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 _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CROSSINGS CARE CENTER/TCU	125 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, started on 05/02/16 and completed on 05/05/16, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included nine additional residents to verify specific concerns during the survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to follow professional standards of practice regarding medication administration for 1 of 4 residents (Resident #4) observed during insulin administration. Failure to ensure accurate transcription of medication orders has the potential to result in medication errors and adverse drug reactions. Findings include: The Geriatric Medication Handbook, 7th ed., American Society of Consultant Pharmacists, page 148, stated, ". . . Steps of Medication Administration . . . Medication administration record (MAR) verified with medication label information . . ." Review of the facility policy titled "Insulin -	F 281	F 281 1. Insulin will be administered to Resident #4 according to the professional standards of practice utilizing the 6 Medication Rights. 2. Residents receiving insulin and other medications have the potential to be affected. 3. The process of transcribing and administering medications was reviewed 5/23/16 and education provided 6/2/16 to ensure insulin and other medication administration according to professional standards of practice. 4. June 13, 2016. 5. Auditing by DON or designee for 1) resident charts to ensure proper transcription of insulin and other medication dosage as follows: 3 times/week for 4 weeks, 2 times/week for 8 weeks, 1 time/week for 12 weeks and	6/13/16

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

Electronically Signed | 06/03/2016

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F 281	Continued From page 1 Subcutaneous" occurred on 05/05/16. This policy, dated May 2013, stated, "Policy: Insulin will be administered as ordered. . . ." Observation of medication pass occurred on 05/02/16 at 5:45 p.m. A nurse (#5) retrieved Resident #4's vial of "Humulin 70/30" insulin from the medication cart. The medication administration record (MAR) identified "Humulin N Suspension (Insulin NPH (Human) (Isophane)) Inject 3 units subcutaneously one time a day for T1DM [Type 1 Diabetes Mellitus]" The staff member withdrew 3 units of insulin from the "Humulin 70/30" insulin vial. When the surveyor identified the discrepancy between the MAR (Humulin N) and the insulin vial (Humulin 70/30), the nurse (#5) stated "the physician's order says 70/30 in the computer" and stated that she will "check the order" and then proceeded to administer the insulin. At 6:00 p.m., the nurse (#5) reviewed Resident #4's medication order for the insulin. The information entered into the computer for the MAR identified "Humulin N Suspension." The nurse (#5) then checked the written physician's orders scanned into the computer. The order, dated 03/30/16, stated "Humulin 70/30 insulin" (7 units in the morning and 3 units in the evening). The nurse confirmed the order had been entered incorrectly into the computer for the MAR. Resident #4 received the correct type and dosage of insulin, but staff failed to seek clarification regarding the discrepancy between the physician order, the MAR, and the medication label prior to administering the insulin. During an interview on 05/03/16 at 5:30 p.m., an	F 281	prn. Results of audits will be brought to QA committee for review and recommendation.	

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F 281	Continued From page 2 administrative nurse (#1) confirmed staff should clarify discrepancies between the MAR and the medication label.	F 281		
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 review of facility policy, the facility failed to provide assistance with activities of daily living (ADL) for 2 of 10 sampled residents (Resident #2 and #8) observed during personal cares. Failure to provide assistance with oral care (Resident #2) and grooming (Resident #8) may result in poor oral/dental health and loss of dignity. Findings include: Review of the facility policy titled "Standards of Care" occurred on 05/05/16. This policy, revised August 2015, stated, ". . . The following standards of care will be followed in providing care to the residents of Eventide. . . . Personal Care: 1. Oral cares are given a minimum of AM [morning] and PM [evening] (teeth/dentures cleansed; mouth rinsed or swabbed). . . ." - Review of Resident #2's medical record occurred on all days of survey. The resident's current care plan stated, ". . . Self care deficit	F 312	F 312 1. Resident #2 no longer resides at facility. Resident #8 will receive cares to maintain good grooming. 2. Residents needing assistance with Activities of Daily Living have the potential to be affected. 3. Review of Eventide Standards of Care and the process used to provide these cares took place 5/13/16 and education provided 6/2/16 to ensure cares provided to residents to maintain good grooming and oral hygiene. 4. June 13, 2016 5. Auditing by DON or designee of resident cares to ensure residents maintain good grooming and oral hygiene as follows: 3 times/week for 4 weeks, 2 times/week for 8 weeks, 1 time/week for 12 weeks and prn. Results of audits will be brought to QA Committee for review and recommendation.	6/13/16

