MAY 0 5 2014

PRINTED: 05/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING ______ B. WING ______	C 04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 No deficiencies were cited as a result of the complaint investigation survey of 4/17/14. Event ID# G4QO11.	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 record review and staff interview the facility failed to transcribe the complete medication list provided on the hospital discharge summary and failed to administer 1 of the 8 medications (Plavix) for the 27 days of admission. Findings Include: The resident was admitted to the facility on 3/3/2014 and discharged on 3/31/2014. The admission Minimum Data Set (MDS) revealed Resident #86 was severely cognitively impaired and required extensive staff assistance with her activities of daily living. Her active medical diagnosis included Anemia, Hypertension, Dementia and Cardiovascular Accident CVA. A record review of the hospital discharge summary dated 3/3/2014 revealed Resident #86 was admitted to the hospital for evaluation of a Cardiovascular Accident (CVA). The CVA was demonstrated by a radiology exam called magnetic resonance imaging (MRI). Resident #86 was on Aspirin; therefore, she was transitioned to Plavix. Medications upon discharge:	F 281	I. Resident #86 that was affected by the alleged deficient practice had been discharged on 3/31/14. II. For residents who have had the potential to be affected by the same alleged deficient practice we have completed an audit on current residents who were admitted within the last 30 days to ensure accurate transcription of admission orders from the hospital discharge summary. III. The measures we have employed to ensure the alleged deficient practice will not occur was to provide education to licensed staff by the Director of Clinical Services, DCS, Assistant Director of Clinical Services, ADCS, Unit Manager, UM and Building Supervisor, regarding admission orders. The systematic change we have begun is to have the admission orders transcribed from the hospital discharge summary and then verified by 2 nurses. Going forward this process will be utilized by the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director / Administrator	5/2/14

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 281	Continued From page 1 1. Plavix 75 milligrams by mouth daily 2. Donepezil [Aricept] 10 milligrams by mouth at bedtime 3. Ferrous sulfate 5 milliliters by mouth daily 4. Namenda 10 mg milligrams by mouth every morning 5. Metoprolol [Lopressor] 50 by mouth twice a day 6. Clonidine 0.2 milligram patch weekly 7. Pravastatin [Pravachol] 40 milligrams by mouth at bedtime 8. Isosorbide mononitrate [Imdur] 30 milligrams by mouth daily The facility copy of the hospital discharge summary dated 2/28/2014 revealed check marks next to the 8 medications listed above. The Patient Discharge Medication List from the hospital included: 1. Donepezil 10 milligram (mg) tablet, one tablet oral daily at bedtime, last dose given 3/2/2014 at 8:42 PM 2. Ferrous Sulfate 220 mg/5 milliliters (ml), 5 ml oral daily, last dose given 3/3/2014 at 10:37 AM 3. Namenda 10 mg tablet, 1 tablet daily every morning, last dose given 3/3/2014 at 5:21 AM 4. Lopressor 50 mg tablet, 1 tablet oral twice a day, last dose given 3/2/2014 at 10:37 AM 5. Clonidine 0.2mg/24 hours patch weekly, one each transdermal every Sunday, last dose given 3/2/2014 at 6:30 PM 6. Pravastatin 40 mg tablet, 1 tablet oral daily at bedtime, last dose given 3/2/2014 at 8:42 PM 7. Isosorbide mononitrate (Imdur) 30 mg tablet extended release 24 hour, 1 tablet oral daily, hold for systolic blood pressure less than 110, and last dose given marked N/A. 8. Plavix 75 mg 1 tablet oral daily stat and then	F 281	DCS/ADCS/UM/Supervisor to complete admission audits daily to include verification of admission orders from the discharge summary. IV. The Executive Director will monitor our compliance by having the DCS audit 3 admission charts weekly for 1 month, 5 admission charts twice per month for 2 months, then 10 new admission charts monthly for 3 months. The results of the DCS's monitoring will be presented and discussed at the monthly Quality Assurance / Performance Improvement Committee Meeting. Any additional training will be provided as needed.	5/2/14

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routine, last dose given 3/3/2014 at 10:37 AM

A record review of a hospital Medication Administration Record (MAR) revealed the Plavix was started on 2/24/2014.

