STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING ______ B. WING ______	C 01/15/2015

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SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 253 SS=E	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 observations, resident and staff interview the facility failed to keep rooms, equipment and personal care items cleaned and stored in a sanitary manner and clean air conditioning/heating units and filters in rooms 106, 109, 216, 305, 307, 314, 321, 505, 512, 516, 602 and The findings included: The following observations were made: a. Observations on 01/12/2015 at 04:02: PM in room 109 revealed a toothbrush not labeled on the sink in the bathroom. Interview at that time with Resident #205 revealed she was not sure how the staff made sure the resident that shared the bathroom did not use her toothbrush. b. Observations on 01/12/2015 at 12:25 PM in room 609 revealed the heating unit had dried debris inside the grate. The window had black substance on the inside of the frame. A second observation on 01/13/2015 at 02:20 PM revealed no changes in the window or heating unit. c. Observations on 01/12/2015 at 12:25 PM in room 503 revealed trash inside the heating unit vent. A second observation on 1/13/15 at 2:00 PM revealed trash remained in the heating unit	F 253	F 253 1. ResidentHs in roomHs 109, 511 and 505 have been provided with new toothbrushes that have been identified by resident name and individually covered by administrator and or designee on 2-6-15. New toothbrushes were then stored in the residentHs room. Heating units identified in room 609,602,516,512,511,505,503,321,307,305 and 218 have been deep cleaned removing debris, dust, trash, peanuts and black substance by the Maintenance Director or designee on 1-28-15. The broken vent slat has been repaired by the Maintenance Director on 1-28-15. The windows in room 609 were cleaned to remove the black substance by the Environmental Services Director on 2-12-15. The floor mat in room 307 has been replaced to eliminate the identified tear by the Maintenance Director on 2-11-15. The identified basins in rooms 609 and 516 were disposed of and the residents were provided new basins that have been	2/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/13/2015

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 253	Continued From page 1 vent. d. Observations on 01/12/2015 at 12:49 PM in room 307 revealed the floor fall mat on the right side of the bed had a 6 inch tear on the side of the mat. In the bathroom a toothbrush on the sink not labeled with a resident's name and the toothbrush was not covered. e. Observations on 01/12/2015 at 02:24 PM in room 307 revealed the heating unit had dust buildup and paper trash inside the vent. f. Observations on 01/12/2015 at 02:27 PM in room 511 revealed a toothbrush on the sink with the bristles resting on the sink not covered and not labeled with a resident's name in a shared bathroom. A second observation on 1/13/15 at 2:30 PM revealed the toothbrush remained with the bristles down on the sink and not covered. Observations on 01/12/2015 at 02:29 PM in room 511 revealed trash in the heating unit vent. Follow up observations on 1/13/15 at 2:20 PM revealed the trash remained in the heating unit vent. g. Observations on 01/12/2015 at 03:02 PM in room 305 revealed the heating unit with heavy dust and a few peanuts in the vent. h. Observations on 01/12/2015 at 03:10 PM in room 609 revealed a basin on the bathroom floor under the sink was not covered or labeled with a resident ' s name. The basin was beside a trash can that was full. A dressing with dried drainage was overflowing from the trashcan. Uncapped used razors were located on a shelf in the bathroom above the commode. The call bell cord outer covering was missing exposing black and	F 253	labeled and covered by the central supply clerk and or designee on 2-11-15. New basins were then stored in the residentHs room. Environmental Services Director validated that trashes for rooms 609 and 516 were emptied by Housekeeping staff on 2-6-15. The Director of Nursing immediately threw the uncapped razors in room 609 into a Biohazard container on 2-6-15. The Director of Maintenance ensured that the outer covering for the call bell was replaced on 2-6-15. The floors and paper debris identified for rooms 505,516 and 602 were cleaned by the Environmental Service Director on 2-6-15. The bed pan for room 516 was disposed of and the residents were provided with a new bed pans that have been labeled and covered by the central supply clerk and or designee on 2-11-15. The new bedpans were stored in the residentHs room or bathroom if covered and labeled. The identified denture cup for room 321 was disposed of and the residents were provided new denture cups that have been labeled by the central supply clerk and or designee on 2-11-15. The new denture cups will be stored in the patientHs room.	