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F 312	Continued From page 3	F 312		

related to weakness and decreased mobility due to intracranial bleed, dementia, HTN [hypertension], and depression . . . Interventions . . . Grooming: assist of one. Set up for teeth brushing BID [twice a day]. Assist as needed with brushing also. . . ."

Observation of Resident #2's personal cares occurred on 05/03/16 at 8:15 a.m. Observation showed Resident #2 in bed with her pajamas on. Two certified nursing assistants (CNAs) (#15 and #16) assisted the resident with dressing and a partial bed bath, but failed to offer/assist with oral cares.

Observation of Resident #2's personal cares occurred on 05/04/16 at 9:50 a.m. Observation showed Resident #2 in bed with her pajamas on. Two CNAs (#19 and #20) assisted the resident with dressing and a partial bed bath, but failed to offer/assist with oral cares.

During an interview on the morning of 05/05/16, a supervisory nurse (#2) agreed staff should offer oral care with morning cares.

- Review of Resident #8's medical record occurred on May 2-4, 2016. The current care plan stated, "Focus: Self care deficit related to weakness secondary to CA [cancer] . . . Goal: Resident will be neat, clean, and well groomed. . . . Interventions: . . . Grooming: assist of 1 . . ."

On 05/03/16 at 8:20 a.m., observation showed three CNAs (#10, #11, and #12) transferred Resident #8 to the recliner following completion of morning cares. Observation showed strands of the resident's hair sticking outward from his head

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F 312	Continued From page 4 in several areas. The CNAs failed to comb the resident's hair. On 05/03/16 at 3:57 p.m., observation showed two CNAs (#13 and #14) transferred Resident #8 from the bed to the recliner. Observation showed several strands of the resident's hair sticking outward from his head. The CNAs failed to comb Resident #8's hair with cares or prior to leaving the room.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/08/15. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 5 sampled residents (Resident #11) observed during a gait belt transfer. Failure to use gait belts appropriately during staff assisted transfers may result in resident injuries or falls. Findings include:	F 323	F 323 1. Appropriate transfer techniques will be used for Resident #1, when requiring assistance with transfers. 2. Residents receiving assistance with transfers via gait belt have the potential to be affected. 3. Demonstrated competency tests will be completed with CNAs and nurses on 60 day evaluation and annually. Education provided 6/2/16 to review proper gait belt usage. 4. June 13, 2016. 5. Auditing by DON or designee of gait	6/13/16

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F 323	Continued From page 5 Review of the facility policy titled "Standards of Care" occurred on 05/05/16. This policy, revised August 2015, stated, ". . . SAFETY: 1. Gait belt use for assisted transfers and ambulations . . ." Review of Resident #11's medical record occurred on May 4-5, 2016. The current care plan stated, ". . . Potential for falls r/t [related to] secondary to decline with mobility. . . . Interventions . . . Transfers: assist of one and walker. . . ." Observation on 05/02/16 at 6:42 p.m. showed a certified nursing assistant (CNA) (#22) attempted to assist Resident #11 to stand from a dining room chair by pulling on her arm. Observation showed the CNA failed to apply a gait belt at that time. The resident was unable to stand after several attempts, and then the CNA applied a gait belt around the resident's waist. Observation showed the CNA grabbed the waistband of Resident #11's pants with one hand, and pulled on her arm with the other to assist the resident to stand. The CNA failed to utilize the gait belt she just applied. Observation on the morning of 05/03/16 showed a CNA (#19) applied a gait belt around Resident #11's waist and attempted several times to assist the resident to stand from a dining room chair. Observation showed the gait belt was loose, sliding up the resident's back and under her arms with each attempt to stand. During an interview on the morning of 05/05/16, an supervisory nurse (#2) agreed staff used gait belts incorrectly.	F 323	belt usage will be completed as follows: 3 times/week for 4 weeks, 2 times/week for 8 weeks, 1 time/week for 12 weeks and prn. Results of audits will be brought to Quality Committee for review and recommendation.	
F 327	483.25(j) SUFFICIENT FLUID TO MAINTAIN	F 327		6/13/16

