STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HWY 801 SOUTH ADVANCE, NC 27006

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to treat a resident with dignity by turning on the overhead light at night while he was sleeping for 1 of 2 residents reviewed for dignity. (Resident #213). The findings included: Resident #213 was admitted to the facility 12/10/13 with diagnoses which included traumatic fracture. Review of Resident #213's most recent Admission Minimum Data Set dated 12/17/13 assessed him as being cognitively intact. An interview was conducted on 02/10/14 at 2:04 PM with Resident #213 who resided in a room on the facility's 300 hall. He stated that frequently at night staff come into his room while he was asleep to empty his trash can. He stated they turn on the bright overhead light which wakes him up. Resident #213 stated he mentioned to a nursing assistant that this bothered him but it continued to happen. An interview was conducted on 02/12/14 at 3:20 PM with Nurse Aides (NA) #2. NA #2 stated he worked on the 2nd shift on the 300 hall. He stated part of his duties was to remove the trash at the end of his shift. He stated he does turn on	F 241	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F241 Dignity A. Corrective action: Nursing Assistants (NA's), RN's and LPN's were in-serviced on 2/16/14 by the DON and Staff Development Nurse (SDC) on dignity and disturbing residents' sleep when entering the room to empty trash. Resident #213 reports that staff no longer turn the light on when entering his room while he is sleeping. B. Identification of other residents who could be affected by this alleged deficient practice: All residents have the potential to be affected by this practice. C. Systemic Changes: In-services were completed on 2/16/14 by the	

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

John Sayton | Administrator | 3/6/14

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.

DHHR NHCS Received Black Mountain MRO
MAR - 7 2014
by: PAM

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F 241	Continued From page 1 residents' lights when he goes into residents' rooms to empty their trash cans. He stated he usually does this just before the end of his shift at 11:00 PM. An interview was conducted on 02/13/14 at 9:38 AM with Nurse #1, the charge nurse for the 300 hall. Nurse #1 stated she expected NA staff to get all duties done for residents at night before the residents go to sleep. She stated staff should not be turning on lights to empty trash cans in resident rooms. Nurse #1 further stated this should be done before residents go to bed at night. An interview was conducted on 02/13/14 at 10:18 AM with the Director of Nursing (DON). The DON stated she expected the staff to only turn on the light in a resident's room at night if there was an absolute need to. She expected staff to know the need of a good night sleep. She stated she expected staff to use common sense and not disrupt sleep for a resident.	F 241	DON and SDC for NA's, RN's and LPN's full and part time on dignity and disturbing residents' sleep and emptying trash before the resident prepares for sleep. Any in-house staff who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and required in-servicing for new hires. D. Monitoring to Ensure Compliance: Using the Quality Assurance Survey Tool, second shift staff nurses will confirm and sign that rounds are being completed prior to residents preparing for sleep to ensure that residents are undisturbed and that trash is emptied. Third shift staff nurses will verify and sign the QA monitoring tool daily verifying that no resident had their sleep disturbed unnecessarily. The DON, Unit manager, or designee will interview 2 residents to determine if they had their sleep interrupted by staff turning on lights entering their rooms while sleeping. This will be done 5 days a week for 4 weeks then weekly for 2 months using the Survey QA Tool.	
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272		

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F 272	Continued From page 2 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide complete Care Area Assessments which included underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions for comprehensive Minimum Data Set assessments for 8 of 8 residents. (Residents #162, #120, #15, #19, # 133, #15, #3, and #92. The findings included:	F 272	The audit will include review of any interrupted sleep patterns and other identified dignity issues. Any issues will be reported immediately to the DON or Administrator for appropriate action. Compliance will be monitored and the on-going auditing program will be reviewed at the weekly Quality Assurance meeting attended by the DON, Administrator, SDC, Unit Director, Support Nurse, Wound Nurse, MDS Nurse, Social Worker, Dietary Manage and other members as needed. E. Completion date: 2/16/14	2/16/14

