STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & RETIREMENT	**4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106**

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		12/4/14

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

Electronically Signed | 11/29/2014

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 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and observations, the facility failed to post the North Carolina Division of Health Service Regulation Complaint Intake Unit contact information in an appropriate location. The findings included: On 11/3/14 at 12:57 PM an observation was made of the bulletin board located on the second floor opposite of the elevators. The Complaint Intake Unit contact information including the toll free and local phone number and the address was not observed to be posted on the bulletin board. The Complaint Intake Unit contact information was not observed to be conspicuously posted in another location during the initial tour of the facility. An interview was conducted with Nurse #5 on 11/3/14 at 1:03 PM. Nurse #5 stated the Complaint Intake Unit contact information was supposed to be posted on the bulletin board located on the second floor opposite of the elevators. Nurse #5 was unable to locate the Complaint Intake Unit contact information on the bulletin board. An interview was conducted with Administrative Staff #4 on 11/3/14 at 1:04 PM. Administrative Staff #4 stated the Complaint Intake Unit contact information was supposed to be posted on the bulletin board located on the second floor opposite of the elevators. She was unable to	F 156	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 156 1. Corrective action has been accomplished for the alleged deficient practice in regards to the posting of the North Carolina Division of Health Service Regulation Compliant Intake Unit on 11/3/2014, the Social Service Director posted the correct compliant line numbers. 2. All resident have the potential to be affected by this alleged deficiency practice. The residents have been made aware by the Social Services Director of the location of Department of Health and Human Service Compliant hotline. This process began on 11-5-14 and was completed by 12-4-14, will be on-going with all new admissions receiving this information. The location of the posting was reviewed verbally as well as a notice posted in the rooms, additionally resident who were cognitively impaired had family	

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F 156	Continued From page 3 locate the Complaint Intake Unit contact information on the bulletin board. An interview was conducted with Administrative Staff #3 on 11/3/14 at 1:15 PM. Administrative Staff #3 stated he expected the Complaint Intake Unit contact information to be posted on the bulletin board located on the second floor opposite of the elevators. He was unable to locate the Complaint Intake Unit contact information on the bulletin board. An interview was conducted with Resident #34 on 11/6/14 at 11:12 AM. Resident #34 stated she did not know where the Complaint Intake Unit contact information was located in the facility. An interview was conducted with Resident #155 on 11/6/14 at 2:05 PM. Resident #155 stated he did not know where the Complaint Intake Unit contact information was located in the facility. An interview was conducted with Resident #140 on 11/6/14 at 2:08 PM. Resident #140 stated he did not know where the Complaint Intake Unit contact information was located in the facility.	F 156	members informed. Additionally letters were written and mailed to RPs of residents that were cognitively impaired. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Education of accurate posting of the North Carolina Division of Health Service Regulation Compliant Intake Unit to Interdisciplinary team (IDT) by the Director of nursing (DON). Education has been provided to residents and staff of the location of the posting of the number by the Social Service Director and Interdisciplinary team (IDT). Social Service Director will audit for the posting daily Monday- Friday and the Weekend Manger on Saturday and Sundays. Audits will be analyze for patterns/trends daily (M-F) for a period of 3 months the monthly for an additional 3 months. Education began on 11-5-14 and was completed by 12-4-14. New residents will be informed of the information and its posted location at the time of admission sign-in through written letter in the admission packet. New IDT team members will be informed of posting location and information during new hire orientation by the DON and/or the Social Services Director. 4. The DON will report the results of the audits for monitor by Quality Assurance Committee monthly for the next three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	

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F 253	Continued From page 4	F 253		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to clean the air vents in the bath/ shower room, hallway and dining room of the skilled nursing unit (second floor). The findings included: On 11/04/2014 at 10:19AM., an observation of the skilled nursing unit was conducted. Four (4) air vents in the hallway were noted to be covered with a black substance-one air vent by the nursing station had a moderate amount of black substance, one air vent by the dining room/ elevator had a moderate amount of black substance, one air vent by the exit door/ elevator had a small amount of black substance and one air vent in the hallway had a small amount of black substance. Two (2) of two (2) air vents observed in the bath/ shower room was observed to have a moderate amount of black substance. Three (3) of five (5) air vents in the dining room had a moderate amount of black substance on the air vents. On 11/05/2014 at 11:03AM, an observation of the skilled nursing unit was conducted and revealed the air vents in the hallway, bath/ shower room and dining room continued to have a black substance on them.	F 253	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 253 1. Air vents indicated in during the survey, to include 4 air vents in the hallway, 1 air vent by the nurses station, 1 air vent by the Dining Room/elevator, 1 air vent by the exit door/elevator, 1 air vent by the hallway, 2 air vents in the bath/shower, and 3 air vents in the Dining Room have been cleaned, painted, and are replaced as necessary by 11-7-14 to provide and maintain a sanitary, orderly and comfortable interior. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The Environmental Services Director will re-educate housekeeping staff beginning on 11-6-14 and completed by 12-4-14 to clean air vents in order to maintain a sanitary, orderly and	12/4/14

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F 253	Continued From page 5 On 11/6/14 at 8:16AM, housekeeping supervisor #1 stated the housekeepers were responsible for keeping the air vents in the hallways and in all the rooms clean. He stated he expected the housekeeping staff to check and clean any area which included the air vents when they were observed to be dirty. On 11/6/14 at 9:11AM, an observation of the skilled nursing unit was conducted with housekeeping supervisor #1. Black material was observed on four air vents in the hallway, three air vents in the dining room and two air vents in the bath/ shower room. On 11/6/14 at 10:10AM, housekeeping supervisor #2 was observed cleaning the air vent near the nursing station. He sprayed a solution on a cloth and proceeded to wipe the black substance off the vent. He had to reapply the cleaning solution three times before the black material was removed.	F 253	comfortable interior. The Environmental Services Director will randomly inspect facility air vents at a minimum of by-weekly during routine rounding inspections (i.e. supervisory rounds made by the Director of Environmental Services that observes, monitors and enhances performance of Housekeeping staff for quality assurance) to assure compliance, and cleanliness. Audits will be recorded on an vent inspection audit tool for three months, and continue as necessary for an additional 3 months. Any areas of concern will be addressed immediately. 4. The results of the audits will be reported in the monthly Quality Improvement and Performance Improvement meeting by the Environmental Services Director for the next three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the	F 309	Preparation, submission and	12/4/14

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F 309	Continued From page 6 facility failed to monitor temperatures for a resident with an elevated temperature for 1 of 1 resident reviewed for temperature monitoring (Resident #165). The findings included: Resident #165 was admitted to the facility on 7/1/14 with multiple diagnoses including left hip fracture with an open reduction and internal fixation, ischemic heart disease, and an abdominal aortic aneurysm. A review of the Minimum Data Set dated 7/10/14 revealed the resident was assessed for cognitive skills for daily decision making. The resident was assessed as having modified independence with some difficulty in new situations only. A review of the Nursing Admission Intake Form dated 7/1/14 at 6:30 PM was conducted. The review revealed the resident ' s temperature was equal to 100.7 degrees Fahrenheit at the time of admission to the facility. A review of the Nursing Daily Skilled Summary dated 7/2/14 at 4:15 AM revealed the resident ' s temperature was equal to 99.7 degrees Fahrenheit. The note stated " On report patient with elevated temperature, but on tonight temperature was equal to 99.7 degrees Fahrenheit. " A review of the Consultation Report dated 7/2/14 revealed the resident ' s temperature while in the orthopedic physician ' s office was equal to 104.0 degrees Fahrenheit in the right ear and equal to 104.8 degrees Fahrenheit in the left ear. The report stated " At this time it is felt that due to patient ' s temperature she will need to go directly to the emergency department. "	F 309	implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F309 1. Corrective action for resident #165 was not accomplish for the alleged deficiency regarding monitoring elevated temperature. Resident was discharged from the facility on 07-02-2014 prior to survey on 11-10-2014. Due to this, unable to accomplish corrective action at that time. 2. Any Resident with elevated temperature have the potential to be affected by the same alleged deficiency. Vital sign forms and nursing daily summary sheets have been audited by the ADON/ UC to identify other pending resident with elevated temperatures. 3. The following measures have been put in to place to ensure that the alleged deficiency will not recur: Education of the IDT to include the ADON, Unit Manager, Unit Coordinator and full time licensed nurses by the DON regarding identification, communication, and follow up of change in condition was completed on 12/2/14 and 12/3/14. Any new member of the IDT hired after 12/3/14 will be oriented of this process by the DON or ADON in the future during orientation and on-boarding. All PRN licensed nurse will	