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F 327 SS=D	Continued From page 6 HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide sufficient fluids to maintain proper hydration for 1 of 2 sampled residents (Resident #2) identified as at risk for dehydration by the facility. Failure to frequently offer fluids to residents places them at risk for dehydration, urinary tract infections, and fluid/electrolyte imbalances. Findings include: Review of the facility policy titled "Standards of Care" occurred on 05/05/16. This policy, revised August 2015, stated, ". . . NUTRITION . . . Offer fluids when completing scheduled cares (toileting, turning, etc.) . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, dysphagia, and constipation. The resident's current care plan stated, ". . . Potential for alteration in nutrition and weight related to dysphagia, history of aspiration pneumonia, low Alb [albumin], and history of constipation. Other diagnoses include . . . hx [history] of dehydration which can influence her nutritional status. . . . Interventions . . . Encourage fluid intake between meals. Total feed. . . ." A dietary assessment,	F 327	F 327 1. Resident #2 no longer resides at facility. 2. Residents reliant upon assistance for hydration have the potential to be affected. 3. Review of Eventide Standards of Care and the process used to assist residents with hydration was completed 5/23/16 and education provided 6/2/16 to ensure fluids offered with cares of residents. Care Plans of residents reliant on assistance for hydration reviewed. 4. June 13, 2016. 5. Auditing by DON or designee of resident cares to ensure residents offered fluids with cares as follows: 3 times/week for 4 weeks, 2 times/week for 8 weeks, 1 time/week for 12 weeks and prn. Results of audits will be brought to Quality Committee for review and recommendation.	

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F 327	Continued From page 7 dated 02/22/16, identified the use of nosey cups and nectar thick liquids. Observation on 05/03/16 at 8:15 a.m. showed two certified nursing assistants (CNAs) (#15 and #16) provided morning cares for Resident #2. The resident chose to remain in bed, so the CNAs did not get her up. The CNAs failed to offer fluids during morning cares. Observation on 05/03/16 at 12:02 p.m. showed a CNA (#19) repositioned Resident #2 in bed and failed to offer fluids. Observation on 05/03/16 at 3:10 p.m. showed two CNAs (#17 and #18) checked and changed Resident #2's brief and repositioned the resident in bed. The CNAs failed to offer fluids with cares. An interview with a CNA (#19) occurred on 05/04/16 at 9:28 a.m. The CNA identified she had not been in Resident #2's room yet to provide cares. At 9:50 a.m., two CNAs (#19 and #20) provided morning cares for Resident #2. Observation showed the resident's brief was dry. The resident chose to remain in bed, so the CNAs did not get her up. The CNAs failed to offer fluids during morning cares. Observations throughout the survey showed a mug with a lid contained thickened water available in Resident #2's room; however, no nosey cups were available. During an interview on the morning of 05/05/16, a supervisory nurse (#2) agreed staff should offer fluids during cares.	F 327		
F 332	483.25(m)(1) FREE OF MEDICATION ERROR	F 332		6/13/16

