STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355124	A. BUILDING _____ B. WING _____	C 03/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CROSSINGS CARE CENTER/TCU	425 13TH AVENUE WEST WEST FARGO, ND 58078

(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 and complaint survey started on March 4, 2013 and completed on March 7, 2013, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency stated. The following plan of correction was written and implemented to remain in compliance with all federal and state regulations. The alleged deficiency has been corrected by the date indicated.	
F 203 SS=C	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the	F 203	F 203 1. Transfer forms will be given to residents #2, #4, #5, #7, #8, and #9 for transfer to hospital on the dates identified. Resident #16 no longer resides at the facility. 2. All residents have the potential to be affected. 3. A process has been developed to ensure transfer forms are given to residents upon discharge/transfer ~~to from~~ the hospital. This process has been shared with all Social Workers and Nurses at meeting March 27, 2013 and by April 11, 2013.	4/11/13 per TC 4/10/13 c Maren Geman, adm. DL

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

Maren K Geman, LNFA | Executive Director | 3/29/13

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 203	Continued From page 1 facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to notify the resident and/or the resident's family/legal representative, in writing, of a transfer, including the destination and the reason for the transfer, and the resident's right to appeal the action, for 6 of 6 sampled residents (Resident #2, #4, #5, #7, #8, and #9), 1 supplemental resident (Resident #16), and 1 closed resident record (Resident #14) transferred to the hospital. Findings include:	F 203	4. Upon resident discharge/transfer Social Services will ensure that discharge/transfer forms have been completed by Social Services or Nursing Departments. Audits for compliance will be completed by DON or designee 1/week for 4 weeks, 2x/month for 3 months, 1x/month for 8 months and prn. Results will be reported to QA committee for review and recommendations. 5. April 11, 2013	

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F 203	Continued From page 2 Review of the facility policy and procedure "Discharge and Transfer Regulations" occurred on 03/07/13. This procedure, revised 11/2009, stated, "Policy: Discharges and transfers will be conducted according to the mandates established under the Omnibus Budget Reconciliation Act of 1987. . . . Procedure: . . . B. Notice of Transfer 1. A 30 day written notice will be given to the resident and family member or legal representative prior to the discharge/transfer. This notice will include the following information: i. The reason for the transfer or discharge. ii. The effective date of transfer or discharge. iii. The location to which the resident is transferred or discharged. iv. A statement that the resident has the right to appeal the action to the State. v. The name, address, the telephone number of the State long-term care ombudsman. 2. A written notice of less than 30 days may be given under the following circumstances: . . . iii. An immediate transfer or discharge is required by the resident's urgent medical needs. 3. Documentation will be made in the medical record that a notice has been given and the reason for the discharge or transfer." - Review of Resident #2, #4, #5, #7, #8, #9, and #16's medical records occurred on all days of survey and identified the residents transferred to the hospital on the following dates: * Resident #2: 12/25/12 * Resident #4: 09/07/12 and 11/20/12 * Resident #5: 01/06/13 * Resident #7: 10/27/12 * Resident #8: 08/01/12 and 08/09/12 * Resident #9: 01/02/13 * Resident #16: 02/27/13 and 03/01/13	F 203		

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F 203	Continued From page 3 Review of Resident #14's closed medical record occurred on March 06 - 07, 2013 and identified the facility transferred the resident to the hospital on 07/15/12. The records for the above residents lacked evidence the facility provided the residents and/or their family/legal representative written notice of the transfers, including the reason for the transfers, the effective date of the transfers, the location to which they transferred the residents, and the right to appeal the actions. An interview with an administrative nurse (#6) occurred on 03/05/13 at 9:40 a.m. The nurse confirmed the facility did not provided notices of transfer to the residents and/or family members when the residents were hospitalized.	F 203		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225	F 225 1. A review of reports made on behalf of residents #1, #7, #14 and #16 was completed and it was determined that no residents were adversely affected by the deficient practice. 2. All residents have the potential to be affected. 3. A review of the current policy on reporting allegations of abuse, neglect, mistreatment, and injuries of unknown origin was completed. All staff education including a review of facilities policy will be completed by April 11, 2013.	4/11/13