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F 309	Continued From page 7 An interview was conducted with Administrative Staff #1 on 11/6/14 at 7:59 AM. Administrative Staff #1 stated the nursing staff was expected to monitor the temperature of all residents twice a day. The temperatures were expected to be monitored before 10:00 AM and around 9:00 PM daily. An interview was conducted with Nurse #6 on 11/6/14 at 8:30 AM. Nurse #6 stated the resident ' s temperature was equal to 99.7 degrees Fahrenheit on 7/2/14 at 4:15 AM. She also stated she did not monitor the resident ' s temperature again during her shift. An interview was conducted with Nurse #3 on 11/6/14 at 9:54 AM. Nurse #3 stated she was the nurse assigned to care for the named resident during the day shift on 7/2/14. Nurse #3 stated she could not recall if she monitored the resident ' s temperature on the morning of 7/2/14 before she left for her physician ' s appointment. She stated the resident ' s orthopedic appointment was scheduled at 9:30 AM on 7/2/14.	F 309	be oriented of this process prior to returning to work. The education will include the clarified process which is as follows: The nurse will notify the MD of any changes in condition by phone, and by written notification in MD book, and completion of an SBAR form. Notification will also be made to the RP of the resident status. The nurse will continue to monitor the resident for the effectiveness of treatment by re-evaluating and notify MD by phone if treatment is not effective. The nurse will obtain additional orders if needed. Acute documentation will continue until resolved. The ADON, UM, UC, or lead nurse will evaluate daily nurses notes and vital sign book to verify resident condition. 4. Monitoring of all vital signs forms book will be review in clinical meeting daily (M-F), by the DON, ADON, UC UM or lead nurse. Saturday and Sunday vital signs will be evaluated by the lead nurse. The Audit tool used to evaluate any abnormal vital signs will be done daily time three months. The DON will report the results of the review in the Monthly Quality Assurance and Performance Improvement meeting for the next three months. The committee will evaluate and make further recommendations as indicated. Date of compliance 12/4/14	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		12/4/14

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F 314	Continued From page 8 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to assess and treat pressure ulcers for 1 of 2 residents (Resident # 157). The findings included: Resident #157 was admitted on 10/22/14 with diagnoses including chronic kidney disease, congestive heart failure and diabetes mellitus. The North Carolina Level of Care Screening Tool dated 10/22/14 revealed " Pressure Ulcer 10/13/14 buttocks inner unstageable blistered, mepilex border dressing - change every 3 days and as needed. " Review of the Nursing Admission Intake Form dated 10/22/14 revealed " open area to coccyx 1.8 cm (centimeters) x 2.5 cm. Surrounding skin pink. Dark area to left heel noted 2.5 x 2.5 " . Review of the Admission Orders dated 10/22/14 revealed no orders for pressure ulcer treatment. Review of the Head to Toe Skin Checks form revealed a documented skin check for 10/22/14, the resident ' s admission date, there were no further skin checks documented. The 10/22/14 skin check indicated that Resident #157 had an open area to her coccyx and a black area to her left heel. Review of the Interim Care Plan, undated, revealed a Pressure Ulcer Problem area. Interventions included: provide wound care per	F 314	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 314 1. Corrective action for resident #157 was not accomplished for the alleged deficient practice in regards to treatment/ prevention/healed pressure sores. Resident was in the facility on 11-05-2014 during survey. On 11-05-2014 head to toe assessment was completed by the staff nurse and documentation of skin assessment on the daily nursing summary. Resident was evaluated by MD on 11-05-2014 with orders for heel protectors to bilateral heels while in bed. On 11-08-2014 re-eval was done by the MD with orders for betadine to bilateral heel blisters. Resident was discharged to the hospital on 11-10-2014.	

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F 314	Continued From page 9 order, observe wound healing, skin checks weekly per facility protocol. The Physician facility Readmission Progress Note dated 10/27/14 revealed " stage II (2) sacral " however a plan of care for this wound was not indicated. The Physician ' s Telephone Orders dated 11/2/14 and the Treatment Record dated 10/22/14 revealed " open area to sacrum - clean with NS (normal saline) apply TAO (triple antibiotic) cover w (with) dry dreg (dressing) daily. " " Lt (left) heel necrotic area - skin prep BID (twice a day). " On 11/5/14 at 11:30 AM Nurse #1 and the MDS Coordinator were observed when providing care to the resident ' s necrotic area on her left heel. According to the measurements taken by Nurse #1 and the MDS Coordinator, the wound measured 2 x 1.5 cm. Nurse #1 applied skin prep to this wound. She also applied skinprep to a previously undocumented fluid filled blister with dark coloration, on the resident ' s left lateral heel. This area measured 3.5 x 5 cm. The MDS Coordinator removed the sock on the resident ' s right foot and discovered a new pressure ulcer on Resident #157 ' s right heel. The MDS Coordinator stated to Nurse # 1 that they would not treat this area yet but would inform the physician and obtain a treatment order. This area was not measured by Nurse #1 or the MDS Coordinator. The MDS Coordinator and Nurse #1 also proceeded to provide treatment to the resident ' s sacral ulcer but it had healed. There was no wound and no dressing present. On 11/5/14 at 3:16 PM Nurse #1 was interviewed. She was asked when the weekly skin assessment was due for Resident #157 and after looking this up stated that it was due on Wednesdays. After reviewing the Head to Toe Skin Checks form Nurse #1 acknowledged that it	F 314	2. Any resident with pressure ulcers have the potential to be effective by the same alleged deficiency. The Unit Coordinator will identify current resident with pressure ulcers, verify current assessment and review physician orders to ensure appropriate treatment and preventive measures are in place by 12-4-14. 3. Measure to be put in place to ensure that the alleged practice does not recur include re-education for IDT, ADON, Unit Manager, Unit Coordinator full time licensed nurses regarding assessment, treatment, prevention and documentation related to residents with pressure ulcers by 12-4-14. The Unit Coordinator / Treatment nurse will review current residents and new admissions with pressure ulcers weekly for 12 weeks to verify appropriate assessment, treatment, implementation of preventative measures, and documentation of pressure ulcers have been completed on a daily basis. During the Clinical meeting the DON, ADON, UM, Unit Coordinator, Treatment Nurse will review all new admissions, to identify residents admitted with pressure ulcers or newly acquired pressure ulcers and verify assessment, treatment, prevention and documentation of pressure ulcer daily in AM clinical meeting. The treatment nurse will monitor weekly that daily skin assessments have been completed by the licensed staff nurse. Measurements of all pressure ulcers will be done every Tuesday by the treatment nurse with documentation in nurses note of pressure area noted and logged on the	