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F 332 SS=D	Continued From page 8 RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of professional reference and manufacturer's instructions, the facility failed to ensure a medication error rate of less than five percent for 3 of 4 residents (Resident #4, #10, and #16) observed during insulin administration. Failure to provide insulin at the correct time in relation to meals may result in hypoglycemia (low blood sugar). Three errors occurred during staff administration of 29 medications, which resulted in a 10 percent error rate. Findings include: "Nursing 2015 Drug Handbook," 35th ed., Wolters Kluwer, Pennsylvania, page 756, states, "Insulin (lispro) Humalog . . . Lispro insulin may be mixed with Humulin N; give within 15 minutes before a meal to prevent a hypoglycemic reaction. . . . " Page 760, states, "Administration: . . . Give NovoLog 5 to 10 minutes before start of meal. . . ." Review of the manufacturer's instructions for Humulin 70/30 insulin, dated September 2015, stated, ". . . Timing of Subcutaneous Administration: Humulin 70/30 should be given subcutaneously approximately 30-35 minutes before a meal. . . ."	F 332	F 332 1. Residents #4, #10, and #16 will receive food within 10-15 minutes of insulin administration. 2. Residents receiving rapid acting insulin have the potential to be affected. 3. Review of insulin administration process took place 5/23/16. Nurse administering insulin or designee will offer food within 10-15 minutes of insulin administration. Education on insulin administration provided 6/2/16. 4. June 13, 2016. 5. Auditing by DON or designee of insulin administration as follows: 3 times/week for 4 weeks, 2 times/week for 8 weeks, 1 time/week for 12 weeks and prn. Results of audits will be brought to Quality Committee for review and recommendation.	

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F 332	Continued From page 9 Review of Resident #4's medical record occurred on all days of survey. Resident #4's medications included Humulin 70/30 (an intermediate acting insulin combined with a short acting insulin) 7 units every morning. - On 05/03/16 at 8:00 a.m., Resident #4 stated the nurse administered his insulin "a short while ago." Review of the medication administration record (MAR) identified the nurse signed the medication as given at 8:00 a.m. Observation showed staff delivered Resident #4's breakfast meal at 9:35 a.m., approximately 95 minutes after the nurse administered the insulin. - Review of Resident #10's medical record occurred on May 4-5, 2016. Current physician's orders included Humalog (a rapid-acting insulin) 11 units three times per day. Observation on 05/02/16 at 5:35 p.m. showed a nurse (#21) administered Resident #10's Humalog, but the resident did not receive his dinner tray until 6:19 p.m. (approximately 44 minutes after insulin administration). - Review of Resident #16's medical record occurred on 05/05/16. Current physician's orders included Novolog (a rapid-acting insulin) 10 units with the evening meal. Observation on 05/02/16 at 5:45 p.m. showed a nurse (#21) administered Resident #16's Novolog, but the resident did not receive his dinner tray until 6:29 p.m. (approximately 44 minutes after insulin administration).	F 332		
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,	F 364		6/13/16

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F 364 SS=E	Continued From page 10 PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED 02/03/16. Based on observation, resident group interview, individual resident interview, review of resident council meeting minutes, review of facility policy, and staff interview, the facility failed to serve foods at palatable temperatures and/or textures for 6 of 11 residents (Resident A, B, C, D, E, F) in the group interview and 4 confidential resident interviews (Resident G, H, I and J). Failure to serve foods at temperatures and textures acceptable to residents may result in decreased satisfaction/enjoyment of meals, decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled, "Food Preparation and Service Guidelines" occurred on 05/05/16. This policy, dated 04/17/14 stated, "Policy: . . . foods shall be prepared by methods that . . . enhance flavor. . . . Procedure: . . . 4. Hot foods are served hot and held at 140 degrees or above. . . ." Review of Resident Council meeting minutes	F 364	F 364 1. Residents identified will receive food at palatable temperatures and textures. 2. All residents who receive oral intake have the potential to be affected. 3. Food will be kept partially covered when serving to maintain temperature. Cooks will use quality procedures including tasting and resident interview to ensure palatable texture. Individual education with staff on processes will be completed by 6/10/16. 4. June 13, 2016. 5. Auditing by Director of Nutrition and Culinary Services or designee of food palatability as follows: 3 times/week for 4 weeks, 2 times/week for 8 weeks, 1 time/week for 12 weeks and prn. Results of audits will be brought to Quality Committee for review and recommendation.	

