STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING _____ B. WING _____	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 58366

(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 May 13, 2013 and completed on May 16, 2013 the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included 4 (four) additional residents to verify specific concerns during the survey.	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide necessary care and services to prevent the formation of a deep vein thrombosis (DVT) for 1 of 1 sampled resident (Resident #9) with a history of DVT. Failure to provide adequate monitoring and review/revise treatment if necessary resulted in Resident #9's admission to the hospital with a blood clot. Findings include: Review of Resident #9's medical record occurred on May 15-16, 2013. Diagnoses included cerebral palsy and a history of DVT. Current medications included Coumadin (an anticoagulant) 2.5	F 309	F309 1. Resident # 9 was transferred to the hospital on 5/15/13 for treatment of a DVT. He came back from the Hospital on 5/24/2013. His orders were for 5 mgs of Coumadin one day a week and 7.5 mgs 6 days a week. PT/INR in 1 week. PT/INR was 5/29/13, results 13.6, INR 1.4. Doctor notified on 5/30/13 Coumadin adjusted to 10 mg on Monday and Thursday and 7.5 on other days. PT/INR was done on 6/3/13, resuts 20.9, INR 2.2. Doctor notified on 6/4/13. No changes in Coumadin order. Was seen by Dr. on rounds 6/6/13. He ordered PT/INR for 6/11/2013. On 6/7/13 resident had 4+ edema on his left leg. He was sent to local ER for evaluation, they sent to a larger regional medical center. They did an ultrasound on left leg. They discharged back to facility on 6/8/13. No change in orders. 2. All resident have the potential to be affected by this practice.	6-21-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Luther Stone	Administrator	6-13-2013

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 309	Continued From page 1 milligrams (mg) daily. A hospital admission history and physical, dated 04/04/13, stated, ". . . He [Resident #9] was seen on rounds because of swelling of his left leg. At this time I examined him and he appeared to have edema below the groin, all the way into his foot. There was questionable tenderness over the calf with a positive Homans [a test used to detect DVT]. . . . Recent hospitalization for pneumonia. . . . Ultrasound showed a deep venous thrombosis of the left common femoral vein. . . . At this time, the patient will be admitted for IV [intravenous] Heparin [an anticoagulant]. Will also start the patient on Coumadin. . . ." Nurses' notes stated the following: *04/04/13 at 5:07 p.m.: ". . . [Physician name] here and examined left lower leg. Has had increased swelling over past two days. Wt. [weight] gain. Orders obtained to send to [hospital name] ER for Doppler study of left leg and chest xray. Concerned due to fact was recently hospitalized and wants to rule out DVT. . . ." *04/04/13 at 7:19 p.m.: ". . . Resident admitted to [hospital name] for a blood clot found in upper LE [left extremity]. . . ." *04/09/13 at 1:01 p.m.: ". . . [Resident #9] returned from acute today at 10:10 a.m. . . . Diagnosis was a DVT of left lower extremities [sic] . . ." A physician's order, dated 04/09/13, identified the initiation of Coumadin at 12.5 mg daily with prothrombin time/international normalized ratio (i.e. PT/INR, a lab test that measures the amount of time it takes for blood to clot) monitoring as ordered. *04/17/13 at 2:27 p.m.: ". . . Resident sent to [hospital name] ER due to dark 'bloodlike'	F 309	3. Effective 6/6/13 All lab orders will be entered into EMAR system to provide reminder to nurse that lab is to be done on that day. All professional nursing staff will be in-serviced on follow through on orders, admission orders, hospital return orders. 4. All hospital return orders will be audited to determine if they have been accurately entered into system. Two residents will be audited to determine if lab orders are being completed. These audits will be done weekly for 2 months. They will then be done monthly. The results will be taken to the QA committee for analysis and follow-up on effectiveness. ... by the DON or her designee Per. Luther Stave on 6/20/13 @ 4:20 pm per telephone call. K. Beechie	