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F 314	Continued From page 10 had not been completed the previous week but also indicated that she would be completing the skin check due on 11/5/14 later in her shift. Nurse #1 was unable to locate a weekly wound assessment for the previous week. When asked who was responsible for completing the wound assessment she indicated that both the wound doctor and the nurse were responsible but she was uncertain of the systems in place to ensure wound assessment occurred weekly. On 11/6/14 at 1:30 PM during interview with the Administrative Staff #1 she stated that the wound doctor does the weekly wound assessment, however the wound doctor did not see the resident the previous week. At this time Administrative Staff #1 was informed that although the resident had two pressure ulcers on admission on 10/22/14, there were no treatment orders until 11/2/14 and treatments were not initiated on the Treatment Record until 11/2/14 as well. Administrative Staff #1 indicated that she had not been aware of this but would look for documentation of wound treatment from 10/22/14 - 11/2/14 however no further documentation was provided. Administrative Staff #1 indicated she did not know why the treatment had not been initiated or why the wound doctor had not seen the resident in the previous week but indicated that treatment should have been initiated on admission and wounds should be assessed weekly.	F 314	Weekly Pressure Ulcer QA&A log. The treatment nurse and wound doctor will do rounds on residents in the building with pressure ulcers every Tuesday. 4. The Pressure Ulcer Audit tool will be completed on a weekly basis by the Unit Coordinator and reviewed weekly by the DON and ADON weekly times three months. The DON will report the results of her reviews and monitoring to the Quality Assurance and Performance Improvement Committee monthly for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		11/14/14

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F 323	Continued From page 11 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain water temperatures within acceptable ranges in 2 (rooms #200 and #201) of 7 resident rooms and in the central bathroom. Findings included: Review of the facility policy, undated, revealed that the water temperatures for resident rooms should be maintained between 105 degrees and 115 degrees or as specified by state requirements. The water temperatures in the resident rooms were to be checked at the end of each wing on a rotating basis and all common areas were to be checked but, no frequency was identified. Observation on 11/4/14 at 10:50 AM revealed the water temperature in room #203 coming from the sink felt too hot. Could not leave hand under running hot water for more than 5 seconds after the water heated up. Observation on 11/4/14 at 11:20 AM revealed the central bath room, on 200 hall, sink and bathtub water coming from the faucet felt very hot and the bathtub faucet fill light emitting diode (LED) temperature reading was 119 degrees. The LED thermometer located on the bathtub is a digital light which displays the temperature of the water coming from the bathtub faucet. Observation on11/4/14 at 11:35 AM accompanied by the Maintenance Manager revealed the facility	F 323	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 323 1. The residents in rooms 200 and 201 were moved to other rooms in the facility and the water that services these two room was turned off. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The Maintenance Director adjusted the water temperature at the mixing valve on 11/4/14, and immediately accomplished corrective action for the alleged deficient practice. Observation by surveyor at 9:38 am on 11/5/14 confirmed temps were between 102 degrees to 114 degrees at that time. The Director of Facility Engineering arrived on site shortly after and began diagnosis of the system to determine if there were water fluctuations in the system. During analysis it was determined that the mixing valve was functioning properly. The	

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F 323	Continued From page 12 hand held thermometer was calibrated at 32 degrees. The Maintenance Manager and surveyors checked the facet water temperatures in the sinks using the calibrated thermometer and the following results were obtained: Room Degrees #200 120 #201 122 The central bath room, on 200 hall, bathtub fill temperature was measured at 108 degrees and the LED tub fill temperature light reading was found to be the same as the hand held thermometer. Interview on 11/4/14 at 11:40 AM with the Maintenance Manager revealed they flushed the system once or twice a month. The pump was changed in July of 2013 and he stated that he thinks the mixing valve is not mixing the cold with the hot water fast enough. Interview on 11/4/14 at 12:30 PM with the Administrator revealed that he was not aware that the water temperature was too hot in some rooms, nor was he aware of the various water temperature changes. The Administrator reported that he would move residents out of rooms #200 and #201 because the water was too hot in those rooms. He also reported that he would take steps for a long-term solution. Observation on 11/4/14 at 2:30 PM revealed residents had been moved out of rooms #200 and #201. Observation on 11/4/14 at 5:20 PM with the Maintenance Manager revealed that the water	F 323	Maintenance Director then adjusted a valve located near the circulating pump to improve circulation. Temps immediately stabilized, with temps of 112 degrees in room 201 and 109 degrees in 217, showing an even flow of water the full length of the hall. With further testing it was determined the high temp limiting solenoid was not working adequately and rebuild kit was immediately ordered and upon arrival, plumbing contractor rebuilt solenoid and adjusted high temperature limit to 115 degrees on 11/7/14. Temps were then monitored at noted areas and random rooms several times daily throughout the week. Upon revisit by Director of Facility Engineering on 11/14/14, a spare mixing valve was brought to building and old mixing valve was pulled, checked for debris, and rebuilt at that time for continued reliability. Temps were again monitored and adjusted as needed. The Maintenance Director will continue to complete daily spot checks and record findings on a water temp monitoring tool (Monday-Friday) of noted areas and at least 2 other rooms daily. The shower area will be monitored on M, W, and F and be recorded on the water temp monitoring tool. On an on-going basis water temps will be monitored and recorded on a water temp monitoring tool at a minimum of bi-weekly to assure continued compliance to include shower rooms. Should any water temp be found to be out of compliance, residents who may be in effective areas will be assisted to non-effected areas of accommodations,	

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F 323	Continued From page 13 temperature coming from the sink in room #202, per his thermometer, was at 116 degrees. Interview on 11/05/14 at 9:38 AM with the Maintenance Manager revealed the water temperatures in rooms #200, #201 and the 200 hall central bath were all within 102 degrees to 114 degrees. The Maintenance Manager also reported that the Director over Maintenance, who was an engineer, was coming today to discuss the water temperatures and how to maintain correct temperatures with in the appropriate range according to the regulations. Review of the facility Water Temperature Logs dated for the month of July, August, September and October revealed that 200 hall resident room water temperatures were randomly checked on 2 to 3 days each week and ranged from 103 degrees to 114 degrees. The 200 hall central bath water temperature was checked weekly and revealed that the water temperature was maintained at 108 degrees.	F 323	the water hot water servicing that area will be turned off at the closest water supply valve, and the necessary service will be performed to correct the observed issue through further evaluation be the Maintenance Director, Director of Facility Engineer, and any needed professional plumber service as required. 4. The Director of Maintenance will report findings to the Administrator who will record finding to the Quality Assurance and Performance Improvement Committee monthly for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 11/14/14	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		12/4/14

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F 329	Continued From page 14 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor the basic metabolic panel (BMP) due to low Potassium (K+) level as ordered, failed to monitor the blood pressure prior to administering the blood pressure medication as ordered and failed to have adequate indication for the use of the antipsychotic medication and failed to monitor the behavior of residents on psychotropic medications for 4 of 5 sampled residents reviewed for unnecessary medications (Residents # 26, # 74, #162 & #151). The findings included: 1a. Resident #26 was originally admitted to the facility on 7/29/14 and was readmitted on 9/10/14 with multiple diagnoses including Congestive Heart Failure (CHF). The current physician's orders revealed that the resident was on Lasix (a diuretic) 20 milligrams (mgs) 4 times a week for CHF.	F 329	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 329 1. Corrective action for residents #26, #74, #162 and # 151 was not accomplished for the alleged deficient practice. Resident #26 with K+ level of 2.6 and the monitoring of blood pressure prior to administering Toprol XL, resident #74, #162 and #151 in regards to anti-psychotropic medication. Resident #74, #151, #162 were in the facility on the	

