STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 01/29/2015

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WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

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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, record review and interviews with facility staff the facility failed to provide maintenance and cleaning services necessary to maintain a safe, orderly and comfortable environment for 4 of 6 halls and 2 shower rooms. (Halls A, B, C, D, Shower Rooms A and D). The findings included: Record review of an undated policy titled " Maintenance " revealed in the section titled " Policy " revealed that the facility ' s physical plant and equipment would be maintenance through a program of preventive maintenance and prompt action to identify areas/items in need of repair. The section titled " Procedure " revealed the Director of Environmental Services would follow all policies regarding routine periodic maintenance. The Director of Environment Services would perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All employees would report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance would be reported to maintenance using the Maintenance Repair Request Form. The form will be completed and placed in a designated area on the nursing unit or in the maintenance office.	F 253	F253 House Keeping & Maintenance Services 1. D Hall shower room toilet with brown colored water. Cleaned toilet tank and flushed. 1/27 Mechanical Lifts, walker with hand breaks, two upholstered chairs. Items Removed 1/25 D Hall Shower Room sink separating from wall. Removed old caulking and reapplied new caulk. 1/24. . Broken Tile and black matter on grout in D Hall shower room. Removed broken tile and cleaned discolored caulking. 1/27. Holes in wall attaching sink. Holes filled in behind sink. 1/27 Pressure washer stored in D Hall shower room. Removed and stored 1/25. Whirlpool in A Hall shower room not connected. Removed whirlpool out of facility and caped off open drain line 1/27. Black matter on grout. Removed and cleaned 1/27. Broken tiles in A Hall Shower room. Removed broken tile and replaced with new tile. 1/28. Room 101 Toilet bowl seal stained tiles around toilet. Removed stained tile and resealed toilet. 1/29. Toilet seemed loose from floor. Tightened toilet floor bolts. 1/28. Room 102 Wardrobe drawer missing. Removed wardrobe and replaced with full	2/22/15

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

Electronically Signed | 02/22/2015

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F 253	Continued From page 1 Environment Services personnel would check for completed for completed forms throughout the day. The Requests would be prioritized and completed according to need. If unable to complete the request in a reasonable period of time, the originator will be notified as to the current status and duture resolution. Record review of the " Housekeeping Daily Routine " , undated, did not reveal any shower cleaning in the daily routines. Record review of the " Buffing Schedule " , undated, revealed on Saturday, the floor technician was to scrub shower room A and shower room D. Observations of D hall shower room on 1/25/15 at 4:30 PM indicated that the toilet in the shower room had brown colored water in it. There was also two mechanical lifts, one shower chair, one walker with hand brakes, two upholstered chairs, one sink separating from the wall was spackled to fill in the gap and was coming loose. Three shower stalls had tile broken along bottom where wall met the floors in all three stalls. There was no privacy curtains on the shower stalls, there was black matter on the floor between the tiles and in the shower stalls where the floor meets the walls. There was a pressure washer in the shower room. Nurse aids where bringing in barrels of soiled clothing, linen and diapers and storing them in the shower room.. Interview with NA #2 on 1/25/15 at 4:30 PM revealed that the in the D shower room because they could not leave them in the halls while passing meal trays on the hall.	F 253	functioning wardrobe.1/28. Tiles around toilet discolored. Stripped tile and resealed. 1/28. Room 104 Peeling wallpaper boarder. Secured peeling wallpaper boarder. 1/28. Room 104 chipped corner near bathroom. Installed corner guard. 1/28. Floor tile behind fire door missing. Replaced missing tile. 1/29. Peeling wallpaper on B Hall Hallway between 109-111. Removed peeling wallpaper. 1/27. Room 110 has stained yellow tile. Stripped tiles to remove yellow stain 1/28. Room 110 missing cove base near bathroom entrance. Installed new cove base. 1/28 Room 110 has detached wallpaper boarder. Reattached and secured wallpaper boarder. 2/2. Room 112 accumulation of black stripping on wall. Removed black substance with magic eraser. Room 113 Stained tile around perimeter of toilet. Removed toilet and replaced discolored tile. 2/3. Room 115 hole behind head of bead. Repaired 2/4. Wallpaper boarder peeling. Secured peeling wallpaper boarder. 2/1. Wooden night stand chipped. Removed night stand and replaced. 2/3. Chipped paint on wall by window. Removed chipped area of paint and repainted.2/5. 115 bathroom has rust colored residue around toilet. Removed discolored tile and replaced. 2/6. Base Board marred by bathroom. Removed and replace marred base board. 2/5. Bathroom wall missing paint. Repainted unpainted area. 2/6. Floor Tiles discolored pink. Removed discolored tile and replaced with new VCT tile. 2/9. Room 116 Paint in Bathroom scraped and marred. Repainted troubled	

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F 253	Continued From page 2 Observation on 1/25/15 at 5:00 PM of shower room on A Hall had 4 diaper barrels in it, the toilet had yellow water in it with toilet paper present in the toilet, the whirlpool was not connected to drain, three upholstered chairs, two shower chairs, a bedside cabinet were all stored in the shower room. The floor in shower stall was black where floor met walls, had broken tile and black matter on grout and in areas that tile was missing. Also there was a bedside commode stored in the shower room. There was no privacy curtain for the shower stall. Interview on 1/26/15 at 1:23 PM with the maintenance director revealed it was the responsibility of the housekeeper to clean shower rooms, resident rooms and halls.. Observations on 1/27/14 at 12:40 PM shower room D revealed three diaper barrels, one television stand, a pressure washer, sink breaking loose from wall, three diaper barrels, three trash barrels, one upholstered chair, one walker with hand brakes, wholes in spackle attaching sink to wall, wrinkled used paper towels on floor, one television stand, one bariatric shower chair, one slide shower chair, two shower chairs, black between tiles where broken tiles were located, where the floor met the wall, two lifts and one shower bed. Observations on 1/27/15 at 12:45 PM revealed shower room A had a whirlpool tube that was not connected to the drain, the drain was not connected to anything, two beside commodes, two shower chairs, three upholstered chairs were all stored in the shower room and there was black colored matter between the tiles where the wall met the floor and broken tiles in the same area.	F 253	area of bathroom. 2/2. Room 117 Tiles missing on the right of floor door opens. Replaced missing tile. 2/1. 117 name plate missing ? of name plate. Replaced with new name plate. 2/2. Room 118B Drywall had chip 5 inches long around bathroom door. Repaired 2/3. Large 2 chip across from toilet in Bathroom. Repaired and spackled 2 chip.2/5. Room 121 Paint chipped on wall adjacent to door. Spackled chipped area 2/2. 5 Brown droplets of paint by door. Removed droplets with floor scraper. 2/5. 2. Audit of Rooms having the potential have been identified by the Maintenance Director and was completed by Maintenance Director . 2/5/15 3. Re-education of staff related to communicating to Housekeeping and Maintenance completed 2/5/15. Notebook will be maintained at the nursing station to log any maintenance concerns. Preventive Maintenance Room Check Sheet will be used by the Maintenance Director or Designee. This Quality Improvement Monitoring will be used to select 4 rooms each week for 12 weeks by the Executive Director or Designee. Rooms selected will be audited and inspected, and any identifiable issues will be marked on the audit tool, and repairs will be remedied. 4. Results of the Quality Improvement Monitoring will be discussed at the monthly Quality Assurance Performance	