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F 272	Continued From page 3 1. Resident #162 was admitted to the facility 10/22/13 with diagnoses which included dementia and osteoarthritis. The admission Minimum Data Set (MDS) dated 10/29/13 indicated the resident experienced memory loss, had poor decision making ability, and required cueing and supervision. The MDS specified the resident required extensive staff assistance for bed mobility, transfers, eating, and toilet use and experienced impaired balance. Falls was one of the care areas that triggered for further staff review. A Care Area Assessment (CAA) dated 10/30/13 and related to falls was reviewed. The Analysis of Findings was documented utilizing a format that listed headings such as "Is this problem/need:" followed by "Potential". The second heading listed "Nature of the problem/condition:" followed by "Rsdt has impaired balance during transitions." The remainder of the Analysis of Findings was in a checklist form with little or no explanation of the issues checked. The CAA did not contain an analysis addressing Resident #162's underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. An interview was conducted with the MDS Coordinator on 02/12/14 at 2:14 PM. She stated she followed the computer program provided by the facility software system which designated the Analysis of Findings as the CAA summary. The MDS Coordinator acknowledged this CAA for Resident #162 was not complete concerning contributing factors related to the potential for falls and did not include an analysis of factors that	F 272	F272 Comprehensive Assessments. A. Corrective action: Residents #'s 162, 120, 115, 19,133,15,3, and 92 Care Area Assessments for MDS Comprehensive assessments dated 10/29/13, 12/20/13, 10/16/13, 11/29/13, 11/20/13, 9/26/13, 12/27/13, and 1/8/14 respectively have been modified to include underlying causes, risk factors and factors that must be considered in developing individualized care plan interventions for the comprehensive Minimum Data Set (MDS) by the MDS Coordinator on 3/6/14. B. Identification of other residents who may be involved with this practice: MDS reviewed the most recent comprehensive assessment for all residents in the facility 3/5/14. 67 residents were determined to have incomplete Care Area Assessments. The Care Area Assessments for these residents are being modified 5 per day to include underlying causes, risk factors and factors that must be considered in developing individualized care plan interventions. C. Systemic Changes: In-servicing was provided on 3/5/14 by the Corporate MDS/Care Plan Nurse	

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F 272	Continued From page 4 must be considered in developing individualized care plan interventions. 2. Resident #120 was admitted to the facility 08/20/13 with diagnoses which included Alzheimer's dementia and personal history of trauma. A significant change Minimum Data Set (MDS) dated 12/20/13 indicated memory loss and impaired cognition. The MDS specified the resident required extensive staff assistance with all care, had an indwelling urinary catheter, and was frequently incontinent of bowels. Urinary incontinence and indwelling catheter was one of the care areas that triggered for further staff review. A Care Area Assessment (CAA) dated 12/23/13 and related to urinary incontinence and indwelling catheter was reviewed. The Analysis of Findings was documented utilizing a format that listed headings such as "Is this problem/need:" followed by "Actual". The second heading listed "Nature of the problem/condition:" followed by "Rsdt is extensive assist with toilet use: has F/C." The remainder of the Analysis of findings was in a checklist form with little or no explanation of the issues checked. The CAA did not contain a summary analysis addressing Resident #120's underlying causes, contributing factors, risk factors, and factors that must be considered in developing individualized care plan interventions. An interview was conducted with the MDS Coordinator on 02/12/14 at 2:14 PM. She stated she followed the computer program provided by the facility software system which designated the Analysis of Findings as the CAA summary. The MDS Coordinator acknowledged the format	F 272	Consultant for the Interdisciplinary Team of MDS Coordinators, Social Services, Dietary Manager and Activities Director on completing comprehensive assessments using the resident assessment instrument specified by the State. Other in-serve topics included completing Care Area Assessments, (Customary, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial wellbeing, physical functioning and structural problems, continence, disease and nutritional status, skin conditions, activity pursuit, medication, special treatments and procedures, discharge potential), documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS) and Documentation of participation in assessment. Any in-house staff member who did not receive in-service training will not be allowed to participate in completing MDS assessments for residents until training has been completed. D. Monitoring: The MDS Coordinator with DON oversight will check five residents using the	

