STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	08/09/2018

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BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 08/06/18 and completed on 08/08/18, the sample included 26 residents for review and two (2) closed records for review.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		9/13/18

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

Electronically Signed | 08/29/2018

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to maintain a comfortable room temperature in 1 of 5 dining rooms. Findings include: On 08/06/18 at 10:11 a.m., an interview was conducted with Resident #76. The resident stated, "Sometimes it's so cold in the dining room, it makes the food cold. I put a napkin over my coffee cup to keep the coffee hot." On 08/06/18 at 11:48 a.m., the Legacy dining room was observed. The thermostat showed the room temperature was approximately 68 degrees. Resident #100 and #76 reported being cold every day in the dining room. They both said they had reported the complaint, but couldn't recall who they told. On 08/06/18 at 11:54 a.m., an interview was conducted with a Certified Nursing Assistant (CNA) (#161). The CNA (#161) stated, "It's usually this temperature in this dining room. It's cooler than the others. I don't know how to adjust	F 584	F584 1. Computer software upgrade for temperature control/supervisory control was installed in June of 2018. External access to system has been obtained. Informational Technology is presently working to have e-mail alerts sent to Maintenance Supervisor (or designee) when temperature is out of parameters. 2. All residents in the skilled nursing facility have the potential to be affected. 3. Mandatory maintenance staff meeting was held on August 21, 2018 to review citation, required air temperature (unless resident requests different), and required monitoring. All staff in-service was held on August 15, 2018 to review survey results and corrective actions. On August 21, 2018 a nurse's survey letter containing review of the citation and corrective action with confirmation response requested by August 29, 2018. All nursing staff meeting will be held on September 4, 2018 to review citation and corrective action. 4. The Maintenance Supervisor (or	

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F 584	Continued From page 2 it. I can't say anyone has really complained. The residents are always cold even if it's scorching hot outside." An interview was conducted with a staff nurse (#17) on 08/07/18 at 12:00 p.m. The nurse stated, "No residents have told me it's cold in the dining room, but some of the staff have. I'm not sure how the thermostat works in there, but maintenance would control it." On 08/07/18 at 1:47 p.m., an interview was conducted with a supervisory maintenance staff member (#193). He stated, "I try to keep the resident areas about 74. The Legacy dining room is running colder. I heard today (for the first time) that it was cold back there. It was either 71 or 72.5, I don't remember. There is a thermostat in that dining room, but I don't know if it controls the temperature in that dining room. The heating and air conditioning company can control the setting on some of our units remotely. There are some areas that I can control and some that I have to call them to change. That dining room has a thermostat on the wall, but it don't do nothing (sic). It may be unhooked. The company is going to come out and go up on the roof and look." The staff member (#193) stated there were areas that he has no control of the air temperature, and he wasn't sure what sections of the home were under the home's control and which areas were controlled remotely by the heating and air contractor. He also stated he monitors temperatures in resident rooms, but not in the common areas like dining rooms. On 08/07/18 at 4:20 p.m., an interview was conducted with an administrative staff member	F 584	designee) will monitor air temperatures in each of the facility dining rooms twice per day for 2 weeks, then daily for 2 weeks, then three times per week for 1 month, then two times per week for 10 months . Thirty percent of resident rooms in facility will be monitored three times per week for 2 months, then 20% three times per week for 1 month, then 10% three times per week for 1 month, then 10% two times per week for 8 months. QA monitoring was initiated on August 8, 2018. The Maintenance Supervisor (or designee) will report results of monitoring to the QA committee monthly. 5. September 13, 2018	

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F 584	Continued From page 3 (#170). The staff member stated, "We used to be able to control the thermostats. Then they changed the computer system and we have to have an upgrade. We have signed the paperwork for the upgrade to the computers so we can control them. Right now, we just have to call them to change the thermostats. I've not heard of any complaints about the temperature." The administrative staff member (#170) clarified they signed the upgrade agreement for the thermostats in December 2017.	F 584		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a safe environment for 6 of 15 sampled residents (Resident #8, #43, #96, #104,#127 and #181) whose hot water temperatures were tested and 1 of 2 sampled residents (Resident #130) reviewed for falls who utilized an air mattress. Failure to maintain acceptable ranges for hot water temperatures creates the potential for burn injuries to residents and staff. Failure to assess the use of an air mattress for Resident #130 may have resulted in preventable falls from the bed. HOT WATER TEMPERATURES	F 689	F689-1 1. Temperature of individual boilers that supply resident rooms were adjusted on August 6, 2018. Circulating pumps in facility were checked and found to be in working condition on the evening of August 6, 2018. 2. All residents in the skilled nursing facility have the potential to be affected. 3. Mandatory maintenance staff meeting was held on August 21, 2018 to review citation, required water temperature, and required monitoring. All staff in-service was held on August 15, 2018 to review	9/13/18