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F 253	Continued From page 2 white wires at the end of the call bell connecting into the wall. Follow up observations on 01/13/2015 at 2:21 PM uncapped razors remained in the bathroom. i. Observations on 01/12/2015 at 03:14 PM in room 218 revealed the heating unit had heavy dust in vent. j. Observations on 01/13/2015 at 08:59 AM in room 505 a toothbrush was on the back of the sink with the bristles resting on the sink. The toothbrush was not labeled with a resident's name in a shared bathroom. The heating unit vent had paper trash inside the vents and the floor was "sticky." A second observation on 01/13/2015 at 02:10 PM revealed the trash remained in the heating unit and the floor was " sticky. " Interview with Resident 164 revealed "the mopping guy had not been by yet." k. Observations on 01/13/2015 at 09:52 AM in room 512 revealed the heating unit had trash inside. A second observation on 1/13/15 at 2:15 PM revealed trash remained in the heating unit. l. Observations on 01/13/2015 at 11:04 AM in room 516 revealed a bed pan with yellow liquid located on the side of the sink. The bed pan was not emptied, rinsed, covered and labeled with a resident ' s name in a shared bathroom. Observations on 01/13/2015 at 11:04 AM in room 516 revealed the heating unit had dried debris inside. The floor had paper trash near the beds and dried debris was behind the beds and nightstands. m. Observations on 01/13/2015 at 01:45 PM in room 321revealed the heating unit had heavy	F 253	The identified lotion in room 321 has been properly labeled with the residentHs name by the central supply clerk and or designee on 2-11-15 and is stored in the residentHs room. The identified sheet in room 602 has been validated as removed by the Director of Nursing Services on 2-6-15. 2. An audit has been completed by the Environmental Services Director and the Maintenance Director to identify any heating unit, floor mat, window trim, floor, trash bin or call light plate in need of cleaning or repair by 2-12-15. Any negative finding will be immediately resolved. An audit has been completed by the central supply clerks and or designee to identify any personal care items not labeled or covered properly to include: tooth brushes, bed pans, denture cups, basins, lotions by 2-12-15. Any negative finding will be immediately resolved. An audit has been completed by the central supply clerks and or designee to identify any personal care items not disposed of properly to include: razors by 2-12-15. Any negative finding will be immediately resolved An audit will be completed by Environmental Services Director by 2-12-15 to identify floors in need to cleaning or with linen or trash cans in	

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F 253	Continued From page 3 dust buildup and a vent slat was broken. Observations on 1/13/2015 at 01:46 PM in room 321 revealed dentures in a cup of water without a lid and not labeled with a resident ' s name. Lotion was on the sink and was not labeled with a resident ' s name in a shared bathroom. n. Observations on 01/13/2015 at 02:02 PM in room 602 revealed the floor was dirty next to the bookcase with dried crumbs along the baseboard. A bed sheet was on the floor next to the wall. Interview with Resident #64 revealed the sheet was from last night when she fell. Resident #64 explained it was used by staff when she hit her head and it had blood on it. Black substance noted on the vent slats of the heating unit. o. Observations on 01/13/2015 at 02:20 PM in room 609 revealed the heating unit had dried debris in the heating unit and a black substance was on the inside of the window track. Interview with the Director of Nursing revealed items should be labeled with the residents' name. Dentures should be stored in a cup with a lid and labeled with the resident's name. She would expect staff to put toothbrushes in a baggie and not leave it on the sink, razors should be inside the sharps and not left out. Further interview revealed personal care items should have the resident's name and be stored in the resident's cabinet. Interview with the Maintenance Director revealed the call bell cord was not " hot wires " and he would replace the call bell, the heating units were cleaned each month and he did not know when the last time they were checked. The broken vent slat could be repaired. He had not received a request to repair the call light or heat	F 253	need of emptying. Negative finding will be immediately resolved. 3. Training as been offered to Environmental Services Staff and Maintenance staff by the Administrator by 2-12-15 regarding proper cleaning and maintenance of heating units, windows, floor mats, floors and call bell cords/plates; proper emptying of trash cans. Training has been offered by the Nurse Practice Educator, Assistant Director of Nursing, Director of Nursing and or Administrator to all staff by 2-12-15 on the proper labeling and storage of personal care items to include: toothbrushes, denture cups, lotions, razors, bedpans and linen. Environmental Services Director and/or Maintenance Director will complete daily audit of facility, Monday thru Friday for 4 weeks and weekly for 3 months. Audit will validate proper cleaning and maintenance of heating units, windows, floor mats, floors and call bell cords/plates; proper empting of trash cans. Department Managers will complete audits for the proper labeling and storage of personal care items at least 3 times per week for 4 weeks and weekly for 3 months. Audit will validate proper labeling and storage of personal care items to include: toothbrushes, denture cups, lotions, razors, bedpans and linen.	