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F 272	Continued From page 5 utilized did not include an analysis of underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. 3. Resident #15 was admitted to the facility 10/09/13 with diagnoses which included after care following joint replacement, congestive heart failure, and pneumonia. An admission Minimum Data Set (MDS) dated 10/16/13 indicated the resident's cognition was intact. The MDS specified the resident required extensive staff assistance with bed mobility, transfers, and toilet use. Activities of daily living (ADL) functional and rehabilitation potential was one of the care areas that triggered for further staff review. A Care Area Assessment (CAA) dated 10/17/13 and related to ADL functional and rehabilitation potential was reviewed. The Analysis of Findings was documented utilizing a format that listed headings such as "Is this problem/need:" followed by "Actual". The second heading listed "Nature of the problem/condition:" followed by "Rsdt is extensive assist with bed mobility, transfers and toilet use." The remainder of the Analysis of findings was in a checklist form with little or no explanation of the issues checked. The CAA did not contain a summary analysis addressing Resident #15's underlying causes, contributing factors, risk factors, and factors that must be considered in developing individualized care plan interventions. An interview was conducted with the MDS Coordinator on 02/12/14 at 2:14 PM. She stated she followed the computer program provided by the facility software system which designated the	F 272	QA Survey Tool that have comprehensive assessments and ensure that the MDS is completed using the resident assessment instrument specified by the State. The MDS Coordinator will also check with DON oversight to make sure that the Care Area Assessments are completed and include underlying causes, risk factors and factors that must be considered in developing individualized care plan interventions for comprehensive care plans. This will be done 5 times a week for 4 weeks and then monthly for 2 months. Identified issues will be reported immediately to the DON or Administrator for appropriate action. Compliance will be monitored and audited on going at the weekly Quality Assurance Meeting attended by the DON, Administrator, Wound nurse, MDS Coordinator, Unit Manger, Support Nurse, Dietary Manager, Social Worker and other members as needed. E. Completion date 3/6/14.	3/6/14

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F 272	Continued From page 6 Analysis of Findings as the CAA summary. The MDS Coordinator acknowledged the format utilized did not include an analysis of underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. 4. Resident #19 was admitted to the facility 11/22/13 with diagnoses which included muscle weakness and Alzheimer's disease. An admission Minimum Data Set (MDS) dated 11/29/13 indicated the resident experienced impaired cognition. The MDS specified the resident required extensive staff assistance with all activities of daily living except dressing which required limited staff assistance. Activities of daily living (ADL) functional and rehabilitation potential was one of the care areas that triggered for further staff review. A Care Area Assessment (CAA) dated 12/03/13 and related to activities of daily living and rehabilitation function was reviewed. The Analysis of Findings was documented utilizing a format that listed headings such as "Is this problem/need:" followed by "Actual". The second heading listed "Nature of the problem/condition:" followed by "Rsdt is extensive assist with bed mobility, transfers and toilet use." The remainder of the Analysis of findings was in a checklist form with little or no explanation of the issues checked. The CAA did not contain an analysis addressing Resident #19's underlying causes, contributing factors, risk factors, and factors that must be considered in developing individualized care plan interventions. An interview was conducted with the MDS Coordinator on 02/12/14 at 2:14 PM. She stated	F 272		

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F 272	Continued From page 7 she followed the computer program provided by the facility software system which designated the Analysis of Findings as the CAA summary. The MDS Coordinator acknowledged the format utilized did not include an analysis of underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. 5. Resident #133 was admitted to the facility on 11/13/13 with diagnoses that included orthopedic aftercare, cerebrovascular disease, hypertension, diabetes mellitus and end stage renal disease. The most recent comprehensive Minimum Data Set (MDS), dated 11/20/13, indicated Resident #133 was assessed as cognitively intact. She required extensive staff assistance to total dependence on staff for most activities of daily living (ADL) and limited assistance with eating. Nutrition was one of the care areas that triggered for further staff review. The nutritional status Care Area Assessment (CAA) summary dated 11/20/13 provided a check list that documented Resident # 133's functional status, decline, and current level of functioning and risk factors that could affect her nutritional needs. Other problems checked on the CAA that could affect Resident #133' s ability to eat included her limitation in range of motion, her inability to perform ADL without physical assistance, her diagnoses of end stage renal disease, diabetes mellitus and her recent surgical procedure. There was little or no explanation of the issues checked. The CAA did not contain an	F 272		

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F 272	Continued From page 8 analysis addressing the nature of Resident #133's condition, complications and risk factors, the presence of causal factors, referrals to any other health professionals and the reasons for a decision to proceed or not to proceed with care planning for nutritional status. An interview was conducted with the MDS Coordinator on 02/12/14 at 2:14 PM. She stated she followed the computer program provided by the facility software system which designated the Analysis of Findings as the CAA summary. The MDS Coordinator acknowledged the format utilized did not include an analysis of underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. 6. Resident #15 was admitted to the facility on 09/19/13 with diagnoses which included lung disease, anxiety, and dementia. A review of Resident #15's admission Minimum Data Set (MDS) dated 09/26/13 indicated Resident #15 was coded by staff as having short and long term memory problems and was cognitively impaired for daily decision making skills. Further review of Resident #15's MDS indicated extensive staff assistance was needed for bed mobility, transfer, toilet use, and personal hygiene. Resident #15 was frequently incontinent of bowel and bladder. One of the care areas that triggered for further staff review for this resident was urinary incontinence. A Care Area Assessment (CAA) dated 09/30/13 related to urinary incontinence was reviewed. The Analysis of Findings was documented	F 272		