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F 689	Continued From page 4 Findings include: - Review of Resident #104's medical record identified diagnoses which included dementia without behavioral disturbance. The Minimum Data Set (MDS) admission assessment, dated 07/01/18, identified the following: * severe cognitive impairment; * independent with eating; * supervision with ambulation, locomotion and bathing; * extensive assistance with bed mobility, dressing, toilet use and personal hygiene; * no functional limitation in range of motion; * used a walker for mobility; * occasionally incontinent of bladder and always continent of bowel; * 1 fall with minor injury since the prior assessment The care plan, dated 07/06/18, indicated the resident was at high risk for elopement, at high risk for falls, had a diagnosis of dementia, and had mixed bladder incontinence related to dementia. On 08/06/18 at 11:43 a.m., the hot water temperature in Resident #104's bathroom sink was 124.7 degrees Fahrenheit (F).. On 08/06/18 at 03:34 p.m., a certified nurse aide (CNA) (#138) was asked if the resident could ambulate to the bathroom and use the sink independently. She stated the resident required assistance with ambulation and staff used a gait belt for support. The CNA was asked if the resident could ambulate by herself to the	F 689	survey results and corrective action. On August 21, 2018 a letter containing review of citation and corrective action was sent to the licensed nurse's with confirmation response requested by August 29, 2018. All nursing staff meeting will be held on September 4, 2018 to review citation and corrective action. 4. On August 8, 2018 daily water temperature checks were initiated for resident #8, #43, #96, #104, #127, and #181 for four weeks, then three times per week for 1 month, then two times per week for two months, then one time per week for 8 months. On August 13, 2018 the maintenance supervisor (or designee) will monitor water temperature three times per week for 4 weeks on 30% of the facility, then three times a week on 20% of the facility for 2 months, the once a week audit on 10% of the facility for 9 months. The maintenance supervisor (or designee) will report results of the monitoring to the QA committee monthly. 5. September 13, 2018. F689-2 1. Air mattress was removed from resident #130. 2. Any resident who utilizes an air flow mattress has the potential to be affected. 3. All staff in-service was held on August 15, 2018 to review survey results and corrective action. On August 21, 2018 a survey letter containing review of the citation and corrective action was sent to the licensed nurse's with confirmation response requested by August 29, 2018.	

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F 689	Continued From page 5 bathroom. She stated the resident would be able to ambulate to the bathroom by herself, but was a fall risk. On 08/06/18 at 3:36 p.m., a CNA #113 was asked if Resident #104 could ambulate to the bathroom and use the sink independently. She stated the resident needed assistance with ambulation and used a walker or staff used a gait belt. The CNA was asked if the resident could get to the bathroom by herself and turn on the water in the sink. The CNA stated the resident could ambulate to the bathroom by herself and turn on the water. - Review of Resident #43's medical record identified diagnoses which included moderate intellectual disability. The quarterly assessment, dated 05/12/18, identified the following: * moderate cognitive impairment; * supervision with ambulation and eating; * limited assistance with transfer; * extensive assistance with dressing, toilet use, personal hygiene and bathing; * frequently incontinent of bladder and bowel The care plan, most recently reviewed/revised on 05/30/18, indicated the resident had a problem related to her impaired cognition and impaired decision making. The care plan further indicated the resident had an activities of daily living (ADL) self care performance deficit related to limited range of motion, musculoskeletal impairment, limited mobility and impaired balance. On 08/06/18 at 11:48 a.m., the temperature of the hot water in the resident's bathroom sink was 122.0 degrees F.	F 689	All nursing staff meeting will be held on September 4, 2018 to review results of survey and corrective action. Facility had been reviewing falls during morning report Monday through Friday with the interdisciplinary team to determine potential causes and new interventions. A new Fall Committee was intiated on August 21, 2018 and will meet weekly for 3 months then 2 times per month thereafter. Monthly fall audits will be implemented starting August 20, 2018 and every month thereafter. 4. The Director of Nursing (or designee) will monitor the following: 1. All residents with an air flow mattress with be audited for safety weekly for 1 month, then two times per month thereafter. 2. Monthly fall audits will be implemented starting August 20, 2018 and every month thereafter. 3. Weekly audit for falls for 3 months, then two times per month thereafter. The Director of Nursing (or designee) will report the results of all of the above to the QA committee monthly. 5. September 13, 2018.	