A record review of the facility Physician Orders Sheet (POS) for 3/3/2014 through 3/31/2014 included the medications as transcribed in the hospital discharge summary:
1. Donepezil
2. Ferrous Sulfate
3. Namenda
4. Lopressor
5. Clonidine
6. Pravastatin
7. Imdur

Plavix was not transcribed to the facility POS. The POS was signed by Nurse #2 and the demographic section completed in his handwriting. The medications were transcribed in a different handwriting.

A record review of the facility MAR for 3/3/2014 through 3/31/2014 included:
1. Donepezil
2. Ferrous Sulfate
3. Namenda
4. Lopressor
5. Clonidine
6. Pravastatin
7. Imdur

Plavix was not transcribed to the facility MAR. The MAR demographic section completed in Nurse #2 ' s handwriting and the medications were transcribed in a different handwriting. All medications transcribed were initialed given as ordered.

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F 281	Continued From page 3 An interview with Nurse #2 on 4/17/2014 at 7:36 AM revealed he did not receive Resident #86 in the room. Nurse #2 reported he worked the 7 AM to 3 PM shift and the admission nurse note documented Resident #86 arrived at 4 PM. Nurse #2 stated " I may have started the paperwork in anticipation " . Nurse #2 does not recall verifying the POS with another nurse but verified the handwriting in the demographic section and signature as his. In addition Nurse #2 verified the handwriting in the demographic section of the MAR was his. Nurse #2 reported the facility practice was if the resident admission packet arrived and the resident was not present the staff started to complete the admission packet. Nurse #2 reported he completed the bottom demographic information and the side orders which included diet and code status and he signed it. Nurse #2 states " I should not have signed it " . He reported the medications transcribed on the POS and the MAR were not his hand writing. He reported the medications were transcribed in Nurse #3 ' s hand writing. An interview with Nurse #3 on 4/17/2014 at 7:49 AM reported the medications on Resident #86 ' s POS and MAR were transcribed in her hand writing. The procedure for transcribing medication was when staffs receive the resident and hospital paperwork they fax the Physician the discharge medication list from the hospital and receive a verbal ok from the Physician to transcribe the medications. Nurse #3 does not recall if Resident #86 was on Plavix or why it was not transcribed. Nurse #3 does not recall if Nurse #2 verified the medications she transcribed on Resident #86 ' s POS and MAR. Nurse #3 stated " it looks like a joint admission if she came between shifts " .	F 281		

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F 281	Continued From page 4 A record review of the facility Medication Discharge Summary on Resident #86 ' s included Plavix 75mg daily. An interview with the Physician on 4/17/2014 at 2:20 PM revealed he transcribed the medications on the facility discharge summary including the Plavix. Resident #86 was placed on Plavix prior to the admission at the facility and the intent was to keep her on Plavix. The Physician does not know why the Plavix was not transcribed from the hospital discharge summery to the facility POS. He reported Resident #86 did not have another stroke while she was at the facility. An interview with the Director of Nursing (DON) on 4/17/2014 at 11:01 AM it was not facility policy to verify the medications transcribed from the hospital discharge summary to the POS. The DON reported she would verify the transcribed orders and she encouraged the staff to verify with a second nurse. It was not an expectation of the DON for Nurse #2 to sign the POS prior to the medication transcription.	F 281		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN 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, and interviews with resident and staff the facility failed to provide a resident with sufficient fluid to maintain hydration by not keeping fluids in room,	F 327	1. The corrective action taken for the alleged deficient practice was to educate the staff specifically to Resident #140's request for fluids and the need to have them available to him. The Care Plan and Care Card were updated for resident #140 to reflect open containers may be left at the bedside for his consumption.	

