STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 07/31/2015

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F 000	INITIAL COMMENTS 1. On 7/27/15 through 7/30/15 a recertification and complaint investigation survey was conducted. On 7/31/15 an extended survey was conducted. 483.25 (F333) at a scope and severity (J) Immediate Jeopardy began on 7/12/15 the facility failed to prevent a significant medication error by administering Lantus insulin, a long acting insulin, to a resident who did not have a diagnosis of diabetes mellitus (Resident #252) and did not have an order for Lantus insulin and not administering a long acting insulin to a resident with a physician ' s order for long acting insulin (Resident #245). The Administrator was informed of immediate jeopardy on 7/29/15 at 6:30 PM and immediate jeopardy was removed on 7/30/15 at 4:55 PM when the facility implemented a credible allegation of compliance. The facility remained out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's	F 157		9/4/15

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

Electronically Signed | 08/14/2015

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F 157	Continued From page 1 physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family and staff interviews, the facility failed to notify the resident and or legal representative of changes in medications for 1 (Resident # 251) of 2 sampled residents. Findings included: Resident #251 was admitted to the facility on 12/16/14 with multiple diagnoses including lumbar stenosis and L 4-5 decompressive laminectomy. Resident #251 was discharged to home on 12/26/14. The hospital discharge instruction dated 12/16/14 was reviewed. The instruction included Exforge	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged	

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F 157	Continued From page 2 (drug for hypertension) 1 tablet daily, Atenolol (drug for hypertension) 50 mgs daily, Crestor (drug for high cholesterol) 10 milligrams (mgs) daily and Prilosec (used to treat gastro esophageal reflux) 20 mgs daily. The facility ' s admission orders dated 12/16/14 were reviewed. The orders included Crestor, Prilosec and Atenolol however the Exforge was discontinued. On 12/18/14, there was an order to discontinue the Crestor and changed it to Lipitor and to discontinue the Prilosec and changed it to Zantac. The blood pressure readings ranged from 143/72 to 188/82 from 12/16/ 14 through 12/22/14. On 12/22/14, there was an order to change Lipitor to Crestor per patient request due to nausea with Lipitor, to change Zantac back to Prilosec and to add Valsartan (blood pressure drug) 160 mgs daily. The nurses ' notes were reviewed from 12/16/14 through 12/26/14. The notes indicated that Resident #251 was alert and oriented to person, place and time. There were no documentation that Resident #251 or the legal representative was informed of the changes in medications. The note dated 12/23/14 at 3:43 PM indicated " resident stable during shift, resident walked with assistance in the room to the bathroom and to chair, writer called son and left message to call (name of facility) for concerns he has regarding medications, informed 3-11 nurse, continue to monitor. " The writer was Nurse #5. The doctor ' s progress notes were reviewed. The notes indicated that Resident #251 was seen	F 157	deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: Resident #251 was discharged from the facility on 12/26/14. 2) Interventions for residents identified as having potential to be affected: Residents and/ or responsible family members are notified on admission of the facility therapeutic interchange program that allows the contracted pharmacy to dispense less expensive medications that are the therapeutic equivalent of medications ordered by the Attending Physician. An audit was performed by the Director of Nursing (DON) and Unit Manager on all new physician orders obtained within the past four (4) weeks completed 08/21/15 to ensure all medication changes were promptly communicated to the resident, legal representative or interested family member. After completion of audit, no additional notifications were required. 3)Systemic Change All Licensed Nurses across all shifts (including weekend and as needed Licensed Nurses) were re-educated by the facility DON on 8/10/15 regarding	

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F 157	Continued From page 3 on 12/19 and 12/22/14 but there were no documentation that the resident or the legal representative was notified of the medication changes. On 7/29/15 at 11:54 AM, a family member of Resident #251 was interviewed. The family member indicated that nobody from the facility had called to inform him/her of the changes in the resident ' s medications. The family member indicated that Resident #251 was allergic to Lipitor and nobody had informed him/her or the resident that Crestor was changed to Lipitor. He/she added that the resident was on Exforge for her blood pressure and nobody had informed him/her or the resident that it was discontinued. On 7/29/15 at 6:00 PM, Nurse #6 was interviewed. Nurse #6 was the nurse who received the orders for the changes in medications. She stated that she thought she had called the son of Resident #251 but acknowledged that she did not document it. She also stated that Resident #251 should know the changes on her medications as she was alert and oriented. Nurse #6 did not say that she had informed Resident #251 of the changes in her medications. On 7/30/15 at 8:20 AM, Nurse #5 was interviewed. She was unable to remember why she called the son of Resident #251 on 12/23/14 and what concerns he has regarding the medications. On 7/30/15 at 9:52 AM, Resident #251 was interviewed. She stated that she knew her medications well. She indicated that nobody from	F 157	notification of resident, legal representative and/or interested family members of changes in medications, change of condition, or accidents promptly with emphasis on ensuring notification is promptly documented in the resident medical record. Inability to reach legal representative or interested family will be documented and reported to Unit Managers or DON. Newly hired Licensed Nurses will be educated by the facility Staff Development Coordinator (SDC) during their orientation period on ensuring resident and/or responsible party notification of medication changes and/or change in condition to include documentation of the notification in the resident medical record. The Unit Manager and/or Weekend Nursing Supervisor will review all new physician orders and the facility "24 Hour Report" for change in condition from the previous day during daily Clinical Management Rounds to ensure any change in condition including medication changes are promptly communicated with resident, legal representative and/or interested family member. 4) Monitoring of the change to sustain system compliance ongoing: An audit will be performed by the DON to ensure proper notification of medication changes and/or change in condition. DON will review the facility "24 Hour Report"	

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F 157	Continued From page 4 the facility had informed her that the Exforge, Crestor and Prilosec were discontinued. If they had inform her, she can tell them that she was allergic to Lipitor but they did not. She also stated that her blood pressure was controlled with Exforge and she was not informed that this was discontinued. She also stated that she kept asking the nurses about the new pills but she had to wait until the physician assistant (PA) came to visit to make the changes.	F 157	and new physician orders of five (5) residents to ensure proper notification of medication changes and/or change in condition. This audit will include ensuring documentation of notification is evident in the resident medical record. Audits will be performed at a minimum, daily for four (4) weeks, then twice weekly for four (4) weeks, then weekly for four (4) weeks to ensure Licensed Nurses compliance with notification of medication changes and/or change in condition. Monthly for a minimum of three months, the DON will report change in condition notification audits results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to resolve grievances promptly for missing partial dentures and for missing	F 166	The statements included are not an admission and do not constitute agreement with the alleged deficiencies	9/4/15