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F 689	Continued From page 6 - Review of Resident #96's 30-day Medicare assessment, dated 06/26/18, identified the following: * cognitively intact; * limited assistance with transfer and ambulation in room; * extensive assistance with toilet use, personal hygiene and bathing; * occasionally incontinent of bladder and bowel The care plan, most recently reviewed/revised on 08/03/18, indicated the resident had an ADL self care performance deficit. On 08/06/18 at 11:29 a.m., the hot water temperature of the resident's in room sink was 122.8 degrees F. On 08/06/18 at 5:46 p.m., Resident #96 was asked about the hot water temperature of his sink. He stated the water was "too hot" and that he had not burned himself. - Review of Resident #181's, Significant Change MDS, dated 07/27/18, identified the following: * moderate cognitive impairment; * extensive assistance or was dependent upon staff for all ADLs; * did not ambulate; * indwelling catheter; * frequently incontinent of bowel The care plan, most recently reviewed/revised 08/03/18, documented the resident had problems related to a communication problem, impaired cognitive function and an ADL self care performance deficit. Appropriate goals and	F 689		

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F 689	Continued From page 7	F 689		

interventions were addressed in the care plan.

On 08/06/18 at 11:29 a.m., the hot water in the resident's bathroom sink was 122.8 degrees F.

- Review of Resident #8's quarterly MDS, dated 04/22/18, noted a BIMS (brief interview for mental status) score of 15 out of 15 indicating no impairment. Resident #8 needed limited assistance from one person for transferring and supervision for ambulating.

During a room observation for Resident #8 on 08/06/18 at 11:41 a.m., the bathroom sink water temperature was noted to be 119 degrees using a facility provided thermometer that was calibrated prior to use.

- Review of Resident #127's 07/12/18 MDS noted a BIMS score of 6 out of 15 indicating severe impairment. Resident #127 required supervision of one person for transferring and for ambulating.

On 08/06/18 at 10:33 a.m., an observation was made of Resident #127's room. During the observation, the bathroom sink water temperature was noted to be 122 degrees using a facility provided thermometer that was calibrated prior to use.

On 08/06/18 at 1:39 p.m., an interview was completed with a maintenance supervisor staff member (#193) . The staff member stated, "We do water temperatures once a month. We check random rooms on every unit. There are three water heater system. The range is up to 110. Rooms on the far end will be a little cooler, the

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F 689	Continued From page 8 room closer will be a little warmer. If it's at 118, I'd consider doing some adjusting." Observation of facility water heaters was completed on 08/06/18 at 1:46 p.m. with the staff member (#193). Water heater #1's exiting water temperature was reported to be 120 degrees by the staff member (#193). He was not sure what sections of the home were supplied by water heater #1. Water heater #2 had an exiting water temperature of 123.3 degrees. The staff member (#193) stated water heater #2 supplied water to rooms on the 2nd and 3rd floors. Water heater #3 had an exit temperature of 119.8 degrees and water heater #4 had an exit temperature of 118 degrees. The staff member (#193) stated that he was not sure what rooms were supplied hot water by water heaters #3 and #4. At 2:00 p.m., room temperatures were rechecked and verified with the staff member (#193). Room 210 was 124 degrees, 301 was 125 degrees, 314 was 118 degrees and room L21 was 114 degrees. A follow up interview was completed with the staff member (#193) on 08/06/18 at 3:38 p.m.. He stated, "If we get temps (temperatures) over 118 (degrees), I usually recheck the temp the next day and mark out the first reading (on the water temperature log)." Temperatures on April 20, 2018 were noted to be 120.4 for room 301 and 121.1 for room N2. There was no recheck. The staff member (#193) stated the maintenance worker who completed those checks was no longer working at the facility and "probably didn't recheck them." The staff member (#193) stated he would sometimes review the water temperature logs.	F 689		