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F 309	Continued From page 2 secretion in his GI [gastrointestinal] tube. . . . Did have episodes of emesis. The emesis looked mostly like snotty mucus, but later did contain blood. . . ." *04/17/13 at 5:24 p.m.: ". . . Res. [resident] returned from [hospital name] ER . . . orders to start Levaquin [an antibiotic] 500 m.g. daily for 10 days, and Phenergan [an antiemetic] gel . . ." *04/18/13 at 2:58 p.m.: ". . . [Provider name] here and examined for rounds. Review last PT/INR. Concerns about last result. No changes made in dosage after Fridays results [04/12/13] and with ER visit yesterday. Order obtained to draw PT/INR now and call results to her tomorrow in the clinic. Will also hold coumadin dosage tonight. Lab drawn . . ." A provider's progress note stated the following: *04/18/13: ". . . recently was known to have some leg swelling on the left leg and had a positive DVT. . . . Now his treatment has been Coumadin 12.5 mg daily. He was apparently in the emergency room [ER] earlier this week with a coffee ground emesis and coughing. . . . ASSESSMENT: . . . Recent left leg DVT, now on a large dose of Coumadin with a GI bleed yesterday. . . ." The provider also wrote an order to hold the Coumadin and check Resident #9's PT/INR on 04/18/13. Nurses' notes further identified: *04/19/13 at 2:17 p.m.: ". . . verified residents labs with [provider]. new orders to start Coumadin 2.5 [mg] daily. Recheck labs on 04-23-14 [sic]. . . ." *05/15/13 at 5:29 p.m.: ". . . Resident has 4+ edema to Lt [left] lower leg. [Physician name] notified, orders made to transfer resident to [hospital name]. . . ."	F 309		

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F 309	Continued From page 3 *05/15/13 at 9:44 p.m.: ". . . Resident will be recieving [sic] treatment at [hospital name]. . . . Resident will be staying at [hospital name] and be treated for a blood clot to left leg. . . ." Resident #9's PT/INR results are as follows: 04/09/13: PT: 17.9 [reference range is 8.9 - 11.1 seconds] INR: 1.8 [reference range is 0.0 - 1.1 seconds, recommended therapeutic range for treatment of DVT is 2.0 - 3.0 seconds] 04/12/13: PT: 34.7 INR: 3.7 04/18/13: PT: 23.2 INR: 2.4 05/15/13: PT: 10.8 INR: 1.1 Facility staff were unable to locate the order or the results of the labs to be drawn on 04/23/13. During an interview on the morning of 05/16/13, a nursing staff member (#12) stated they transferred Resident #9 to the hospital on 05/15/13 for treatment of a DVT. The staff member was unable to find information about lab work from 04/23/13 and stated the order must have gotten missed. The staff member also stated she called the lab, who had no record of labs ordered for Resident #9 on 04/23/13. Although the nurse's note on 04/19/13 identified a	F 309		

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F 309	Continued From page 4 decrease in Coumadin dose from 12.5 mg to 2.5 mg (one-fifth of the previous dose) with follow-up labs to be done on 04/23/13, there is no evidence that staff ordered or drew the lab. As a result, Resident #9's PT/INR was not monitored for over three weeks. Failure to adequately monitor Resident #9 (who was previously hospitalized with a DVT) after decreasing his anticoagulation medication and review/revise the dose if necessary resulted in re-admission to the hospital with a blood clot in his left leg.	F 309	F312 1 An assessment was done and Care Plan was modified for Resident #4. The use of a bedpan has been removed from careplan because of resident choice and comfort. Staff assists and cues Resident #4 during all meals. Dietary Staff will not serve meals until staff are available to assist. Water will be available for the resident in her room. Resident #4 will receive oral care. 2 All resident have the potential to be affected by this practice. 3 Nursing and Dietary staff will be in-serviced by 6/21/13 on the need to assist all resident that need help with their ADL's 4 The Director of Nursing will audit 3 residents weekly for two months to observe if we are meeting the resident's ADL needs. These audits will be reduced to monthly if the results are good. The results of these audits will be taken to the QA committee for further monitoring.	6-21-13
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide necessary assistance to meet the needs of 1 of 9 sampled residents (Resident #4) who required assistance with activities of daily living (ADLs). Failure to provide assistance to residents who cannot independently perform ADLs (such as nutrition, toileting, and oral cares) places them at risk for inadequate nutrition, incontinence, poor hygiene, and a loss of dignity and comfort. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnoses included	F 312		