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F 253	Continued From page 4 vent slat.	F 253	4. The Administrator will complete tracking and trending on the audit results monthly. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee. The QAPI Committee will make recommendation on additional actions or changes that need to be taken to ensure continued compliance.	
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 review and staff interviews the facility failed to assess and provide routine orders for one of one sampled residents with constipation. Resident # 67. The findings included: Resident #67 was admitted to the facility on 9/12/09 with diagnosis of arthritis, dysphagia and Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 11/4/14 indicated the resident had short and long term memory impairment and impaired daily decision making abilities. This MDS indicated	F 309	1. On 1-15-15, the standing orders were started for Resident # 67 with effective results documented on the Medication Administration Record (MAR) by hall nurse for Resident #67. On 2-3-15, the care plan for Resident #67 was reviewed and interventions added to address risk for constipation by the Assistant Director of Nursing Services. 2. Resident Bowel Movement (BM) documentation have been audited for all residents on 2-11-15 by the DNS, ADSN and or designee to assure Bowel Protocol was implemented as indicated for	2/13/15

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F 309	Continued From page 5 Resident #67 received enteral feedings for nutrition and was always incontinent of bowel. Resident #67 was assessed as receiving a schedule pain medication. The care plan dated 10/29/14 did not include a problem of constipation. Record review revealed pain medication given on a scheduled basis was Fentanyl patch 2.5 micrograms per hour (mcg/hr) and changed every three days. Multivitamins and folic acid were administered on a daily basis. All three medications had side effects of constipation. Record review of bowel movements recorded by the aides, for the months of October, November and December 2014 and January 2015, revealed Resident #67 had a bowel movement pattern of every five to six days. Review of the standing orders indicated the nurse would do the following: - If a resident had no bowel movement (BM) in 3 days, MOM (Milk of Magnesia laxative) 30 milliliters would be given for a one time dose; - If no BM on the 4th day, Dulcolax suppository would be given for a one time dose; - If no BM on the 5th day, a Fleet enema would be administered. If there were no results (no BM) the nurse was to call the physician. Record review of the Medication Administration Records for the months of October, November, December and January revealed no interventions were recorded as being provided for constipation. Record review indicated Resident #67 had a	F 309	patients. 3. Training has been offered to Certified Nursing Aides (CNA) by the NPE,DNS and or ADNS by 1-12-15 regarding the documentation of bowel movements (BM) in the Activities of Daily Living (ADL) book and reporting of residentHs who have not had a BM in 3 days. Bowel protocol standing orders have been added to the Medication Administration Records (MARs) by the DNS, ADNS and or designee by 1-15-15. The NPE, DNS and or ADNS provided training for Licensed Nurses by 1-12-15 regarding the assessment of frequency of BMHs and implementation of routine orders regarding constipation thru nurses review of ADL books to assess need for frequency of BM and implementation/documentation of standing orders. The DNS/ADNS and or Scheduling Manager will complete weekly audits of ADL Book and MAR to ensure assessment and implementation of routine orders for constipation for 3 months. Negative findings will be immediately corrected. 4. The DNS will complete tracking and trending on the audit results. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee monthly for 3 months. The QAPI	