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F 329	Continued From page 15 Review of the laboratory reports revealed that on 10/15/14, the K+ level was low 2.6 (normal level 3.6 - 5.1). The physician was informed and ordered to administer Potassium Chloride (KCL) 40 milliequivalent (meq) by mouth now and to repeat the dose in 6 hours and to recheck BMP on Friday (10/17/14). Review of the laboratory results revealed that there was no BMP result for 10/17/14. On 11/5/14 at 4:06 PM, Nurse #2 was interviewed. She stated that she had called the laboratory and there was no BMP done for Resident #26 on 10/17/14. She indicated that the nurse who wrote the order should have entered the ordered laboratory (BMP) in the book and the night nurse to fill out the laboratory request. She added that the ordered laboratory was not entered in the book and so there was no request available. On 11/5/14 at 4:30 PM, the attending physician was interviewed. She stated that a stat BMP needed to be done. 1b. Resident #26 was originally admitted to the facility on 7/29/14 and was readmitted on 9/10/14 with multiple diagnoses including Hypertension. The physician's progress notes were reviewed. On 9/11/14, the notes revealed that Resident #26's blood pressure can be marginal at times. An order was written " if systolic blood pressure (SBP) is 100-110 give 25 mgs of Toprol XL instead of 50 mgs and if systolic blood pressure is less than 100 hold the Toprol. "	F 329	date of survey. Monitoring Behavioral Tool was not in place at that time. All Licensed nurses will be re-educated on Behavioral Monitoring Tool by 12- 04-2014 by the Director of Nursing. Resident #162 was discharged home on 11-20-2014. Resident #151 was discharged to ALF on 11-14-2014. Resident # 26 was in the facility on the date of survey. She was on Lasix and Potassium and on 10-15-14, the facility failed to administer Potassium and obtain a BMP. On 11-05-2014 a STAT BMP was obtained and reviewed by the MD with no new orders. Licensed nurses will be re-educated on following MD orders for monitoring of BP before administering hypertensive medication if ordered by the DON. Resident # 26 has been discharged to ALF on 11-04-2014. 2. All Resident with abnormal lab value, and who receive anti-psychotropic medication have the potential to be affected by this alleged deficient practice. 3. The DON, ADON, or Unit Manager will re-educate full-time licensed nurses on the requirements for laboratory monitoring, anti-psychotropic medication effectiveness and behavioral monitoring tool by 12/4/14. New Hire licensed nurse after 12/4/14 will be educated on this process by the ADON and Unit Manager of this process on orientation day and while orienting as staff nurse on the unit by the Unit Manager, Unit Coordinator, or Lead Nurse. PRN licensed nurses will be oriented prior to them working on the floor of the process by the DON, ADON or Unit Manager. The Unit Manager will audit	

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F 329	Continued From page 16 On 9/11/14, there was a telephone order to " check blood pressure before Toprol XL. If SBP is 100-110 give 25 mgs of Toprol XL instead of 50 mgs and if SBP is less than 100 hold Toprol XL. " The Medication Administration Records (MARs) were reviewed. The MAR for September, 2014 revealed that the blood pressure was not checked consistently prior to administering Toprol XL. Toprol XL 50 mgs was administered daily and there were only three blood pressure readings documented from September 11-30, 2014, on 9/13/14 (130/80), 9/20/14 (107/61) and 9/21/14 (140/112). The MARs for October, 2014 revealed that Toprol XL 50 mgs was administered daily and there was no blood pressure reading documented the entire month. On 11/5/14 at 4:50 PM, administrative staff #1 was interviewed. She stated that it was an error, nurses should have been checking the blood pressure prior to administering the Toprol and had to follow the doctor's order. On 11/5/14 at 5:00 PM, Nurse #3 was interviewed. She stated that she didn't transcribe the order correctly to the MAR. She should have discontinued the Toprol 50 mgs and write the new order. 2. Resident #74 was admitted to the facility on 10/1/14 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 10/8/14 indicated that Resident #74 had severe cognitive impairment and was on antipsychotic medication.	F 329	carbon copies of physician orders daily at clinical meeting to verify labs was obtain and results received by physician and treatment render as ordered. Unit Coordinator will be monitoring behavioral monitoring tool weekly to verify that anti-psychotropic medication is indicated, and that outcomes of its use is properly recorded. UC monitoring audit will include, residents name, diagnosis, completed Behavior Monitoring tool, last dose reduction, last Dr. visit, any noted recent behaviors, and RP notification. 4. The results of the monitoring will be reported monthly in the QAPI meeting by the DON X 3 months. The committee will evaluate and make further recommendation as indicated. Date of compliance 12/4/14.	

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The care plan dated 10/14/14 indicated that Resident #74 required administration of psychotropic medication and the goal was for the resident to receive the medication at smallest dosage that continues to be effective through the next review date. The approaches included to observe for medication effectiveness and document via flow checklist.

The current physician's orders were reviewed. The orders included Seroquel (an antipsychotic drug) 12.5 mgs 1 tablet by mouth at bedtime as needed (PRN) for agitation.

Review of the MARs (October and November, 2014) was conducted. The MARs indicated that Resident #74 had received Seroquel 12.5 mgs on October 5, 7, 8, 20, 30 and November 2, 2014. There was no documentation on the MARs, nurse's notes or behavior monitoring form the reason and effectiveness on the dates Seroquel was administered to the resident.

On 11/4/14 at 11:15 AM and 3:30 PM, Resident #74 was observed. She had no behavior problem noted.

On 11/5/14 at 11:33 AM, Administrative staff #2 was interviewed. She stated that the indication for the use of the Seroquel was agitation and Resident #74 exhibited behaviors like yelling and screaming. Administrative staff #2 also added that nurses should document the reason and effectiveness when giving the PRN Seroquel.

11/5/14 at 2:50 PM, Nurse # 3 was interviewed. She stated that when giving PRN medication, it should be documented at the back of the MAR or

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in the nurse's notes the reason and the effectiveness of the medication.

On 11/6/14 at 9:30 AM, the pharmacist was interviewed. She stated that she had reviewed the chart and could not find documentation as to why PRN Seroquel was administered on those dates. She also stated that she would recommend to the physician to discontinue the use of the PRN Seroquel.

3. Resident # 162 was admitted to the facility on 10/27/14 with the following cumulative diagnoses: depressive disorder, anxiety, hypertension and joint knee replacement. She had not resided long enough to have an Admission Minimum Data Set (MDS) assessment yet, however, a cognitive assessment performed on 11/3/14 found her to be cognitively intact.
The October and November, 2014 Medication Administration Records (MAR) were examined and revealed that Resident #162 was prescribed Cymbalta 30 milligram (mg) mornings and 60 mg at bedtime, for depression, Ambien 10 mg, as needed (prn) at night for sleep as well as Xanax 0.5 mg at night for anxiety.
An AIMS (Abnormal Voluntary Movement Scale) test had been completed on 10/29/14 and there were no concerns noted.
The MAR indicated that Ambien was given between 10/28-10/31/14 and 11/3-11/4/14. The MAR reflected that nurses did not document the reason for use, or the result/response to treatment. The nurse's notes for the days in question were reviewed and did not yield explanations for Ambien use.
Further, the nurse's notes did not reflect behavioral monitoring for the administration of Xanax.

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An interview was conducted with Administrative Staff #1 on 11/5/14 at 4:20 pm. She stated that the nursing staff was expected to document information on the behavioral monitoring sheet every shift.
On 11/6/14 at 2:50 pm, Nurse #2 was interviewed. She said that prn meds are documented on the back of the MAR or in the nurse ' s notes and it should mention if it was effective or not.
4. Resident #151 was admitted to the facility on 10/27/14 with multiple diagnoses including alcohol poisoning, depression and a history of a cerebral vascular accident.

A review of the Interim Plan of Care dated 10/27/14 revealed the resident was at risk for falls related to the use of psychotropic medications. The interventions included to observe for potential medication related causes.

A review of the physician ' s orders revealed an order dated 10/27/14 which stated " Xanax 0.5 milligrams by mouth every 8 hours as needed for anxiety. "

Resident #151 was observed on 11/3/14 at 4:46 PM. No adverse behaviors were identified.