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F 225	Continued From page 4 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure all alleged and potential violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately to administrative staff for 4 of 6 abuse/neglect allegations (Resident #1, #7, #14, and #16) reviewed. Failure to promptly report allegations of abuse or neglect limited the facility's ability to consider corrective action if necessary and placed all residents at risk of potential abuse and neglect. Findings include:	F 225	4. Audits of timeline for reporting of incidents will be completed by DON or designee 1/week for 4 weeks, 2x/month for 3 months, 1x/month for 8 months and prn. Results will be reported to QA committee for review and recommendations. 5. April 11, 2013	

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F 225	Continued From page 5 Review of the facility policy and procedure "Vulnerable Adult - Nursing Home" occurred on 03/07/13. The procedure, revised 01/2012, stated, "POLICY: It is the policy of Eventide that all staff, residents, and families are required to report suspected abuse or neglect of vulnerable adults. The DON [Director of Nursing] or designee shall be responsible for maintaining a log of any suspected and /or actual cases of abuse or neglect. They shall verify that the report to the proper officials has been made and that appropriate intervention has been taken. . . . Administration will take disciplinary action against any person who is required to report and fails to follow this Policy and Procedure. . . . 6. Reporting a. When resident abuse or neglect is suspected it should be reported immediately to any of the following: 1) Your immediate Supervisor 2) Charge Nurse 3) Clinical Coordinator 4) Director of Nursing (DON) 5. Administrator 6) Social Services Department 7) Administrator on Call . . . d. **The Nursing DON/Clinical Coordinator (or designee on-call) must be immediately notified to begin the investigation. They will notify: the Administrator - **Must be Notified Immediately by director/manager on-call**, DON,; and Clinical coordinator. . . ." Review of the facility's investigations of allegations of abuse/neglect occurred on 03/06/13 at 4:30 p.m. with an administrative nurse (#6) and identified the following: * Resident #7: incident occurred 03/30/12 at 4:30 p.m. - DON notified on 04/01/12 (no time given) * Resident #1: incident occurred 05/01/12 at approximately 4:00 p.m. - Clinical Coordinator notified on 05/02/12 at 12:00 p.m. * Resident #14: incident occurred 06/24/12	F 225		

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F 225	Continued From page 6 "sometime on the day shift" - DON notified by email on 06/27/12 at 3:21 p.m. * Resident #16: incident occurred on 11/10/12 at 8:06 p.m. - DON notified on 11/13/12 at 11:30 a.m. During the above review, the administrative nurse (#6) confirmed staff did not immediately report the allegations of abuse/neglect to the required staff member(s).	F 225		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia for 1 of 4 sampled residents (Resident #5) with dementia and on as needed (PRN) antipsychotic and antianxiety medications. Failure to implement appropriate individualized interventions (including non-pharmacological interventions) and establish accurate on-going monitoring of the behaviors has the potential to prevent this resident from achieving his highest practicable physical, mental, and psychosocial well-being.	F 309	F309 1. For Resident #5, non-pharmacological approaches will be used prior to antipsychotic medications for behavioral interventions. Documentation will be completed as appropriate for all prn antipsychotic medication. Facility protocols for interventions to promote regular bowel movements will be followed for Resident #5. 2. All residents with ordered prn antipsychotic medications have the potential to be affected by the deficient antipsychotic medication practice. All residents have the potential to be affected by the deficient practice involving bowel movement interventions.	4/11/13

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F 309	Continued From page 7 Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances, explosive personality disorder, and depression. The annual Minimum Data Set (MDS), dated 01/25/13, indicated the resident usually makes self understood, usually understands others, has short and long term memory impairment, and severe impairment in decision making. This MDS indicated the resident wandered from 1 to 3 days, with no impact on himself or others, and no other behaviors noted. Resident #5's current care plan included the focus, ". . . Can become aggressive and behaviors are unpredictable due to dementia." Interventions included, "Administer mediation as ordered . . . allow resident time to communicate; anticipate & [and] meet needs . . . consistent routine, caregivers, and environment as able; followed by [name of psychiatric service] . . . provide re-orientation prn . . . use a consistent approach explaining procedures in short, clear, and simple sentences." Another focus stated, ". . . behavior is unpredictable and has a hx [history] of physical abuse toward another resident. Activities will be geared toward 1:1 participation." Interventions included, "Encourage family to stay on the unit when visiting [name of Resident #5] as he has a hx of becoming agitated when leaving the unit. . . . Enjoys [name of television program] . . . Provide resident with new and old recreational opportunities daily." A third focus stated, "Diagnosis of depression, dementia with behavioral disturbance . . . episodes of abusive language . . . easily agitated, especially when	F 309	3. Education for nursing staff was completed on March 27, 2013 regarding proper behavioral interventions and use of anti-psychotic medications, including documentation. This included trying non-pharmacological approaches prior to using prn anti-psychotic medications. If non-pharmacological approaches are unsuccessful and prn anti-psychotic medications are used, the reason and response will be documented in the medical record. A dietary review was completed of all residents to ensure needed interventions are in place for constipation. Re-education on facility protocol to promote regular bowel movements was completed at nurses meeting March 27, 2013 and by April 11, 2013. This education includes a) how and when to run BM reports, b) protocol of Milk of Magnesia given ~~after 3 days~~ on day 3 of no BM, and Suppository given ~~after 4 days~~ on day 4 of no BM, c) results documented in nursing progress notes. - per T.C 4/10/13 z Maren Geman, adm. AL	

