable surfaces increased the risk of foodborne illnesses for all the residents. Findings include: North Dakota Requirements for Food and Beverage Establishments, approved 04/01/12, require in part the following: * 33-33-04-07. Potentially hazardous foods - Hot and cold holding. "1. . . . potentially hazardous food shall be maintained: . . . b. Forty-one degrees Fahrenheit [5 degrees Celsius] or less	B1800		

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B1800	Continued From page 26 for a maximum of seven days. 2. Refrigeration facilities shall be provided to assure the maintenance of potentially hazardous food and shall operate at forty-one degrees Fahrenheit . . . or less. . . . 5. Frozen flood shall be kept frozen and should be stored at a temperature of zero degrees Fahrenheit . . . or below. . . ." * 33-33-04-07.1. Ready-to-eat, potentially hazardous food - Date marking. ". . . 2. . . . refrigerated, ready-to-eat, potentially hazardous food commercially prepared and packaged by a good processing plant shall be clearly marked, at the time the original container is opened . . . to indicate the date or day by which the food shall be consumed . . ." * 33-33-04-32. General equipment and utensils materials and use. "Multiuse equipment and utensils . . . shall be smooth, easily cleanable, . . ." * 33-33-04-43. Nonfood-contact surfaces. ". . . Nonfood-contact surfaces of equipment must be cleaned as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris." * 33-33-04-51. Wiping cloths and working containers - Use limitation. ". . . 3. Cloths used for cleaning nonfood-contact surfaces of equipment, such as counters, dining tabletops, and shelves, must be clean and rinsed as specified in subsection 2 [2. Cloths used for wiping food spills on kitchenware and food-contact surfaces of equipment must be clean and rinsed frequently in one of the sanitizing solutions permitted in section 33-33-04-52 and used for no other purpose. . . .]. These cloths must be stored in the sanitizing solution between uses. . . ." * 33-33-04-52.2. Warewashing machines - Manufacturers' operating instructions. "1. A warewashing machine and its components shall be operated in accordance with the machine's	B1800		

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	8025	A. BUILDING: _____ B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MEMORIAL HOME	610 S MAIN ST MC CLUSKY, ND 58463

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B1800	Continued From page 27 data plate and other manufacturer's instructions. . . ." * 33-33-04-53. Mechanical warewashing equipment - Wash solution temperature. ". . . 2. The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than one hundred twenty degrees Fahrenheit . . ." Review of the facility policy titled "Kitchen and Food Area" occurred on 05/19/15. This policy, dated June 2014, stated, ". . . Outdated foods should be destroyed. Proper storage of precooked foods and leftovers including covering, labeling and dating such containers. All containers of food need dated the date it's opened. . . . A thermometer needs placed in each cooling unit, to be checked frequently. . . . Appliance and work surfaces thoroughly cleaned following each meal." The facility failed to provide a policy related to dishwashing, sanitizing of tables and counters, worn equipment, and ice buildup in freezers. Review of the "Machine Operational Requirements" label on the Mizer dish machine occurred on 05/18/15. The label stated: "Wash temperature - 120 degrees F [Fahrenheit] Wash - 45 seconds per cycle Dwell - (Drain and Flush) 15 seconds Rinse - 33 seconds per cycle Required - 50 ppm [parts per million] available chlorine . . ." SANITIZING DISHES During an interview on 05/18/15 at 10:15 a.m., a cook/nurse aide (NA) (#3) described the dishwashing process as "The first sink is used to prewash the dishes with detergent and a little bleach. The second sink is to prewash the dishes	B1800		

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B1800	Continued From page 28	B1800		

with soapy water. The third sink is to rinse with bleach water. Then the dishes go in the dishwasher, and add one teaspoon of white detergent (Lemon Scent Automatic Dishwashing Detergent) with each wash." Observation showed a gallon bottle of bleach on the floor under the dish machine connected to the machine by rubber tubing.