A review of the Nurses ' Notes revealed a noted dated 11/3/14 at 5:16 PM which stated " Patient increased noted shaking. Blood Sugar=118. Vital Signs with in normal limits. MD informed. Anxiety med given. Decreased shaking noted after med given. "

A review of the Behavior Monitoring Form-Anti-Psychotic Medications for the months of October 2014 and November 2014 was

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F 329	Continued From page 20 conducted. A diagnosis of " agitation " and a target behavior of " verbally abusive " were documented. Xanax was documented as the medication resulting in the need to monitor behaviors for resident #151. The form stated " For each shift, chart the number of episodes (target behavior occurrences). " There was no behavior monitoring information documented on the Behavior Monitoring Form for the months of October 2014 and November 2014. An interview was conducted with Nurse #1 on 11/5/14 at 2:34 PM. Nurse #1 stated she was the nurse assigned to care for resident #151 on 11/5/14. Nurse #1 reviewed the Behavior Monitoring Form for the month of November 2014 and stated no information had been documented on the form. An interview was conducted with Administrative Staff #1 on 11/5/14 at 4:20 PM. Administrative staff #1 stated the nursing staff was expected to document information on the behavior monitoring sheet every shift.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate at 5% or below by not following the doctor's orders. There were 3 errors	F 332	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions	12/4/14

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F 332	Continued From page 21 of 25 opportunities for error resulting in a 12% error rate (Residents #157 & #149). Findings included: 1a. Resident #157 was admitted on 10/22/14 with multiple diagnoses including Atrial Fibrillation. The current physician's orders revealed that Resident #157 was on Digoxin (antiarrhythmic drug) 0.125 milligrams (mgs) by mouth 3 times a week (Monday, Wednesday and Friday) for Atrial Fibrillation. The Digoxin was scheduled to be given at 8:00 AM. On 11/5/14 at 8:08 AM, Nurse # 1 was observed during the medication pass. Nurse #3 was observed to prepare and to administer the medications by mouth to Resident #157. Nurse #1 was not observed to prepare and to administer the Digoxin 0.125 mgs. tablet. The MARs for October and November, 2014 were reviewed. There were 6 nurse's initials on the MARs including 11/5/14, indicating that the Digoxin was administered 6 times to the resident. The Digoxin medication card revealed that only 4 tablets were taken and one tablet was borrowed from the emergency box. The count revealed that the Digoxin medication card had one extra tablet. On 11/5/14 at 8:45 AM, Nurse #1 was interviewed. She looked at the Digoxin card, pulled one tablet and administered it to Resident #157. She didn't provide an explanation as to why she missed to administer the Digoxin. 1b. Resident #157 was admitted on 10/22/14 with	F 332	set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 332 1. Corrective action for resident #157 & #149 was not accomplished for the alleged deficient practice. Resident #157 in regards to missing medication dosage and administration of incorrect medication and resident #149 administered the incorrect dosage. Resident # 157 and # 149 were in the facility at the time of survey. Both residents were discharged on 11-10-2014. Resident #157's licensed nurse #1 was educated on the difference of MVI with minerals and plain MVI, and the cart was restocked with MVI on 11-05-2014. A medication Variance form was completed for the administration of the MVI with Minerals and the omission of Digoxin on 11-05-2014 and the resident, RP, and MD was informed. Resident # 149 was administered the Haldol 2mg on 11-05-2014. On 11-05-2014 DON notified pharmacy of the error. Nurse #3 filled out a medication variance form and notification to Resident, RP and MD notified by nurse #1 and nurse #2 on 11/05/14. Education was done by nurse #1 and nurse #2 by the DON and pharmacist in-service was completed on 11/13/14. 2. Any resident receiving medications have the potential to be effected by this	

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F 332	Continued From page 22 multiple diagnoses including Atrial Fibrillation. The current physician's order's revealed that Resident #157 was on Multivitamin 1 tablet by mouth daily for supplement. The Multivitamin was scheduled to be given at 8:00 AM. On 11/5/14 at 8:08 AM, Nurse # 1 was observed during the medication pass. Nurse #3 was observed to prepare and to administer the medications by mouth to Resident #157 including Multivitamin with minerals 1 tablet. On 11/5/14 at 8:45 AM, Nurse #1 was interviewed. She stated that the facility had no stock for plain Multivitamins and therefore she had been giving the one with minerals. On 11/5/14 at 11:50 AM, administrative staff #2 was interviewed. She stated that the nurse had administered the wrong Multivitamin. She added that the plain Multivitamins was available and the nurse didn't know it. 2. Resident #149 was admitted on 10/9/14 with multiple diagnosis including delusional disorder. Record review revealed that Resident #149 was taking Haldol for the delusional disorder and the current medication order dated 10/9/14 revealed the Haldol order was for 1 milligram (mg) by mouth once a day. Observation on 11/5/14 at 8:20 AM revealed that Nurse #3 administered Haldol 2 mg by mouth to resident #149. Review of Resident #149 s Medication Administration Record (MAR) revealed that the MAR orders were typed printed from the	F 332	alleged deficient practice. 3. DON will re-educate full-time licensed nurses on the five right of medication administration according to the physician orders to be completed by 12-3-14. The Pharmacist will re-educate full-time licensed nurses on medication administration 11/13/14. All new hire licensed nurse after 12/4/14 will be educated at orientation and while receiving on boarding training on unit by DON, ADON or Unit Manager. The DON, ADON,or Unit Manager will perform 5 random observations of medication administration over all shifts and on weekends weekly for 12 weeks to verify accurate medication administration. Observation of medication pass will include administration of digoxin, vitamins and psychotropic meds. These audits will be documented on the monitoring tool. Opportunities will be corrected daily as identified during these observations. 4. The results of the audit will be reported by the DON monthly in Quality Assurance and Performance Improvement Committee for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	

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F 332	Continued From page 23 pharmacy and the Haldol dosage was indicated as 2 mg every day. Review of the medication package containing Resident #149's Haldol revealed the medication dosage and administration instructions on the label were for Haldol 2 mg by mouth every day. It was further verified by Nurse #3 that the tablets inside the medication pack was Haldol 2 mg tablets. Interview on 11/5/14 at 9:00 AM with Nurse #3 revealed that Nurse #3 administered Haldol 2 mg by mouth according to the instructions on the MAR. Interview on 11/5/14 at 9:59 AM with Administrative Staff #1 revealed that the order was supposed to be for Haldol 1 mg instead of Haldol 2 mg and the expectation was for the new monthly MARs to be reconciled correctly.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to administer the Digoxin (antiarrhythmic drug) and Haldol (antipsychotic drug) as ordered by the physician for 2 (Residents #157 & #149) of 5 residents observed during the medication pass. Findings included:	F 333	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable	12/4/14

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F 333	Continued From page 24 1. Resident #157 was admitted on 10/22/14 with multiple diagnoses including Atrial Fibrillation. The current physician's orders revealed that Resident #157 was on Digoxin 0.125 milligrams (mgs) by mouth 3 times a week (Monday, Wednesday and Friday) for Atrial Fibrillation. Digoxin requires the resident to be titrated to a specific blood level. The Digoxin was scheduled to be given at 8:00 AM. On 11/5/14 at 8:08 AM, Nurse # 1 was observed during the medication pass. Nurse #3 was observed to prepare and to administer the medications by mouth to Resident #157. Nurse #1 was not observed to prepare and to administer the Digoxin 0.125 mgs. tablet. The MARs for October and November, 2014 were reviewed. There were 6 nurse's initials on the MARs including 11/5/14, indicating that the Digoxin was administered 6 times to the resident. The Digoxin medication card revealed that only 4 tablets were taken. Interview with the administrative staff #2 on 11/5/14 at 11:50 AM revealed that one tablet of Digoxin 0.125 mgs was borrowed from the emergency kit on 10/24/14. The count revealed that the Digoxin medication card had one extra tablet. On 11/5/14 at 8:45 AM, Nurse #1 was interviewed. She looked at the Digoxin card, pulled one tablet and administered it to Resident #157. Nurse #1 didn't provide an explanation as to why she missed to administer the Digoxin.	F 333	state and federal regulatory requirements. F 333 1. Corrective action for resident #157 & #149 was not accomplished for the alleged deficient practice. Resident #157 in regards to missing medication dosage and administration of incorrect medication and resident #149 administered the incorrect dosage. Resident # 157 and # 149 were in the facility at the time of survey. Both residents were discharged on 11- 10-2014. Resident #157's licensed nurse #1 was educated on the difference of MVI with minerals and plain MVI, and the cart was restocked with MVI on 11-05-2014. A medication Variance form was completed for the administration of the MVI with Minerals and the omission of Digoxin on 11-05-2014 and the resident, RP, and MD was informed. Resident # 149 was administered the Haldol 2mg on 11-05-2014. On 11-05-2014 DON notified pharmacy of the error. Nurse #3 filled out a medication variance form. Resident, RP and MD notified by nurse#1 on 11/5/14. Education of nurse #1 and nurse #2 was done on 12/2/14 and 12/3/14 by DON. 2. Any residents receiving medication have the potential to be effected by this alleged deficient practice. 3. DON and Pharmacist will re-educate full-time licensed nurses on the five right of medication administration according to the physician orders by 12/4/14. All new hire licensed nurse after 12/4/14 will be educated at orientation and while	