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F 272	Continued From page 9 utilizing a format that listed headings such as "Is this problem/need:" followed by "Actual". The second heading listed "Nature of the problem/condition:" followed by "rsdt requires extensive assist with toileting and is frequently incontinent with bladder: dx include demenia, depression, seizure/o, psychosis". The remainder of the Analysis of Findings was in a checklist form with little or no explanation of the issues checked. The CAA did not contain an analysis addressing Resident # 15's underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. An interview was conducted with the MDS Coordinator on 02/12/14 at 2:14 PM. She stated she followed the computer program provided by the facility software system which designated the Analysis of Findings as the CAA summary. The MDS Coordinator acknowledged the format utilized did not include an analysis of underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. 7. Resident #3 was admitted to the facility on 02/18/13 with diagnoses which included depressive disorder, falls and dementia. A review of Resident #3's significant change Minimum Data Set (MDS) dated 12/27/13 indicated Resident #3's cognition was moderately intact for daily decision making skills. The MDS specified extensive staff assistance was needed for bed mobility, transfer assistance, toilet use, and personal hygiene. One of the care areas that triggered for further staff review was psychotropic	F 272		

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F 272	Continued From page 10 drug use. A Care Area Assessment (CAA) dated 12/31/13 in relation to psychotropic drug use was reviewed. The Analysis of Findings was documented utilizing a format that listed headings such as "Is this problem/need:" followed by "Actual". The second heading listed "Nature of the problem/condition:" followed by "Rest has received psychotropic medication during look back; dx include depression. The remainder of the Analysis of Findings was in a checklist form with little or no explanation of the issue checked. The CAA did not contain an analysis addressing Resident #3's underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. An interview was conducted with the MDS Coordinator on 02/12/14 at 2:14 PM. She stated she followed the computer program provided by the facility software system which designated the Analysis of Findings as the CAA summary. The MDS Coordinator acknowledged the format utilized did not include an analysis of underlying causes, risk factors, and factors and must be considered in developing individualized care plan interventions. 8. Resident #92 was admitted to the facility on 05/09/12 with diagnosis which included enlarged prostate, Alzheimer's disease, diabetes and chronic airway obstruction. A review of Resident #92's annual Minimum Data Set (MDS) dated 01/08/14 indicated Resident #92's cognition was moderately impaired for daily decision making skills. Further review of	F 272		

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F 272	Continued From page 11 Resident #92' s MDS specified extensive staff assistance was needed for bed mobility, transfer, toilet use, and personal hygiene. The MDS assessed the resident with an indwelling urinary catheter. One of the care areas that triggered for further staff review for this resident was urinary incontinence and indwelling catheter. A Care Area Assessment (CAA) dated 01/09/14 in relation to urinary incontinence and indwelling cather was reviewed. The Analysis of Findings was documented utilizing a format that listed headings such as "Is this problem/need" followed by "Actual". The second heading listed "Nature of the problem/condition:" followed by "Rest is extensive assist with toilet use and has Foley catheter". The remainder of the Analysis of Findings was in a checklist form with little or no explanation of the issues checked. The CAA did not contain an analysis addressing Resident #92"s underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions. An interview was conducted with the MDS Coordinator on 02/12/14 at 2:14 PM. She stated she followed the computer program provided by the facility software system which designated the Analysis of Findings as the CAA summary. The MDS Coordinator acknowledged the format utilized did not include an analysis of underlying causes, risk factors, and factors that must be considered in developing individual care plan interventions.	F 272		
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

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	345543	A. BUILDING _____ B. WING _____	02/13/2014