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F 309	Continued From page 6 bowel movement recorded by the sixth day. Interview with aide #2 on the 3-11 shift revealed her assignment sheet had a place to write down a resident ' s bowel movements. Aide #2 explained her method of communication with the nurse included giving her assignment sheet to the nurse at the end of the shift. The nurse would know if a resident had a BM by her assignment sheet documentation. Interview with nurse #3 on 01/14/20 at 15 3:33 PM revealed the aides documented in their ADL (activities of daily living) note book any bowel movements that had occurred for residents on their shift. The aides would notice if a resident had not had bowel movements in a few days. She further explained the aides would inform her if a resident was having problems with constipation. The ADL note book for Resident #67 was reviewed with nurse #3 for the month of January. Resident #67 had not had a bowel movement in 6 consecutive days. She explained she was not aware Resident #67 had gone 6 days with no bowel movements. Nurse #3 was aware of the standing orders that should be implemented for constipation. Interview with the Director of Nursing on 01/14/2015 at 4:01 PM indicated the nurses were expected to check with the residents and ask if they had a BM. The nurse would review the aides ' documentation in a note book for the presence or lack of bowel movements. Further interview revealed she would expect the nurses to follow the standing orders for treatment of constipation.	F 309	Committee will make recommendation on additional actions or changes that need to be taken to ensure continued compliance.	
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		2/13/15

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F 312 SS=D	Continued From page 7 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide assistance with personal hygiene for facial shaves for one of four sampled residents dependent on staff. (Resident #36) The findings included: Resident #36 was admitted to the facility on 3/20/13 with diagnosis of anemia, heart failure and dementia. Review of the quarterly Minimum Data Set (MDS) dated 11/7/14 indicated Resident #36 had moderate impairment with cognition and exhibited no behaviors. This MDS indicated he required total assistance of one staff for personal hygiene and bathing. The care plan dated 11/10/14 included problem of Activities of Daily Living (ADL) assistance was required for personal hygiene due to functional deterioration. The approaches included for nursing staff to provide a bath of the resident's choice and assist with daily hygiene needs. Observations on 01/13/2015 at 09:55 AM	F 312	1. On 1-15-15, The Director of Nursing Services (DNS) validated that Resident #36 was shaved. 2. Residents needing assistance with facial shaving have the potential to be affected by this alleged deficient practice. An Audit will be completed by the DNS, ADNS, NPE or designee identifying residents who need assistance with shaving by 2-12-15. Any negative finding will be resolved. 3. Training has been offered to Certified Nursing Aides (CNA) and Nurses by the NPE, DNS and or ADNS by 1-12-15 regarding provision of assistance for ADLs including shaving of facial hair. Shaves will be provided on shower days and as requested by the resident PRN. Scheduling Manager, DNS, ANDS and or designee will complete a weekly audit for 3 months of residents to ensure residents who need assistance with shaving had been provided assistance. 4. The DNS will complete tracking and	

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F 312	Continued From page 8 revealed Resident #36 had stubble on his face. Observations on 01/13/2015 at 4:31 PM revealed Resident #36 had not been shaved and had stubble on his face. Observations on 01/14/2015 at 10:50 AM revealed Resident #36 had stubble on his face and had not been shaved. Interview on 01/15/2015 8:23 AM with aide #3 revealed she provided the following care each day: a partial bath, dressed the resident, set up his meals, got him out of bed and whatever else he would need. When asked if she shaves residents on her shift, she stated yes. Aide #2 further explained his bath would be on evening shift. When asked why he had not been shaved, she smiled and would not answer. Stated she would shave him this morning. Interview with nurse #2 on 1/15/2015 at 8:30 AM revealed Resident #36 would refuse care at times. She knew he did on Tuesday during morning care. She was not aware he had not been shaved this week. She was not here on Monday and had not seen him today. Nurse #2 explained she would check on him today. She indicated aide#2 had been assigned to Resident #36 for the past 3 days. Observations on 01/15/2015 at 1:40 PM revealed Resident #36 had received a shave. Interview with Resident during the observations revealed he replied "yes and it feels good" when asked if he received a shave. Interview with the Director of Nursing on 1/15/15 at 2:40 PM revealed she would expect the staff to	F 312	trending on the audit results. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will make recommendation on additional actions or changes that need to be taken to ensure continued compliance.	