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F 327	Continued From page 5 within reach, and not providing assistance to open thickened liquid container for 1 of 2 residents (Resident #140) reviewed for hydration. Findings included: Resident #140 was admitted on 1/9/14 with diagnoses including urinary tract infection, lack of coordination, muscle weakness, dysphagia, hypertension, and history of falls. A review of the nutritional evaluation dated 1/9/14 revealed the resident's daily fluid needs were greater than or equal to 1990 milliliters. Resident #140's care plan dated 1/13/14 revealed: · At nutritional risk related to cognitive loss. Interventions included a mechanical soft diet, encourage fluids, and nectar thick liquids. Resident #140's care plan dated 1/22/14 revealed: · At risk for aspiration and requires nectar thickened liquids. Interventions included observe for signs and symptoms of dehydration. · Risk of dehydration and recurrent urinary tract infection. Interventions included offer fluids with meals, medications, at bedtime and as needed. Thickened liquids kept at bedside, available upon request or as needed in personal or unit refrigerator. Observe for signs and symptoms of dehydration such as poor skin turgor, dry mucus membranes, and confusion. · Requires extensive to total assist for all activities of daily living (ADLs). Interventions included the resident can feed himself after setup. Open cartons and packages and assist as needed.	F 327	2. The corrective action taken for those residents having the potential to be affected by the alleged deficient practice was to review all residents on thickened liquids for hydration preference and for accessibility to the coolers where their thickened liquids are kept. 3. The measures taken to ensure the alleged deficient practice does not occur in the future was to have the nursing staff educated by the Director of Clinical Services, DCS and Assistant Director of Clinical Services, ADCS, on offering thickened fluids to the residents who require thickened liquids between meals and at HS. The Dietary staff has added additional fluids for the residents on thickened liquids at snack times as well as placing extra containers in the Nutrition Room refrigerator.	

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F 327	Continued From page 6 The physician assessment dated 3/23/14 indicated Resident #140's appetite was fair, he could feed himself, needed increased assistance for all of the activities of daily living, and had dysphagia. It further indicated he could communicate his needs. The Minimum Data Set (MDS) dated 4/10/14 indicated the resident was severely cognitively impaired, required supervision with one person assist with eating, and was on a mechanically altered diet. He participated in the assessment, could hear adequately, and speak clearly. He made himself understood sometimes with his ability was limited to making concrete requests and he responded adequately to simple, direct communication. During an interview on 4/13/14 at 6:44 pm, when asked if he received the fluid he wanted between meals, Resident #140 stated, "You can't get any water here. I have asked." The resident indicated he gets fluids on his meal tray but no other time and stated, "I am thirsty." The resident showed signs of dehydration including dry skin, dry lips and mouth. An observation of the resident's room revealed a sealed 4 ounce container of nectar-thickened water on his overbed table. The table contained his dinner tray but no other fluids or cups on the tray. There were no fluids on the bedside table or any other areas of the room. There was no cooler bag or refrigerator in the room. Observations on 4/14/14 at 10:25 am and 2:00 pm revealed there were no fluids or cooler bag that contained thickened liquids in the resident's room. Staff was not observed offering fluids.	F 327	4. The facility will monitor our compliance by having the DCS, ADCS, UM or Building Supervisor audit residents with thickened liquids for acceptance of fluids daily for 1 month, weekly for 1 month, two times per month for 1 month, then monthly for 3 months. The results of the DCS's monitoring will be presented and discussed at the monthly Quality Assurance / Performance Improvement Committee Meeting. Any additional training will be provided as needed.	5/2/14

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An observation on 4/15/14 at 9:45 am revealed there were no fluids or cooler bag that contained thickened liquids in the resident's room. Staff was not observed offering fluids.

An observation on 4/15/14 at 2:37 pm revealed there was a sealed, 4 ounce nectar-thick water on the overbed table. There were no other fluids or cooler bag in the resident's room. Staff was not observed offering fluids.

An observation on 4/15/14 at 3:30 pm revealed there were no fluids or cooler bag that contained thickened liquids in the resident's room. Staff was not observed offering fluids.