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F 166	Continued From page 5 necklaces for one of one resident (Resident #165). The findings included: A review of the Grievance and Complaint Policy dated March 2014 was conducted. The policy stated " If a grievance is submitted orally, the facility employee taking the grievance must write it up on the report form. The written grievance is to be forwarded to the facility ' s Administrator within 24 hours of receipt. Upon receipt of a written grievance and/or complaint, the Administrator will refer it to the appropriate department head for investigation. " Resident #165 was admitted to the facility on 10/13/13 and readmitted on 2/1/15. The Minimum Data Set dated 6/3/15 revealed the resident was assessed as being moderately cognitively impaired. A review of the Grievance/Complaint Log from 1/1/15 to 7/27/15 revealed no grievance was filed on behalf of missing partial dentures or missing necklaces for Resident #165. An interview was conducted with Administrative Staff #1 on 7/31/15 at 11:34 AM. Administrative Staff #1 stated a grievance form was not completed for the resident ' s missing partial dentures or for her missing necklaces. He stated the resident ' s family made a verbal grievance over the phone to Nurse #1 regarding missing necklaces. He stated that Nurse #1 did not complete a grievance form for the missing necklaces. He stated he expected Nurse #1 to complete the grievance form for the missing necklaces. He stated the nursing staff verbally informed him that the resident ' s partial dentures	F 166	herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: A grievance form was completed on 7/31/15 for Resident #165. The grievance form referenced the missing partial dentures and necklace. Resident #165 was scheduled for a dental exam with the facility contracted Dentist on 8/11/15. Legal representative was notified of the dental appointment on 8/11/15 via voicemail and certified letter to home address. Resident #165 was discharged to the hospital on 8/6/15. Resident #165 did not return to this facility. The facility searched for the missing necklaces. The necklaces were not located. The facility Administrator sent a certified letter to Resident #165's legal representative explaining details of Admission policy whereby the facility is not responsible for loss of such items. 2) Interventions for residents identified as having the potential to be affected:	

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F 166	Continued From page 6 were missing, but he could not recall the date he was informed. He stated it was an oversight that he did not complete the grievance form regarding the missing partial dentures. Administrative Staff #1 stated the staff searched throughout the facility, but were unable to locate the missing partial dentures or the necklaces. An interview was conducted with Nurse #1 on 7/31/15 at 11:59 AM. Nurse #1 stated the resident ' s family called the facility and spoke with her about the resident ' s missing necklaces on 7/9/15. Nurse #1 stated she informed the oncoming day shift nurse that the resident ' s necklaces were missing. She stated she put a note on the nurses ' communication board to alert the staff that the resident ' s necklaces were missing and to begin looking for them. Nurse #1 stated she expected the day shift nurse to complete a written grievance form regarding the missing necklaces.	F 166	Interviews were conducted with all current alert, oriented and interviewable facility residents by the facility Department Managers the week of 8/10/15. Interviews included ensuring residents did not have any unresolved grievances. No issues were identified after interviews. Legal guardian/ responsible party interviews were conducted week of 08/24/15 for non-interviewable residents by the Administrator & Social Worker to ensure residents did not have any unresolved grievances. After interviews completed, no issues have been identified as of 08/28/15. All Licensed Nurses, Certified Nursing Assistants, Therapy Staff, Dietary Staff, Housekeeping Staff and Department Managers (across all shifts including weekend and as needed scheduled) were re-educated the week of 8/10/15 & completed 08/28/15 by the facility Administrator and Director of Nursing (DON) regarding facility grievance policy and use of grievance forms. All grievances will be promptly documented on the grievance form when resident grievances are received. The grievance form will be given to the Administrator or Director of Nursing for prompt and proper follow-up. 3) Systemic Change A notebook/ binder with the facility	

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F 166	Continued From page 7	F 166	grievance policy and Grievance Forms has been placed at all Nurse Stations, Nurse Station 2, and in the Rehab Department. Grievance forms are being made readily available to all facility staff to ensure resident grievances are documented and proper follow-up occurs. Additionally each Department Manager will maintain a copy of the Grievance Form and reproduce as necessary. The Administrator will continue to maintain log of grievances as well as binder with resolved cases. Resident grievances will be discussed and addressed at Stand-Up Meeting each morning ongoing (Monday - Friday). All staff will initiate grievance forms & direct the form to the administrator. Department Managers will interview resident &/ legal guardian/ interested family member for all concerns identified. Resolution of grievance will be logged by Administrator. Department Managers which includes the DON, Admission Director, Business Office Manager, Human Recources Coordinator, Activities Manager, Social Services Manager, Housekeeping Manager, Maintenance Director and Therapy Manager will utilize the facility "Guardian Angel" rounds checklist and will perform audits weekly for a minimum of three (3) months to ensure residents do not have any unresolved grievances. 4) Monitoring of the change to sustain system compliance ongoing:	

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F 166	Continued From page 8	F 166	Monthly for a minimum of three months, the Administrator will review grievance log and discuss resolutions of grievances with the Quality Assurance and Performance Improvement Committee (QAPI). The QAPI Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain clean air supply vents (vents that blow air into the room) in one of two dining rooms (three out of four air vents in the main dining room) and failed to keep one of two windows in the main dining room free of cobwebs. The findings included: 1. On 7/27/15 at 12:30PM, an observation of the main dining room revealed the following: black material was noted on a supply air vent located in the ceiling with black material that had blown on four tiles around the air vent; the second air vent in the ceiling had black material on the air vent with black material blown from the air vent on two of the tiles around the air vent; the third air vent had black material noted on the air vent. All three of the four vents observed was blowing air directly	F 253	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident:	8/31/15

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F 253	Continued From page 9 into the room over dining room tables and/ or where residents were seated. On 7/28/15 at 2:30PM, three of the four air supply vents in the main dining room continued to have black material on the air vents and on the surrounding tiles checked dining room and noted to be the same as above. On 7/29/15 at 3:45PM, an observation of the supply air vents was conducted and revealed all three of the air vents and surrounding tiles continued to have black material on them. On 7/30/15 at 4:15PM, an observation of the supply air vents was conducted and revealed all three of the air vents and surrounding tiles continued to have black material on them. On 7/31/15 at 10:10AM, a tour of the main dining room was conducted with administrative staff #1. Three of the four air supply vents and surrounding tiles were noted to be covered with a black material. Administrative staff #1 stated it would be a maintenance/ housekeeping function to keep the tiles and vents clean. He stated he expected all air vents and tiles to be clean and free of black material. Administrative staff #1 did not identify the black material. On 7/31/2015 at 10:19AM, the maintenance director stated he was not aware of the black material on the three air supply vents and tiles. He stated any staff member could fill out a maintenance requisition which was available at every nursing station. The maintenance director stated he checked for requisitions daily and had not been informed of any problems with the air vents/ tiles in the main dining room. He did not identify the black material. 2. On 7/27/15 at 12:30PM, an observation of the main dining room revealed cobwebs in the top corners of one of two windows in the main dining	F 253	On 7/31/15, the facility Main Dining room vents were immediately removed from ceiling and cleaned by the Housekeeping Supervisor. Tiles were cleaned and/or replaced by 8/1/15 by the Housekeeping Supervisor and Maintenance Director. The Main dining doom window was cleaned by the Housekeeping Supervisore and all cobwebs were removed. 2) Interventions for residents identified as having the potential to be affected: All facility vents and windows were checked and cleaned as necessary by the Housekeeping Supervisor on 7/31/15 and high dusting was performed as needed throughout the building by the Housekeeping Supervisor. 3) Systematic Change: All Housekeeping Staff (across all shifts including weekend and as needed scheduled) were in-serviced starting the week of 8/10/15 to be completed by 8/26/15 by the Housekeeping Supervisor regarding proper techniques for high dusting, vent cleaning, and window maintenance to maintain a sanitary, orderly, and comfortable interior. Facility rounds will be completed by the Maintanence Director and Housekeeping Manager daily (Monday-Friday) for a minimum of three (3) months, utilizing the "Housekeeping Quality Inspection"	