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F 253	Continued From page 3 Observations on 1/28/15 at 8:00 AM revealed in shower room D a plastic razor cap was on the floor, a shower bed, three shower chairs, one slide shower chair, a pressure washer, a television stand, a walker, an upholstered chair and one disposable brief barrel were all stored in the shower room. The floors remained unchanged with black between the broken tiles. The grout was black where the floor met the walls. There was paper on the drain plate in the third shower stall. Interview on 1/28/15 at 8:05 with housekeeper #1 revealed that A shower room was clean. Went to the shower room with the housekeeper and she reported that she wiped the shower stall down twice a day. She would spray a disinfectant and wipe down the stall. She also indicated that she mopped the floor daily. When asked if she had reported the broken tiles to the maintenance director she said " no " but she was sure he knew they needed to be replaced. The housekeeper continued that the floor tech used a scrubber broom to scrub to clean the floor twice a week. She continued that the chair shouldn ' t have been in the shower room but in the dining room, the bedside commode should be in the storage building, the television stand had been there a long time, the broken tiles were reported to her supervisor and therapy brought the walker in the shower room. There was a book to write in items that needed to be done but she had not written those items in the book. She said the barrels were pushed into the shower room when the trays came out. Interview with housekeeping supervisor on 1/28/15 at 8:10 AM revealed that she checked the	F 253	Committee meeting for three months. The committee will recommend revisions to the plan to sustain substantial compliance. (Part 2)- 1. On 1/29/15 all clutter and equipment was removed from Shower room D. All black matter was removed and repair was provided by maintenance. Privacy curtain was replaced in shower room for D hall. 104B privacy curtain was replaced. 101 bathroom floor was cleaned, 101 commode was cleaned and disinfected. 102 bathroom floor and room floors were cleaned. 110 A floor tile was cleaned. On 2/25/15 the floor is scheduled to be stripped and refinished. 111A white fan motor was cleaned. 115B base around toilet was cleaned. 118B maintenance request completed on 2/20/15 to replace caulk surrounding commode. 2. On 1/29/15 an audit was completed for shower room A and D by the regional & District Housekeeping managers. Areas of black matter in tile, corners, and where the floor met the wall was cleaned. The privacy curtain was replaced. Shower rooms A and D floors were pressure washed. On 1/29/15 an audit was conducted for all resident's rooms and bathrooms for cleanliness and areas of concern were addressed. A privacy curtain audit was conducted for the facility and any room identified was listed for curtain replacement. 3. Quality control inspection of each housekeeping assigned areas have been	

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F 253	Continued From page 4 resident rooms and the shower rooms after the housekeepers complete the day. They deep cleaned a resident room daily. The housekeepers were suppose to report broken tiles. The maintenance director had a maintenance book and staff wrote what maintenance items needed to be done. He knew about that. Observations on 1/28/15 at 8:15 AM of shower room D revealed six barrels of soiled linen, adult soiled briefs and trash, the sink coming off the wall, two lifts, a power washer, one upholstered chair, television stand, were all stored in the shower room. There were no privacy curtains hanging at the three shower stalls. Interview and observation of shower room D with Housekeeper #2 at 8:30 AM on1/28/15, revealed that the facility had stored in shower room D barrels the aides brought in to the shower room from the halls, the sink attached to wall had not been reported, the lifts went to restorative and to clean floor the floor tech used a brush on them or used the power washer every weekend. The television stand had been there a long time, the broken tiles were reported to her supervisor. There was a book to write maintenance problems that needed to be done. She continued that she had not reported these maintenance problems. Therapy brought in the walker. Interview on 1/28/15 at 10:36 AM with the maintenance director revealed one or two tiles needed to be replaced. He said he had to get to it. When there were maintenance issues, he talked to staff. The staff was to write a work order or contact him personally for any maintenance problems. The maintenance director continued	F 253	completed 5x a week beginning 1/28/15 with revision with QAPI meeting. In-services will be completed with all staff by 2/22/15 on revisions to daily cleaning routines. In-service housekeeping staff on required bathroom cleaning and maintenance. In-service and training for housekeeping staff on revision of daily focus calendar including a weekly deep cleaning of shower rooms. In -service housekeeping staff on shower room quality control tool. an audit was completed for privacy curtains by housekeeping manager on 1/29/15. A list of privacy curtains needing replacement was given to Executive Director on 2/20/15. An in-service was completed with housekeeping staff on recording maintenance related issues in the maintenance request log located at the nurse station. A housekeeping log and laundry log will be placed at the nurse station to report needs. The Housekeeping Manager will be responsible for the Quality Control Inspection of the housekeeping areas on an ongoing daily basis. The District Manager will be do unit inspections ongoing on a monthly basis. 4. Results of the quality improvement monitoring will be discussed in the Quality Assurance Performance Improvement Committee meeting monthly for three months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance. 5. Allegation of Compliance date: 2/22/15	

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that staff said there were no broken tiles, the issue was with the grout. He continued that the pressure washer was for cleaning wheelchairs. The whirlpool was not working and had never worked since he had been at the facility, over one year. He said he did go into the shower rooms to make sure lights were working and take hot water temperatures. He did not clean. He had not had time to check out showers to see what maintenance problems needed to be repaired.

Observation on 1/25/15 at 4:24 PM revealed the C hall had was two wheelchairs, one geri chair, one carton of gloves with one box in the carton, one lateral file cabinet in a crate, a television and a cushion that were all sitting in the hall way, narrowing the hallway.

Interview on 01/29/2015 at 8:24 AM with the floor technician revealed that he cleaned the shower rooms once a week on Sundays. He last cleaned the shower rooms on Sunday at 10:00 AM.

Observations on 1/29/15 at 8:24 AM revealed that he was hanging privacy curtains in shower room D.

Observations on 01/26/2015 at 09:40 AM in room 101B revealed that the resident reported that she did not want to use the "nasty bathroom", stain during the observation revealed that the toilet bowl seat there was a substance similar to fecal material. Housekeeper #1 was requested to clean the area prior to the resident using the commode. There was stained floor tile and the base of the commode was loose and not attached to the floor when touched.

Observations on 01/26/2015 at 09:33 AM

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revealed the closet drawer for 102A was missing. There was a build up of black colored stains around the perimeter of the toilet base. The bathroom floor had dried stains for the floor in front of the toilet.

Observation on 01/26/2015 at 10:09 AM in room 104B revealed an approximate 3 foot gap when privacy curtain was pulled around bed B.

Observations on 1/26/15 at 10:11 AM revealed in room 104B a 2 foot gap in curtains when drawn.

Observations on 1/26/15 at 10:14 AM revealed in room 104B peeling wall paper border, 2 separate areas of peeling pain on the walls near A bed. There were chipped wall on the corners near bathroom entrance.

Observation on 01/26/2015 at 02:36:42 PM revealed missing floor tile behind the door. There was also peeling wall paper on wall in hallway between rooms 109-111.