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F 364	Continued From page 11 occurred on 05/02/16 at 2:30 p.m. The meeting minutes identified the following: *January 13, 2016: ". . . In response to previous cold food concerns from the Nutrition and Culinary Manager: . . .The Nutrition and Culinary manager has visited with staff again regarding methods of keeping the food as warm as possible during service as well. . . . You will also see the Nutrition and Culinary Manager or her dietetic intern conducting audits on food temperature as palatability [sic] at random times through out the upcoming months . . ." * February 24, 2016: ". . . Dietary . . . Food is not always warm . . . Suggestion to get food warmers in the kitchenette window . . ." A group resident interview occurred on 05/02/16 at 3:00 p.m. Six residents (Resident A, B, C, D, E, and F) stated the food is not served hot, and in particular the vegetables are "cold." The residents stated they have told the facility about their concerns, but the cold food has continued to be a problem. During a confidential interview on 05/03/16 at 8:10 a.m., Resident G stated the food is "a little cold sometimes." During a confidential interview in the afternoon on 05/04/16, Resident H stated "the food is cold and the vegetables are always cold." Observation on 05/02/16 at 6:10 p.m. showed a staff member (#8) serving food from the Long Term Care (LTC) kitchenette with all of the food in the steam table open to the air, without a cover. During this same meal at 6:15 p.m., Resident E,	F 364		

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	355124	A. BUILDING _____ B. WING _____	05/05/2016

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F 364	Continued From page 12 seated at a table in the LTC dining room, stated the green beans are "cold" and Resident A stated, "I don't know if my chicken is done. I am having a hard time chewing it." On 05/02/16 at 6:26 p.m., the dietary staff member (#8) served the last meal tray for the evening. The dietary staff member prepared a test tray for the surveyors. The surveyors agreed the green beans tasted cold, and the chicken had a rubber-like consistency. On 05/03/16 at 8:25 a.m., observation showed Resident J eating breakfast in the dining room. The facility served the resident cooked cream of wheat cereal of liquid consistency. Resident J attempted to eat the cereal and stated, "It is too thin. They should not have put so much milk in it." The resident asked for the cereal to be removed and ordered pancakes. Observation of the breakfast tray line at the LTC kitchenette occurred on 05/03/16 at 8:50 a.m. Observation showed a dietary staff member (#7) served cooked cream of wheat cereal with a ladle. The cooked cereal appeared watery and thin. At 9:05 a.m. in the LTC dining room, Resident E stated an aide would not give her milk for her cooked cereal because "it would be too watery." Resident E stated the milk would help the cereal to taste better, but agreed with the aide the cereal was too thin and she would have to "drink" it. The CNA [certified nursing assistant] offered to get pancakes for the resident instead of having the cereal. At 9:10 a.m., Resident I, a resident sitting at another table, stated the cereal is very "watery."	F 364		

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	355124	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 364	Continued From page 13 During an interview on the morning of 05/05/16, an administrative dietary staff member (#4) stated she was aware of the cold food concerns and that the facility has plans to conduct food audits/interviews with residents regarding the food, but the interviews/audits have not started yet.	F 364		
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, review of facility policies, review of dishwashing machine temperature logs, and staff interview, the facility failed to serve, prepare and store food in a safe and sanitary manner in 1 of 1 kitchen and 2 of 2 kitchenettes (Long Term Care (LTC) and Transitional Care Unit (TCU)). Failure to ensure staff report or seek corrective action for incorrect dishwashing temperatures; failure to store raw meat below ready-to-eat food, failure to store food away from soap/cleaning buckets; failure to properly store scoops for powdered ready-to-eat thickeners and supplements; failure to ensure appropriate use of gloves when serving ready-to-eat food, and failure to clean food storage and dispensing	F 371	F 371 1. Food will be stored, prepared, and served under sanitary conditions in kitchen and kitchenettes. 2. All residents have the potential to be affected. 3. Dishwasher temperature logs were revised to prompt action when temperatures out of range. Individual packets for food thickener and protein powder will be used. Processes in place to ensure food storage, cleaning, and glove use were reviewed and appropriate changes made. Individual education with staff on processes will be completed by	6/13/16

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	355124	A. BUILDING _____ B. WING _____	05/05/2016