On 05/18/15 at 12:33 p.m., a cook/NA (#3) checked the chlorine concentration of the dish machine and it read 50 ppm, with the water temperature at 100 degrees F. The administrator (#2) stated the water temperature needs to reach 120 degrees F before a chlorine test can be done. The cook/NA checked the chlorine concentration after the water reached 120 degrees F and it read greater than 200 ppm. Then the administrator ran the dishwasher to check the chlorine level and obtained greater than 200 ppm. The administrator stated she would have maintenance adjust the chlorine level. The administrator (#2) stated the staff working in the kitchen are to check the chlorine level of the dish machine on the day and evening shifts, but a log is not kept. She added, the staff notify her if the concentration is not correct.

During an interview on 05/18/15 at 4:25 p.m., the administrator (#2) stated she left a message with [name of a chemical company] to request information on the proper sanitation procedure for the dish machine, as she was not able to locate the manufacturer's instruction book.

On 05/19/15 at 8:10 a.m., observation showed a cook/NA (#5) prewashing dishes in the one sink, transferring them to a second sink to wash, and to a third sink to rinse. She stated she planned to run them through the dishmachine to sanitize

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B1800	Continued From page 29 them. At 8:28 a.m., another cook/NA (#3) ran the dishmachine without adding detergent. The cook stated the administrator instructed her to not add detergent. The chlorine level tested during the rinse cycle read 50 ppm. During an interview on 05/19/15 at 10:18 a.m., the administrator stated a representative from [name of chemical company] returned her call and stated the facility should not use the "Cascade" type of detergent or bleach in the dish machine, but a different detergent, sanitizer, rinse aid, and delimer. At 12:00 p.m., the administrator (#2) educated the cooks/NAs (#3 and #5) on use of the three compartment sink process, posted instructions, and informed them not to use the dish machine until the new chemicals arrive. SANITIZING TABLES On 05/18/15 at 10:20 a.m., a cook/NA (#3) stated, "Sol-U-Mel is used to disinfect the tables after meals." On 05/19/15 at 8:39 a.m., observation showed a cook/NA (#5) washed the dining room tables with soapy water after breakfast, sprayed the tables with a Sol-U-Mel mixture, wiped the tables with the wet washcloth, and let the tables air dry. This NA/cook stated staff poured a capful of Sol-U-Mel solution in the spray bottle [500 milliliters] filled with water, and the solution is used until it is gone. Review of the directions on the original "Sol-U-Mel Stain Remover" bottle stated to add three capfuls to a 16 ounce bottle of water for "natural everyday cleaner," five capfuls for "stain remover," and 2/3 cup for "odor eliminator." During an interview on 05/19/15 at 3:30 p.m., the administrator (#2) agreed Sol-U-Mel was not an approved sanitizer, but stated it was a "Melaleuca" product the prior administrator	B1800		

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B1800	Continued From page 30 ordered and insisted staff use. The administrator (#2) discarded the Sol-U-Mel and stated staff will use bleach to sanitize the tables and counters. OTHER During a tour of the kitchen, dining room, and storage room on the morning of 05/18/15 with a cook/NA (#3), observation and interview identified the following: - The cook stated she records the temperature of the walk-in cooler and freezer daily, but not the others (two refrigerators and one milk cooler in the dining room, and one chest freezer in the storage room). - Both refrigerators (one older and one newer) lacked thermometers in the freezer compartments. - The older refrigerator's thermometer read 46 degrees F, and the refrigerator contained potentially hazardous food. - The milk cooler contained one open pint of Half & Half milk and one open pint of heavy whipping cream with Use By dates of 05/03/15 (15 days ago) and 05/14/15 (four days ago) respectively. The cook (#3) stated the milk was expired and should not be used, and then discarded both cartons. The cooler also contained one unopened pint of Half & Half milk and three unopened pints of heavy whipping cream with Use By dates of 05/10/15 (eight days ago) and 05/14/15 respectively. - The milk cooler contained an open five pound container of low fat cottage cheese with a stamped (sell by) date of 05/09/15. The container lacked an open date. The cook (#3) stated cottage cheese is usually used up in two to three weeks, and verified staff failed to label the container when it was opened. - The chest freezer contained ice build-up, with a large amount on the right inside wall to the top	B1800		