Observations on 01/26/2015 at 02:05 PM revealed in room 109A, the handrails had an accumulation of dried brown substance on both upper hand rails

Observations on 01/26/2015 at 02:09 PM in room 110 A revealed dried golden color spill in front of bed A at the foot of the bed, approximately 12 inch by 6 inch chunk of wall plaster missing, there was also missing cove molding near the bathroom entrance, yellow stained floor tiles noted in between the closet and dresser drawer and the wall paper boarders were partially detached from the wall

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F 253	Continued From page 7 Observations on 1/28/15 at 3:30 PM revealed that resident room 111A had a white fan on the wall that was covered with dust on the fan and motor. Observations on 1/26/2015 at 03:52 PM in room 112 A revealed the wall beside bed had an accumulation of black striped markings on the wall. Observations on 01/26/2015 at 02:50 PM revealed on room 113 A the bathroom floor had stained floor tile and the perimeter of the commode was dirty Observations on 1/26/2015 at 02:22 PM revealed in room 115 B that the paint in the room had multiple scrape marks; the wooden nightstand had chipped white paint; there was chipped paint on outside wall by window; wallpaper border peeling/discolored on bottom. There was a large hole in wall (10"x3" behind HOB) (head of bed) that was all the way through the dry wall. The baseboard in the corner by bath room was marred. The bathroom appeared to have brown, rusty colored residue around toilet; floor tiles had brown/black discolored areas between tiles; tiles were discolored (pink); paint problems with large areas not painted and all walls had heavy scrapes on them. Observations on 01/26/2015 at 03:13 PM revealed in room 116A the paint in the bathroom was scraped/marred; (freshly re-caulked around toilet); Observations on 1/25/15 at 4:20 PM revealed that room 117 had tiles missing on the floor at the right side of door where the door opened. The resident name plate hanging on the wall was	F 253		

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F 253	Continued From page 8 broken, about one fourth of the name plate was missing. Observations on 01/26/2015 at 03:38 PM in room 118 A had drywall in room that had a chipped area approx 5" long going around the corner of the bath room door. In the bathroom there was a large chip approximately 2" off of the bathroom wall across from toilet and there was a black/brown residue around base of the toilet, black/brown residue noted between tiles in the bathroom. Observations on 01/26/2015 at 03:54PM revealed in room 118B drywall in room had a chipped area approximately 5" long going around the corner of the bath room door. In the bathroom there was a large chip approx 2" off of the bathroom wall across from the toilet, there was a black/brown residue around base of the toilet; black/brown residue noted between tiles in the bathroom. Observations on 01/26/2015 at 03:46 PM revealed in room 121 A that paint was chipped on wall adjacent to door; 5 brown droplets approximatelt 6" long of paint by door.	F 253		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR 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	F 312		2/21/15

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F 312	Continued From page 9 by: Based on observations, record review and interviews with facility staff and family member, the facility staff failed to provide nail care for 1 of 1 sampled resident. (Resident #19). The findings included: Resident #19 was admitted to the facility on 4/28/10 and readmitted to the facility on 9/19/14. Admitting diagnoses included rehabilitation, altered mental status, anemia, deconditioning, cerebral vascular accident and hemiplegia. Care Plan last updated 12/18/14 Problem: Cognitive/Communication impaired resident requires assistance with ADLs (Activities of Daily Living) due to left side weakness. Goal: Resident will be clean dressed and out of bed daily to wheelchair as tolerated X 90 days. Approaches: Promote optimal participation. Anticipate needs. Orient to task. Careful not to overwhelm Allow sufficient time for completion of task Praise resident for any attempts at self care. Provide one to two person assistance with ADLs. Encourage independence and involvement. The most recent quarterly MDS (Minimum Data Set) dated 12/22/14 revealed that the resident had problems with short and long term memory, Resident #19 required extensive assistance with one person physical assistance with bed mobility, transfers and dressing. The resident required	F 312	F312- 1. Resident # 19 had his nails cleaned of debris and clipped immediately after the surveyor identified the issue. 2. An audit was completed on 01/28/15 for all residents that reside in the facility to assess the need for nail care by the Director of Clinical Services, Unit Manager and the charge nurses. Nail care was provided to all residents identified. Any resident identified that would require the services of a podiatrist was added to the upcoming visit list. 3. All licensed and certified staff was retrained in ADL care by the Director of Clinical Services and Unit Manager on 01/28/15 regarding the need to provide nail care per policy. Nail care will be provided on shower days and as needed to meet the resident□s needs. Quality Improvement Monitoring for 10 % of resident population will be completed by the DCS or designee 3 times weekly x 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 4 weeks 4. Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Improvement Committee Meeting monthly for three months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance. 5. Date of alleged compliance 02/18/15	

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supervision with set up help only for eating and required total dependence with one person physical assistance with toilet use, personal hygiene and bathing. He had no impaired with range of motion, was not incontinent with bladder but always incontinent of bowel. His weight was stable.

An undated policy titled " Care of Nails " revealed the following procedure:

Explain procedure to resident and bring the following equipment to resident ' s bedside: Basin, towel, emery board, orange stick, nail clippers. Place towel beneath the area to be treated. May soak one hand in basin half full with warm water if needed. Trim fingernails. Clean nails with orange wood sticks.

Interview on 1/26/15 at 1:49 PM with family member revealed that the facility did not keep the residents finger nails trimmed and cleaned as often as the resident would have, prior to coming to the facility. She continued that he ate some foods with his fingers and his nails needed to be cleaned after each meal.

Observations on 1/26/15 at 3:30 PM revealed that the resident was taking a nap. His finger nails were about ¼ of an inch over the tip of his fingers and were jagged. They also had brown matter under them.

Observation on 01/28/15 12:58 PM revealed Resident #19 sitting up in bed eating his lunch. His finger nails needed trimmed. They were about 1/4" above the tip of his fingers and were jagged at the top with brown matter under them.

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F 312	Continued From page 11 Interview on 01/28/15 at 1:33 PM with NA #1 (nurse aid) revealed the she cleaned finger nails every other day but did not do any today. NA #1 continued that she did clean nails during the resident ' s daily bath. She cut finger nails if they needed it with the finger nail clippers. Interview on 01/28/15 at 1:49 PM with Nurse #4 revealed that she would try to help the NAs cut finger nails. She would tell the NAs what needed to be done. All of the residents needed about the same type care. Observation with the DON (Director of Nursing) on 1/28/15 at 4:15 PM revealed that she did not think the nails were to long because he was not hurting himself or picking at stuff. Her expectation was that when the nails were soiled, they needed to be cleaned. Trimming was up to resident preference or safety issue.	F 312		
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 observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 33 opportunities for 2 of 6 residents (Resident #37 and Resident #56) observed during medication	F 332	F-332 1. Resident # 37 was provided a sandwich and juice and the physician was notified of the medication being given too early. The instructions were to observe the resident for any signs or symptoms of	2/21/15