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F 309	Continued From page 8 routine is changed & when in large groups. . . . Becomes very upset when others wander into his space. Is resistive with cares . . ." Interventions included, "Staff to be aware of location and provide redirection back to his room/unit. . . . Provide 1:1 visits for conflict resolution . . . When [name of Resident #5] is upset offer him the opportunity to call & talk to his family as this sometimes calms him." Resident #5's medications included: * Ativan (anxiolytic) 1 milligram (mg) orally (po) daily at bedtime * Ativan 1 mg intramuscular (IM) every three hours PRN agitation * Ativan 0.5 mg po up to five times per 24 hours PRN anxiety/agitation * Zyprexa (antipsychotic) 2.5 mg po daily at 8 a.m. and 2 p.m., and 7.5 mg daily at bedtime * Zyprexa 2.5 mg po three times daily PRN agitation; or Zyprexa 2.5 mg IM three times daily PRN, if will not take PO - both discontinued 02/05/13 * Seroquel (antipsychotic) - discontinued 01/10/13 Review of Resident #5's Medication Administration Records (MARs), dated 01/01/13 to 03/05/13, showed the PRN antipsychotic/antianxiety usage, and the corresponding progress notes showed the number of times an alternative was utilized prior to administering the medication: * Seroquel administered 1 time with no alternative tried * Zyprexa 2.5 mg IM administered 5 times with an alternative tried 2 times * Ativan 1 mg IM administered 10 times with an alternative tried 5 times	F 309	4. Audits for compliance with behavioral/prn antipsychotic medication administration and bowel movement interventions will be completed by DON or designee 1/week for 4 weeks, 2x/month for 3 months, 1x/month for 8 months and prn. Results will be reported to QA committee for review and recommendations. 5. April 11, 2013	

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F 309	Continued From page 9 * Ativan 0.5 mg po administered 17 times with an alternative tried 3 times Staff listed anxiety and/or agitation (versus the specific behavior) as the reason to give the above medications on four occasions, and failed to list any reason on 1 of the 33 occurrences above. Failure of staff to try an appropriate non-pharmacological intervention related to Resident #5's behavior and monitor the effectiveness of that intervention prior to administering an antipsychotic or antianxiety medication does not allow staff to evaluate what interventions are most effective for the behavior and may miss an opportunity to decrease the resident's antipsychotic medication. Failure to document a reason (identify a specific behavior) for administering a PRN antipsychotic or antianxiety medication does not allow for an assessment of the effectiveness of the medication related to those behaviors. During an interview on 03/06/13 at 4:30 p.m., a supervisory nurse (#9) stated alternatives or interventions used prior to PRN medications are charted in the nursing progress notes, and agreed staff should chart the specific behavior exhibited prior to giving PRN antipsychotic or antianxiety medication. 2. Based on review of facility protocol, record review, and staff interview, the facility failed to provide interventions to promote regular bowel elimination for 1 of 9 sampled residents (Resident #5) with a diagnosis of constipation. Failure to follow their bowel protocol and provide dietary interventions to relieve constipation has the	F 309		