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F 312	Continued From page 5 hemiplegia (paralysis on one side of the body), epilepsy, cerebrovascular disease, and weight loss. The current Minimum Data Set (MDS), dated 04/12/13, identified severely impaired cognition, frequent urinary and bowel incontinence, limited assistance from one person for eating, and extensive assistance from one person for personal hygiene. Resident #4's current care plan stated, ". . . Problem . . . Hydration . . . Diuretic use . . . Approach . . . Offer fluids at meals, round [sic] and throughout the day . . . Problem . . . Episodes of bladder incontinence . . . Approach . . . Offer bedpan before and after meals, and HS [bedtime] and as needed. . . . Problem . . . Self care deficit as a result of left hemiparesis from CVA [cerebrovascular accident] . . . Approach . . . Oral cares BID [twice per day]. . . ." Observation on 05/13/13 at 12:27 p.m. showed Resident #4 asleep in bed. A bedside table containing a mug of water sat at the end of the resident's bed (not within the resident's reach). Observation on 05/14/13 at 8:21 a.m. showed Resident #4 asleep in bed and her bedside table (containing a mug of water) located across the room near her dresser (not within the resident's reach). At 8:54 a.m., two certified nursing assistants (CNAs) (#7 and #8) assisted Resident #4 with morning cares. The CNAs failed to offer Resident #4 the use of a bed pan and instead checked and changed the resident in bed. The CNAs also failed to offer/assist with fluids or provide oral cares. A CNA stated, "Your lips are dry." During the observation, Resident #4 stated, "A cup of coffee would be good" multiple times.	F 312		

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The CNAs stated they would get the resident some coffee. At 9:23 a.m., the CNA (#8) brought Resident #4 to the dining room for breakfast. Observation showed no other residents or staff in the dining room. The CNA left the dining room and failed to bring Resident #4 coffee. The resident took a couple bites of her hot cereal and then sat at the table, making no further effort to feed herself. The resident stated, "Coffee?" but observation showed the dining room was empty. At 9:44 a.m., observation showed Resident #4 fell asleep at the dining room table. At 9:48 a.m., a supervisory nurse (#2) entered the dining room and offered to assist Resident #4 with her meal. The resident accepted the help, and then took several bites on her own. At 9:52 a.m., the surveyor asked an unidentified dietary staff member if the resident could have some coffee, as she had asked for it earlier. The dietary aide stated, "She usually doesn't drink it anyway. I'm surprised she drank that much [indicating the resident's empty glass of lemonade]." At 9:58 a.m., a supervisory nurse (#2) assisted Resident #4 out of the dining room.

Observation on 05/14/13 at 11:33 a.m. showed two CNAs (#7 and #9) assisted Resident #4 to lie down in bed and checked and changed her brief. The CNAs failed to offer Resident #4 fluids or the use of the bed pan as per her care plan.

Observation on 05/15/13 at 4:04 p.m. showed two CNAs (#10 and #11) assisted Resident #4 out of bed. The CNAs checked the resident's brief in bed and failed to offer the use of a bed pan. A CNA (#11) asked, "Are you hungry?" and the resident stated, "Hungry for water." The CNA then handed Resident #4 a sipper cup with water and

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F 312	Continued From page 7 the resident took several sips. During an interview on 05/16/13 at 8:22 a.m., a CNA (#8) stated "oral cares BID" means with morning and evening cares. She stated it is part of their normal routine to assist residents with oral cares. During an interview on 05/16/13 at 9:45 a.m., a supervisory nurse (#2) stated she expected staff to offer fluids with cares, perform oral cares in the morning, offer the bed pan to promote continence, and assist Resident #4 with meals as the resident allowed.	F 312	F323 1 Mixing valves have been replaced in all 3 resident areas. A thermostat has been replaced on the water heater in the 400 wing. All doors to the cabinets where chemicals are stored are in the resident bathing areas are locked. 2 All resident have the potential to be affected by this practice.	6-21-13
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: During a standard recertification survey starting on 05/13/13 and ending on 05/16/13, it was determined the facility failed to monitor the hot water temperatures in the facility and allowed the water temperature at the hand washing sinks in residents' room to reach temperatures as high as 145 degrees Farenheit (F) for 2 of 3 resident wings (200 and 400 wing). Water temperatures recorded on 05/14/13 between 12:15 p.m. and 1:35 p.m. on the two wings reached 145.2	F 323	3 Mixing valves have been replaced in all 3 resident halls. A thermostat was replaced in the 400 wing hot water heater. Doors to the chemicals that are stored in the cabinets of the bathing rooms are locked. All staff have been in-serviced on reporting any potential safety concern to administration promptly. Staff have also been in-serviced on the proper storage of poison and chemicals. 4 The temperatures in all 3 resident areas are monitored 5 times a week by the Administrator or his designee. These audits will be done for 2 months. If they are satisfactory they will be reduced to weekly. The proper storage of	