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F 332	Continued From page 12 pass, resulting in a medication error rate of 6%. The findings included: 1) Resident #37 was admitted to the facility on 4/23/12 with cumulative diagnoses which included diabetes. During the medication administration observation on 1/27/15 at 4:18 PM, Nurse #1 was observed as she checked Resident #37 ' s blood sugar level and obtained a result of 147 milligrams/deciliter (mg/dl). A typical normal result for a random blood sugar test is less than 140 mg/dl. Immediately after checking Resident #37 ' s blood sugar, Nurse #1 prepared and administered 6 units of NovoLog insulin (with a generic name of insulin aspart) to the resident as a subcutaneous (under the skin) injection. NovoLog insulin is a rapid-acting insulin analog which is normally administered as a premeal component of the insulin regimen. A review of the January 2015 Physician ' s Monthly orders for Resident #37 included a scheduled order for 6 units of NovoLog insulin to be injected subcutaneously three times daily with meals at 8 AM, 12 PM, and 6 PM. According to the manufacturer ' s prescribing information for NovoLog insulin (revised 1/2015), " NovoLog has a more rapid onset of action and a shorter duration of activity than regular human insulin. An injection of NovoLog should immediately be followed by a meal within 5-10 minutes. " An interview was conducted with Nurse #1 on 1/27/15 at 4:38 PM. During the interview, the	F 332	hypoglycemia. No negative outcomes were noted. Resident # 56 had the fentanyl patch applied per manufactures guidelines Resident # 56 was assessed for side effects related to improper application of the Fentanyl patch with no negative outcome. 2. All residents that receive Insulin were review by the director of Clinical Services on 1/28/17 to ensure that medication was given as directed and licensed staff was adhering to manufactures guidelines. Medications for all residents that are currently receiving a Fentanyl patch as part of their pain management were assessed By the Director of Clinical Services 1/28/15 to identify those in need to have first aide tape applied to outer edges to ensure that the Fentanyl patch stayed in place. No other resident were identified. 3. All licensed staff were re-educated on the recommended time frames for the administration of insulin by the Director of Clinical services on 1/28/15, Unit Manager on 1/29/15 the and the Nurse Pharmacy consultant 2/16/15. This will be completed through medication pass observation for a shift weekly (5 shifts) for 4 weeks, then one nurse per shift monthly for 3 months All charge nurses were educated on the proper application of the Fentanyl patch by the Director of Clinical Services on 1/28/15, the unit manager on 1/29/15 and Pharmacy Nurse Consultant on 2/16/15. The facility will monitor application of the Fentanyl through the compliance of documentation on the MAR. An audit of the charge nurses initials and validate	

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F 332	Continued From page 13 scheduled time for the NovoLog insulin (6:00 PM) was discussed and the nurse acknowledged that the NovoLog insulin was given before it was scheduled to be administered. Upon inquiry, the nurse stated that " between 5 PM and 7 PM " would have been an acceptable time frame to give a dose of NovoLog insulin scheduled for 6:00 PM. When asked what she needed to do at this point in time, the nurse indicated that she needed to give the resident something to eat so his blood sugar would not drop too low. An interview was conducted with the Director of Clinical Services (DCS) on 1/27/15 at 4:50 PM. During the interview, the DCS reported that she would expect the NovoLog insulin to be given with a meal, as ordered by the physician. The DCS reported that while most medications could be administered 60 minutes before or after their scheduled time of administration, this would not be recommended for NovoLog insulin. The DCS indicated that she would expect NovoLog insulin to be given closer to the scheduled administration time for this medication as it needed to be coordinated with the timing of a resident ' s meal. The DCS acknowledged that giving Resident #37 his dose of NovoLog insulin 1 hour and 40 minutes before its scheduled administration time was too early and that such timing could potentially increase the resident ' s risk of experiencing hypoglycemia (low blood sugar). 2) Resident #56 was admitted to the facility on 10/23/09 with cumulative diagnoses which included hemiplegia (weakness or paralysis of one side of the body). During the medication administration observation on 1/28/15 at 10:25 AM, Nurse #2 was observed	F 332	that proper placement of fentanyl on the resident every 3 times weekly for 4 weeks and the 1 time weekly for 2 weeks and then 1 time monthly for 2 months. 4. Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Improvement Committee Meeting monthly for three months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance. 5. Compliance met on 2/16/15	

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F 332	Continued From page 14	F 332		

as she removed a fentanyl patch (an opioid analgesic used for the management of severe pain) dated 1/25/15 from Resident #56 ' s upper left chest. This patch was observed to have first aid tape adhering to it. After disposing of the removed patch, Nurse #2 was observed as she removed a 25 microgram/hour (mcg/hr) fentanyl patch from its packaging, dated it, and applied the new patch on the resident ' s upper right chest area. After the new patch was applied to the resident ' s skin, the nurse placed first aid tape on the patch. As she applied the first aid tape to the patch, Nurse #2 reported that the tape was used to ensure the patch remained in place.

A review of the January 2015 Physician ' s Monthly orders for Resident #56 included an order for a 25 mcg/hr fentanyl patch with instructions to apply one patch topically every 72 hours (remove old patch first).

According to the manufacturer ' s prescribing information (revised 5/2014), " If problems with adhesion of the fentanyl transdermal system occur, the edges of the patch may be taped with first aid tape. " Additional guidance provided by the manufacturer ' s Instructions For Use read, in part: " If you have a problem with the patch not sticking, apply first aid tape only to the edges of the patch. "

An interview was conducted with Nurse #2 on 1/28/2015 at 2:30 PM. During the interview, inquiry was made as to how the first aid tape was intended to be applied in relation to the fentanyl patch used for Resident #56. Nurse #2 stated, " Over the entire patch. " Upon request and with permission of the resident, Nurse #2 brought the resident to her room and inspected the fentanyl

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F 332	Continued From page 15 patch and application of first aid tape. When asked how much of the fentanyl patch was covered with the first aid tape, the nurse replied, "the whole thing." Upon review of the manufacturer ' s prescribing information which indicated that first aid tape should only be applied to the edges of the patch, Nurse #2 indicated that she was unaware of this. An interview was conducted with the Director of Clinical Services (DCS) on 1/28/15 at 2:45 PM. The practice of using first aid tape to cover Resident #56 ' s fentanyl patch was discussed. The DCS stated she was not aware that first aid tape should not be used to cover the fentanyl patch as this was the usual practice for applying the fentanyl patch to the resident. The DCS indicated that she would confer with the facility ' s consultant pharmacist on this topic and that a nursing in-service would need to be done to educate staff on the application of a fentanyl patch. A telephone interview was conducted with the facility ' s consultant pharmacist on 1/28/2015 at 3:30 PM. The pharmacist indicated he had contacted the manufacturer of the fentanyl patch and was told that tape should only be used around the edges of the fentanyl patch. The pharmacist reported that he was in the process of obtaining additional information from the manufacturer in regards to the adhesion of a fentanyl patch.	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.	F 333		2/20/15