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F 253	Continued From page 10 room. On 7/28/15 at 2:30PM, an observation of the main dining room revealed cobwebs in the top corners of one of two windows in the main dining room. On 7/29/15 at 3:45PM, an observation of the main dining room was conducted. Cobwebs remained in the top corners of one of two windows. On 7/30/15 at 4:15PM, an observation of one of two windows in the main dining room was conducted and the cobwebs remained in the top corners of one of two windows. A tour of the main dining room was conducted with administrative staff #1 on 7/31/2015 at 10:10AM. He stated it would be the responsibility of the housekeeping staff to keep the windows and window frames clean. Administrative staff 1 stated he expected all areas to be free of cobwebs. On 7/31/2015 at 10:16AM, the housekeeping supervisor stated the housekeeping staff dusted the top of the windows and cleaned the window areas daily. An observation of the cobwebs at the corners of one of the main din room windows was conducted with the housekeeping supervisor. He stated he expected the windows to be cleaned daily and free of cobwebs.	F 253	checklist to ensure all air vents, ceiling tiles and windows are free from dust, debris and/or cobwebs. Particular attention will be given to the vents in both dining areas- Willows Dining for Independent Residents and Main Dining Area. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Housekeeping Supervisor will report audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		8/31/15

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F 282	Continued From page 11 by: Based on record review, resident and staff interviews, the facility failed to follow the care plan for monitoring the dialysis access site for one of one sampled residents reviewed for dialysis (Resident #87). The findings included: Resident #87 was admitted to the facility 12/11/2012. Cumulative diagnoses included: end stage renal disease and dialysis. An Annual Minimum Data Set (MDS) dated 4/23/2015 indicated Resident #87 was cognitively intact. No mood or behaviors noted. Dialysis was noted as "yes" for Resident #87. A care plan last reviewed on 6/25/2015 stated Resident #87 needed hemodialysis related to end stage renal failure. Interventions included, in part, " monitor access site upon return from dialysis for bleeding, redness, swelling, pain and non-functioning graft-notify MD as needed. Resident #87 has an AV (arteriovenous-abnormal pathway between a vein and an artery) shunt/ fistula, shunt or graft position extremity so that fistula is easily palpated. Palpate gently over area with fingertips or palm of hand to feel for bruit or thrill (vibration). Auscultate (listen) over fistula with stethoscope to detect bruit. Assess for signs of infection, bleeding or sensation impairment around fistula. " Dialysis communication sheets for June 2015 were reviewed. There was no documentation by the facility regarding the assessment of the dialysis access site on 6/2/2015, 6/4/2015, 6/6/2015, 6/9/2015, 6/11/2015, 6/13/2015, 6/16/2015, 6/18/2015, 6/22/2015, 6/25/2015 and 6/30/2015. These were dialysis days. Dialysis communication sheets for July 2015 were reviewed. There was no documentation by the facility regarding the assessment of the dialysis access site on 7/2/2015, 7/4/2015,	F 282	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: Resident #87 care plan was reviewed by the Director of Nursing (DON) on 7/31/15. Physician notified and orders were obtained to monitor and document presence of thrill/bruit for Resident #87 daily. 2) Interventions for residents identified as having the potential to be affected: On 8/10/15, all Licensed Nurses (including weekend only scheduled and as needed scheduled Licensed Nurses) were re-educated by the facility DON on proper procedure for documentation of assessment for dialysis residents, obtaining dialysis access monitoring orders for shunts and fistulas, and care plans to reflect care being given. All residents who receive dialysis services	

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F 282	Continued From page 12 7/7/2015, 7/9/2015, 7/11/2015, 7/14/2015, 7/18/2015, 7/21/2015, 7/23/2015 7/25/2015, 7/28/2015 and 7/30/2015. A review of the Medication Administration Records (MARS) and Treatment Administration Records (TARS) for June 2015 and July 2015 revealed no documentation by nursing staff regarding thrill and bruit monitoring of the dialysis access site. Nursing notes from June and July 2015 were reviewed. There was no documentation for assessment of the dialysis site for the month of June. There was one nursing note dated 7/30/15 at 11:00AM that stated the left shunt site dressing was dry and intact, + bruit/ thrill. On 7/30/2015 at 4:04PM, NA # 2 stated the nurses did all the vital signs and monitoring of the dialysis site. He stated Resident #87 was alert and oriented and would tell staff if he had any problems concerning dialysis. On 7/30/2015 at 4:16PM, an interview was conducted with Resident #87 ' s nurse. Nurse #7 stated Resident #87 had an AV shunt (dialysis site) in his upper arm. She said she checked Resident #87 ' s dialysis site for thrill/ bruit, bleeding and for signs and symptoms of infection (warmth, redness) at the access site. Nurse #7 stated documentation regarding the thrill/ bruit and resident condition was either on the dialysis communication sheets and/or documented in the computer progress notes. Nurse #7 stated she would document her findings in the computer nursing notes. On 07/31/2015 at 9:03AM, an interview was conducted with Resident #87 who stated he went to dialysis on Tuesdays, Thursdays and Saturdays. He said he received dialysis in his left upper arm. Resident #87 stated nursing staff checked the access site but not every day saying	F 282	were reviewed by the DON and Unit Manager on 7/31/15. After review, physician orders were obtained for three (3) residents to include monitoring and documenting presence of bruit/thrill. All dialysis resident care plans were reviewed by the DON and revised as needed. Licensed Nurses will ensure new admissions who receive dialysis services and utilizes a shunt or fistula to receive their dialysis treatment will have orders to document thrill/ bruit at least daily. Newly hired Licensed Nurses will be educated during their orientation period to ensure residents that receive dialysis services have physician orders to document bruit/thrill for residents utilizing a shunt/fistula for dialysis treatments. Licensed Nurse or Minimum Data Set(MDS) Nurse will update care plans as needed to reflect resident dialysis status. 3) Systemic Change: The DON, Unit Manager or Nurse Supervisor will perform an audit to ensure documentation of thrill and bruit is evident in the medical records. Audits will be completed on ALL dialysis residents weekly for a minimum of twelve (12) weeks. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the DON will report audit findings at the facility Quality Assurance and	

