STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 000	INITIAL COMMENTS On August 20, 2015, the 2567 was amemded at F371	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess and document findings for 1 of 1 residents observed with a medication at bedside for the ability to safely administer her own inhaler without staff supervision (Resident #33). The findings included: A review of the facility policy on 'Self-Administration of Medications' (revised December 2012) indicated residents who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. The policy interpretation and implementation procedures included a general evaluation of the resident's decision-making capacity by the staff and practitioner along with a specific skills assessment, documentation of their findings of residents who are capable of self-administering medications, and periodic reevaluation of the resident's ability to continue to self-administer medications.	F 176	Plan of Correction: Tag 176 Resident Self-Administer Drugs if Deemed Safe #1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A self-administration assessment was completed for Resident #33 on 8/5/15. Resident #33 was assessed as being able to self administer Advair Discus inhaler and a physician's order was obtained for resident #33 to self administer Advair Discus inhaler. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the same deficient practice. The IDT team (SDC, MDS, Admissions) audited the facility to see if any other residents were self administering medication on 8/5/15. The results of the	9/4/15

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

Electronically Signed | 08/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 176	Continued From page 1 Resident #33 was admitted to the facility on 3/21/05 with diagnoses which included asthma. A review of the most recent quarterly Minimum Data Set (MDS) dated 5/13/15 revealed the resident had intact cognitive skills for daily decision making. She required extensive assistance to total dependence on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring supervision only for eating. A review of the resident's current Care Plan was completed. The Care Plan did not address the self-administration of medications by Resident #33. A review of Resident #33's current physician orders included the following: Advair Diskus 250/50 micrograms (mcg) inhaler to be given as one puff (inhalation) by mouth twice daily and scheduled for administration at 8 AM and 8 PM each day. An additional notation was made in the order which read, "Rinse mouth after use." Advair Diskus inhaler is a combination medication containing a steroid (fluticasone) to reduce inflammation and a long-acting beta-2 agonist (salmeterol) to relax bronchial smooth muscle for the treatment of asthma. The administration guidelines specified by the manufacturer of Advair Diskus inhaler includes patient instructions to rinse the mouth with water after use and spit to reduce the risk of oral candidiasis (thrush). On 8/4/15 at 11:12 AM, Resident #33 was observed to have an Advair Diskus 250/50 mcg inhaler on the bedside table in front of her. The hall nurse was not in her room at the time of the observation. Upon inquiry about the Advair inhaler, the resident stated the nursing staff would leave the inhaler for her so she could use it when	F 176	audit indicated that no other residents were self administering medications. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The Staff Development Coordinator conducted in-services with responsible licensed nursing staff on the policy and procedures of self-administration of medication. The in-services were completed by 8-25-15. All new hired licensed staff will be educated on the policy and procedures for self administration on orientation. The MDS coordinator will audit charts monthly for self administration orders to verify that a physician's order has been obtained and a self-administration assessment has been completed per Facility policy. #4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The results of the self-administration audits will be compiled monthly and presented to the Quality Assurance Committee monthly by the Director of Nursing . The Quality assurance Committee will review the audits and make recommendations as appropriate. These audit will be completed by the Director of Nursing or designee monthly for three months then quarterly for one year. The Quality Assurance committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 176	Continued From page 2 she was ready to do so. Resident #33 stated she had not yet used the Advair that morning. The resident reported she would give the Advair to a nursing assistant after she had used it so the inhaler could be returned to the hall nurse for storage. When asked if she needed to do anything special after using the inhaler, the resident stated, "No." When asked specifically if she rinsed her mouth out with water after using the Advair inhaler, the resident shook her head and said, "Oh, no." A review of Resident #33's medical record revealed it did not include either an assessment of the resident's abilities to self-administer medications or a physician's note/order in regards to the resident's ability to self-administer the inhaler. An interview was conducted on 8/4/15 at 2:08 PM with Nurse #1. Nurse #1 was the first shift nurse assigned to care for Resident #33. During the interview, inquiry was made in regards to the Advair Diskus inhaler observed to be left on Resident #33's bedside table. Nurse #1 reported if Resident #33 was busy at the time of the medication pass, they (the nursing staff) may leave the Advair Diskus with her to self-administer and would pick it up later. When asked if the resident rinsed her mouth out afterwards, the nurse stated he didn't know. Information obtained during the resident interview was shared with Nurse #1, which indicated she did not rinse her mouth out after each use. Nurse #1 then stated he would need to stay in her room to be sure this was done after she used the inhaler. Inquiry was made as to how he would know which residents could safely self-administer a medication, the nurse reported he would know by	F 176	will determine if continued monitoring is necessary after one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 176	