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F 312	Continued From page 9 provide a shave for any resident that had stubble on their face. Any nursing staff could provide that. Interview with aide #4 on 3-11 shift on 01/15/2015 at 3:30 PM revealed Resident #36 receives showers on Tuesdays and Fridays. On Tuesday, he had refused care. The 3-11 shift can do shaves if the day shift was not able to do them. She did not know why he did not receive a shave on Wednesday but she would shave him if he would allow today.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a two person assist for bed mobility for 1 of 4 sampled residents (Resident #211) reviewed for accidents. Resident #211 was admitted to the facility on 12/9/14 with diagnosis of chronic kidney disease, anemia, obesity and respiratory failure, for palliative care and discharged home with a home health agency on 12/12/14. Review of the nursing admission assessment	F 323	1. Resident #211 is no longer a resident of the facility. 2. Residents who need assistance with bed mobility by two staff have the potential to be affected by this deficient practice. The Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), Nurse Practice Educator (NPE) and or designee will complete an audit to identify residents needing assistance of two for bed mobility on 2-11-14. Resident	2/13/15

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F 323	Continued From page 10	F 323		

dated 12/9/14 at 6:00PM indicated that Resident #211 was completely immobile, the upper and lower extremities were impaired on both sides.

The care plan initiated on 12/10/14 revealed that Resident #211 was dependent for care in bathing, grooming, dressing, eating, bed mobility and transfers due to chronic diseases compromising functional ability.

The nurse ' s note dated 12/10/14 at 11:19 AM revealed that the nurse aide was providing am care to the resident and the resident was turned toward nurse aide on her right side and slid out of bed with lower portion of body sliding to the floor and upper body still on bed with resident holding on to side rail. The resident was lowered to floor by 4 staff members. Resident #211 was assessed and an abrasion was noted under both breast. Resident #211 was assisted back to the bed with the hoyer lift and assistance of 4 staff.

Review of the nurses ' s note dated 12/10/15 at 2:00 PM indicated there was purple bruising noted under left chin area from fall where she was hanging on to the side rail.

An interview with Nurse #1 on 1/14/15 revealed that Nurse aide #1 called her to the room and upon entering the room Resident #211 " s legs and lower portion of body had slid out of the bed unto the floor and the resident was holding on to the side rail. Resident #211 was lowered to the floor and placed back into bed with the hoyer lift.

An interview with Nurse Aide #1 on 1/15/15 at 10:00 AM revealed that she was going to provide care for Resident #211 and rolled the resident towards her unto her right side and the resident '

bed mobility status will be reflected on the Kardex.

3. Licensed Nurses and Nursing Assistants were re-educated by the NPE starting 2-8-15 on reviewing the Kardex, which is located on the interior of the residents closet door, prior to giving care to determine the assistance required by residents.

The DNS, ADNS and or NPE will audit the Lift Transfer Evaluation of residents and compare to the Kardex to ensure that the information corresponds as residentHs condition changes monthly for 3 months. The Lift Transfer Evaluation and Kardex will be audited by the ADNS on newly admitted residents to ensure that the correct information is present for the nursing assistants within 24 hours of admission for 3 months.

4. The DNS will complete tracking and trending on the audit results. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will make recommendations on additional actions or changes that need to be taken to ensure continued compliance.

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F 323	Continued From page 11 s lower body and legs slid off the bed to the floor. Nurse Aide #1 indicated that she did not know that Resident #211 required the assistance of 2 staff. Nurse Aide #1 further indicated that she did not get a report regarding the residents care needs and she did not have a Kardex or communication sheet regarding Resident #211 ' s care needs. During an interview with the Director of Nurses (DON) on 1/15/15 at 1:00 PM revealed that Resident #211 ' s flow sheet or kardex could not be located. The DON further revealed that she would have expected Resident #211 to have the assistance of 2 staff for her care needs.	F 323		
F 329 SS=D	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 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	F 329		2/13/15

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F 329	Continued From page 12 drugs. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete the assessment to monitor abnormal involuntary movements for two of four sampled residents requiring the assessment. (Residents #67 and 76). The findings include: 1. Resident #76 was admitted to the facility on 9/3/13 with diagnosis including Alzheimer's dementia with behaviors. The Minimum Data Set (MDS) dated 10/14/14 indicated Resident #76 had short and long term memory impairment and had no behaviors. The MDS coded the use of an antipsychotic medication 7 of the last 7 days. Record review revealed the Abnormal Involuntary Movement Scale (AIMS) assessments dated 9/3/13 and 3/3/14 had been completed for the medication Haldol. There were no AIMS assessments completed after 3/3/14 Review of the physician ' s orders revealed Haldol (an antipsychotic medication) 1 milligram (mg) had been given every night until 11/12/14. The medication was discontinued per family request. Review of the Pharmacy monthly review notes for	F 329	1. An Abnormal Involuntary Movement Scale was completed on resident # 76 and #67 was completed by the Director of Nursing Services (DNS) or designee on 2-9-15 and 1-15-15. 2. Any resident receiving an antipsychotic medication or Reglan have the potential to be effected by the alleged deficient practice. The DNS and ADNS completed audit on 2-8-15 of residentsH physician orders to identify resident that are receiving antipsychotic medication or Reglan. After completing the audit of physicianHs orders, the DNS and ANDS completed an audit to identify residents that may not have a updated AIMS on 2-8-15. 18 residents were identified and AIMs was completed by the licensed nurse. 3. Licensed nurses were reeducated on the completion of an AIMS when a new med is started, every 6 months, when a medication dose is changed and if medication is discontinued by NPE, DNS and or ADNS starting 2-8-15. The DNS and/or ADNS will complete an audit monthly for 3 months to ensure that AIMS are being completed. Newly admitted residents, along with daily written	