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F 689	Continued From page 9 On 08/06/18 at 3:45 p.m., an interview was completed with an administrative staff member (#170). The staff member (#170) stated the supervisory maintenance staff member (#193) brings water temperature logs to the Quality Assurance (QA) meetings. "There was a time or two where the water was over 120 and he adjusted the thermostats. He would have rechecked them (water temperatures). The administrative staff member (#170) verified there was no facility policy on checking water temperatures; but wrote up the current process. The document noted, "Maintenance completes random checks monthly of water temperatures. If temperatures are out of range, adjustments have been made to the water heaters and recheck has been completed. These are reported to the QA committee." FALLS/MATTRESS Findings include: - Review of Resident #130's medical record identified diagnoses of hypotension and dizziness. A Significant Change MDS, dated 07/20/18, indicated that Resident #130 required extensive assistance with 2 staff for bed mobility and transfers and walking did not occur during the assessment period. Review of facility incident reports identified on 06/30/18 at 5:40 p.m., Resident #130 was found on the floor next to his bed. Resident #130 stated he was trying to put on his slipper and slid off the bed. The report noted that Resident #130	F 689		

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"attempts to self-transfer. Encouraged to use the call light and not self-transfer."

A second incident report, dated 07/10/18 at 3:30 p.m., revealed Resident #130 had rolled off the side of his bed and onto the floor. He stated he was trying to get out from under the covers. The investigation identified Resident #130 continued to transfer without assistance. The intervention was to place Resident #130 on 30 minute monitoring.
A Health Status note, dated 07/12/18 at 8:46 a.m., indicated Resident #130 was seen by a physician for "increased confusion, hallucinations and decline." Resident #130 and his family agreed to a hospice consult at that time.

On 08/06/18 at 5:35 p.m., Resident #130 was observed with his hips on edge of the bed; legs hanging off the bed with his feet just off the floor. He was noted to be on an air mattress that was compressed where his legs were and the part of the mattress he was not on was fully inflated, tipping him towards the floor. Upper side rails were below the level of the mattress. Resident #130 stated he gets up by himself and sits on the side of the bed or transfers to the wheel chair. He also stated he required assistance to get to the bathroom. A CNA (#28) was notified and responded, picking Resident #130's legs up and putting him back on the bed.

An observation of Resident #130 was completed on 08/08/18 at 9:43 a.m. The resident was in bed, with his eyes closed and both feet were on the edge of the bed.

On 08/08/18 at 9:52 a.m., an interview was

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F 689	Continued From page 11	F 689		

completed with a staff nurse (#220) who was the nurse on duty for Resident #130 on 08/06/18 at 5:35 p.m. The nurse (#220) said the CNA (#28) had not reported the incident with Resident #130 on 08/06/18 when he had to reposition the resident back in the bed. She said, "It's not an unusual occurrence for (Resident #130). He likes to hang his feet off the bed. I probably put his feet back up a couple times a day."

On 08/08/18 at 11:20 a.m., an interview was completed with a supervisory nurse (#17). The nurse (#17) was identified as the unit manager for the unit where Resident #130 resided. The nurse stated Resident #130 "fell last night about 3:40 a.m. I saw the incident report when I came in this morning. The air mattress was added to the care plan on 06/18 and would have put on the bed around that same day. I'm not aware of any issue with the mattress and him trying to get out of bed. He uses a mechanical lift to transfer, but sometimes he tries to get up himself." The nurse (#17) stated she was not aware of Resident #130 coming partially out of the bed on 08/06. "When there is an incident, we talk about it in morning report and discuss what we can do. The mattress didn't really come up as a possible cause." The nurse (#17) reported the only other fall Resident #130 had was on 05/28/18 when he fell while walking in his room after getting dizzy.