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F 280	Continued From page 12 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews the facility failed to notify residents' responsible parties of care plan conferences for 2 of 3 residents whose families were interviewed. (Resident #50 and # 104) The findings included: Resident #50 was admitted to the facility on 12/31/11 with diagnoses which included dysphagia, diabetes, and dementia. Resident #50's most recent Quarterly Minimum Data Set (MDS) assessed her as having short and long term memory loss as well a needing assistance with daily decision making.	F 280	F280 Right to Participate Planning Care – Revise CP. A. Corrective action: Facility has notified residents #50 and #104 responsible parties (RP) of care plan conferences dates and has scheduled care plan conferences to be held on 2/26/14 and 3/12/14 respectively. B. Identification of other residents who may be involved with this practice: MDS reviewed the most recent comprehensive assessment for all residents in the facility on 3/5/14. 19 residents and or residents' RP's were determined to have not been notified about care plan conferences. The MDS Coordinator has notified these residents or residents' RP's of care plan conferences and have scheduled care plan conferences with them to be held weekly beginning 3/5/14. C. Systemic Changes: In-servicing was provided on 3/5/14 by the Corporate MDS Nurse Consultant for the interdisciplinary Team of MDS Coordinators, Social Services, Dietary, Therapy and Activities. Topics included: Residents' right (unless adjudged incompetent or otherwise found to be incapacitated under the laws of	

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F 280	Continued From page 13 A family interview was conducted on 02/11/14 at 10:37 AM with Resident #50's Responsible Party(RP). The RP stated the facility had not notified her of the resident's care plan conferences. She stated when Resident #50 was first admitted to the facility they attended several care plan conferences. An interview was conducted on 02/12/14 at 10:19 AM with the facility's Social Worker (SW). The SW stated her process was to send out invitations to the residents who were alert and oriented and to the families notifying them of when the care plan conference had been scheduled. She stated she had not given a notification to Resident #50's family for the last care plan conference. The SW stated she had gotten behind with scheduling care plan conferences. She stated the care plan meeting had to be initiated based on when the MDS was completed. She stated she had not sent out care plan conference notices to any families or RPs for any resident in the facility since 12/12/12. An interview was conducted on 02/12/14 at 10:19 AM with the MDS Nurse. The MDS Nurse stated she gave the SW a list of residents that have care plan conferences due. She stated the SW was to generate an invitation letter for families, RPs and alert and oriented residents to attend the conference. The MDS Nurse stated she recently noticed no families or residents were attending. She added she put a plan into place last week on 02/07/14 to correct this problem. An interview was conducted on 02/12/14 at 11:08 AM with the Administrator. He stated his expectation was for staff to adhere to the company policy and hold care plan conferences	F 280	the State) to participate in care planning and treatment or changes in care and treatment and also included completing a comprehensive assessment plan within 7 days after the completion of a comprehensive assessment prepared by the interdisciplinary Team and the importance of including the attending physician, a registered nurse with responsibility for the resident and other appropriate staff as determined by the resident's needs and to the extent practical , the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Any interdisciplinary staff member or any in-house staff involved with the completion of comprehensive assessments who did not receive in-servicing will not be allowed to participate in completing comprehensive care plans until in-servicing has been completed. D. Monitoring: The MDS Coordinator will use the QA Survey Monitoring Tool to check five residents that have comprehensive care plans completed within 7 days	

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F 280	Continued From page 14 timely as required to meet the guidelines. He stated care plan conferences should be held every 90 days or upon certain changes in condition. He stated he had just been made aware that morning that families had not received care plan conference invitations since 12/12/12. He stated he had just received the plan that had been written on 02/07/14 to fix this problem but it had not been taken to his Quality Assurance Committee meeting yet. 2. Resident #104 was admitted to the facility 12/05/12 with diagnoses which included dementia, osteoporosis, anxiety, and depression. The latest Quarterly Minimum Data Set (MDS) dated 11/12/13 indicated the resident experienced memory loss and moderately impaired cognition. The MDS specified Resident #104's ability to make decisions was poor and required cues and supervision. An interview was conducted on 02/10/14 at 3:24 PM with a family member listed as Resident #104's Responsible Party (RP). The RP stated he was the person notified when changes occurred in the resident's condition. The RP added he had never received a notice from the facility regarding quarterly care plan conferences nor had he attended any care plan conferences. An interview was conducted on 02/12/14 at 10:19 AM with the facility's Social Worker (SW). The SW stated her process was to send out invitations to the residents who were alert and oriented and to the families notifying them of	F 280	after the completion of a comprehensive assessment and ensure that the residents and or resident's RP's have been notified of care plan conferences and have a care plan conference scheduled. This will be done 5 times a week for 4 weeks then monthly for 2 months. Identified issues will be reported immediately to the DON or Administrator for appropriate action. Compliance will be monitored and audited on going at the weekly Quality Assurance meeting attended by the DON, Administrator, Wound nurse, MDSS Coordinator, Unit Manager, Support Nurse, Dietary Manager, Social Worker and other members as needed. E. Completion date 3/5/14.	3/5/14