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F 329	Continued From page 13 September, October and November 2014 indicated there were no recommendations to Nursing to complete an AIMS assessment. Review of the November Medication Administration Record (MAR) revealed the last dose of Haldol was administered on 11/11/14. Interview on 1/15/15 at 10:00 AM with the Director of Nursing revealed the AIMS would be completed every six months. An AIMS should have been completed in September. Interview with the Pharmacy Consultant on 01/15/2015 at 11:52 AM revealed an AIMS should be completed for use of an antipsychotic medication. It was explained the monthly reviews consisted of review of the " hard copy " chart and did not include the electronic chart. The pharmacist explained he did not have access to the assessment in the electronic chart to review for completion. 2. Resident #67 was admitted to the facility on 9/12/09 with diagnosis of arthritis, dysphagia and Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 11/4/14 indicated the resident had short and long term memory impairment and impaired daily decision making abilities. This MDS indicated Resident #67 received enteral feedings for nutrition. Record review revealed a nurse practioner ' s progress note dated 12/12/14 indicated Resident #67 may have gastroparesis (delayed emptying of the stomach) due to symptoms of nausea and vomiting. An order for Reglan 5 milligrams (mg)	F 329	telephone orders will be reviewed to determine if an antipsychotic medication and/or Reglan was ordered. The DNS and or ADNS will assure the licensed nurse completed the AIMs during this audit 5 days a week for 3 months. 4. The DNS will complete tracking and trending on the audit results. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will make recommendation on additional actions or changes that need to be taken to ensure continued compliance.	

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F 329	Continued From page 14	F 329		

before meals and at night would be started.

Review of the telephone orders revealed an order dated 12/12/14 for Reglan 5mg orally before meals and at night.

Interview on 01/15/2015 at 8:19 AM with nurse #2 revealed the AIMS (Abnormal Involuntary Movement Scale) would be done for the medication Reglan. The AIMS would be completed when the medication was started and then quarterly. Continued interview revealed she was not sure who would be responsible for doing the AIMS when it was first ordered. Further interview revealed she was not sure how long after the medication was started the AIMS would be completed.

A follow up interview with nurse #2 on 01/15/2015 at 8:35 AM revealed the AIMS should have been completed when the medication was started, then every 6 months thereafter. She did not find an AIMS for this resident.

Interview on 1/15/15 at 10:00 AM with the Director of Nursing revealed the AIMS would be completed when the medication was started and then every six months.

Interview with the Pharmacy Consultant on 01/15/2015 at 11:52 AM revealed an AIMS should be completed for use of an antipsychotic medication. It was explained the monthly reviews consisted of review of the " hard copy " chart and did not include the electronic chart. The pharmacist explained he did not have access to the assessment in the electronic chart to review for completion.