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F 309	Continued From page 10 potential to cause discomfort due to lack of regular bowel elimination. Findings include: Review of facility protocol titled "Med [Medication] Nurse Information" occurred on 03/06/13. This undated protocol stated, " Every day on the day shift: . . . BM [bowel movement] list made with people not having a bowel movement - three days (AM's [day shift medication nurse] will give MOM [Milk of Magnesia]) and four days (AM's are to give them a supp [suppository])." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included constipation and dementia. The annual Minimum Data Set (MDS), dated 01/25/13, indicated severe impairment in decision making, total assistance of two or more people to transfer and toilet, frequently incontinent of bowel, and presence of constipation. Medications included the laxative Senokot 8.6 milligrams (mg) three times daily, bisacodyl rectal suppository 10 mg daily if needed (PRN) for constipation, Fleet (sodium phosphates) rectal (enema) daily PRN for constipation, and Milk of Magnesia 30 milliliters (ml) daily PRN for constipation. Resident #5's current care plan included the focus "Potential for changes to bowel and bladder function r/t [related to] medications and immobility," the goal "Will have a BM at least every 2-3 days," and interventions "Administer bowel medications as ordered and monitor for effectiveness. . . . Monitor for changes in bowel/bladder functioning and contact practitioner as needed. . . ." The care plan failed to include	F 309		

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F 309	Continued From page 11 any dietary interventions related to constipation. Resident #5's bowel record showed the absence of a BM on the following days and the Medication Administration Record (MAR) showed laxatives provided: * October 14-18 = 5 days. Bisacodyl supp on 10/19/12 (day 6) resulted in a BM. Staff failed to give MOM on day 3 and bisacodyl supp on day 4. * October 27-29 = 3 days. Bisacodyl supp on 10/30/12 (day 4) resulted in a BM. Staff failed to give MOM on day 3. * November 4-6 = 3 days. Bisacodyl supp on 11/07/12 (day 4) resulted in a BM. Staff failed to give MOM on day 3. * December 6-8 = 3 days. Bisacodyl supp on 12/09/12 (day 4) resulted in a BM. Staff failed to give MOM on day 3. * December 12-15 = 4 days. MOM on 12/14/12 (day 3) was ineffective. Bisacodyl supp given on 12/16/12 (day 5) resulted in a BM. Staff failed to give bisacodyl supp on day 4. * January 26-28 = 3 days. MOM on 01/29/13 (day 4) resulted in a BM. Staff failed to give MOM on day 3, and gave MOM versus bisacodyl supp on day 4. * February 10-13 = 4 days. MOM on 01/13/13 (day 4) resulted in a BM on 01/14/13 (day 5). Staff failed to give MOM on day 3, and gave MOM versus bisacodyl supp on day 4. * February 21-23 = 3 days. MOM on 02/24/13 (day 4) resulted in a BM. Staff failed to give MOM on day 3, and gave MOM versus bisacodyl supp on day 4. Resident #5's nutritional assessment, dated 02/04/13, failed to address the resident's constipation episodes and lacked dietary	F 309		

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F 309	Continued From page 12 measures to promote regular bowel elimination. During an interview on 03/06/13 at 5:15 p.m., an administrative nurse (#6) agreed nursing staff should give MOM on day 3 without a BM and a bisacodyl suppository on day 4, as per facility policy.	F 309	F371	4/11/13
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: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner 1 of 1 kitchen and 2 of 2 kitchenettes (Long Term Care Unit and Transitional Care Unit), and failed to identify the lack of a monitoring system for proper sanitation of dishware and implement an alternative method of monitoring when facility staff documented dish machine gauge temperatures below the required temperature for sanitation of dishware using 2 of 2 dish machines. These practices placed residents at risk for contamination of food during storage, preparation, and service which can lead to food borne illness. Failure to provide a method	F 371	1. A thorough review to correct deficient practice was completed. All refrigerators were immediately inspected to verify no raw meat was stored above cooked meat and all food was in acceptable food storage time lines. Any food that was found to be potentially impacted by incorrect storage guidelines and past appropriate storage timelines were disposed of immediately. All dish washers and dish washer temperature gauges were inspected to be working properly by running tests run of trays and dish machine test strips. Microwaves were immediately cleaned and sanitized. All other equipment was inspected to ensure sanitary conditions were present. Any equipment not meeting sanitary standards was immediately cleaned and sanitized.	