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F 333	Continued From page 25 2. Resident #149 was admitted on 10/9/14 with multiple diagnosis including delusional disorder. Record review revealed that Resident #149 was taking Haldol for the delusional disorder and the current medication order dated 10/9/14 revealed the Haldol order was for 1 milligram (mg) by mouth once a day. Observation on 11/5/14 at 8:20 AM revealed that Nurse #3 administered Haldol 2 mg by mouth to Resident #149. Review of Resident #149's Medication Administration Record (MAR) revealed that the MAR orders were typed printed from the pharmacy and the Haldol dosage was indicated as 2 mg every day. Review of the medication package containing Resident #149's Haldol revealed the medication dosage and administration instructions on the label were for Haldol 2 mg by mouth every day. It was further verified by Nurse #3 that the tablets inside the medication pack was Haldol 2 mg tablets. Interview on 11/5/14 at 9:00 AM with Nurse #3 revealed that Nurse #3 administered Haldol 2 mg by mouth according to the instructions on the MAR. Interview on 11/5/14 at 9:59 AM with Administrative Staff #1 revealed that the order was supposed to be for Haldol 1 mg instead of Haldol 2 mg and the expectation was for the new monthly MARs to be reconciled correctly.	F 333	receiving on-boarding training on unit by DON, ADON or Unit Manager. The Pharmacist will re-educate licensed nurses on medication administration on 11/13/14. The DON, ADON, Unit Manager over all shifts and on the weekend will perform 5 random observations of medication administration weekly for 12 weeks to verify accurate medication administration. These audits will be documented on the monitoring tool. Opportunities will be corrected daily as identified during these observations. Observation of medication pass will include administration of digoxin, vitamins and psychotropic meds. 4. The results of the audit will be reported by the DON monthly in Quality Assurance and Performance Improvement Committee for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		12/4/14

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F 356	Continued From page 26 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to accurately post the nurse staffing information. The findings included:	F 356	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of	

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F 356	Continued From page 27 An observation was made on 11/3/14 at 12:49 PM of the Daily Staff Posting dated 11/3/14. The staff posting stated there was a total of five nursing assistants administering care to the residents on the first shift. The staff posting also stated there was one medical technician (MT) administering care to the residents on the first shift. An observation of the staff administering care to the residents during the first shift on 11/3/14 revealed there were three nursing assistants administering care to the residents during the first shift. The observation also revealed there was not a MT administering care to the residents during the first shift. An observation was made on 11/4/14 of the Daily Staff Posting dated 11/4/14. The staff posting stated there were six nursing assistants administering care to the resident during the first shift. The staff posting also stated that one MT and one Med Aide (MA) were administering care to the residents during the first shift. The staff posting stated one MA and two medical technicians administered care to the residents during the second shift. An observation of the staff administering care to the residents during the first shift on 11/4/14 revealed there were four nursing assistants administering care to the resident during the first shift. There was one additional nursing assistant administering care to the residents on the assisted living unit and the long term care unit during the first shift. The observation also revealed there was not a MA or a MT administering care to residents during the first shift.	F 356	Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 356 1. Corrective action has been accomplished for the alleged deficient practice in regards to the daily staff posting on 11/3/14, the Assistant Director of Nursing posted the correct daily staff. 2. All resident have the potential to be affected by the same alleged deficiency. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Education of accurate daily staffing requirement to Interdisciplinary team (IDT) by the Director of nursing (DON). Also a mandatory meeting was held on 12/2/14 and 12/3/14 for all staff and education was done by DON and Administrator. All new staff hired after 12/4/14 will be educated on this process during orientation by the ADON/Staff Development. The ADON will audit the daily posting (Mon-Fri) daily for 2 week, then weekly for 11 weeks to ensure posting is timely and accurate. The Unit Coordinator and lead nurse on each shift will monitor for posting and accuracy. The lead nurse on each shift is responsible for updating the posting daily as changes occur. Any new staff that responsible for maintaining this role will be educated on the process by the Director of nursing during orientation to his/her new role. 4. The results of the audit will be reported by the DON monthly in Quality Assurance and Performance	

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F 356	Continued From page 28 An interview was conducted with Nurse #2 on 11/4/14 at 4:45 PM. Nurse #2 stated there was not a MT or a MA administering care to the residents during the second shift. An interview was conducted with Administrative Staff #2 on 11/5/14 at 8:34 AM. Administrative Staff #2 stated she was the person responsible for completing the Daily Staff Posting for the assisted living unit and the long term care unit. She stated she was including the staff assigned to work on the assisted living unit on the Daily Staff Posting for the long term care unit which accounted for the inaccuracy of the posting. Administrative Staff #2 stated she was not aware she was expected to exclude the staff working on the assisted living unit from the Daily Staff Posting on the long term care unit.	F 356	Improvement Committee for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to provide hot food for breakfast to residents who received food trays in their rooms. The findings included: Resident #162 was admitted to the facility on 10/27/14. During stage one of the recertification	F 364	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality	12/4/14

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F 364	Continued From page 29 survey, she was determined to be alert and oriented and cognitively intact. On 11/3/14 at 4:37PM, Resident #162 stated the food items served at the breakfast meal were cold (eggs, grits and oatmeal). Resident #154 was admitted to the facility on 10/13/2014. An Admission Minimum Data Set (MDS) dated 10/20/14 indicated Resident #154 was cognitively intact. On 11/3/14 at 4:27PM, Resident #154 stated she received her breakfast tray around 8:00AM and the eggs, grits and toast was always cold when the tray was served to her. Resident #163 was admitted to the facility 10/30/14. During stage one of the recertification survey, she was determined to be alert and oriented and cognitively intact. On 11/5/14 at 11:30AM, Resident #163 stated the food was the biggest problem and cold, mostly breakfast. On 11/5/14 at 8:10AM, an observation was conducted during breakfast. Resident #163 stated to the nursing staff that breakfast was cold. She stated the grits was cold and the butter did not melt when she put it on the grits. She also stated the eggs were lukewarm. On 11/5/14 at 6:45AM, an observation of breakfast food preparation and delivery was conducted. At 7:55AM, food trays for the skilled nursing residents were prepared and sent to the floor for delivery. Nursing staff completed delivering the breakfast trays at 8:10AM. At 8:15AM, a test tray of breakfast food (regular diet) was tasted by the surveyor and by the dietary manager. The test tray was checked for temperatures and palatability at 8:15AM with the dietary manager. Foods tasted were grits,	F 364	of care and to comply with all applicable state and federal regulatory requirements. F 364 1. The Dietary Manager conducted interviews with Residents #154 and #163 to identify specific issues related to their meals. Dietary staff were re-educated on achieving and maintaining proper food temperatures by the HSG District Manager on 11-5-14. 2. All residents receiving meals have the potential to be effected this alleged deficient practice. 3. Dietary staff were re-educated on proper food temperatures for the tray line on 11-5-14 by the HSG District Manager. On 12-2 and 12-3 Line staff we re-educated include Resident Care Specialist, Nurses, and care givers on the process of re-heating food items upon request of a resident in the microwave located in the main dining room. New staff will be educated on the process of re-heating food items that as needed and requested during orientation by the ADON/Staff development and Dietary Manager. Additionally the tray cart process to serve the rooms on the hall has been changed to allow for a 3 cart process VS a 2 cart process, which will allow additional time for the trays to be passed in a more expedient process, allowing for less time to pass between tray line to resident service. Cooks will complete a Food Temperature log for each meal to record the temperature of food items on the line. Food temp logs will	