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F 371	Continued From page 15	F 371		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to serve meat and vegetables from the tray line at a temperature of at least 135 degrees one of three steam tables. The findings included: Observations on 1/12/15 at 12:00 PM of the steam table on the 500/600 hall revealed all of the serving pans did not fit into the steam table. Dietary aide #1 placed a serving pan of stuffed peppers with meat on top of a serving pan on the steam table. Dietary aide #1 placed a serving pan of cauliflower at the back of the steam table, tilted against the front cover. The cauliflower serving pan was not in contact with the steam or pans in the steam table. On 01/12/15 at 12:19 PM a request for temperatures to be taken of the stuffed peppers with meat and cauliflower, which were being served from the tray line revealed both foods had internal temperatures of 120 degrees Fahrenheit	F 371	1. Foods Temperatures in all dining areas were re- checked for correct temperature and food reheated to 165 prior to service. 2. Resident have the potential to be impacted by this deficient practice exclude only those resident who are NPO or obtain sustenance from alternative sources (example: Tube Feeding). An Audit has been completed by the DM, Administrator and or Designee to identify impacted residents on 2-10-15. 3. Hot foods are to be placed in smaller (1/3 size or less) steam table pans so that they will all fit within the 3 steam table wells that are available in each dining area. Cold foods will be kept refrigerated or on ice throughout service. Temperatures are to be taken and recorded at least 3 times, once when preparation is complete, once when	2/13/15

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F 371	Continued From page 16 (F). Interview with the assistant dietary manager on 1/12/15 at 12:25 PM revealed the meat in the stuffed peppers would be removed and reheated. The assistant dietary manager further stated the dietary aide should have removed both the meat and vegetable from the tray line to be reheated. The assistant dietary manager removed both foods from the tray line to reheat them. Observations on 01/12/15 at 12:40 PM revealed Dietary Aide #1 removed a serving pan of stuffed peppers from an insulated cart and checked the temperature. Interview with Dietary Aide #1 revealed the temperature of the stuffed peppers was 130 degrees F. Interview with Dietary Aide #1 on 1/12/15 at 12:45 PM revealed the holding temperature of meat on the serving line should be at least 135 degrees F. Dietary Aide #1 was observed to continue to plate the stuffed peppers for on resident meal trays. Interview with the Dietary Manager on 1/15/15 at 2:15 PM revealed he would expect the food to be removed from the tray line and reheated if it was not at the proper serving temperature of at least 135 degrees F. The food should be heated to the correct temperature and not have been served.	F 371	serving begins and at least one additional time during service to ensure temperatures remain safe and food is palatable. DDS will ensure that temperature logs are available and maintained on a daily basis. All dietary staff in-serviced re: Serving foods at appropriate temperatures, holding all foods on a heated/refrigerated source, correct procedure for serving foods that fall below (above) acceptable temps, and recording all food temperatures both prior to and during meal service. DDS will complete 4 tray assessments at least 3x weekly x 4 weeks, then weekly on-going. Also, DDS will complete audits of temperature logs at least 4x weekly x 4 weeks, then 2x weekly x 2 months. 4. The DDS will complete tracking and trending on the audit results. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will make recommendation on additional actions or changes that need to be taken to ensure continued compliance.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		2/13/15

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F 428	Continued From page 17 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record reviews, pharmacy interview and staff interview the pharmacy failed to review for the presence of an abnormal involuntary movement assessment and report the irregularity for one of five sampled residents receiving antipsychotic medications. (Residents #76). The findings included: Resident #76 was admitted to the facility on 9/3/13 with diagnosis including Alzheimer's dementia with behaviors. The Minimum Data Set (MDS) dated 10/14/14 indicated Resident #76 had short and long term memory impairment and had no behaviors. The MDS coded the use of an antipsychotic medication. Record review revealed the AIMS assessments dated 9/3/13 and 3/3/14 had been completed for the medication Haldol. There were no AIMS completed after 3/3/14. Review of the physician ' s orders revealed Haldol (an antipsychotic medication) 1 milligram (mg) had been given every night until 11/12/14. The medication was discontinued per family request. Review of the November Medication	F 428	1. On 1-30-15, Consultant Pharmacist completed a drug regimen review for Resident #76. On 2-9-15, the Director of Nursing Services (DNS) completed an assessment for abnormal involuntary movement (AIM) on Resident #76. 2. All residents on Antipsychotic medications and or Reglan have the potential to be affected by this deficient practice. An Audit was completed on 2-2-15 by the DNS. Consultant Pharmacist completed drug regimen reviews on patients and made appropriate recommendations. 3. On 2-8-15, Consultant Pharmacist was provided access to electronic medical record to ensure full access to complete record for monthly reviews by the Administrator. Consultant Pharmacist will complete a monthly drug regimen review and make appropriate recommendation to include: AIM assessments. Consultant Pharmacist was provided education on accessing electronic medical records and expectation for drug regimen	