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F 333	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer a dose of NovoLog insulin in accordance with the scheduled administration time, physician ' s order and manufacturer ' s prescribing information for 1 of 1 residents who received an insulin injection during the medication administration observation. The findings included: Resident #37 was admitted to the facility on 4/23/12 with cumulative diagnoses which included diabetes. During the medication administration observation on 1/27/15 at 4:18 PM, Nurse #1 was observed as she checked Resident #37 ' s blood sugar level and obtained a result of 147 milligrams/deciliter (mg/dl). A typical normal result for a random blood sugar test is less than 140 mg/dl. Immediately after checking Resident #37 ' s blood sugar, Nurse #1 prepared and administered 6 units of NovoLog insulin (with a generic name of insulin aspart) to the resident as a subcutaneous (under the skin) injection. NovoLog insulin is a rapid-acting insulin analog with an onset of action of 0.2 - 0.3 hours (12 - 18 minutes). NovoLog insulin is normally administered subcutaneously as a premeal component of the insulin regimen. A review of the January 2015 Physician ' s Monthly orders for Resident #37 included a scheduled order for 6 units of NovoLog insulin to be injected subcutaneously three times daily with	F 333	F-333 1. Resident #37 was provided a sandwich and juice after Novolog insulin was not given with meal. MD was made aware that Novolog insulin was given early. Charge nurse was provided education and was instructed to monitor for signs or symptoms of hypoglycemia. Resident # 37 had no adverse reaction to Novolog insulin that was given to early. 2. This practice could affect all residents who receive medications ordered to be given with meals. An audit by the Director of clinical services on 1/30/15 was completed of all residents with medication orders to give with meals to assure the times of medications prescribed with foods or meals were scheduled appropriately. All residents could potentially be affected by this practice of administering medications outside the prescribed timeframes. Education was provided by the Director of Clinical Services to licensed staff including medication required to give with food with an emphasis compliance of medication time frames of 1 hour before or 1 hour after unless contraindicated. Medication pass was completed for each licensed staff member by 2/16/15 with the Director of Clinical Services or designee. 3. The DCS retrained the licensed nursing staff on the need to administer	

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F 333	Continued From page 17 meals at 8 AM, 12 PM, and 6 PM. Based on the facility ' s meal schedule, evening meals were served in the Dining Room at 5:30 PM - 5:40 PM and on the D Hall (Resident #37 ' s hall) at 5:45 - 5:50 PM each day. According to the manufacturer ' s prescribing information for NovoLog insulin (revised 1/2015), " NovoLog has a more rapid onset of action and a shorter duration of activity than regular human insulin. An injection of NovoLog should immediately be followed by a meal within 5-10 minutes. " Under the heading of Warnings and Precautions, the prescribing information for NovoLog also reported, " Hypoglycemia (low blood sugar) is the most common adverse effect of all insulin therapies, including NovoLog ....The timing of hypoglycemia usually reflects the time-action profile of the administered insulin formulations. " An interview was conducted with Nurse #1 on 1/27/15 at 4:38 PM. During the interview, the scheduled time for the NovoLog insulin (6:00 PM) was discussed and the nurse acknowledged that the NovoLog insulin was given before it was scheduled to be administered. Upon inquiry, the nurse stated that " between 5 PM and 7 PM " would have been an acceptable time frame to give a dose of NovoLog insulin scheduled for 6:00 PM. When asked what she needed to do at this point in time, the nurse indicated that she needed to give the resident something to eat so his blood sugar would not drop too low. An interview was conducted with the Director of Clinical Services (DCS) on 1/27/15 at 4:50 PM. During the interview, the DCS reported that she would expect the NovoLog insulin to be given with	F 333	Insulin at the recommended times or as prescribed by the physician on 1/27/15 The DCS or designee will complete a medication pass observation and do immediate retraining with all licensed nursing staff by 2/16/15. Medication observation pass will be completed weekly with one nurse from each shift (total of 5 shifts) for 4 weeks, then monthly for 3 months. Medication passes to include insulin administration times. 4. The Director of Clinical Services or designee will complete one medication pass observation from each shift weekly (total of 5 shifts) for 4 weeks and then once (5 shifts) for 3 months. Medication passes to include medication times. Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Improvement Committee for three months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance 5. Date of alleged compliance 2/18/15	

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F 333	Continued From page 18 a meal, as ordered by the physician. The DCS reported that while most medications could be administered 60 minutes before or after their scheduled time of administration, this would not be recommended for NovoLog insulin. The DCS indicated that she would expect NovoLog insulin to be given closer to the scheduled administration time for this medication as it needed to be coordinated with the timing of a resident ' s meal. The DCS acknowledged that giving Resident #37 his dose of NovoLog insulin 1 hour and 40 minutes before its scheduled administration time was too early and that such timing could potentially increase the resident ' s risk of experiencing hypoglycemia (low blood sugar). An interview was conducted on 1/29/15 at 2:08 PM with the Nurse Practitioner (NP) caring for Resident #37. During the interview, the timing observed for the administration of Resident #37 ' s NovoLog insulin on 1/28/15 was discussed. Upon inquiry, the NP addressed the potential severity of administering rapid-acting insulin 1 hour and 40 minutes prior to its scheduled administration time and the resident ' s mealtime. The NP stated, "It could potentially cause an adverse event ....would prefer it (NovoLog insulin) be given with a meal." The NP also indicated that based on the literature, she would prefer that the nursing staff checked a resident ' s blood sugar level prior to mealtime (if ordered), then waited until the resident's meal tray was available before administering a rapid-acting insulin such as NovoLog.	F 333		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		2/21/15

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F 334	Continued From page 19 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal	F 334		

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F 334	Continued From page 20 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, nurse practitioner and staff interviews, the facility failed to develop a policy/procedure that included how the facility would monitor, track, and identify the immunization status of the resident. The policy and procedure failed to address issues of what the facility would do should the vaccine not be availability or contraindicated. The facility failed to track which residents or responsible parties were provided consent forms and educational information regarding influenza and pneumococcal vaccinations. This was evident in 5 of 6 residents reviewed for the administration of	F 334	F-334 1. Resident # 7 RP was provided education on flu and pneumonia vaccine. Consent was obtained and both vaccines were administered 01/29/15. Resident # 32 RP was provided education regarding the flu and pneumonia vaccine by phone and the flu and pneumonia vaccine was administered on 01/ 29/15. Resident # 44 RP was provided information regarding flu and pneumonia vaccine. The RP declined the vaccine at this time. Resident had received the flu	

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F 334	Continued From page 21 the influenza and pneumococcal vaccinations. (Residents #7, #103, #56, #44 and #32) Findings included: A review of the policy and procedure for influenza vaccine (undated) revealed the following: 1. There was no processes to address issues that were out of the facility ' s control such as the availability of the vaccines due to production delay or distribution problems. 2. There was no processes to address the presence of a precaution in a resident that may warrant a delay in being vaccinated. 3. There was no identification, tracking and monitoring of a resident ' s vaccination status that included a medical contraindication or the delay in administration of the vaccines. Record review revealed an email dated August 28, 2014 at 12:42 PM was sent Nurse #9(an administrative nurse who worked during the director of nurses (DON) transition) and the interim DON with high importance. This e-mail from the corporation addressed the 2014-1015 influenza information. The email included consent for immunization and logging the influenza vaccine. Interview on 1/29/15 at 12:16 PM via the phone with Nurse #9 in the presence of the corporate representative was conducted. During the interview Nurse #9 revealed she sent out consent forms and educational information regarding the vaccinations to responsible parties and provided the same to alert and oriented residents in late September and October 2014. Nurse #9 could not indicate which residents or responsible parties received the information. Further interview with Nurse #9 indicated that she	F 334	and pneumonia vaccine at his primary care physician at Bethany Medical Center in High Point earlier in October. Resident# 56 RP was provided education on the flu and pneumonia vaccine. Consent was obtained and the flu and pneumonia vaccine was administered on 01/29/15. Resident # 103 was provided education on the flu and pneumonia vaccine. Resident declined both vaccines stating that had received them earlier in October. Documentation on the immunization record was placed in each chart. 2. An audit of all residents records was completed by the Director of Clinical Services and the unit manager on 1/28/15. Residents that did not have a flu consent form noted in chart; the Director of clinical services, unit manager and the nurse practitioner provided education via phone or in person to the resident or RP. Consent forms were completed and the facility provided either documentation of the vaccine being given or that the resident had declined the vaccine in the medical record. 3.The facility put into place a form used for tracking consent forms for the flu and pneumonia and providing residents or responsible party with education on the flu and pneumonia vaccine. The tracking consists of date consent sent, obtained, acceptance or refusal of vaccine for flu and pneumonia as well as the date the vaccine was administered. Education was providing to the staff by the Director of Clinical Services on obtaining consent forms. The Admissions Director will address with each new admission the	