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F 282	Continued From page 13 they " check it sometimes " . On 7/31/2015 at 9:41AM, administrative staff #2 stated she expected the results of the auscultation for the thrill/ bruit to be documented in the nursing progress notes or on the TAR (treatment administration Record). Administrative staff #2 said she had asked nursing staff to write a physician ' s order for Resident #87 on 7/31/2015 to check for thrill/ bruit every shift, notify MD (physician) of complications and to monitor dialysis site for signs and symptoms of infection every shift, if present document and notify.	F 282	Performance Improvement (QAPI) Committee to ensure ongoing compliance. The QAPI Committee will review the audits to make recommendations to ensure compliance is sustained ongoing, and determine the need for further auditing beyond the three (3) months.	
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to prevent a significant medication error by administering Lantus insulin, a long acting insulin, to a resident who did not have a diagnosis of diabetes mellitus (Resident #252) and did not have an order for Lantus insulin and not administering a long acting insulin to a resident with a physician ' s order for long acting insulin (Resident #245). The immediate jeopardy began on 7/12/15 when a long acting insulin (Lantus) was administered to Resident #252 and a long acting insulin (Lantus) was not administered to Resident #245. The immediate jeopardy was removed on 7/30/15 at 4:55 PM when the facility provided an acceptable credible allegation of compliance. The facility will	F 333	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	8/31/15

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F 333	Continued From page 14 remain out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm) that is not immediate jeopardy to ensure monitoring systems put into place are effective. The findings included: 1. Resident # 252 was admitted to the facility on 7/9/15 and was discharged from the facility on 7/21/15. Cumulative diagnoses were reviewed and did not include a diagnosis for diabetes mellitus. A physician order was entered in to the computer on 7/11/15 with start date of 7/12/15 stated Lantus solution (long acting insulin) 100 unit/ milliliter (ml)--inject 20 units subcutaneously at bedtime for diabetes mellitus (DM). On 7/13/15, a physician ' s order for FSBS (fasting blood sugars) four times a day was written. A record of blood sugars for July 2015 was reviewed and stated the following: 7/13/15-96; 7/14/15--113; 7/15/15-not recorded and 7/16/15-172. A 5 day Minimum Data Set (MDS) dated 7/16/15 indicated Resident #252 was severely impaired in cognition, Diabetes mellitus was not checked as a diagnosis for Resident # 252. The MDS indicated four insulin injections were received during the assessment period. The July Medication Administration Record (MAR) was reviewed and revealed Resident #252 received Lantus insulin 20 units subcutaneously at 9:00PM on 7/12, 7/14, 7/15, 7/16. It was noted that the Lantus insulin was not administered on 7/13/15 due to a blood sugar of 94. A Physician progress note dated 7/17/15 indicated the physician was asked to call family about Resident #252 being started on insulin. Resident #252 was mistakenly started on Lantus. They were reassured that the blood sugars were stable and she did not have any low blood sugars	F 333	1) Interventions for affected resident(s): Resident #252 and #245 are discharged from the facility. Medication variance worksheets were completed on 07/17/15 and an action plan started. New orders were received. Physician assistant & responsible party were notified. Pharmacy Consultant was notified. Additional monitoring was initiated. Nurse involved was provided one on one education by the Director of Nursing(DON). 2) Interventions for residents identified as having the potential to be affected: On 07/29/15, a physician order recap review was performed by Unit Manager & DON on all current residents to ensure no medication variances and confirm accuracy of transcription for current physician orders. On 07/29/15, a diabetic audit was performed by the Unit Manager & DON on all current residents with diabetes diagnosis to confirm insulin orders(if applicable)and ensure supplementary documentation of blood glucose results. Three orders were updated to reflect automatic prompt for documentation of blood glucose results in the Electronic Medical Record (EMR). On 07/29/15, a care plan audit was performed by Unit Manager on all current residents with diagnosis of diabetes to ensure was care planned with goals/	

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F 333	Continued From page 15 as a result of giving her Lantus insulin. The Lantus insulin and blood sugars were discontinued. A medication variance report dated 7/17/15 stated a medication (Lantus insulin) was entered by (name of nurse) on 7/11/15and was supposed to be ordered for (Resident #245) but was ordered for (Resident #252). Resident #252 received Lantus insulin dose on 7/12, 14, 15, 16-2015 4 doses. This was a transcription issue. Notification: supervisor, attending physician, administrator, resident/ family. Investigation was conducted on 7/17/15 and was found to be a transcription error. Consultation was done with the physician assistant and pharmacist. Blood sugars were normal with therapy. No long term effects noted. Action: blood sugars monitored; monitored for signs and symptoms of hypoglycemia. Accuchecks (blood sugars) discontinued. Medication discontinued. Action plan implemented. " An in-service dated 7/17/15 given by the Director of Nursing was reviewed. The contents of the in-service included the following: confirmation of all orders with two nurses. There would also be an order re-cap performed by the 11-7 nurses nightly and all of this included all physician orders. The in-service was completed on 7/27/15 with two nurses not receiving the in-service. The in-service will be given to those two nurses prior to their working on the floor. On 7/29/2015 at 8:28AM, Administrative staff #2 was interviewed. She stated, on 7/11/15, the nurse who was working 3-11 shift had checked a blood sugar on Resident #245 and called the physician assistant to get an order because the blood sugar was high. Resident #245 was already a diabetic and on high doses of insulin at that time. The physician assistant on call gave an	F 333	interventions established. By 7/30/15, all Licensed Nurses were re-educated by the DON and Regional Clinical Director on the following: * Accurate transcription of physician orders and ensuring orders verified by two (2) nurses. Second nurse will confirm new order transcription is accurate in EMR. * Ensuring blood glucose results are documented under supplemental documentation in EMR. * Daily order recap process. Nurses on 11p-7a shift will perform 24 hour recap audit on all new physician orders. Newly hired nurses will be trained by Staff Development Coordinator (SDC) during orientation period on accurate physician order transcription, documentation of blood glucose results in EMR,24 hour order recap process and order verification by second nurse. 3) Systemic Change: On 08/05/15, re- education was provided to all Licensed Nurses and Med Aides (including weekend and as needed Licensed Nurses and Med Aides) regarding medication error prevention, order transcription accuracy, med cart checks, documentation,& medication orders by the Pharmacy Consultant. The DON or Unit Manager will provide additional education to all Licensed Nurses & Med Aide to include accurate order transcription, med error prevention,	