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F 371	Continued From page 13 of monitoring final rinse temperatures of the dishmachine has the potential for improperly sanitized equipment and utensils, resulting in subsequent contamination by food and may effect all residents in the facility. Findings include: The 2009 Food Code, page 128, stated, "(A) . . . in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be . . . less than . . . (2) For all other machines, . . . (180 [degrees] F [Fahrenheit]) . . . ." The 2009 Food Code, published by the Food and Drug Administration, Public Health Reasons, page 462, stated, ". . . The surface temperature must reach at least . . . (160 [degrees] F as measured by an irreversible registering temperature measuring device to affect sanitation. . . . (180 [degrees] F for other machines . . . are based on the sanitizing rinse contact time required to achieve the . . . (160 [degrees] F) utensil surface temperature." Review of the facility's policies occurred on the afternoon of 03/05/13 and included the following policies: *"Food Preparation and Service Guidelines," dated November 2009, stated, ". . . 9. Open containers of food must be labeled, dated, and properly sealed and stored in the appropriate area. And discarded in appropriate storage guidelines. . . . 11. Raw meats are stored on bottom shelves of refrigerators with drip pans to accumulate juices. . . ."	F 371	2. All residents have the potential to be affected. 3. All Dietary staff education will be provided through Dietary meeting held 3/28/13 and by April 11, 2013 with topics including: a) proper food storage guidelines and timeframes, b) education on dish machine temperature requirements and documentation of temperatures, c)policy of general equipment sanitation. New dish machine temperature documentation records have been made to include area for action taken if temperature recorded was below required temperatures. 4. Department manager will inspect temperature records at least monthly to ensure staff are consistently and appropriately filling out temperature records. Audits to assess compliance will be completed by department manager or designee 1 /week for 4 weeks, 2x/month for 3 months, 1x/month for 8 months and prn. Results will be reported to QA committee for review and recommendations. 5. April 11, 2013	

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F 371	Continued From page 14 *"Refrigerator Food Storage Chart Quick Reference" stated, "Luncheon meats - opened 3-5 days." *"Dish washing," dated 06/28/11, stated, ". . . 5. Thermometers monitor the water temperatures and should be checked occasionally to assure proper temperatures are being maintained. Dish machine temperatures are logged at least two times daily. Minimum temperatures are as follows: Wash - 160 degrees and final rinse - 180 degrees. . . ." *"Equipment Cleaning," dated 02/28/02, stated, ". . . It is the policy of [facility name] to clean all food service equipment on a regular basis. . . ." - The initial dietary tour of the kitchen occurred on 03/04/13 at 7:45 a.m. Observation of the walk-in cooler showed a tray containing a case of two ten pound thawing raw turkey roasts stored on top of two thirteen pound thawing cooked pork roasts stored in plastic bags on a tray. Observation showed liquid seeped from the bags containing the pork roasts onto its tray indicating the bags were permeable. During an interview following this observation, a dietary staff member (#1) stated, "Raw meat should be stored on the bottom shelf with cooked meat above the raw meat." Observation of the walk-in cooler also showed two bunches of celery with no packaging stored directly on a shelf. Observation of a reach-in cooler showed the following:	F 371		

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F 371	Continued From page 15 *One open container of approximately three pounds, diced, cooked ham, labeled "02/21" (12 days prior) *One open container of approximately three pounds, diced, cooked ham, labeled "pulled 02/25/13" (8 days prior) *One open container of approximately one pound, diced, cooked turkey, labeled "pulled 02/26/13" (7 days prior). During an interview following this observation, an administrative dietary staff member (#2) stated the luncheon meat should be discarded per facility policy. - A main tour of the kitchen and kitchenettes occurred on 03/05/13 at 9:30 a.m. with an administrative dietary staff member (#2). Observation showed a temperature log for the dish machine gauge posted in the dishwashing area. Review of the "Dish Machine Temperatures" log for March for the a.m. shift showed 2 of 4 recorded final rinse temperatures ranged from 160 - 170 degrees Fahrenheit (F) and 2 days with no temperatures recorded. Review of the log for the p.m. shift showed 2 of 5 recorded final rinse temperatures ranged from 160 - 175 degrees F. The log included the statement, "Contact maintenance if any temperature does not reach minimums. (Wash: min [minimum] 160) (Rinse: min 180)." Interview of an administrative dietary staff member (#2) on the morning of 03/05/13, confirmed the dish machine to be a hot water sanitizing machine. This staff member then passed a thermochromatic color change strip (an irreversible registering temperature measuring	F 371		