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(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 334	Continued From page 22 instructed the interim DON and the current DON to place a copy of the returned consents in a binder and stated the facility had no established tracking mechanism. Nurse #9 indicated that she stopped working at the facility before the immunizations were administered. Interview on 1/29/15 at 11:00 am with the current DON revealed an inquiry was made for the tracking and identification of the resident's immunization. The DON indicated that she and the nurse practitioner (NP) had a discussion about the problems with the tracking and identification of the resident's immunization but at the time of the survey had not developed a plan to address these problems. Interview on 1/29/15 at 11:10 am with the NP revealed on her monthly visits she has been determining whether or not the vaccines had been provided to her resident. During the interview the NP indicated that she just called (1/29/15) the responsible party for verbal consent for Resident #56 to be administered the flu vaccine. Review of the Medication Administration Record (MAR) revealed Resident #56 was immunized with the flu vaccine on 1/29/15. Resident # 7 consent was obtained on 1/29/15 and was administered the flu vaccine. Additionally the NP indicated on 1/29/15 she called the responsible party of Resident #32 (who was readmitted on 9/19/13). A consent was obtained on 1/29/15 and orders were written on 1/29/15 for the administration of the influenza vaccine and the pneumococcal vaccine. Interview on 1/29/15 at 11:30 am with the unit manager (who shared joint responsibility for the infection control program with the current DON)	F 334	consent forms to accepted or decline the flu and pneumonia vaccine this will be given to the Director of Clinical Services or designee to log and follow up for compliance. The Director of Clinical Services will send consent forms in September to all residents that reside at the facility. Tracking of the return forms will be maintained by the Director of Clinical Services or designee. Weekly follow-up for forms that were not returned will begin the 1st week in October and continue until all consents have been accounted for by the Director of Clinical Services or designee. 4. Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Committee Meeting monthly for three months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance 5. Compliance 2/16/15	

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F 334	Continued From page 23 indicated the facility have did not have a system for the immunization of the flu or pneumococcal vaccine. The unit manager indicated she was currently being trained by the DON and was just provided signed influenza consent forms. Continued interviews with the unit manager indicated she then gave these signed consents to the 3 PM- 11 pm shift nurse but was not sure which one. Interview on 1/29/15 at 11:52 PM with the administrator and DON was held. The DON repeated that the facility did not have a developed policy and procedure that ensured each resident received the flu vaccinations Record review revealed Resident #103 ' s immunization record was blank. There was no evidence that the resident received the flu or pneumonia in the medical record. An inquiry was made to Nurse #6 about the status of Resident ' s #103 immunizations. Further interview on 1/29/15 at 3:57 PM with Nurse #6 revealed she asked Resident #103 on 1/29/15 at 4 PM whether she had received her immunization. Resident #103 indicated that prior to admission she had received her flu shot. Review of Resident #44 ' s medical record revealed the resident was admitted on January 5, 2015 and there was no evidence to support whether the influenza or pneumococcal was administered prior to the admission to the facility. The RN/unit manager reviewed the medical record with the surveyor and was not able to determine whether the resident was immunized. The immunization record in the medical record was blank.	F 334		

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F 334	Continued From page 24 Interview on 1/29/15 at 5:42 PM with the administrator revealed he expected his staff to log, monitor follow-up on consents received and which resident was immunized.	F 334		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION 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.	F 356		2/20/15

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F 356	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interview, the facility failed to post an accurate daily staffing form since January 19, 2015. The facility failed to the post daily staffing form that was accurate and indicated the facility name. This was evident in 5 of 5 days of the recertification and complaint investigation survey. The findings included: Observation on 1/25/2015 at 4:45 PM during the initial tour revealed the " Daily Nursing Staffing Form " was posted on the wall across from the nurses ' station dated 1/19/15 (6 days). This form was blank in the evening and night shift columns for the resident census and 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 such as registered nurses, licensed practical nurses and certified nurse aides. The facility name was not on the staffing form. .Observation on 1/26/15 through 1/29/15 revealed the " Daily Nursing Staffing Form " was posted but did not bear the facility ' s name. An interview on 1/27/15 at 10:56 AM was completed with the RN Unit Manager responsible for completing the staff posting hours. During the interview, the RN Unit Manager reported she was unsure as to why the staff posting hours had not been completed since 1/19/15. An interview on 1/29/15 at 5:42 PM was completed with the Administrator. During the interview, the Administrator stated that he expected the staff posting to be completed and	F 356	1. There were no individuals immediately affected by the failure of the facility to post the staffing requirements. The posting was corrected immediately after being reported by the surveyor. 2. All residents or visitors could potentially be affected if they chose to view the facility staffing levels. The facility will assure the staffing is posted correctly daily and revised for each shift. 3. The licensed staff was educated on the requirements for staff posting of hours and census. The staffing will be posted daily by the charge nurse working the #1 cart for each shift. The Director of Clinical Services or designee will monitor daily for compliance. This monitoring will be daily for 3 months. 4. Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Improvement Committee meeting monthly for three months. The Quality Assurance Performance Improvement committee will recommend revisions to the plan to sustain substantial compliance. 5. Date of compliance 2/16/15	

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F 356	Continued From page 26 posted daily.	F 356		
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, record review and resident and staff interviews, the facility failed to clean and air dry dishes to prevent food borne illness. The facility also failed to label and date the dialysis snacks for 3 of 3 dialysis residents (Res. # ' s 27, 43 & 84), and failed to keep the dialysis snacks refrigerated during transport from the facility to the dialysis center. Findings included: Review of the undated facility policy entitled: Storage of Pots, Dishes, Flatware, Utensils, read: " Pots. dishes,and flatware are stored in such a way to prevent contamination by splash, dust, pests, or other means. Procedures: Air dry dishes before storage, or store in a self- draining position. Store dishes 6 inches above the floor. Invert the top plate, bowl, or dish of any stack of dishes. 1. During the initial Kitchen/Food Service	F 371	1. No residents were injured related to this citation. The dishes that were stacked and stored inappropriately were re-washed, allowed to dry completely and stored appropriately per policy. The unlabeled, undated dialysis bags were discarded immediately. New dialysis bags were prepared, labeled, and dated per policy, then stored in the cooler. 2. All residents have the potential to be affected by this citation. An audit was completed of foods, checking for proper labeling and expiration dates, on 1/25/15 by the Food Service Manager. 3. The Food Service Manager inserviced all dietary aides and cooks on proper storage of dishes as well as proper labeling and dating of all foods, including newly prepared foods, leftovers, and, specifically, dialysis lunch bags on 1/27/15. An inservice was also conducted	2/21/15