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F 333	Continued From page 16 order to start the following day giving a low dose basal insulin (Lantus) at bedtime. The nurse put the order in the computer and the order went in on the incorrect patient (Resident #252). The next day, the nurse checked the blood sugar and gave the insulin to Resident #252. On 7/13/15, the Lantus insulin was not given because the blood sugar was low. The Lantus insulin was then given on 7/14, 7/15, 7/16. On the 17th, the MDS (minimum data set) nurse reviewed Resident #252 ' s chart for MDS purposes and noted that the insulin order was new for Resident #252. She started the investigation because she had not noted a diabetes diagnosis. Administrative staff #2 reviewed the orders and asked the physician assistant to review the chart, evaluate Resident #252 and notify the family of the medication error. Resident #252 was monitored for any signs and symptoms of hypoglycemia; the pharmacist was notified who stated the blood sugars were normal with the therapy and there were no long term effects and did not cause any harm. On 7/17/15, a process was put into place that the nurses would write the orders on paper when they received a telephone order prior to putting the order into the computer and the order would be checked by a second nurse when the order was entered onto the computer. A recap of all residents ' orders was done on 7/17/15 and was ongoing. Administrative staff #2 in-serviced all nursing staff on 7/17/15 and finished 7/25/15 (weekend and regular staff). The night nurses did a recap of every physician order (a review of all physician orders) for the prior 24 hours and made sure the orders matched the patient. Any error was to be reported to the unit managers immediately and notification of any change of orders to the family prior to administration of medication. Random	F 333	med cart checks, documentation, and notification of change to residents/ legal guardian, family member utilizing materials from Point Click Care, Nursing Area Health Education Center (AHEC), Pharmacy, and Nursing Educators. This training will be completed by 08/25/15. The DON, Unit Manager, or Nurse Supervisor will review (15) charts physician orders to ensure accurate transcription in EMR. The DON, Unit Manager or Nurse Supervisor will audit (15) residents with diabetes diagnosis with orders for accuchecks to ensure supplementary documentation is completed and noted in EMR. The DON, Unit Manager, or Nurse Supervisor will audit 24 hour recap form daily to ensure 24 hour recap order protocol is followed. All audits will be performed daily(including weekends) for three (3) months, then weekly for three (3) months, then monthly for six(6) months. 4) Monitoring of change to sustain system compliance ongoing: The DON will review the audit results with the facility Quality Assurance & Performance Improvement Committee meeting monthly for twelve (12)months. The Quality Assurance & performance Improvement Committee will review audits to make recommendations to ensure compliance is sustained ongoing & determine need for further auditing beyond twelve (12) months.	

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monitoring would be done by the unit manager. Administrative staff #2 stated they had already put an action plan in place effective 7/17/15 and were following the results to be discussed in Quality Assurance and Performance Improvement meetings.
On 7/29/15 at 11:00AM, Nurse #2 stated she worked 3-11 shift on 7/11/15. She stated she had notified the physician for orders for Lantus insulin for another resident who had very high blood sugars. When she was putting the physician orders in the computer at the end of her shift, she thought she put the Lantus insulin order in the computer for the correct resident. Nurse #2 stated, when she returned to work on 7/17/15, she was asked by the MDS nurse if she had put the insulin order she had received on 7/11/15 in the computer under Resident #252. Nurse #2 stated she did not know how it happened that the insulin order was placed under Resident #252 ' s orders.
On 7/29/15 at 4:30PM, Administrative staff #2 was interviewed regarding " random monitoring " . She stated the unit manager would randomly check physician orders in the computer to make sure the correct physician ' s order was in the computer for the correct resident. She stated Nurse #3 was performing the monitoring.
On 7/29/15 at 4:45PM, Nurse #3 stated she reviewed physician orders for residents admitted over the weekend on Monday mornings. Nurse #3 stated she had not monitored specifically for insulin orders or checked orders on residents already in the facility-only new admissions. No random monitoring had been done or recorded by Nurse #3.
2. Resident #245 was admitted to the facility on 7/9/15 and was discharged from the facility on 7/20/15. Cumulative diagnoses included diabetes

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mellitus.
An Admission MDS dated 7/16/15 stated Resident #245 had a diagnosis of diabetes mellitus. Insulin injections were noted as having been administered seven days during the observation period.
Physician orders and Medication Administration Records (MAR) for Resident #245 were reviewed and revealed the following:
7/9/15 Humalog 100 unit/ ml (insulin Lispro)-inject 1 dose subcutaneously every 6 hours (12midnight--6:00AM-- 12noon-6:00PM) for diabetic sliding scale insulin BG (blood glucose)-140 divided by 40 = number of units to give. This order was discontinued on 7/13/15
7/10/15 Insulin glargine (Lantus) 40 units subcutaneously daily (6:30AM). The medication was administered times one dose and the order was discontinued on 7/10/15
7/11/15 insulin glargine (Lantus) 60 units subcutaneously daily (6:30AM). The insulin was administered on 7/11/15, 7/12/15, 7/13/15 and discontinued on 7/13/15
7/13/15 Humalog (insulin Lispro) inject 15 unit subcutaneously every 6 hours (12midnight-6:00AM-12noon-6:00PM). Do not give if BS<(less than) 80, give 6 units if BS 80-120. The MAR indicated Resident #245 received the Lispro insulin until discharge from the facility on 7/20/15.
7/13/15 insulin glargine (Lantus) 78 units subcutaneously daily (6:30am). Hold if BG <80, give 40 units if BG between 80-120-begin 7/14/15. The MAR did not indicate this medication was given and the order was discontinued on 7/14/15
7/14/15 insulin glargine (Lantus) inject 85 units subcutaneously daily (6:30AM). Hold of BG <80, give 40 units if BG between 80-120. The MAR

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indicated the insulin was administered from 7/15/15 through 7/20/15.
A review of the blood glucose levels for Resident #245 documented with insulin glargine (Lantus) for 6:30AM from 7/11-7/20/15 revealed the following: 7/11/15-320; 7/12/15--369; 7/13/15--377; 7/14/15--381; 7/15/15-211; 7/16/15-168; 7/17/15-269; 7/18/15-256; 7/19/15-128; 7/20/15-178.
Sliding scale insulin with blood glucose checks done every 6 hours (12 midnight-6am-12 noon-6pm) and sliding scale coverage was reviewed with the following blood sugars noted from 7/11/15 through 7/17/15:
7/11/15 6PM--424
7/12/15 12midnight-- 412; 6AM-369; 12noon-392; 6PM-399
7/13/15 12midnight-406; 6AM-377; 12noon-353; 6PM-536
7/14/15 12midnight-466; 6AM-381; 12noon-417; 6PM-175
7/15/15 12midnight-259; 6AM-211; 12noon-210; 6PM-146
7/16/15 12midnight-193; 6AM-168; 12noon-248; 6PM-124
7/17/15 12 midnight-211; 6AM-269; 12noon-281; 6PM-268
On 7/29/15 at 4:30 PM, Administrative staff #2 stated the facility had completed a medication variance report on 7/17/15 for Resident #245. Administrative staff #2 stated the unit manager would randomly check physician orders in the computer to make sure the correct physician ' s order was in the computer for the correct resident. She stated Nurse #3 was performing the monitoring.
A review of the Quality Assessment action plan revealed the following;
1. Resident/ family and physician were notified