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F 371	Continued From page 14 equipment has the potential to increase the risk of foodborne illness and can affect all residents who consume food stored, prepared or served in these areas. Findings include: Review of the facility's dietary policies occurred on 05/05/16. The "Food Preparation and Service Guidelines" policy, dated 04/17/14, stated, "Policy: . . . foods shall be prepared by methods that ensure food safety . . . Procedure: . . . 9. Raw meats are stored on the bottom shelves of refrigerators with drip pans to accumulate any juices. . . ." The "Maintaining/Cleaning Foodservice Equipment" policy, dated 04/17/14, stated, "Policy: . . . to properly maintain, clean and sanitize all foodservice equipment on a regular basis. . . . Procedure: 1. All pieces of foodservice equipment will be cleaned and sanitized regularly by Nutrition and Culinary Services staff . . . 3. Any malfunctioning equipment should be reported to Supervisor or maintenance department. . . ." The "Dishwashing" policy, dated 04/17/14, stated, "Policy: . . . to properly clean and sanitize dishes and utensils. . . . Procedure: Machine Washing: . . . 5. For heat sanitizing machines thermometers monitor the water temperatures and should be checked occasionally to assure proper temperatures are being maintained per state and federal regulations. Dish machine temperatures are logged daily. . . ."	F 371	6/10/16. 4. June 13, 2016. 5. Auditing by Director of Nutrition and Culinary Services or designee of sanitary conditions for food storage and preparation will be completed as follows: 3 times/week for 4 weeks, 2 times/week for 8 weeks, 1 time/week for 12 weeks and prn. Results of audits will be brought to QA Committee for review and recommendation.	

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F 371	Continued From page 15 The "Cold Storage" policy, dated 04/17/16, stated, "Policy: . . . all perishable refrigerated and frozen items are stored according to state and federal regulations. . . . Procedure: . . . 4. Raw meat, poultry and eggs need to be stored below "ready to eat" foods and produce, and must have drip pans below them to accumulate any juices. . . ." An initial tour of the kitchen occurred on 05/02/16 at 10:45 a.m. with an administrative dietary staff member (#4). Observation showed the following: *A large build-up of ice on the ceiling of the walk-in freezer. *Review of the May 2016 dishwashing machine log in the main kitchen indicated two columns to record dishwashing temperatures - morning and evening. The log showed a Thermolabel (temperature strip) from May 1, 2016 which did not change color, indicating the water did not reach the required 160 degree temperature to sanitize the dishes. The administrative dietary staff member stated she was not aware of this and stated staff should have contacted her or the maintenance department. Observation on 05/02/16 at 6:20 p.m. in the kitchen showed a bucket of soap water directly next to an open pan of cooked beef. The cook (#9) lifted a rag out of the bucket and began to squeeze the water out. During this observation, the administrative dietary staff member (#4) immediately removed the open pan of cooked beef to another location. Observation on 05/03/16 at 12:15 p.m. showed a dietary staff member (#7) serving food in the LTC kitchenette. The staff member wore gloves	F 371		

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F 371	Continued From page 16 throughout the entire time of serving food, using her gloved hands to pick up the beef from the steam pan and place it on a bun, and then used the same gloved hands to do all other tasks, such as open the refrigerator door, microwave food, etc. Observations on the evening of 05/03/16 in both facility dining rooms showed three opened containers of "Thick & Easy" (a powdered food thickener) and one open container of "Beneprotein" (a protein powder supplement) with the scoops stored inside the containers. Observations on the evening of 05/04/16 showed the containers of "Thick & Easy" and "Beneprotein" remained in the dining rooms with the scoops stored inside the containers. Observation of the kitchen on 05/05/16 at 9:40 a.m. with an administrative dietary staff member (#4) showed the following: *Raw turkey in a box without a drip pan and raw pork in a box without a drip pan stored above containers of cooked squash in the walk-in cooler. *Large build-up of ice remained on the ceiling of the walk-in cooler and ice build-up below this area on a box of cooked beef steaks. *Review of the May 2016 dishwashing machine log for the main kitchen showed staff recorded the machine temperature 1 out of 4 times for the evening meal. Review of the April 2016 dishwashing machine log for the main kitchen showed three Thermolabels that did not change color, indicating the water did not reach the required temperature to sanitize the dishes. The "action" section on the log did not identify a	F 371		