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F 371	Continued From page 27 observations conducted on 01/25/15 at 4:30 PM twenty-eight of thirty-one sectional plates were observed stored for service with accumulated food debris dried onto the plates. Three of the thirty-one sectional plates were also observed stored for service wet. Seven of twenty-two dessert plates were observed stored for service wet. Three of seventy dinner plates were observed stored for service with dried on accumulated food debris. Twenty-two of thirty one soup bowls were observed stored for service with accumulated dried food debris and ten of the twenty-two soup bowls were also stored for service wet. One three layered dish rack where the soup bowls were stored, was observed with accumulated food debris on three of three dish racks. A staff interview was conducted on 01/25/15 at 4:50 PM with Dietary Aide #1 and the Evening Cook. When asked the reason the dishes were not cleaned and air dried for service, the Cook and Dietary Aide #1 indicated, "They (referring to Administration) cut back our staff on the evening shift to one Dietary Aide instead of two, about two weeks ago." Interview conducted on 01/27/2015 at 12:45 PM with the Certified Dietary Manager indicated a staff in-service on dish washing and storage would be conducted for all dietary staff, as part of the facility ' s action plan to correct the problem with storage of the dishes. An administrative interview was conducted on 01/29/2015 at 5:35 PM regarding the concerns related to the dishes not being clean and not air dried, and the three layered storage rack not being clean. The Administrator indicated his	F 371	with the transportation coordinator on the process for refrigerating dialysis bags for transportation to dialysis center on 1/27/15. 4. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of the dish storage 5 times per week for 4 weeks, 3 times per week for 8 weeks, 2 times per week for 8 weeks and 1 time per week for 4 weeks and until substantial compliance is obtained. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of proper labeling/ dating of dialysis lunch bags 3 times per week for 4 weeks, 2 times per week for 8 weeks, and 1 time per week for 4 weeks and until substantial compliance is obtained. The results of these audit will be reported to the Quality Assurance Performance Improvement Committee for 6 months and until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but are not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services, Activities Director, Maintenance Director, Food Service Manager, and Minimum Data Assessment Nurse.	

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F 371	Continued From page 28	F 371		

expectations included a written plan of action to correct the dishwashing and storage rack concerns.

Review of the undated facility policy entitled: Food and Supply Storage Procedures - Refrigerated Storage read: Leftovers: Cover, label, date, and store above raw foods. Discard leftovers not utilized within 48 hours.

2. During the Initial tour conducted on 01/25/15 at 4:45 PM of the Kitchen/Food Service area, two of two prepared lunches for residents receiving dialysis were observed not dated and not labeled. The lunches were stored in sealed plastic bags. One of the sealed bags had two chicken salad sandwiches in it, which were not labeled or dated.

3. During the Initial tour conducted on 01/25/15 at 4:45 PM of the Kitchen/Food Service area, one full sized pan of prepared jello was observed stored in the walk-in refrigerator out dated with a date of 01/14/2015. The jello was observed to have a very firm consistency with a rubbery texture to the touch.

A staff interview with the Evening Cook was conducted on 01/25/15 at 5:00 PM. The interview revealed the facility protocol for keeping leftovers such as chicken salad and jello, " Is seven days after being prepared."

An observation of resident # 84 was conducted on 01/26/15 at 11:00 AM. The resident was observed carrying his dialysis snack in a plastic bag out of the facility, unrefrigerated.

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An interview with resident #84(who was deemed by staff as alert and oriented) was conducted on 01/27/15 at 10:50 AM regarding the dialysis snack, and whether the snacks are refrigerated during transport to dialysis. The resident stated, "I get it in a plastic bag. Sometimes it's chicken salad, egg salad, or turkey and cheese. They don't refrigerate the snacks, they just give them to us to hold onto when we leave for dialysis. I usually eat mine around 12:30 PM. "

A staff interview was conducted on 01/27/15 at 10:30 AM with Dietary Aide #2 regarding when the chicken salad sandwiches for the dialysis snacks were prepared and sent with 3 of 3 residents to dialysis on Monday 01/26/15. Dietary Aide # 2 indicated, "The sandwiches were made on Saturday 01/24/15." When asked the reason the dialysis snacks were stored in the reach- in refrigerator not labeled and not dated, the aide could not give a reason. When asked about the process for getting the snacks to the residents on dialysis days, Dietary Aide #1 stated, "We make the snack bags in here (referring to the kitchen), and the Nursing Assistant comes and gets them when it is time for the resident to go to dialysis. We send only the plastic bag (referring to the dialysis snack). We did have little coolers to put the dialysis snacks in, but I don't have them now."

A staff interview conducted on 01/27/15 at 10:15 AM with the NA #1 regarding the system for sending dialysis snacks with residents to dialysis, indicated: "When we are ready to take the residents to dialysis, then the driver gets the plastic snack bag out of the kitchen to take to dialysis."

An interview with resident # 27(who was deemed

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by staff as alert and oriented) was conducted on 01/27/15 at 10:50 AM regarding whether the dialysis snacks are sent with the resident refrigerated. The resident indicated, "No, the snack comes in a plastic bag, and it's not refrigerated. When asked whether the snacks are refrigerated during transport to dialysis, the resident stated, "I get it in a plastic bag. Sometimes it's chicken salad, egg salad, or turkey and cheese. They don't refrigerate the snacks, they just give them to us to hold onto when we leave for dialysis. I usually eat mine around 12:30 PM. "

A resident interview conducted on 01/27/15 at 11:00 AM with Res. #43(who was deemed by staff as alert and oriented) regarding whether the dialysis snack is sent to the resident refrigerated. The resident indicated, "I got chicken salad sent on Monday. They put it in a plastic bag and sometimes a paper bag." When asked if the snack is put in a cooler, the resident indicated, "They don't put it in a cooler. I am there through lunch. I usually eat my snack at 2:30 PM."

An additional resident interview was conducted on 01/27/15 at 11:20 AM with Resident #84 regarding whether the dialysis snack was sent with the resident to dialysis, refrigerated. The resident indicated, "The dialysis sandwich snack is sent in a plastic bag only, and it is not refrigerated."