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of the medication error on 7/17/15.
2. Resident #245 was evaluated by the PA (physician assistant).
3. All nurses and medication aides were in-serviced by the Director of Nursing. The contents of the in-service included the following: confirmation of all orders with two nurses. There would also be an order re-cap performed by the 11-7 nurses nightly and all of this included all physician orders. The in-service was completed on 7/27/15 with two nurses not receiving the in-service. The in-service will be given to those two nurses prior to their working on the floor.
4. 1:1 review was conducted with the nurse involved in the transcription error for Resident #252 and #245.
5. systemic change-confirming nurse to verify orders and initial (double check) and 11-7 nurse to do order recap (review the past 24 hours of physician orders against the Medication Administration Records in the computer) to ensure the correct orders were put in the computer for the correct resident.
6. All charts were audited on 7/17/15 and no variances were noted.
7. Decision was made to take to QA on 7/17/15.
8. Order reviews to be done by unit manager at random.
On 7/29/15 at 4:30PM, Administrative staff #2 stated the facility had completed a medication variance report on 7/17/15 for Resident #245. Administrative staff #2 stated the unit manager would randomly check physician orders in the computer to make sure the correct physician ' s order was in the computer for the correct resident. She stated Nurse #3 was performing the monitoring.
On 7/29/15 at 4:30 PM, Administrative staff #2 was interviewed regarding " random monitoring "

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SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

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. She stated the unit manager would randomly check physician orders in the computer to make sure the correct physician ' s order was in the computer for the correct resident. She stated Nurse #3 was performing the monitoring.
On 7/29/15 at 4:45PM, Nurse #3 stated she reviewed physician orders for residents admitted over the weekend on Monday mornings. Nurse #3 stated she had not monitored specifically for insulin orders or checked orders on residents already in the facility-only new admissions.
On 7/29/15 at 6:30PM, the administrator was notified of the immediate jeopardy.
The facility provided the following credible allegation on 7/29/15 at 4:55PM for F 333 as follows:
The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center ' s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.
Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:
Resident #252 is currently discharged from the facility to home on 7/21/15.
Upon discovery of medication variance on 07/17/15 for Resident #252 during her stay at the facility, the facility Director of Nursing (DON) began an investigation and initiated an action plan on 07/17/15.
The action plan included the following:
Medication Variance Worksheet completed on

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F 333	Continued From page 22 07/17/15. Lantus and Accuchecks were discontinued and new order was received from the Physician Assistant to monitor resident for signs and/or symptoms of hypoglycemia from 07/17/15. Resident was monitored for signs and symptoms of hypoglycemia every shift from 7/17/15 through 7/21/15 (date of discharge) and was documented on the Medication Administration Record (MAR). Responsible Party was notified of medication variance by Physician Assistant on 07/17/15. Pharmacy Consultant was notified of medication variance on 07/17/15. Physician notified of medication variance by DON on 07/17/15. Resident #252 was evaluated and medical record reviewed by Physician Assistant on 07/17/15. Director of Nursing performed comprehensive physician order review of all residents ' charts to ensure no other medication variances. After review, no other medication variances were noted. This was completed 7/17/15. Education was provided by the facility DON to Licensed Nurses including the medication aide related to medication variance prevention, transcription order accuracy with verification of accuracy by another nurse and the facility 24 hour order recap process by the 11-7 shift nurses. This was completed on 7/26/15. Resident #245 is currently discharged from the facility. Medication Variance Worksheet completed on 07/17/15. Responsible Party was notified by Physician Assistant on 7/17/15. Physician notified by DON on 07/17/15. Resident #245 was evaluated and medical record reviewed by Physician Assistant on 07/17/15. Pharmacy Consultant was notified of medication variance. Director of Nursing performed comprehensive	F 333		

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physician order review of all residents ' charts to ensure no other medication variances. After review, no other medication variances were noted. This was completed on7/17/15.
Although the medication variance was identified on 7/17/15, Resident #245 did have changes to her hyperglycemic drug regimen on 07/13/15 to include increasing scheduled Lispro and Lantus insulin doses. Resident #245 ' s blood sugar results had improved after the changes in the insulin doses. The blood sugar results were 377 (7/13), 175 (7/14), 211 (7/15), 168 (7/16), 269 (7/17), 256 (7/18), 128 (7/19) and 178 (7/20). Resident #245 was discharged to the hospital on 7/20/15 due to abdominal distention.
Individual re-education on accurate physician order transcription was provided by the DON to nurse involved in medication variance on 07/17/15.
How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:
On 7/29/15, a physician order recap review was performed by facility Unit Manager and DON on current facility residents to ensure no medication variances and confirm accuracy of transcription for current physician orders. After review, no other transcription errors were noted.
On 7/29/15, a diabetic audit was performed by the facility Unit Manager and DON on current residents with a diagnosis of diabetes to confirm accurate insulin orders (if applicable) and ensure supplementary documentation of blood glucose results are evident in the medical record. Three (3) residents' physician orders were updated to reflect automatic prompt for documentation of blood glucose results in the electronic medical record Facility has contacted Information Services to request supplementary

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documentation auto populate to prompt documentation of blood glucose levels on all hypoglycemic medicines and Accucheck orders.

On 7/29/15, a care plan audit was performed by Unit Manager on facility residents with diagnosis of diabetes to ensure diagnosis of diabetes was care planned and goals/interventions are established. After review, all residents with a diagnosis of diabetes had appropriate care planning with goals and interventions.
Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:
Licensed Nurses were educated by the Director of Nursing and Regional Clinical Director on the following date: 7-30-15 on the following:
1) Accurately transcribing physician orders and ensuring new physician orders are verified for accuracy by two nurses. A Licensed Nurse will obtain a secondary nurse to confirm that the transcription of new orders is accurate in the electronic medical record by comparing the new physician order sheets (paper) located in the new order daily binder to the electronic medical record. A notation (with verifying nurse ' s initials) will be written on the new physician order sheet confirming that the new orders were verified for accuracy by a second nurse.
2) Licensed Nurses to ensuring blood glucose results are documented under supplementary documentation in electronic medical record after results are obtained.
3) Daily 24 hour order recap process. This process includes reviewing new physician orders from the previous day to ensure accuracy of transcription of new order.
Licensed Nurses on 11p - 7 am shift will perform a daily 24 hour recap audit of all new physician

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orders by reviewing both the new order daily binder (which has all new orders) and the electronic medical record. This audit will include a review of all new physician orders from the previous day to ensure accuracy of transcription of new orders and the daily binder (paper) physician orders will be removed monthly and placed in medical records.
Newly hired Licensed Nurses will be trained by the facility Staff development Coordinator during their orientation period on ensuring accuracy of transcription for new physician orders, documentation of blood glucose results in electronic medical record when obtained and ensuring verification of accuracy for new physician orders by a second nurse. Education will also include the facility 24 hour order recap process.
Any Licensed Nurses not available for the education will be removed from the schedule and education will be required to be completed prior to nurse working on an assignment.
On 7/30/15 at 4:55PM, the credible allegation was validated. All resident ' s orders were audited for accuracy on 7/29/15. In-servicing of all licensed staff was completed on 7/29/15. Staff interviews with licensed nursing staff over all shifts revealed the facility had implemented the following: a double check with two nurses when a telephone order was obtained by writing the physician order out on paper and two nursing staff checking the paper order with the order placed in the computer to ensure the order was correctly transcribed and entered into the computer for the right resident.
The night shift nursing staff (11-70 would run a re-cap of all physician orders obtained during the past twenty four hours and check the computer orders against the recap to ensure accuracy of the orders.