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F 371	Continued From page 16 device), provided by the surveyor, through the dish machine and this strip indicated the final rinse cycle temperature at the utensil/plate level to be at least 160 degrees F. This is an acceptable temperature for sanitization of equipment and utensils. During an interview following this observation, a dietary staff member (#3), washing dishes, stated the minimum final rinse temperature for the dish machine as 175 degrees F at the gauge. Review of the kitchen's dish machine temperature logs for January and February 2013, on the morning of 03/05/13, identified the following: *January - 13 of 31 entries for the p.m. shift recorded final rinse temperatures ranged from 160 - 175 degrees F and 5 of 31 a.m. shifts lacked an entry. *February - 19 of 28 entries for the p.m. shift recorded final rinse temperatures ranged from 140 - 175 degrees F and 9 of 28 a.m. shifts lacked an entry. Observation showed a facility dish machine located in a utility area. Review of this dish machine's log for January and February 2013, on the afternoon of 03/05/13, identified the following: *January - 4 of 31 entries for the p.m. shift recorded final rinse temperatures ranged from 133 - 175 degrees F and 11 of 31 p.m. shifts lacked an entry. *February - 2 of 28 entries for the p.m. shift documented final rinse temperatures ranged from 160 - 175 degrees F and 11 of 28 p.m. shifts lacked an entry. An interview with a dietary staff member (#4),	F 371		

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F 371	Continued From page 17 responsible for washing dishes, occurred on 03/05/13 at 12:45. The staff member stated the minimum final rinse temperature as 80 degrees F at the gauge. On 03/06/13 at 9:20 a.m., this staff member passed a thermochromatic color change strip, provided by the surveyor, through the dish machine and this strip indicated the final rinse cycle temperature at the utensil/plate level to be at least 160 degrees F. During an interview on the morning of 03/05/13, an administrative staff member (#2) stated her awareness of the low dish machine final rinse temperatures at the end of February. She provided evidence of preventative maintenance for the dish machine in the kitchen completed on February 4 and March 4, 2013. Review of these reports identified replacement of dish machine parts on March 4, 2013 (56 days after the initial documented final rinse temperature less than required at 160 degrees noted on January 6, 2013). This staff member identified an alternative method of monitoring final rinse temperatures, a holding thermometer, was available to determine the final rinse temperature at the utensil/plate level. It was determined through investigation that the dish machine was sanitizing the dishes but the dietary staff were not aware of the proper target temperatures and had not been consistently recording the dish machine temperatures at the gauge or completing an alternative method of monitoring the final rinse temperatures with dish machine gauge temperatures less than 180 degrees F. Observation of the two kitchenettes showed the	F 371		

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F 371	Continued From page 18 interior surfaces of the microwave in each area soiled with food debris. Review of the cleaning schedules for these areas identified they did not include the microwaves. During an interview on the morning of 03/05/13., an administrative dietary staff member (#2) confirmed raw foods should be stored on the bottom shelf of walk-in cooler, foods stored in a container/covered, the dish machine temperatures recorded, reported if less than required, and microwaves should be cleaned daily.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F425 1. Brown bottle was removed from medication cart 3/4/13. Medication carts containing stock medication have been inspected to ensure no stock medications have been repackaged. 2. All residents potentially using stock medications have the potential to be affected. 3. Only originally labeled containers from the pharmacy are used. A meeting was held with the consultant pharmacist and the pharmacy will not dispense separate empty bottles. The pharmacy will hold education with their staff members on this topic.	4/11/13

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F 425	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to ensure adequate pharmaceutical services, including procedures that assure the accurate dispensing and labeling of all drugs and biologicals, for 1 of 2 medication carts (South) involving 1 of 3 residents (Resident #10) observed receiving stock Calcium with Vitamin D during medication pass. Failure to have authorized staff repackage and accurately label medications has the potential for residents to receive the wrong and/or expired medication, with potential loss of efficacy and potency. Findings include: Review of the facility policy titled "Medication Administration Information" occurred on 03/07/13. This policy, revised December 2011, stated, ". . . Procedure: . . . Medication containers - medications will be kept in the containers/packaging as they are dispensed from the pharmacy. Labeling of the medications will be according to accepted pharmacy standards. . . ." On 03/04/13 at 5:44 p.m., observation showed a licensed nurse (#14) preparing Resident #10's medications. The nurse retrieved a plain brown bottle from the South wing medication cart. An attached label on the bottle included the contents as Calcium 500 milligrams (mg) with Vitamin D 200 units, a prescription number, and the name of the pharmacy. The label did not include an expiration date. The nurse stated the pharmacy sent this labeled brown bottle so staff could fill it from the original Calcium/Vitamin D bottle, which	F 425	Education with the nursing department on dispensing medications related to the nursing scope of practice was completed March 27, 2013 and by April 11, 2013. 4. Audits of medication carts/stock medication for compliance with dispensing of medications will be completed by DON or designee 1/week for 4 weeks, 2x/month for 3 months, 1x/month for 8 months and prn. Results will be reported to QA committee for review and recommendations. 5. April 11, 2013	