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B1800	Continued From page 31 edge of the seal. - Three rubber spatulas in a kitchen cupboard had worn jagged edges. The cook threw the spatulas in the garbage. - An electric can opener on a kitchen counter had food debris on its surface. The cook stated, "The night shift does cleaning" of equipment. On the morning of 05/19/15, observation showed the following: - The temperature of the older refrigerator was 50 degrees F - Both refrigerators lacked thermometers in the freezer compartment. - The chest freezer contained the same ice build-up as the previous day. - The electric can opener remained soiled. During an interview on the afternoon of 05/19/15, the administrator (#2) stated she replaced the thermometer of the older stand-up refrigerator and the temperature read 50 degrees F, so staff discarded the food and will discard the refrigerator. The administrator (#2) agreed the chest freezer should be defrosted.	B1800		

Plan of Correction for B910 regarding specific delegation of medications.

Date of completion: 6/8/15

Long term goal is to have employees complete a CMA1 course within 6 months.

1. All staff will be provided with information on each medication for each resident, including trade and generic name of medication, route, frequency, common side effects, and when to call licensed professional. All staff will be provided with information regarding all medication changes which they have to initial after reading and after a week the information will be filed in a binder under the designated resident's name. This information will be accessible at all times to employees. All PRN medications will have specific instructions for employees for proper usage and before any narcotic PRN med is to be dispensed, the employee shall contact the licensed professional for permission to dispense. This shall be recorded in the MAR by the staff. All new employees shall go through the new employee orientation to medications with the licensed professional before they dispense medications and they shall be registered nurses' aides.
2. All residents receiving medications are affected.
3. There is a new policy that has been completed.
4. Date of correction is 6/8/15 with a long term goal of having all employees complete a CMA1 course within 6 months.
5. The Administrator will monitor medication information sheets for staff initialing that they received the information. This will be monitored and documented once a week for 4 weeks, once a month for three months, and then quarterly for 3 quarters.

Plan of Correction for B0920 in regards to Dishwashing, Disinfecting, and testing water levels. Completed 7/6/15

1.The dishwasher was not properly working and improper sanitizer products were being used.

Water levels being tested were not being logged and monitored.

Improper sanitizer was being used on kitchen and dining surfaces.

2. All residents were directly affected by not having the proper sanitizer and not having a properly functioning dishwasher.

3. A new policy has been written (included) on proper sanitizing of kitchen and dining surfaces. New policies were written on proper use of dishwasher and 3 tier sink procedure (included in previous papers sent) A new log sheet has been created and implemented for employees to document QAC levels of disinfectant water solution. A log sheet has been created and implemented for the dishwasher chlorine levels. (previously sent)

4. Date of correction and implementation of all logs is 7/6/15

5. The administrator will provide education to all staff members on proper use of disinfectant, Maxim and a log sheet has been provided for employees to record the QAC levels of disinfectant water solution three times a day. The staff will also be testing the dishwasher water three times a day and logging results on the provided log. The Administrator will monitor that staff is properly utilizing the Maxim solution and logging appropriately on a weekly basis and record on a log sheet for three months and then monthly for one year. The Administrator will also be monitoring that the staff is properly utilizing the dishwasher and also testing the dishwasher water for proper chlorine levels weekly for three months and then monthly for one year.

Created 7/6/15 MA/CW

Plan of Correction for B928: Policy on checking state registries and licensure boards prior to employment.

Corrected Date: 7/6/15

1. There was no policy in regards to checking new employees with the state registry and licensure boards prior to hiring for employment issues in the past.
2. All residents were affected by not checking into new hires backgrounds with the state registry.
3. A new policy has been created in regards to doing a state registry and licensure board check prior to any new hiring. All current employee files have been completed (sent previously). A section on the new employee orientation checklist has an area to be checked that states the registry and licensure has been checked (see new form addition).
4. Date of correction: 7/6/15
5. The Administrator has checked all files and updated them (sent with previous papers). An area on the orientation checklist has been added for the administrator to check off when state registry and licensure has been checked on a new employee. The administrator will review new employee files monthly for three months and then quarterly for a year and log on a check list.