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and staff interviews, the facility failed to label and date food items in the dry storage area and in one of three nourishment refrigerators (refrigerator for A and B hall) and failed to discard expired food items in the dry storage, walk in refrigerator and freezer. The findings included: A review of the facility policy titled " Food Storage Principles " revised 6/18/14 stated, in part, storing all foods: 3. Label each package, box, can, container, etc. with the expiration date, date of receipt, or when the item was stored after preparation. Store products with the labels facing forward. A. Discard foods that have exceeded their expiration date. B. Discard leftover foods that have not been used within 48 hours of preparation. " 1. a. On 7/27/15 at 10:30 AM, an initial tour of the kitchen was conducted with the dietary manager. The following was observed in the dry storage area: approximately two (2) cups of raisin bran in a container with the discard date of 7/23/15. b. On 7/27/15 at 10:30AM, a tour of the walk in refrigerator revealed a container of cottage	F 371	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: All unlabeled or outdated items found in the facility kitchen freezer, walk in refrigerators and dry storage area were discarded on 7/27/15. All unlabeled or outdated items found nourishment refrigerators on Hall A and B	8/31/15

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F 371	Continued From page 27 cheese with an open date of 7/17/15. The dietary manager stated the cottage cheese was good for seven days and should have been discarded on 7/24/15. On 7/27/15 at 10:45AM, the dietary manager stated all of the items should have been labeled and dated when opened and there should be a discard date on all items. All items out of date should be discarded. c. On 7/27/15 at 11:00AM, a tour of the freezer was conducted and revealed the following: 1. two pieces of cooked turkey was noted in a plastic bag dated 6/2/15. Use by 6/5/15. 2. Several pieces of coated fish with a use by date of 6/26/15. No prepared date was noted on the label. 3. A large rack of cooked pork loin was wrapped in tin foil and plastic that had been torn and the meat was open to the air. The label on the pork loin stated cooked 11/7/14. On 7/27/15 at 11:00AM, dietary staff #1 stated the cooked turkey, coated fish and the pork loin should have been discarded. 2. a. On 7/27/15 at 10:30 AM, an initial tour of the kitchen was conducted with the dietary manager. The following was observed in the dry storage area: one (1) plastic container of cheerios-undated; one plastic liter container 3/4 full of brown liquid with a label attached that was unable to be read to determine what it was. There was no date opened or a date of when to discard the item. b. On 7/29/15 at 2:45PM, an observation of the nourishment refrigerator on A and B hall was conducted. The assistant dietary manager was present during the observation. There were two eight ounce glasses of brown liquid and one eight ounce glass of orange juice in the nourishment refrigerator. None of the glasses were labeled or dated. The assistant dietary manager stated the	F 371	were discarded on 7/29/15. 2) Interventions for residents identified as having the potential to be affected: On 7/29/15, all facility kitchen dry storage areas, refrigerators, freezers and nourishment rooms refrigerators were thoroughly inspected by the Dietary Manager for accurate date and expiration. All outdated items were discarded immediately. On 8/11/15, all dietary staff (including weekend only scheduled and as needed scheduled) were educated by the facility Dietary Manager on facility storage guidelines including proper labeling, dating, and discarding food items timely. Food items not desired by residents will be discarded, not refrigerated. 3) Systemic Change: Daily rounds will be implemented utilizing the facility "Quick Rounds" sheets. The rounds will be completed daily for a minimum of three (3) months and will be completed by the Dietary Manager or Assistant Dietary Manager with focus on the following areas: all dry storage, food nourishment stations, walk in freezer, and refrigerators to ensure proper dating, labeling, and discarding of items. The facility Administrator will perform a facility round with the Dietary Manager or Assistant Dietary Manager utilizing the	

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F 371	Continued From page 28 glasses of brown liquid was a fortified chocolate shake that had been prepared in the kitchen and the orange juice was nectar thickened orange juice. He stated the fortified shakes and nectar thickened liquids were labeled and dated when they came from the kitchen and pointed to the plastic top where it was noted that something had been removed from the top of the glasses. He said the items should be discarded if the resident refused the shake or juice and should not have been placed in the nourishment refrigerator. On 7/29/15 at 2:45PM, the dietary manager stated the nursing staff should discard any items not consumed by the resident and inform her that the resident refused. She stated the dietary staff checked the nourishment refrigerators every day and discarded outdated items. On 7/31/2015 at 12:44PM, Nurse #2 stated nursing staff on all shifts try to check the nourishment refrigerators and discard any undated, outdated items. The kitchen staff also checked the nourishment refrigerators daily. On 07/31/2015 at 12:46PM, administrative staff #2 stated the dietary department checked every day when they put the nourishments out and they would discard any unlabeled outdated items.	F 371	facility "Quick Rounds" weekly for a minimum of three (3) months with emphasis on ensuring proper labeling, dating and discarding of food to ensure all food is stored, prepared, and distributed under sanitary conditions. Ongoing weekly huddles with the dietary staff will be implemented by the Dietary Manager to communicate important policies or changes and how they pertain to appropriate dating, labeling, and discarding of food items. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Dietary Manager or Administrator will report results of the dietary daily "quick rounds" sheets to the Facility Quality Assurance and Performance Improvement (QAPI)Committee. The QAPI Committee will review the results of the rounds and make recommendations as needed to ensure compliance is sustained ongoing and determine the need for further auditing beyond the three (3) months.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in	F 412		9/4/15

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F 412	Continued From page 29 making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interview, staff interviews and observations, the facility failed to provide dental services to one of one resident (Resident #165) with missing partial dentures. The findings included: Resident #165 was admitted to the facility on 10/13/13 and readmitted on 2/1/15 with multiple diagnoses including glaucoma, dementia, depression and a history of a transient ischemic attack. The Minimum Data Set (MDS) dated 6/3/15 revealed the resident was assessed as being moderately cognitively impaired. The MDS dated 6/3/15 did not indicate the resident ' s partial dentures were missing. The Plan of Care reviewed 6/17/15 indicated resident # 165 was assessed with the potential for oral health problems related to refusing to wear dentures. The interventions included to encourage the resident to wear her dentures as tolerated and to have a dental consult as ordered by the physician. A review of the Nurses ' Notes revealed a note dated 5/12/15 at 9:09 AM which read " Dentures lost. " A review of the medical record revealed a dental	F 412	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: Resident #165 was scheduled by the facility to be evaluated on 8/11/15 by the facility Dentist. However, resident was discharged on 8/6/15 and did not return to this facility. 2) Interventions for residents identified as having the potential to be affected: On 8/10/15, an audit was completed by the facility Director of Nursing (DON) and Unit Manager to ensure all residents	