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F 280	Continued From page 15 when the care plan conference had been scheduled. The SW stated she had gotten behind with scheduling care plan conferences. She stated the care plan meeting had to be initiated based on when the MDS was completed. She stated she had not sent out care plan conference notices to any families or RPs for any resident in the facility since 12/12/12. An interview was conducted on 02/12/14 at 10:19 AM with the MDS Nurse. The MDS Nurse stated she gave the SW a list of residents that had care plan conferences due. She stated the SW was to generate an invitation letter for families, RPs and alert and oriented residents to attend the conference. The MDS Nurse stated she recently noticed no families or residents were attending. She added she put a plan into place last week on 02/07/14 to correct this problem. An interview was conducted on 02/12/14 at 11:08 AM with the Administrator. He stated his expectation was for staff to adhere to the company policy and hold care plan conferences timely as required to meet the guidelines. He stated care plan conferences should be held every 90 days or upon certain changes in condition. He stated he had just been made aware that morning that families had not received care plan conference invitations since 12/12/12. He stated he had just received the plan that had been written on 02/07/14 to fix this problem but it had not been taken to his Quality Assurance Committee meeting yet. Continued interview with the Social Worker on 02/12/14 at 2:49 PM confirmed Resident #104's RP had never received notice of quarterly care plan conferences since the resident's admission	F 280		

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F 280	Continued From page 16 to the facility.	F 280		
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 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.	F 431	F431 Label and Store Drugs. A. Corrective action: Expired Insulin, Plavix, Levaquin and lanoxin were removed from the the pyxis and medication cart and new medications were ordered from the pharmacy for the residents and the pyxis on 2/13/14. B. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. All med carts and pyxis machine were checked 2/14/14 for expired meds by the DON and Unit Manager with no other medications identified past expired date. C. Systemic Changes: On February 16, 2014 all Nurses LPN's and RN's full and part time were in-serviced by the DON on expired meds. Topics included: checking medications for expiration in the medication carts daily or with use. The pyxis procedure was also reviewed and is as follows: An audit of the pyxis will be conducted monthly by the DON, Unit Manager or designee. Any expired medications will be removed immediately and the pharmacy will be contacted for replacement. Any medication	

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F 431	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to discard expired insulin, Plavix (an anticoagulant), Levaquin (an antibiotic) and Lanoxin (a cardiac medication) from a drug cart and a pixis in 1 of 2 medication storage rooms and 1 of 5 medication carts. The findings included: On 02/13/14 at 10:45 AM 2 vials of Regular insulin available for use, labeled with the open date of 12/21/13 were found in the 100/300 medication cart. An interview was conducted on 02/13/14 at 10:55 AM with Nurse #2. She stated the insulin should have been discarded 30 days after it was opened. During inspection of the main medication room on 02/13/14 at 11:05 AM medications stored in the facility's pixis, available for residents' use if needed was 19 Plavix tablets, 1 bag of Levaquin 500 milligrams/100 milliliters, and 12 Lanoxin tablets all which had expired 01/2014. An interview was conducted on 02/13/14 at 11:19 AM with Nurse #3 who was the charge nurse for the 100 and 300 halls. Nurse #3 explained the process for checking for expired medications in the pixis. She stated because the pixis had a computer the pharmacy should know when the medications expire because they fill it and replace expired medications. She stated she did not know why they had not caught the expired medications. She further reported the nurses who work the floors were to check their medication carts for expired medications and insulins. Nurse #3 stated	F 431	expiring within one month will have replacement requests emailed to the pharmacy. Any in-house staff who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and required in-servicing for new hires. D. Monitoring: The DON, Unit Manager or designee will audit medication carts and the pyxis for expired meds using the QA Survey tool. This will be done 5 days a week for 4 weeks and then weekly for 2 months. Any issues identified will be reported immediately to the DON or Administrator for appropriate action. Compliance will be monitored and audited on-going and reviewed at the weekly Quality Assurance meeting attended by the DON, Administrator, SDC, Unit Manager, Support Nurse, Wound nurse, Social worker, Dietary Manager and other members as needed. E. Completion date: 2/16/14	2/16/14

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F 431	Continued From page 18 the expired insulin vials should have been discarded by the nurse who used the medication cart. An interview was conducted on 02/13/14 at 11:30 AM with the Director of Nursing (DON). The DON stated it was her expectation that there would be no expired medication on the carts. She stated the nurses should discard the expired insulin 30 days after it has been opened. She further stated the pharmacy generally will refill medications in the pixis after they expire.	F 431		