On 4/15/14 at 3:35pm, Resident #140 was observed sitting in the hall at the nurses' station. When asked about the fluids he received that day, he indicated the only fluids he has been given were the ones on his meal tray and he was thirsty. He was wearing short sleeves and both arms revealed dry, flaky skin. His lips appeared dry.

On 4/16/14 at 8:18 am, Resident #140 was observed sitting in his bed, feeding himself breakfast. There were 2 6 ounce cups on the breakfast tray with a yellow liquid and white liquid residue. There was a sealed, 4 ounce, nectar-thick water on the overbed table. There was no cooler bag in the room. The resident was observed picking up a 6 ounce cup that was covered in plastic wrap and contained a light brown thickened liquid. He had pushed his finger through the plastic and was drinking the liquid through the hole in the plastic.

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F 327	Continued From page 8 During an interview on 4/16/14 at 8:24 am with Nurse aide (NA) #1, she stated, "[Resident #140] is supposed to have a cooler [for his thickened liquids]. I am not sure where his cooler is. There is not one in here. I give him his breakfast and set up while his aide is in the dining room. I gave him his tray this morning and was going to take his tea away when I left his tray. The water was already here and is [sealed]. He has opened the water before. I guess he can do that. We are supposed to be sure he has a cooler, that it has the thickened liquid available. The cooler is kept at the bedside where the resident can get it." During an interview on 4/16/14 at 8:32am with NA #2 she indicated she was assigned to Resident #140 and he should get thickened liquids with his meals or he could request water. She further indicated he did not have a cooler in his room, he should have one, and she did not know why he did not. An observation of Resident #140's room on 4/16/14 at 8:38 am revealed a cooler bag had been placed in the resident's room and contained 6 nectar-thick, sealed, 4 ounce waters. The bag was on the bedside table. Resident #140 was asked if he could reach the bag that contained his water. He made multiple attempts and was unable to reach the bag. During an observation on 4/16/14 at 8:40 am with NA #1, Resident #140 was again unable to reach the cooler bag, but was given a sealed water by the aide. He attempted for three minutes to open the nectar-thick water. When the top of the water was removed by NA #1, Resident #140 drank all 4 ounces immediately.	F 327		

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F 327	Continued From page 9 During an interview on 4/16/14 at 9:03am with Unit Manager #1, she stated, "[Residents who drink thickened liquids] are supposed to have a cooler in their room and the aides are supposed to be sure they have the thickened liquids in [the] cooler [bag]. I don't know why [Resident #140] doesn't." During an observation 4/16/14 at 9:30 am, Nurse #4 checked the skin turgor on the resident's right lower arm. The skin on his arm remained elevated for 2 seconds. The resident's membranes appeared dry and his skin remained dry and flaky. Nurse #4 indicated that she observed the resident's skin remaining elevated and was slow to return to its normal position. She stated, "That means he is dehydrated." An observation revealed the resident did not have any opened and available water on his overbed table. During an observation of Resident #140 on 4/16/14 at 10:30 am with NA #1, the resident did not have any opened and available water on his overbed table. Resident #140 was asked if he could reach the bag that contained his water. He attempted, but was unable to reach over to bedside table to get the cooler bag. NA #1 opened a water for him and placed it on his bedside tray. He picked it up the water and drank all 4 ounces immediately. During an observation on 4/16/14 at 5:15 pm Resident #140 was lying in bed, asleep. There were no fluids opened and within his reach. On 4/16/14 at 5:19 pm, NA #3 was observed delivering Resident #140's meal tray. Upon awakening the resident, she asked, "Do you want	F 327		