Review of an Incident Report for Resident #130 was completed on 08/08/18 11:26 a.m. The Incident Report, dated 08/08/18 at 3:40 a.m., noted Resident #130 was found on the floor on his back. The "head of the bed was elevated almost 90 degrees. Resident #130 stated he was hallucinating and reaching for his wheel chair."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain a medication administration error rate of less than 5% with 3 errors out of 25 opportunities for 1 of 4 residents (Resident #107) observed during Medication Pass. The practice of not administering all of the medications resulted in an error rate of 12%. Findings include: Review of Resident #107's medical record identified diagnoses of amyotrophic lateral sclerosis and gastric tube. Resident #107 was receiving hospice services. Review of Resident #107's physician's orders identified an order, dated 12/29/17, for a multivitamin, an order, dated 08/07/18, for Sudafed with directions to, "Give morning dose prior to breakfast with Flonase, crushed in apple sauce," and an order, dated 08/08/18, for Lisinopril (antihypertensive). Observation of medication administration for Resident #107 was completed on 08/07/18 at 10:21 a.m. The resident was given his medications through a gastric tube. The three pills were crushed and poured into a cup of	F 759	F 759 1. Licensed nurse involved with resident #107 was re-educated on the process of medication administration via feeding tube with competency check list completed on August 7, 2018. 2. All residents that receive medications via feeding tube have the potential to be affected. 3. All staff in-service was held on August 15, 2018 to review survey results and procedure of medication administration via feeding tube. On August 22, 2018 a nurse's survey letter was sent out containing review of citation and corrective action and policy and procedure with confirmation response requested by August 29, 2018. All nursing staff meeting will be held on September 4, 2018 to review results of survey and corrective action. 4. The Director of Nursing (or designee) will complete competency checklist on all licensed nurse's who provide medication administration via feeding tube by September 7, 2018. The Director of Nursing (or designee) will complete random audits of medication administration via feeding tube two times	9/13/18

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F 759	Continued From page 13 water. Powder from the pills floated on top of the water. A staff nurse (#34) attempted to mix the powder in the water with a spoon and then poured the cup of water into the syringe. There was a large amount of pill residue in the cup and in the syringe that was not administered. The cup was thrown away and the syringe was rinsed out in the sink. An interview was completed with a staff nurse (#34) on 08/07/18 at 10:28 a.m. The nurse stated "(Resident #107) doesn't swallow anymore so we put the pills in the g-tube (gastric tube) and he likes to take his pills later...the vitamin is really hard to dissolve so some gets left." On 08/07/18 at 11:05 AM, an interview was completed with a supervisory nurse (#17). The nurse (#17) stated, "If the medication is sticking (crushed medications in water), I would expect the nurse to call hospice to see if there is a liquid version or if we needed to continue the meds (medications). I would also try to add more water."	F 759	per week for 1 month, then weekly for 3 months, then biweekly for 8 months. The Director of Nursing (or designee) will complete annual competency for medication administration via feeding tube. The random audits were initiated the week of August 13, 2018. The Director of Nursing (or designee) will report results to the QA committee monthly. 5. September 13, 2018	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		9/13/18

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F 761	Continued From page 14 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medication carts were locked when unattended. This affected 1 of 5 medication carts (Legacy hall) used in the facility. Twelve residents resided on the hall where the unattended medication cart was observed. Findings include: The facility's "Medication Security" policy and procedure documented: "The Licensed Nurse (charge nurse) or other lawfully authorized staff member is responsible for safety and security of medications...Medication carts are locked when left unattended, out of vision of the nurse..." On 08/07/18 at 8:15 p.m., an unlocked, unattended medication cart was observed sitting between rooms L9 and L11. No residents were observed walking/wandering in the hallway. At 8:17 p.m., a staff nurse (#35) returned to the	F 761	F761 1. Re-education was provided to licensed nurse involved with leaving medication cart unlocked occurred on August 7, 2018. 2. All medication carts in the facility have the potential to be left unlocked. 3. All staff in-service was held on August 15, 2018 to review survey results and corrective actions. On August 21, 2018 a nurse's survey letter was sent out containing review of citation and corrective action with confirmation response requested by August 29, 2018. All nursing staff meeting will be held on September 4, 2018 to review results of survey and corrective action. 4. The Director of Nursing (or designee) will monitor randomly three times per week for 1 month, then two times per week for 1 month, then weekly for 2 months, then biweekly for 8 months. The	

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F 761	Continued From page 15 medication cart. She was asked if the cart had been left unlocked and unattended. She stated, "Yes." She was asked if it is supposed to be left unlocked and unattended. She stated, "No."	F 761	random QA audits were initiated on August 13, 2018. The Director of Nursing (or designee) will report the results of monitoring to the QA committee monthly. 5. September 13, 2018.	