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F 364	Continued From page 30 scrambled eggs, oatmeal, bacon, toast, apple juice and 2% milk. Temperatures of the foods were noted: apple juice tasted cool at 46.4 degrees, 2% milk was cool at 43.7 degrees; scrambled eggs were lukewarm at 102.5 degrees; oatmeal was lukewarm at 113 degrees; grits were lukewarm at 117 degrees; bacon was tasted and barely warm and the toast was cool. The dietary manager stated the food was not palatable and he would have had to ask to have the food reheated.	F 364	continue to be monitored on a daily basis to assure adequate temperatures of item on the food tray line. The Dietary Manager will meet with individual residents as well as attend the next 3 monthly Resident Council meeting to discuss any concerns related to meals. Concerns will be documented on the Facility Concern Form, investigation completed by the Dietary Manager and follow up completed as required. 4. The results of the Dietary Managers monitoring will be reported monthly in Quality Assurance and Performance Improvement Committee by the Dietary Manager for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	
F 371 SS=F	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, policy review and staff interviews, the facility failed to wash hands after handling dirty dishes and before handling clean	F 371	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or	12/4/14

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F 371	Continued From page 31 dishes, failed to maintain dishwashing temperatures at 150 degrees Fahrenheit or higher, failed to label and date opened food and failed to discard outdated food. The findings included: 1. A HCSG (Health Care Services Group) policy undated and titled "Hand Washing" stated, in part, When should you wash your hands: after handling soiled dishes, foods, or trash. How to wash you hands: 1. Use a dedicated hand-washing sink, wet hands thoroughly under warm running water. 2. Apply a sufficient amount of soap to hands and using friction rub hands until a soapy lather appears. 3. Continue to rub hands for at least 20 seconds, making sure to rub between fingers and under fingernails. 4. Rinse hands thoroughly under warm running water and then shake hands to remove excess water. 5. Leave the water running while drying hands with a clean disposable towel. 6. Use a clean towel to turn off the faucet." On 11/5/14 at 8:45AM, kitchen staff #1 was continuously observed operating the dishwashing machine. He was observed handling the dirty and clean dishes with no gloves on. He loaded the dirty dishes in the dishwashing machine, pulled the clean dishes out of the dishwashing machine, wiped his hands with a paper towel and stacked the clean dishes. He was not wearing gloves and did not wash his hands with soap and water between handling the dirty dishes and the clean dishes. Kitchen staff #1 performed this task three times without washing his hands between tasks. On 11/5/14 at 9:05AM, kitchen staff #1 stated he rinsed the dirty dishes, put the dirty dishes in the	F 371	agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 371 1. Dietary staff were immediately re-educated by the HGS District Manager on 11/5/14 on proper hand washing procedures, dish machine temperature requirements, and dating and labeling expectations. All out of date or not dated and labeled food items were discarded. 2. All residents have the potential to be effected this alleged deficient practice. 3. Dietary staff were re-educated on proper hand washing techniques by the HSG District Manager. A service tech from ECOLAB adjusted the dish machine on 11-5-14 to provide the necessary minimum temperatures of 150 Wash and 180 Rinse. Dietary staff will record dish machine temperature 3 times a day for monitoring of accurate temperatures. An ECOLAB tech will perform a monthly service on the machine for the next 3 months to assure proper temperatures. All dietary staff will be responsible for monitoring and checking items in the cooler/freezer and reach in cooler on each shift to verify that items are dated and labeled as required. The Dietary manager will monitor staff for proper hand washing procedures, the dish machine temperature log for proper temperatures, and the walk in cool/freezer and reach in	

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	345149	A. BUILDING _____ B. WING _____	C 11/06/2014

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F 371	Continued From page 32 dishwashing machine, removed the dishes from the dishwashing machine, wiped his hands with a paper towel and stacked the clean dishes for the next meal. Kitchen staff #1 stated his usual routine was to dry his hands with a paper towel before handling the clean dishes. On 11/5/14 at 9:15AM, an observation was conducted with the dietary manager. The dietary manager observed kitchen staff #1 operating the dishwashing machine, handling the dirty dishes, putting them in the dishwashing machine, removing the clean dishes, using a paper towel to wipe his hands and stacking the clean dishes. He stated he expected dish staff to rinse hands with soap and water and dry their hands after handling dirty dishes and prior to touching clean dishes. 2. A HCSG policy undated and titled "Ware washing" stated, in part, " The Food Services Director ensures that all the dish machine water temperatures are maintained in accordance with manufacturer recommendations for high temperature or low temperature machines". The Sanitizer/ Temperature Log indicated the standards for a high temperature dish washer was "Wash--150--160 degrees; Rinse--180 degrees". On 11/5/14 at 8:45AM, an observation was conducted on the washing cycle and rinse cycle of the high temperature dish machine. The wash cycle was 147 degrees A review of the October temperature log for the dish machine was reviewed and revealed the following: 10/1/14 breakfast wash temperature--130	F 371	cooler for proper dating and labeling, this will be completed on an audit tool M-F by the Dietary Manager, and by the cook on Sat, and Sun. New staff will receive instructions on hand washing procedures, dish machine water temperature, and dating and labeling of food items during the orientation and on-boarding process by the dietary manager. 4. The results of the Dietary Managers monitoring will be reported monthly in Quality Assurance and Performance Improvement Committee by the Dietary Manager for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	

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F 371	Continued From page 33 degrees Fahrenheit (F) 10/3/14 breakfast wash temperature--138 degrees F; lunch wash temperature--140 degrees F 10/4/14 breakfast wash temperature--130 degrees F; lunch wash temperature--146 degrees F 10/5/14 breakfast wash temperature--130 degrees F, lunch wash temperature--130 degrees F, dinner wash temperature--147 degrees F 10/6/14 breakfast wash temperature--139 degrees F; lunch wash temperature--142 degrees F 10/7/14 breakfast wash temperature--139 degrees F 10/8/14 breakfast wash temperature--140 degrees F; lunch wash temperature--148 degrees F 10/9/14 breakfast wash temperature--130 degrees F 10/10/14 breakfast wash temperature--140 degrees F 10/11/14 breakfast wash temperature--144 degrees F; dinner wash temperature--148 degrees F 10/13/14 lunch wash temperature--149 degrees F 10/14/14 lunch wash temperature-- 145 degrees F 10/15/14 breakfast wash temperature--140 degrees F 10/16/14 breakfast wash temperature--139 degrees F; lunch wash temperature--145 degrees F 10/17/14 breakfast wash temperature--139 degrees F 10/18/14 breakfast wash temperature--140 degrees F 10/19/14 breakfast wash temperature--130 degrees F	F 371		

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F 371	Continued From page 34 10/20/14 breakfast wash temperature--140 degrees F; lunch wash temperature--149 degrees F 10/21/14 breakfast wash temperature--130 degrees F; lunch wash temperature--140 degrees F 10/23/14 breakfast wash temperature--144 degrees F; lunch wash temperature--140 degrees F 10/24/14 breakfast wash temperature--140 degrees F; lunch wash temperature--140 degrees F 10/25/14 breakfast wash temperature--138 degrees F 10/27/14 breakfast wash temperature--130 degrees F 10/28/14 breakfast wash temperature--139 degrees F 10/29/14 breakfast wash temperature--130 degrees F 10/31/14 breakfast wash temperature--140 degrees F A review of the November temperature log for the dish machine was reviewed and revealed the following: 11/1/14 breakfast wash temperature--130 degrees F; lunch wash temperature--140 degrees F 11/2/14 dinner wash temperature 149 degrees F 11/3/14 breakfast wash temperature--130 degrees F, lunch wash temperature--145 degrees F 11/4/14 breakfast wash temperature--130 degrees F; lunch wash temperature--145 degrees F On 11/5/14 at 9:05AM,the dietary manager stated he expected the kitchen staff to notify him	F 371		

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F 371	Continued From page 35	F 371		

immediately if the wash/ rinse temperatures were not within the acceptable parameters of 150-160 degrees F for the wash cycle and 180 degrees f for the rinse cycle. He stated the dish machine had been recently serviced but the service was not for unacceptable temperatures. He did not indicate if he had reviewed the temperature logs and/or had noted the temperatures that were below the acceptable wash temperature of 150 degrees.