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F 327	Continued From page 10 to eat?" Resident #140 stated, "No, I'm thirsty. I want water." She took a sealed water from his dinner tray, opened it, and the resident drank all 4 ounces immediately. During an interview on 4/16/14 at 11:40am the Director of Nursing (DON) indicated she expected Resident #140 to have fluids within his reach and available in his room at all times and for staff to provide the assistance he needed such as opening the sealed water for him. A nurse's note on 4/16/14 at 7:00 pm indicated Resident #140 was alert and oriented to self, fed himself dinner after set up, and was able to make needs known verbally. On 4/17/14 at 8:15 am Resident #140 was observed sitting up in his bed, eating his breakfast and drinking an opened, thickened milk independently. An observation of Resident #140's room on 4/17/14 at 10:20 am revealed there were no fluids within his reach. The cooler bag was on the bedside table and contained 3 unopened waters. During an interview on 4/17/14 at 10:25 am, the Dietician stated, "[Thickened liquids] are shelf stable. They don't change consistency at all and can be kept at room temperature, so they don't have to stay in the cooler bag. They are shipped at room temperature, stored at room temperature, and can be consumed at room temperature. It is more personal preference as far as keeping them cold." She indicated the nectar-thick water could be opened and left on the resident's overbed table. Review of the product information indicated the nectar-thick	F 327		

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F 327	Continued From page 11 water could remain at room temperature and should be discarded 8 hours after being opened. During an interview on 4/17/14 3:25 pm with NA #4, who was assigned to Resident #140, she stated, "He gets thickened liquids but he usually is sleeping all day. He can drink them himself. He can open the top of the thickened liquids himself. I wouldn't really have to check on him about fluids since he can use his arms. He can get it himself." She indicated Resident #140 could get thickened water out of his cooler bag, open it, and consume it independently.	F 327		
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 and interviews the facility failed to monitor storage areas for labeling and dating of opened food items and leftovers, failed to clean the inside panel of the ice machine, failed to clean the oven, and failed to empty and clean oil and debris from the fryer. Findings included:	F 371	1. The corrective action taken for the alleged deficient practices was to ensure all items being placed in the walk-in refrigerator, reach-in refrigerator and freezer are labeled and dated correctly. All items that are not dated or labeled will be discarded. The oven was cleaned. The ice machines were cleaned. The oil in the deep fryer was removed / disposed of and the deep fryer unit was cleaned. 2. Additional corrective actions that were taken include cleaning all other equipment, tables, carts, floors, walls and dry storage areas.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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F 371	Continued From page 12 1. During initial tour of the kitchen on 4/13/14 beginning at 3:20 pm there were opened and stored food items in storage areas which were not labeled and dated. In the dry storage area, there were 3 large, opened cereal bags that were not labeled or dated and were not in a sealed package or container. In the walk-in freezer there was an opened package of dried egg patties that was undated and unsealed. In the walk-in refrigerator there was a package of sliced ham that had been opened, wrapped in plastic wrap and was not dated. There was a gallon plastic container of grape jelly that was not labeled and dated. There were 2 opened, 4-pound containers of pimento cheese, 15 prepared sandwiches and 6 prepared salads that were all not dated. In the reach-in cooler there was a large pan of apple crisp that was not covered, labeled, or dated. During an interview with the Dietary Manager on 4/13/14 at 4:10 pm he stated, "Everything in the fridge should be labeled with a date, either individually or with a date on the tray." He further indicated the undated ham, grape jelly, salads, sandwiches, pimento cheese, and any other undated items should be dated. During a follow-up visit of the kitchen on 4/15/14 at 12:15pm there were 2 packages of sliced ham that were opened, wrapped in plastic wrap, and not labeled or dated in the walk-in refrigerator. The dietary manager indicated the packages should be labeled and dated. 2. During initial tour of the kitchen on 4/13/14 beginning at 3:20 pm there were dark gray spots on an inside panel of the ice machine. The Manager in Training (MIT) took a paper towel and with one swipe wiped off most of the gray spots.	F 371	3. The measures taken to ensure change in the alleged deficient practice was to re-educate the dietary staff on proper cleaning techniques for all areas and equipment in the department. The systematic changes made were to develop new monitoring tools, Weekly Cleaning Assignments (with Employee Initial Section and Supervisor Signature Section) and the Proper Dating and Labeling Log. The staff has been educated on the use and implementation of the monitoring tools. Any new staff hired will be educated to these forms and their corresponding duties. 4. The Dietary Manager or his designee will monitor labeling and dating seven times per day for the reach-in refrigerator and the walk-in refrigerator / freezer and initial the log for 30 days. Then the Dietary Manager or his designee will monitor labeling and dating for these areas three times per day (after each meal) going forward to ensure compliance. The Weekly Cleaning Assignments job duties will be monitored by the Dietary Manager on a weekly basis to ensure all job duties are completed. The Executive	