The concerns related to the lack of labeling of the dialysis snacks in the reach-in refrigerator and the transporting of the dialysis snacks unrefrigerated were shared with the Administrator on 01/29/2015 at 5:35 PM. The Administrator indicated the facility would write an action plan to correct the

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F 371	Continued From page 31 concerns.	F 371		
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 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		2/21/15

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F 431	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility: 1) Failed to label medications with an expiration date in 2 of 3 medication carts (A/F Unit Cart and D/E Unit Cart); 2) Failed to store medications in an a container labeled with the minimum information required for a prescription medication in 2 of 3 medication carts (A/F Unit Cart and D/E Unit Cart); and, 3) failed to keep 1 of 3 medication carts clean. (B/C/D Unit Cart) The findings included: 1a) An observation of the A/F Unit medication cart on 1/27/15 at 7:30 AM revealed an undated, prefilled Lantus insulin pen labeled for Resident #11 was stored on the medication cart. The insulin pen was not labeled with either the date it was put into use or the date it had been placed on the cart. The manufacturer ' s product information indicated that Lantus prefilled insulin pens, once punctured (in use), should be stored at room temperature and used within 28 days. The product information also noted that unopened prefilled pens may be stored at room temperature for up to 28 days. A review of Resident #11 ' s January 2015 Physician Orders revealed there was a current order for the use of Lantus insulin. An interview was conducted with Nurse #3 on 1/27/15 at 7:50 AM. Nurse #3 was the first shift nurse assigned to the A/F Units and the A/F Unit medication cart. Upon inquiry, Nurse #3 reported that any insulin vials or pens needed to be dated with both the date the vial or pen was opened (put	F 431	F-431 1. An audit of medication cart A/F, B/C/D, and D/E was completed by the Director of Clinical Services. For resident #11 the Lantus insulin was delivered on 01/26/15. The Lantus Insulin pen was not placed into refrigerator on delivery. The Lantus insulin pen was dated for the date of delivery which brought this medication into compliance. On cart A/F all loose medications were discarded according to manufactures guidelines. The Spiriva Inhaler capsules were discarded per manufactures guidelines. For Cart D/E was completed by the Director of Clinical Services. Resident # 1 Levemir insulin and Humulin R U-100 were dated for the day of delivery and dates to indicate when medication was placed into services was brought into compliance. The unidentified oblong pill was discarded per pharmacy approved disposal guidelines. An audit of cart B/C/D was completed by The Director of Clinical Services and all medication bottles were cleaned and were free of sticky residue. Medication bottles were wiped and drawer was cleaned. 2. Medication carts for A/F, B/C/D, and D/E were audited by the Director of Clinical Services for medications requiring dates of when they were placed into service. All carts were brought into compliance Medication carts A/F, B/C/D, and D/E were cleaned and all loose medications were removed immediately by the charge nurse. Medication carts A/F, B/C/D, D/E were brought into compliance.	

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F 431	Continued From page 33 into use) and the date it expired. An interview was conducted on 1/27/15 at 11:25 AM with the Director of Clinical Services (DCS). During the interview, the DCS stated that insulin needed to be dated as soon as it was taken out of the refrigerator and/or opened. The DCS reported that staff education would be provided on the dating of insulin. 2a) An observation of the A/F Unit medication cart on 1/27/15 at 7:30 AM revealed that 4 and 1/2 loose, unidentified tablets were lying on the bottom of one of the medication cart drawers. An interview was conducted on 1/27/15 at 7:50 AM with Nurse #3. Nurse #3 was assigned to the A/F Units and the A/F Unit medication cart. During the interview, Nurse #3 stated the loose, unidentified pills needed to be discarded. The nurse was observed as she discarded the unidentified tablets. An interview was conducted on 1/27/15 at 11:25AM with the Director of Clinical Services (DCS). During the interview, the observation of the loose pills lying at the bottom of the A/F Unit medication cart drawer was discussed. The DCS indicated her expectation was for the pills to be stored in properly labeled containers and that any loose, unidentified pills would need to be discarded. 2b) An observation of the A/F Unit medication cart on 1/27/15 at 7:30 AM revealed that eight Spiriva Handihaler capsules sealed in the foil overwrap were lying on the bottom of one of the medication cart drawers. The Spiriva Handihaler capsules were not labeled with the minimum information	F 431	Medication carts A/F, B/C/D, and D/E were cleaned and no sticky residue were noted. All carts were brought into compliance 01/28/15 3. Re-education by the Director of Clinical Services was conducted with all licensed staff regarding cleanliness, proper storage and dating of medications when placed into service on 2/2/15. A cleaning schedule was devised for weekly cleaning of each mediation cart. Education and requirements for proper storage of medication was conducted by the Director of Clinical Services, Unit Coordinator on 1/27/15 and the Pharmacy Nurse Consultant 2/16/15.Through the Quality Assurance Process the nursing department will conduct an audit of the carts 3 x a week for 3 weeks, 2 carts a week for 3 weeks and then a cart per week for 3 weeks. 4. The Quality Assurance Performance Improvement Committee Meeting will be conducted monthly to discuss corrective measure put into place and observations. The QAPI committee/IDT will recommend revisions to the plan to sustain on-going substantial compliance 5. Compliance 2/16/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 34 (including the resident ' s name and directions for use) required for a prescription medication. An interview was conducted on 1/27/15 at 7:50 AM with Nurse #3. Nurse #3 was assigned to the A/F Units and the A/F Unit medication cart. During the interview, Nurse #3 stated that the unlabeled Spiriva Handihaler capsules would need to go back to the pharmacy because, "There's no way to tell who they belong to." An interview was conducted on 1/27/15 at 11:25AM with the Director of Clinical Services (DCS). During the interview, the observation of the unlabeled Spiriva Handihaler capsules lying at the bottom of the A/F Unit medication cart drawer was discussed. The DCS indicated her expectation was for all medications to be stored in properly labeled containers. 1b) Observation on 1/27/15 at 7:05 am of the D hall (for rooms 119, 120, 122, 124, 126 and 128) and E hall (for rooms129-136) medication cart with Nurse #7 revealed Resident #1 prescribed Levemir insulin and Humulin R U100 vials were opened and undated. The manufacturer ' s product information indicated that: · Levemir insulin vials must be discarded when opened after 42 days of use, even if there is insulin left in the vial. · The Humulin R U-100 vial when opened and in-use must be used within 31 days or be discarded, even if they still contain Humulin R U-100. Interview at the time of the observation with	F 431		

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F 431	Continued From page 35 Nurse #7 revealed the insulin vials should be dated when opened. An interview was conducted on 1/27/15 at 11:25 AM with the DCS. During the interview, the DCS stated that insulin needed to be dated as soon as it was taken out of the refrigerator and/or opened. The DCS reported that staff education would be provided on the dating of insulin. 2c) Observation on 1/27/15 at 7:05 am of the D hall (for rooms 119, 120, 122, 124, 126 and 128),and E hall (for rooms129-136) medication cart with Nurse #7 revealed one (1) unidentified loose white oblong pill was noted in the bottom of the drawer. An interview was conducted on 1/27/15 at 11:25AM with the DCS who indicated her expectation was for the pills to be stored in properly labeled containers and that any loose, unidentified pills would need to be discarded. 3) Observation on 1/23/15 at 7:23 am of the medication cart for units B (rooms 109-116), C (rooms 117-118) and D (rooms 121-123-125) revealed nine (9) stored bottles of polyethylene glycol containers. Two (2) of nine (9) containers were stuck to the bottom of the cart. Continued observation revealed a clear sticky substance had spilled and dried in the bottom of the medication cart where the 9 bottles were stored. Interview at the time of the observation with Nurse #2 and Nurse #8 revealed the facility had been monitoring the condition of the cart for weeks and the bottles and cart should be clean.	F 431		