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F 425	Continued From page 20 is too big for the cart. On 03/05/13 at 8:10 a.m., observation showed a licensed nurse (#8) preparing Resident #7's medications. The nurse retrieved a large 1000 tablet bottle of Calcium 500 mg with Vitamin D 200 units (inscribed by the manufacturer) from the South wing medication cart. The smaller brown bottle of Calcium/Vitamin D was no longer in the cart. During an interview on 03/06/13 at 5:15 p.m., an administrative nurse (#6) agreed staff are not supposed to put medications from the original container into a smaller bottle.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F441 1. Focused education on proper hand washing/infection control procedures with the CNAs working at the time of the observed deficient practice was completed by April 11, 2013. Residents #4, #5, and #7 have no known adverse affects related to the deficient practice. 2. All residents receiving perineal cares have the potential to be affected. 3. Education with the nursing department on hand washing/infection control was completed March 27, 2013 and by April 11, 2013.	4/11/13

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F 441	Continued From page 21 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to follow infection control practices for 3 of 8 sampled residents (Resident #4, #5, and #7) observed during toileting. Failure to perform hand hygiene after providing perineal care has the potential to spread infection to residents, staff, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 03/07/13. This policy, dated October 2012, stated, "Policy: . . . Hand hygiene will be done: a. Before and after resident contact (before you leave the room) . . . c. after every dirty procedure . . ." - On 03/04/13 at 5:25 p.m., observation showed two gloved certified nurse aides (CNA) (#11 and	F 441	4. Audits of resident cares for compliance with hand washing/infection control will be completed by DON or designee 1/week for 4 weeks, 2x/month for 3 months, 1x/month for 8 months and prn. Results will be reported to QA committee for review and recommendations. 5. April 11, 2013	

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F 441	Continued From page 22 #12) assisted Resident #5 (who was incontinent of urine and stool) off the toilet with a full-body mechanical lift. One CNA (#11) cleansed the resident's bottom with multiple wet wipes. The CNAs removed their gloves, placed a new brief, adjusted Resident #5's clothes, lowered him into the wheelchair, and removed the mechanical lift sling. One CNA (#11) pushed Resident #5 to the sink, cued him to wash his hands, combed his hair, cleaned his glasses and placed them on his face. The CNAs washed their hands prior to leaving the room. The CNA (#11) failed to perform hand hygiene after providing perineal care and before assisting Resident #5 with other personal cares. - On 03/04/13 at 12:40 p.m., observation showed a CNA (#13) gloved, removed Resident #7's brief, wet with urine, and assisted the resident to the toilet. After Resident #7 voided, the CNA assisted the resident to stand, provided perineal care, and removed her gloves. The CNA placed a new brief, adjusted Resident #7's clothes, and assisted the resident into her wheelchair. The CNA then wheeled Resident #7 out of the bathroom, assisted her to stand and pivot into the recliner, and removed the gaitbelt from the resident's waist. The CNA then washed her hands. The CNA (#13) failed to perform hand hygiene after providing perineal care and before assisting Resident #7 with other personal cares. - Observation on 03/05/13 at 8:35 a.m. showed a CNA (#5) assisting Resident #4 to the toilet. After the resident voided, the CNA donned gloves, performed perineal cares, removed her gloves, and assisted the resident to transfer to a recliner. Without performing hand hygiene, the CNA (#5)	F 441		

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F 441	Continued From page 23 provided the resident's call light, a blanket, the television remote, and placed her nasal cannula for oxygen. The CNA (#5) failed to perform hand hygiene after completing perineal cares and before assisting with other personal cares. During an interview on 03/06/13 at 5:10 p.m., an administrative nurse (#6) stated staff should not perform other tasks following perineal cares without washing their hands first.	F 441		
F9999	FINAL OBSERVATIONS Based on observation, record review, resident interview, group interview, and staff interview, the complaints investigated in conjunction with the standard Medicare/Medicaid survey were not substantiated.	F9999		