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F 323	Continued From page 8 degrees F. The survey team contacted management staff at the State Agency (SA) on 05/14/13 at 1:45 p.m. to discuss a potential immediate jeopardy situation. At 2:30 p.m., the survey team determined (in concurrence with management staff at the SA) that an immediate jeopardy situation existed. At 2:45 p.m., the survey team notified the facility Administrator and the Director of Nursing (DON) of the immediate jeopardy situation. At 3:00 p.m., the maintenance supervisor (#3) recorded water temperatures of 137.8 degrees F on the 400 wing and 140.2 degrees F on the 200 wing. At this time, the maintenance supervisor (#3) adjusted the hot water heaters located on each wing. At 3:30 p.m., an administrative staff member (#1) provided a plan for corrective action responding to the immediate jeopardy. The plan included measuring and recording water temperatures in all 3 wings of the facility every hour starting at 4:00 p.m. on 05/14/13 until 8:00 a.m. on 05/15/13. At 3:40 p.m., the survey team contacted the SA by phone and informed them the team received an acceptable corrective action plan related to the immediate jeopardy identified. At 6:15 p.m. the survey team, an administrative staff member (#1), the maintenance supervisor (#3), and a staff nurse (#4) recorded temperatures on all 3 wings of the facility. The highest water temperature recorded was 106 degrees F. At this time the survey team reduced the immediate jeopardy. On 05/15/13 at 8:15 a.m., the survey team met with an administrative staff member (#1) and reviewed the water temperatures gathered during	F 323	chemicals in the bathrooms is being audited weekly by the Director of Nursing or her designee. These audits will be done weekly for two months and then reduced to monthly. The results of these audits will be taken to the QA committee for further monitoring.	

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the evening and overnight hours. The information showed that staff failed to monitor hourly temperatures (between the hours of 2:00 a.m. and 6:00 a.m.) as identified on their corrective plan of action.

At 10:35 a.m., a conference telephone call occurred with the SA management staff, the survey team, and an administrative staff member (#1). The facility indicated they would resubmit a plan and continue to monitor water temperatures every hour throughout the day. Temperatures recorded hourly from 6:00 a.m. to 5:00 p.m. on 05/15/13 identified 119 degrees F as the highest water temperature (i.e. an acceptable temperature range).

At 5:30 p.m., an administrative staff member (#1) provided the survey team with a new plan to maintain safe water temperatures which included new mixing valves, additional staff education, and continued monitoring.

After the survey team determined the immediate jeopardy situation in the facility was reduced, the scope and severity was lowered to an "E."

1. Based on observation, review of facility policy and procedure, and staff interview, the facility failed to maintain safe water temperatures at hand washing sinks in residents' room located on 2 of 3 wings (200 and 400). Failure to ensure safe water temperatures may result in injuries/burns to the residents of the facility.

Findings include:

Review of the facility policy titled "Safety of Water Temperatures" occurred on 05/16/13. This policy, dated 02/02/11, stated, ". . . 1. Water heaters that

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F 323	Continued From page 10 service resident rooms, . . . shall be set to temperatures of no more than 115 [degrees] F, or the maximum allowable per state regulations. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these in a maintenance log. 3. Maintenance staff shall conduct periodic tap water checks and record the water temperatures in a safety log. 4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. . . ." - Observation on 05/13/13 at 3:45 p.m., showed a nursing staff member (#6) washed her hands at the sink in a resident's room. This staff member stated "the water was hot" and adjusted the water flow. A similar observation on 05/14/13 at 12:00 p.m., occurred involving the same staff member in the same resident's room. On 05/14/13, the water temperatures taken in residents' bathroom sinks revealed the following hot water temperatures: Room 208 at 12:15 p.m., 144.5 degrees F Room 404 at 12:23 p.m., 130.1 degrees F Room 213 at 1:25 p.m., 139 degrees F Room 405 at 1:35 p.m., 145.2 degrees F Review of a "MAINTENANCE QA [quality assurance] MONTHLY HOT WATER TEMPERATURE CONTROL" occurred on 05/16/13. This log indicated staff last recorded water temperatures on 02/13/12. The facility failed to provide additional information regarding monitoring of water temperatures since 02/13/12.	F 323		