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F 371	Continued From page 17 corrective action. The administrative staff member (#4) confirmed staff should notify her or the maintenance department if the water is not reaching the correct temperature. Observation of the dishwashing machine in a separate room near the LTC and TCU occurred on 05/05/16 at 10:00 a.m. The administrative dietary staff member (#4) placed a Thermolabel on a plate in the dishmachine 3 separate times, with the temperature strip not changing color to the required temperature level. The surveyor obtained a temperature strip from her/his supply and the dishmachine reached the required temperature. Review of the dishwashing machine logs showed staff recorded temperatures for the evening meal 2 out of 4 times in May. Observation on the TCU on 05/05/16 at 10:15 a.m. showed dried food debris on the shelves and bottom of refrigerator located in the hallway. Observation in this area also showed a dried, crusty build-up of debris on the spouts of the juice dispenser. Observation on the LTC unit on 05/05/16 at 10:25 a.m. showed a dried, crusty build-up of debris on the spouts of the juice dispenser.	F 371		
F 441 SS=E	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	F 441		6/13/16

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F 441	Continued From page 18 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 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, review of facility policy, review of professional literature, and staff interview, facility staff failed to properly disinfect the blood glucose meter during 2 of 4 observations (05/02/15 and 05/03/15) of blood glucose testing for three residents (Resident #4,	F 441	F 441 1. Glucometers will be properly disinfected for Residents #4, #8, and #17. 2. Residents who have blood glucose testing have the potential to be affected. 3. Location and availability of germicidal	

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F 441	Continued From page 19 #8, and #17). Failure to correctly disinfect the meters may result in the transmission of organisms and pathogens to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Blood Glucose Monitoring" occurred on 05/05/16. This policy, dated May 2013, stated, "Procedure: . . . 7. . . . Disinfect the unit. Remove gloves and wash hands. Disinfecting: **After each use the unit must be disinfected with a germicidal wipe** . . ." A Centers for Disease Control and Prevention publication titled "Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration," dated 03/08/11, stated, ". . . General: . . . Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. . . . Blood Glucose Meters: 1. . . . Infectious agents, such as HBV [hepatitis B Virus] can be transmitted through indirect contact transmission, even in the absence of visible blood. . . . Healthcare personnel hands can become contaminated with blood at various points while performing assisted blood glucose monitoring including pricking the patient's finger or handling the test strip. Blood can then be transferred to the meter . . . 2. . . . FDA [Food and Drug Administration] has recently released guidance for manufacturers regarding appropriate products and procedure for cleaning and disinfection of blood glucose meters. . . . 'The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B	F 441	wipes reviewed. Education on recent FDA guidance for cleaning glucometers done 6/2/16. 4. June 13, 2016. 5. Auditing by DON or designee of blood glucose testing as follows: 3 times/week for 4 weeks, 2 times/week for 8 weeks, 1 time/week for 12 weeks and prn. Results of audits will be brought to Quality Committee for review and recommendation.	

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F 441	Continued From page 20 virus. . . . Please note that 70% ethanol (alcohol) solutions are not effective against viral bloodborne pathogens . . ." - Observation on 05/02/16 at 5:45 p.m. showed a nurse (#5) tested Resident #4's blood with a blood glucose meter. After testing the resident's blood, the nurse (#5) placed the meter on the cart and moved the cart to Resident #8's room. After the nurse checked Resident #8's blood, she placed the meter back in the cart. When prompted about cleaning the meter, the nurse (#5) cleaned the meter with a "Super Sani-Cloth Disinfectant Wipe" and stated she should have cleaned the meter between the two residents. - Observation on 05/03/16 at 7:55 a.m. showed a nurse (#6) tested Resident #17's blood with a blood glucose meter. After testing the resident's blood glucose, the nurse (#6) placed the meter back in the medication cart and stated she had completed blood glucose monitoring for the morning. When prompted about cleaning the meter, the nurse then wiped the meter with an alcohol pad. On further questioning, the nurse (#6) stated staff can either use alcohol or the Super Sani-Cloths for cleaning the glucose meter. During an interview on 05/03/16 at 5:30 p.m., an administrative nurse (#1) confirmed staff should clean the meter with a disinfectant wipe after each use.	F 441		