3. A company policy by HSFG stated, in part, " Ready to eat, time/ temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked at the time the original container is opened in a food establishment and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified."

On 11/3/14 at 10:50AM, an initial tour of the kitchen was conducted with the dietary manager. An observation of the walk-in refrigerator revealed 1/2 container of chili dated 10/27 with no discard date and a box that contained four (4) oranges, two (2) cucumbers and one (1) tomato with mold on all of the items. An observation of the freezer revealed four (4) pork chops in plastic bag opened and four (4) hot dogs in an opened plastic bag with no open date or discard date. An observation of the reach in refrigerator revealed one (1) gallon of sweet tea and one (1) quart of unsweetened tea undated and one (1) container of sausage and gravy dated 10/25/14 with a discard date of 10/30/14.

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F 371	Continued From page 36 On 11/3/14 at 11:15AM, the dietary manager stated all the food items (chili, pork chops, hot dogs, sweet tea and unsweetened tea) should have been dated with an opened date and a discard date. He said the food that was moldy and the outdated items should have been discarded. He stated it was the responsibility of every kitchen staff employee to check for undated/ outdated items.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to administer the	F 425	Preparation, submission and implementation of this Plan of Correction	12/4/14

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F 425	Continued From page 37 correct dosage of Haldol (antipsychotic medication) as ordered by the physician for 1 (resident #149) of 5 residents observed during the medication pass on 200 hall. Findings included: Resident #149 was admitted on 10/9/14 with multiple diagnosis including delusional disorder. Record review revealed that Resident #149 was taking Haldol for the delusional disorder and the current medication order dated 10/9/14 revealed the Haldol order was for 1 milligram (mg) by mouth once a day. Observation on 11/5/14 at 8:20 AM revealed that Nurse #3 administered Haldol 2 mg by mouth to Resident #149. Review of Resident #149's Medication Administration Record (MAR) revealed that the MAR orders were typed printed from the pharmacy and the Haldol dosage was indicated as 2 mg every day. Review of the medication package containing Resident #149's Haldol revealed the medication dosage and administration instructions on the label were for Haldol 2 mg by mouth every day. It was further verified by Nurse #3 that the tablets inside the medication pack was Haldol 2 mg tablets. Interview on 11/5/14 at 9:00 AM with Nurse #3 revealed that Nurse #3 administered Haldol 2 mg by mouth according to the instructions on the MAR. Interview on 11/5/14 at 9:59 AM with	F 425	does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 425 1. Corrective action for resident #149 was accomplished for the alleged deficient practice. Resident #149 was administered the incorrect dosage due to pharmacy transcription error. Resident #149 was in the facility during survey and was administered Haldol 2mg on 11- 05-2014. On 11-05-2014 medication variance was completed, resident, RP, and MD were notified. On 11-06-2014 the correct dosage was administered to resident # 149. 2. All residents receiving medication have the potential to be effected this alleged deficient practice. 3. Monthly MAR medication order reviews will be conducted by two nurses to verify accurate transcription during the preparation of the new month□s MAR□s. A third nurse will perform a final review on the last day of the month to include and new physician orders that have been received. Nurse that is receiving the medication in from the pharmacy will assure that the right medication has been sent prior to putting in the medication cart by cross reference with the MAR, this will include medication for new admits. Medication orders that have been	

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F 425	Continued From page 38 Administrative Staff #1 revealed that the order was supposed to be for Haldol 1 mg instead of Haldol 2 mg and the expectation was for the new monthly MARs to be reconciled correctly.	F 425	identified as Pharmacy errors will be corrected by completion of a medication variance form and notification to pharmacy. The DON or ADON will monitor and review all medication variance forms to assure timely and accurate follow-up during daily (M-F) clinical meetings. 4. The results of the audit will be reported by the DON monthly in Quality Assurance and Performance Improvement Committee for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	
F 431 SS=E	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	F 431		12/4/14

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F 431	Continued From page 39 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to date multi-dose medications when opened and failed to remove expired medications in 1 of 2 medication carts (200 hall Cart #2) and 1 of 1 medication room (200 hall). Findings included: The facility's policy on storage/expiration/beyond use date (undated) was reviewed. The policy indicated that Humulin 70/30, Humulin R, Lantus, Novolog, and Humulin N must be used within 28 days once opened. The Levemir must be used within 42 days once opened. The manufacturer's specifications for Advair Diskus (steroid/bronchodilator) and Prostat (protein supplement) were reviewed. The box of Advair Diskus read " expire 30 days after foil overwrap was removed. " The bottle of Prostat read " discard 3 months after opening. "	F 431	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 431 1. The expired medications were discarded and replaced immediately following identification. Muti-dose vials was immediately dated for the date received from pharmacy. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The DON and pharmacist will re-educate licensed nurses on the policy and procedure for labeling and storing	

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F 431	Continued From page 40 1. Observation on 11/6/14 at 11:35 AM of medication storage room refrigerator revealed the following medications were opened, however, had no labeled open dates: · Humulin R - 1 bottle - located in the house stock container · Humulin 70/30 - 1 bottle · Lantus - 1 bottle · Tuberculin Purified Protein Derivative Diluted Aplisol - 2 bottles Observation on 11/6/14 at 11:38 AM of medication storage room refrigerator revealed a bottle of opened Vancomycin Oral - 250 miligrams per 5 milliliters with an expiration date of 10/17/14. Interview on 11/6/14 at 11:40 AM with Nurse #3 revealed that she thought third shift checked for expired medications and any nurse that opened bottles or insulin should have recorded the open date on the bottle. Interview on 11/6/14 at 11:45 AM with Nurse #1 revealed that she thought third shift checked for expired medications and any nurse that opened bottles or insulin should have recorded the open date on the bottle. Interview on 11/6/14 at 11:51 AM with administrative staff #1 revealed the 3rd shift nurse was supposed to check the medication room and the medication carts for expired medications. Her expectation was for 3rd shift to have found the expired medications and for any nurse that opened medication to have dated the bottle with the opened date.	F 431	medication by 12/4/14. This education will be done verbally at a mandatory meeting and included time frames for discarding meds after opening. Placed in front of each medication record is a time frame of discarding medication removal after open date. Each 7p-7a nurse is responsible for discarding and removing medication nightly. The weekend unit coordinator will do audits of carts and medication room to ensure that medication have be discarded. The Unit Manager, Unit Coordinators, and lead nurse will audit medication rooms and carts weekly to verify storage per policy. These audits will be documented on the monitoring tools. Opportunities will be corrected by the daily as identified doing these audits. 4. The results of the audit will be reported by the DON monthly in Quality Assurance and Performance Improvement Committee for three months. The committee will evaluate and make further recommendations as indicated. Date of Compliance 12/4/14	

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F 431	Continued From page 41 2. On 11/6/14 at 11:05 AM, medication cart #2 on the 200 hall was observed. Inside the cart, the following were observed opened/used and were undated: Prostat, Advair Diskus 500/50, Advair Diskus 100/50, Humulin 70/30, Humulin R, Lantus, Levemir, Novolog, and Humulin N. A vial of opened Humulin R was observed with the date open of 9/10/14. On 11/6/14 at 11:15 AM, Nurse # 1 was interviewed. She stated that the nurse who first opened the insulin vials and the Advair should have dated them. The nurse acknowledged that the opened bottle of Humulin R dated 9/10/14 was already expired. She also indicated that she was not aware that Prostat was expired 3 months after opening. Interview on 11/6/14 at 11:51 AM with administrative staff # 1 revealed the 3rd shift nurse was supposed to check the medication room and the medication carts for expired medications. Her expectation was for 3rd shift to have found the expired medications and for any nurse that opened medication to have dated the bottle with the opened date.	F 431		