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F 428	Continued From page 18 Administration Record (MAR) revealed the last dose of Haldol was administered on 11/11/14. Review of the Pharmacy monthly review notes for September, October and November 2014 indicated there were no recommendations to Nursing to complete an AIMS assessment. Interview on 1/15/15 at 10:00 AM with the Director of Nursing revealed the AIMS would be completed every six months. An AIMS should have been completed in September. Interview with the Pharmacy Consultant on 01/15/2015 at 11:52 AM revealed an AIMS should be completed for use of an antipsychotic medication. It was explained the monthly reviews consisted of review of the " hard copy " chart and did not include the electronic chart. The pharmacist explained he did not have access to the assessment in the electronic chart to review for completion.	F 428	review on 2-9-15. Physician orders will be audited by the DNS, Assistant Director of Nursing (ADNS) and or designee daily Monday thru Friday to identify residents with new orders, changed orders, or Discontinuation orders associated with psychotropic medications or other medications that require monitoring for AIMs. Assessment will be completed upon identification for needed assessment or admitted patients on Antipsychotic medication or Reglan within 72 hours of admission. 4. The DNS will complete tracking and trending on the audit results. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will make recommendation on additional actions or changes that need to be taken to ensure continued compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		2/13/15

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F 431	Continued From page 19 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to date opened multi dose vials of medication and remove expired medication from use in one of two medication rooms and one of five medication carts. The findings included: 1. Observations of medication storage on 1/14/15 at 12:10 PM in the medication room for the 100 to 300 halls revealed a multi dose vial of Lantus insulin was opened and not dated when opened or when it would expire. A second multi dose vial	F 431	1. The opened multiple dose of Lantus insulin without a date in the medication room for 100 and 300 halls was disposed of and new bottle ordered for the resident by the Director of Nursing Services on 1-15-15. The vial of Levmir insulin dated 12/14 was disposed of by the Director of Nursing Services (DNS) on 1-15-15. The bottle of Novolog insulin along with the vial of Levemir without a date of opening on 100 hall cart with the expired date of 1/13/15 was disposed and new bottle obtained for resident on 1-15-15 by DNS.	

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F 431	Continued From page 20 of Levemir insulin was dated " 12/14. " Interview with nurse #4 on 1/14/15 at 12:14 PM revealed she would discard the insulins. It should have been dated when opened and she did not know when the " 12/14 " was opened. Interview with the Director of Nursing on 1/15/15 at 2:00 PM revealed her expectations were for nurses to date the multi dose vials when opened and discard medications that were expired. 2 . Observations on 1/15/15 at 9:42 AM of the medication cart for the 100 hall revealed Novolog insulin had expired per the date on the label on 1/13/15. Levemir insulin was opened, not dated when it was opened and no expiration date provided. A multi dose vial of sterile water for injection was opened, not dated and no expiration date provided. Interview with nurse # 4 on 01/15/2015 at 12:14 PM revealed the expired insulin had been left in the cart. Further interview revealed the expired insulin should have been removed. Interview with the Director of Nursing on 1/15/15 at 2:00 PM revealed her expectations were for nurses to date the multi dose vials when opened and discard medications that were expired.	F 431	The undated vial of sterile water for injection was disposed. 2. Any vial of medication used in the center has the potential to be effected by the alleged deficient practice. Both medication rooms and the 5 medication carts were inspected by the Director of Nursing Services (DNS) on 2-2-15 and zero (0) opened updated or expired medication vials were found. 3. The licensed nurses were provided educated by DNS, Assistant Director of Nursing (ADNS) and or Nursing Practice Educator (NPE) by 2-12-15 on dating vials when opened and to check for the expiration dates and dispose of medication. The licensed nurses that work the third shift and the first shift will inspect the vials of medication on the cart for expiration dates and for dates when medication is opened during the shift report daily for one month, then weekly for 2 months The DNS, ADNS and or designee will randomly inspect all medication carts weekly for 3 months. The DNS, ADNS and or designee will inspect the medication room 5 days a week for one month, then weekly for 2 months for expired and or opened vials without dates. The DNS will complete tracking and trending on the audit results. 4. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee monthly for 3 months by the DNS. The QAPI Committee will	

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F 431	Continued From page 21	F 431	make recommendation on additional actions or changes that need to be taken to ensure continued compliance.	