Plan of Correction for B0929 regarding employee J, I, G, and D's personnel files. Date of completion 7/6/15

1. The above listed employees did not have complete employee files containing job descriptions, verification of credentials and records of training and education.
2. All new employees who are hired to pass medications are affected.
3. New employees will have nurse aide licensing before passing medications.
4. Date of correction: 7/6/15
5. The administrator will be monitoring the completion of new employee personnel files monthly for the next 3 months for completion of files, and then quarterly for a year. Education requirements for the year are also being monitored by the administrator and a list of what education in services is being kept by her.

Plan of Correction for B1020 in regards to fire drill schedule.

Date of Correction: 6/9/15

1. Staff and residents will have one fire drill each month that will be unannounced. Each month a random day shall be chosen and each month a different shift shall be chosen. Each of the three shifts will have a fire drill occur every quarter. A full evacuation will be held once a year, where all staff and residents must evacuate the building.
2. All residents and staff have been affected by the lack of proper fire drill schedule with not getting the proper training. By having monthly, rotating shift fire drills all residents and staff will be better equipped in case of an emergent situation.
3. A new policy has been made.
4. Date of Correction is 6/9/15
5. The administrator will perform the fire drills monthly and document the date and time of drill, which shift the drill is conducted on, duration of drill, location of fire, resident's escape path, and which staff and residents participated. The administrator will review the fire drill reports monthly for three months, then quarterly for 3 quarters to ensure that the drills are being conducted on all shifts and log it on a sheet.

Plan of Correction for B1040 in regards to recording of fire drills

Date of Correction: ~~5/28/15~~ 7/6/15

1. Fire drill information shall be recorded on designated forms monthly. Information included is month, date, year, fire location, duration of drill, residents and staff that participated, and escape path for residents. Once a year a full evacuation drill will be held and will be indicated on the designated form.

2. All staff and residents will be affected by not having the proper training. All residents and staff will benefit from having the proper training indicated for emergent situations. The proper documentation will be beneficial to keep track of all types of training and evacuation routes.

3. A new policy is being created. ~~See attached.~~ Per TC & Adm 7/16/15 dl.

4. Date of Correction was ~~5/28/15~~ 7/6/15

5. The administrator will hold the monthly fire drills and document the appropriate information on the designated forms. The licensed professional will audit the fire drill reports monthly for three months, then quarterly for three quarters, for documentation of a brief description of the fire drill, including the escape path used, the duration of the drill, and the names of the residents who participated in the drill or their absence and why and logged on the appropriate log sheet.

Plan of Correction for B1150 in regards to education for activity director
Date of Correction: 7/6/15

1. The activity director will attend at least two educational programs related to activities each year.
2. The activity director not possessing the proper educational hours directly affects not only the activity director but the residents. The activity director has been missing out on essential education to ensure the residents are getting proper activities to stimulate them.
3. Activity director will attend in-services regarding activity ideas for the residents each year.
4. Date of Correction: 7/6/15~ In-services are currently being sought out for activity director to attend.
5. The administrator will monitor Activity Director's file for activity related in-services monthly until the Activity Director has completed two in-services in the next 12 months.

Plan of Correction for 12-40 Care planning; tags on Resident #1, Resident #2, Resident #3, Resident #4, Resident #5.

Date of Correction: 6/9/15

1. For Resident #1, the care plan has been corrected with the addition of charting on incontinence.

~For resident #4, the care plan has been corrected with the addition of charting on diabetes and blood sugar checks, utilizing his CPAP, and adding to his fall care plan the use of his reacher.

~For resident #5, the care plan has been corrected with the addition of charting on his O2 use, self administration of medication (Pro Air and Chloraseptic spray) and his port.

~For resident #2, the care plan has been corrected with the addition of charting on her falls in regards to her legs giving our, her behaviors in relation to UTI's, and being incontinent. See copies.

~For resident #3, the care plan has been corrected with the addition of charting on his O2 use, actual falls, hearing aides and changing his ambulatory aide from cane to walker.

2. All resident's care plans will be reviewed to make sure they are individualized specifically to them, so care that is provided by staff can be individualized. All resident's care is affected by the changes as their care plans will be more specific to their care.

3. All care plans will be reviewed and individualized to each resident.

4. Date of correction is 6/9/15

5. The Administrator will review 8 resident's care plans monthly for three months and then quarterly for three quarters and log on designated form.