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F 371	Continued From page 13 She indicated the ice machine should be cleaned once a month but was unsure when it was last cleaned, who should clean it, or what the gray substance in the ice machine was. During an interview on 4/17/13 at 10:04 am with the Dietary Manager regarding how cleaning of equipment in the kitchen was monitored, the Dietary Manager stated, "They should follow the cleaning assignment schedule. There is nothing that gets signed off showing the cleaning. It used to happen that I would go behind them so they would be accountable, but there is nothing to sign off." He indicated he could not state when the ice machine was last cleaned. An observation and review on 4/17/13 at 10:10 am of the Daily Cleaning Assignments by Position schedule, posted on the bulletin board in the hallway outside the Dietary Manager's office, did not include the ice machine on any days of the month. 3. An observation of the oven, during initial tour of the kitchen on 4/13/14 beginning at 3:20 pm, revealed a greasy, dark brown substance on the inside of the oven doors and covering the racks inside the oven. There was a 1/4" thick, black substance accumulated on the entire floor of the oven. The deep fryer was filled with oil. A tan-colored substance was floating on the surface of the oil and was accumulated around the edge of fryer. An observation of the oven on 4/17/14 at 9:45 am revealed the thick, black substance remained on the floor of the oven. A greasy, dark brown substance remained on the oven doors and racks. The deep fryer was filled with oil and the	F 371	Director will make weekly rounds with the Dietary Manager to ensure overall compliance. The results of the monitoring will be presented to the Quality Assurance / Performance Improvement Committee Meeting on a monthly basis for discussion and review. Any additional training will be provided as needed.	5/2/14

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F 371	Continued From page 14 tan substance remained unchanged from the initial tour observation. During an interview on 4/17/13 at 10:04 am with the Dietary Manager regarding how cleaning of equipment in the kitchen is monitored, the Dietary Manager stated, "They should follow the cleaning assignment schedule. There is nothing that gets signed off showing the cleaning. It used to happen that I would go behind them so they would be accountable, but there is nothing to sign off." Regarding cleaning of the oven, he stated, "You have to scrape the bottom of the oven and take the racks out to clean. The bottom gets dirty because of all the meats and cooking." He indicated he could not state when the floor of the oven or the doors were last cleaned. Regarding the use and cleaning of the fryer, he stated, "On this [month's] menu there is only one thing that gets fried. We do fried fish every 30 days on a Friday. We have to change the oil out before we fry. We clean the fryer before we fry the fish typically. We let the old oil sit in there until we use it next." Upon review of the monthly meal menu, he stated, "We last had fried fish 4 weeks ago as of tomorrow. We will have it again tomorrow. We only have fried fish once a month on Friday." He indicate the oil that was in the fryer had been sitting in the fryer for 27 days, and that it should be changed/emptied according to the cleaning assignment schedule. An observation and review on 4/17/13 at 10:10 am of the Daily Cleaning Assignments by Position schedule, posted on the bulletin board in the hallway outside the Dietary Manager's office, revealed the oven racks were to be cleaned on Thursdays by the [morning] cook and the inside of the oven was to be cleaned on Thursdays by	F 371		

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F 371	Continued From page 15 the [afternoon] cook. "Change oil in fryer" was to be done by the [afternoon] cook on Saturday. During an interview on 4/17/14 at 2:54 pm Cook #1 (afternoon cook) stated, "I am new, about 2 weeks, and have no idea when the oven was cleaned or who is supposed to clean it. Is there a posted schedule for cleaning? I do wipe down the steamer and the stove every day but don't clean it thoroughly like they did today."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. In accordance with State and 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. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	I. The corrective action taken was that the medications were removed and disposed of from the shower room. The white pill was removed and disposed of from the storage closet on 100 Hall. II. The corrective action taken to ensure other residents are not affected by the alleged deficient practice was to have the medication carts and medication rooms assessed for appropriate medication storage by the Director of Clinical Services, DCS, Assistant Director of Clinical Services, ADCS, Unit Manager, UM and Building Supervisor. The shower rooms and storage closets have been inspected finding no other items to be inappropriately placed or stored.	