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F 412	Continued From page 30 consult was not scheduled for Resident # 165 after her partial dentures were reported missing on 5/12/15. A review of the Meal Intake Report from 6/16/15 to 7/29/15 revealed the resident consumed from 0% to 100% of her meals. A review of the Nurses ' Notes from 5/12/15 to 7/30/15 revealed no documentation of physician notification of the missing partial dentures. An interview was conducted with NA #1 on 7/29/15 at 10:08 AM. NA #1 stated the resident had a partial for her upper teeth which was lost approximately two months ago. The NA stated the partial had not been replaced. She stated the resident was eating approximately 50% to 75% of her meals. An interview was conducted with Resident # 165 on 7/30/15 at 10:06 AM. She stated she would like to have a new partial denture made because it would make it easier for her to eat food. An observation of Resident # 165 was made on 7/30/15 at 10:06 AM. The resident was not observed wearing an upper partial denture. An interview was conducted with Administrative Staff #1 on 7/31/15 at 9:00 AM. Administrative Staff #1 stated a dental consult for the replacement of the partial dentures had not been scheduled after they were reported as missing, because the resident had refused to wear them in the past. Administrative Staff #1 did not indicate that the resident ' s attending physician or dentist were notified of the missing partial dentures.	F 412	requiring use of dentures have their dentures. Audits included confirming dentures were not lost or damaged. No other issues were identified after completion of the audit. Residents with lost or damaged dentures will be referred to the dentist promptly for evaluation. Dental Services will continue to be offered for residents identified as having dental concerns or need for services. Appointments will be scheduled in a timely manner for dental needs. On 8/24/15, a care plan review was completed by the Minimum Data Set (MDS) Nurse(s) on all residents requiring use of dentures to ensure dentures are care planned. 3) Systemic Changes: Residents with lost or damaged dentures will be referred to the dentist promptly for evaluation. Also, the facility Dentist will be notified of any resident that is care planned for use of dentures but refuses to wear their dentures. The resident legal representative or interested family member will also be notified of the resident refusal to wear dentures. All Licensed Nurses and Nurse Aides (across all shifts including weekend and as needed scheduled) were educated by the Director of Nursing and Unit Manager regarding reporting of lost or damaged dentures, or any dental concerns needing evaluation by Dental Services beginning	

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F 412	Continued From page 31	F 412	on 08/14/15 with completion by 08/29/15. Audits will be performed by the DON, Unit Manager or Nurse Supervisor to ensure all residents that require use of dentures have their dentures. These audits will be performed on (10) residents that require use of dentures to ensure dentures are not lost or damaged monthly for three (3) months. Residents noted with lost or damaged dentures will be referred to the dentist promptly for evaluation. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the DON will report denture audit results to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review the audit results to make recommendations to ensure compliance is sustained ongoing, and determine the needs for further auditing beyond the three (3) months.	
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.	F 431		8/31/15

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F 431	Continued From page 32 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. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date the Budesonide (steroid for the treatment of asthma and Chronic obstructive pulmonary disease (COPD) when opened and failed to discard a single dose Zofran (used to prevent nausea and vomiting) vial in 2 (cart B - rooms 15-30 and cart C - rooms 31-42) of 6 medication carts observed. Findings included: 1. On 7/31/15 at 11:50 AM, the medication cart B was observed. There were two Budesonide	F 431	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 07/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 33 boxes that were opened. In each box, there was an opened foil with vials of Budesonide left. The foil did not have a date of opening. The instruction on the box read " once the foil envelope opened, use vials within 2 weeks. " On 7/31/15 at 11:56 AM, Nurse #4 was interviewed. She stated that the Budesonide foil should have been dated when opened. On 7/31/15 at 12:19 PM, the pharmacy technician was interviewed. She indicated that she had checked the medication carts and didn ' t know that the Budesonide should be dated when opened but after reading the instruction on the box she agreed that the foil should have been dated when opened. 2. On 7/31/15 at 12:15 PM, the medication cart C was observed. There was an opened vial of Zofran 4 milligrams (mgs) per 2 milliliter (ml) observed with no date of opening. The vial read " 2 ml single dose vial. " On 7/31/15 at 12:18 PM, Nurse #2 was interviewed. She stated that one of the residents was using the Zofran on a PRN basis (as needed). She also added that her supervisor (assistant director of nursing) indicated that it was a multi dose vial. Nurse #2 indicated that it should have been dated when opened but it was not. On 7/31/15 at 12:19 PM, the pharmacy technician was interviewed. She indicated that she had checked the medication carts but didn ' t notice the opened Zofran. She looked at the Zofran vial and stated that it was a single dose vial and should have been discarded after use.	F 431	deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: Licensed Nurse on Cart B removed the opened and undated Budesonide package from the medication cart on 7/31/15 and discarded it. Licensed Nurse on Cart C removed the opened single dose vial of Zofran from the medication cart on 7/31/15 and discarded it. All facility medication carts were audited by the facility Director of Nursing (DON) and Unit Manager on 7/31/15. No other opened and undated or opened single dose vials were noted on the medication carts. No expired medications were noted on the medication carts. 2) On 8/10/15, All Licensed Nurses and Med Aides (including weekend only scheduled and PRN scheduled) were re-educated by Director of Nursing on dating of internal medication packages and discarding of single use vials of medications. Medication quality assurance practices were discussed. Licensed Nurses and Med Aides will check all medications prior to administration for appropriate dating. 3) Systemic Change: Licensed Nurse or Med Aide will complete	

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F 431	Continued From page 34	F 431	a medication cart audit two times per week for a minimum of three (3) months. Pharmacy Consultant or Pharmacy Technician will perform medication cart audits during their facility visit monthly for a minimum of three (3) months. DON, Unit Manager, or Nurse Supervisor will audit ALL medication carts once per week for a minimum of three (3) months to validate no (opened) undated, no expired or open single dose vial medications are on the medication cart. Any Licensed Nurse or Med Aide found to have undated/ or open single dose medications on cart will complete one on one education by Pharmacy Consultant, DON, SDC, or Unit Manager. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the DON will report the medication cart audit findings to the Quality Assurance and Performance Improvement (QAPI)Committee. The QAPI Committee will review the audits to make recommendations to ensure compliance is sustained ongoing: and determine the need for further auditing beyond the three (3) months.	