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(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 323	Continued From page 11 During an interview on 05/14/13 at 2:45 p.m., an administrative staff member (#1) stated he thought staff monitored water temperatures about three months ago. 2. Based on observation, review of facility policies and procedures, and review of warning labels on containers of chemicals, the facility failed to maintain an environment free of hazardous chemicals on 3 of 3 resident care areas (200, 300 and 400 wings). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents and/or injury. Findings include: Review of the facility's policy titled "Safety and Supervision of Residents" occurred on 05/16/13. This policy, dated 05/10/12, stated, "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities." During the initial tour, on 05/13/13 at 12:47 p.m. observation showed open doors to the shower rooms for each wing, 200, 300, and 400. Each shower room contained a set of lockable cabinets. Random observations of the environment on 05/14/13 at 10:30 a.m. and on 05/15/13 at 8:55 a.m. and 4:00 p.m. identified the following chemicals stored in the shower rooms: * 200 wing: a gallon pump bottle of Lysol IC Quaternary disinfectant Cleaner Concentrate with the warning "Keep out of Reach of Children,"	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING _____ B. WING _____	05/16/2013

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F 323	Continued From page 12 Foamy Q & A Acid disinfectant cleaner with the warnings "Keep out of reach of Children" and "DANGER Corrosive," and a spray bottle of diluted (for use) Lysol IC * 300 wing: a gallon pump bottle of Lysol IC Quaternary disinfectant Cleaner Concentrate and two spray bottles of diluted (for use) Lysol IC * 400 wing: a spray bottle of diluted (for use) Lysol IC During an observation on 05/15/13 at 4:00 p.m., an administrative staff member (#1) attempted to lock the cupboard containing a gallon pump bottle of Lysol IC Quaternary disinfectant Cleaner Concentrate and Foamy Q & A Acid disinfectant cleaner located on the 200 unit, but the lock failed to secure the contents. During the environment tour on 05/16/13 at 9:00 a.m. with a maintenance supervisor (#3), the cupboard located on the 400 wing contained the unsecured spray bottle of Lysol IC.	F 323	F371 1. All sanitizing buckets will have sanitization levels not to exceed 200 ppm or manufacturer guidelines and industry guidelines if another product is used. 2. All resident have the potential to be affected by this practice. 3. Dietary staff will make sure that the sanitation levels do not exceed 200 ppm or manufacturer and industry guidelines. All Dietary staff will be in-serviced on proper food storage and sanitation. 4. The Dietary Manager or her designee will audit to make sure that all food safety and sanitation guidelines are being followed. These audits will be done weekly for 2 months and then monthly if the results are good. The results of these audits will be reviewed by the QA committee for further review and monitoring.	6-21-13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING _____ B. WING _____	05/16/2013

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F 371	Continued From page 13 Based on observation, review of facility policy, review of manufacturer's recommendations, review of professional reference, and staff interview, the facility failed to prepare sanitizing solutions per manufacturer's guidelines in 1 of 1 kitchen and 1 of 1 dining room. Failure to use the correct sanitizing concentration may result in chemical contamination of food. Findings include: The manufacturer's directions for "Quat Rinse" stated, "Food Contact Sanitizing Performance: At 1 ounce per 4 gallons [of water] this product (200 ppm [parts per million] active) eliminates 99.999% of the following bacteria in 60 seconds . . ." Review of the facility policy titled, "Sanitization" occurred on 05/16/15. This policy, dated 05/12/10, stated, ". . . 4. Sanitizing of environmental surfaces must be performed with one of the following solutions: . . . b. 150-200 ppm quaternary ammonium compound . . ." The 2009 Food and Drug Association Food Code, page 186 stated, ". . . Chemical SANITIZERS and other chemical antimicrobials applied to FOOD-CONTACT SURFACES shall meet the requirements specified in 40 CFR [Code of Federal Regulation] 180.940 . . ." Review of this CFR section stated, ". . . dimethyl ethylbenzyl ammonium chloride [an active ingredient in the sanitizer used at the facility] . . . When ready for use, the end-use concentration of all quaternary chemicals in the solution is not to exceed 200 parts per million [ppm]. . . ."	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 14 - During the initial kitchen tour on 5/13/13 at 12:27 p.m., an administrative dietary staff member (#6) tested a sanitization bucket used on the food preparation counter and a bucket used for sanitizing the dining room tables. These buckets tested at 400 ppm. During the full kitchen tour on 05/14/13 at 2:10 p.m., an administrative dietary staff member(#6) tested a sanitization bucket used for food preparation areas. This bucket tested at 400 ppm. A random check of the kitchen sanitization bucket, on 05/15/13 at 11:30, showed a reading of 300-400 ppm. The administrative dietary staff member (#6) verified the concentration of sanitizer was too high.	F 371		