Plan of Correction for B1520 in regards to Narcotic Reconcilliation and double locking schedule 2 narcotics. Date of Correction: 5/27/15

1. A policy has been written and implemented to show a way of accounting and reconciling our narcotics. Residents #1, 2, and 5 receive scheduled narcotics and employees will administer them in the following manner: Employees will dispense scheduled narcotics in the manner of the calendar date and the number on the pre packed medication will coordinate. Dates must match up when checked weekly. Residents #1, 2, 4,5, and 8 all have PRN narcotics and will be signed out as follows: The employee will sign out the narcotic as they did previously on the PRN medication sheet with the addition of what number the pill is in the pack ie. Hydrocodone 5/325mg (1) tab #3/15 (meaning it is the third tablet out of 15 in the pack to be dispensed.). Also included in this policy is that all Scheduled 2 narcotics shall now be double locked. A locked box with all schedule 2 narcotics are now kept in the locked medication closet with the key kept in a separate location.

2. All residents on narcotics or other controlled medications have the potential to be affected by this practice.

3. A new policy has been written and implemented as of 5/27/15.

4. Date of correction was 5/27/15

5. The Administrator will review residents #1, 2, 4, 5, and 8 along with 5 random resident's MAR's weekly for 4 weeks, then monthly for 3 months, and then quarterly for 3 quarters for proof staff documented the number of the narcotic or controlled medication given. The administrator will check at this same time to ensure that the schedule 2 narcotics are double locked. Both will be logged on a designated form.

Plan of Correction for B1540 in regards to setting up of medications 1 hour before dispensing.
Date of Correction: 6/9/15

1. Employees shall not set up their medications any earlier than 1 hour before dispensing them.
2. This deficiency affected all residents receiving medications.
3. Policy revised.
4. Date of correction: 6/9/15.
5. The administrator and licensed professional monitored staff daily for 2 weeks, and will monitor weekly for 4 weeks, monthly for 3 months, and quarterly for 2 quarters to ensure that staff are setting up meds no earlier than one hour before they are dispensed. This will be logged on a designated form.

Plan of correction for B1800 in regards to dietary services.

Correction Date:

1. The dishwasher will be fixed and proper detergent and sanitizer for low temperature dishwasher will be used. In the mean time, a proper three compartment sink wash sequence and procedure are being used. (dishwasher was fixed on 6/10/15)
~Thermometers have all been replaced in all fridges and freezers in the facility and log sheets have been implemented for each fridge and freezer to have the temperature read twice a day by staff and recorded accordingly. The deep freeze in the pantry has been defrosted and will be defrosted quarterly from here on out and logged accordingly.
~The can opener will be cleaned after each use.
~All spatulas that had cuts in them have been disposed of and are in the process of being replaced.
~A new sanitizer, Maxim, has been purchased and implemented into our daily routine for cleaning of all surfaces in the kitchen and dining area. It can be used also in the three compartment sink procedure as well.

2. All residents who receive meals here have the potential to be affected by this deficient practice.

3. A new policy has been developed. ~~See attached.~~ per TC adm 7/6/15 dl
Employees will have yearly training on food safety from First District Health.
The staff will monitor the chlorine levels of the dishwasher/three compartment sink with each use with the provided testing strips and log results on form to assure that levels of detergent and sanitizer are at the proper levels. Staff will dispose of any spatulas that have any cuts or damage to them immediately. The staff will log all fridge and freezer temps on log sheets twice a day. The pantry freezer will be defrosted quarterly and logged on the appropriate sheet. The new sanitizer, Maxim, will be used properly in the cleaning of all surfaces in the kitchen and dining area. The can opener will be cleaned after each use by the staff member using it.

4. Date of correction: 6/10/15

5. Licensed professional will monitor fridge/freezer temperature logs, correct dishwasher procedure, correct table/counter sanitizing procedure, sanitizing logs completed, labeling of potentially hazardous food open dates, no expired food items kepf for consumption, cooking equipment in clean and in good condition, and freezers frost free weekly for two weeks, monthly for two months, and quarterly for 3 quarters.