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F 431	Continued From page 16 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 secure medications in a locked storage area for 2 of 2 medications observed for medication storage. Findings include: 1) On 4/13/2014 at 3:40 PM on initial tour 2 tubes of A & D ointment and 1 tube of 2% Miconazole anti-fungal cream were observed in an unlocked cabinet next to sink in the community shower room at the 300-400 nurse station. The door to the community shower room has a punch code lock but was easily opened without the code. A 2nd observation was made on 04/13/2014 at 8:40 PM of the community shower room at the 300-400 nurse station. The unlocked cabinet next to sink still contained 2 tubes of A & D ointment and 1 tube of 2% Miconazole anti-fungal cream. A 3rd observation was made on 04/14/2014 at 10:10 AM of the community shower room at the 300-400 nurse station. The unlocked cabinet next to sink still contained 2 tubes of A & D ointment and 1 tube of 2% Miconazole anti-fungal cream. A 4th observation at 9:40 AM 4/15/2014 made by two state surveyors of the community shower room at the 300-400 hall nurse station revealed	F 431	III. The measures taken to ensure that the alleged deficient practice will not occur was to provide education to nursing staff by the DCS/ADCS/UM/Supervisor on appropriate storage of medications and disposal of medications. This education will also be extended into our orientation process for new hires. IV. The plan for monitoring compliance will be to have the DCS, ADCS, UM, or Building Supervisor to audit 5 med carts weekly for 1 month, then 5 med carts twice per month for 2 months, then 5 med carts monthly for 3 months. The Maintenance Director or his assistant will audit shower rooms for presence of medicated ointments/shampoos/creams 5 days per week for 1 month, then twice per week for 2	

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F 431	Continued From page 17 the door to the shower room was still easily accessed and the unlocked cabinet next to the sink contained 2 tubes of A&D ointment (lot # hx13037) and one tube of 2% Miconazole antifungal cream (lot # 30425A). On 4/17/2014 at 1:30 PM an observation and interview with the Assistant Director of Nursing (ADON) revealed easy access to the community shower room at the 300-400 nurse station without using the door lock code; the unlocked cabinet next to the sink with a removable lock inside the cabinet; and the medication 2% Miconazole still present. The ADOD identified the Miconazole in the unlocked cabinet and reported that it was to be kept in the locked treatment cart. 2) On 4/13/2014 at 3:40 PM on initial tour an observation was made on the 100 hall. The 100 hall consisted of cognitively intact and cognitively impaired residents; and ambulatory and total dependent residents. At the end of the 100 hall next to resident room 121 was an unlocked storage closet. An observation was made of a medication, identified as a small white round pill, on the floor of the storage closet. A 2nd observation was made on 04/13/2014 at 8:40 PM of the medication, identified as a small white round pill, on the floor of the unlocked storage closet on the 100 hall. A 3rd observation was made on 04/14/2014 at 10:10 AM of the medication, identified as a small white round pill, on the floor of the unlocked storage closet on the 100 hall. An observation and interview on 4/15/2014 at 9:40 AM with Nurse #1 revealed Nurse #1	F 431	months, then once per week for 3 months. The results of the monitoring completed by the DCS and Maintenance Directors will be presented and discussed at the monthly Quality Assurance / Performance Improvement Committee Meeting. Any additional training will be provided as needed	5/2/14

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F 431	Continued From page 18 identified the small white round pill on floor of the storage closet as medication. Her plan was to report a found medication pill to her unit manager.	F 431		