Continued From page 3 previous knowledge of the resident "being with it," as well as previous observations of the resident taking medications appropriately. An interview was conducted on 8/5/15 at 10:56 AM with Nurse #2 and Nurse #3. Nurse #2 and Nurse #3 assumed responsibility for completing the residents' MDS assessments and interdisciplinary care plans. Upon inquiry as to what procedures the facility followed to ensure a resident could safely self-administer medications, the nurses indicated a staff assessment would need to be completed and a physician's order obtained. They also reported the self-administration of medications would need to be a part of the interdisciplinary care plan. The MDS nurses revealed no residents at the facility were currently evaluated/assessed for the safe self-administration of medications. An interview was conducted on 8/5/15 at 2:07 PM with the Director of Nursing (DON). During the interview, the DON reviewed the facility's policy and procedures on the self-administration of medications by a resident within the facility. The DON reported a nurse and practitioner assessment would need to be completed, a practitioner order (physician or nurse practitioner) obtained, and the self-administration of medications incorporated into the resident's plan of care. He stated his expectation was for staff to follow the policy and procedures for the safe self-administration of medications by a resident.	F 176		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		9/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility had a. Stained and sticky floor tiles that had an accumulation of a black/brown colored substance in the corners and entrance to resident rooms. This was evident in 3 of 4 resident units. (Secured Unit, Unit 1 and Unit 2) b. The facility had door frames with chipped paint in 1 of 4 units (Secured) c. The facility had an accumulation of dust and trash on the floor in 1 of 4 resident care areas. (Secured unit) d. The facility had an ice cart and ice cooler that was stained with an accumulation of a black colored substance on 1 of 4 units (Rehab unit). e. The facility shower curtains were soiled and discolored. 1 of 4 units (Unit 2). Findings included: a. Observation on 8/4/15 at 2:30 PM revealed the hallway white colored floor tiles on the secured unit were discolored. Corners of the floor at the entrance of Resident Rooms #2, #3, #4, #5, and #6 had with an accumulation of brown/black colored substance. Observation of the environment on 8/5/15 at 2 PM - 3:25 PM was conducted. At 2:35 PM the Director of Maintenance and the floor tech joined the observation. These observations revealed: On the Secured unit: 1. The corners of the floor at the entrance of Resident Rooms #2, #3, #4, #5, and #6 remain with an accumulation of brown/black colored substance. 2. Observation of the hallway floor tiles remained discolored. 3. The corners and perimeter of the floor in the	F 253	Plan of Correction: Tag 253 Housekeeping & Maintenance Services #1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; All areas affecting F253 for Housekeeping and Maintenance Services requirements were identified and corrected: a) Secured Unit: 1. The corners at the entrance of Resident Rooms #2, #3, #4, #5, and #6 were identified, cleaned, stripped and waxed. 2. The hallway discolored floor tiles were identified cleaned, stripped and waxed. 3. The corners and perimeter of the floor in the area where activities are held were identified, cleaned, stripped and waxed. 4. The corners of the floor near the supply room were identified, cleaned, stripped and waxed. 5. The hallway floor near the Janitor's closet were identified, cleaned, stripped and waxed. 6. The floor tile near the storage room was identified, cleaned, stripped and waxed. 7. The over bed in the dining room with missing veneers was identified and discarded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 5 area where activities are held had the perimeter of the area with an accumulation of brown/black colored substance. 4. The corners of the floor near the supply room had an accumulation of brown/black colored substance. 5. The hallway floor near the Janitor ' s closet had an accumulation of a brown/black colored substance. 6. The floor tile near the storage room had dried and sticky stains. 7. The veneer of the over bed table used in the dining room had veneer that was missing on the sides. 8. There was an accumulation of brown colored particles in the corner of the carpet near the window in the lounge area. Interview on 8/5/15 at 2:20 PM with Housekeeper (HK #1) revealed her routine was to sanitize and clean the bedroom floors, dining room floors and vacuum the lounge floor carpet. HK #1 indicated the floors on the secured unit were discolored, stained and she attempted in the past (could not be specific) to scrape the accumulation in the corner of the floors but was unsuccessful. Continued observations of the environment on Unit 1 revealed: 1. The floor in the hallways are discolored. 2. Behind the fire doors near Room #129-130 had an accumulation of a brown/black colored substance in the floor corners. 3. The floor corners of the entrance to the shower room and the lounge had an accumulation of a brown/black colored substance. Interview on 8/5/15 at 2:35 pm with Maintenance/housekeeping and laundry supervisor and floor technician was held. The supervisor indicated his employment at the facility	F 253	8. The carpet near the window in the lounge area was identified and cleaned. Unit #1: 1. The discolored hallway floor tiles were identified cleaned, stripped and waxed. 2. Areas behind the fire doors near Room #129-130 were identified cleaned, stripped and waxed. 3. The floor corners of the entrance to the shower room and the lounge were identified cleaned, stripped and waxed. Unit #2: 1. Stained floor tiles located across from the nurse's station were identified and replaced was identified cleaned, stripped and waxed. 2. The floor area under the water fountain was identified cleaned, stripped and waxed. b) door frames with chipped paint c) dust and trash on floor d) stained and dirty ice cart and ice cooler e) soiled and discolored shower curtains #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All other areas throughout the facility affecting F253 for Housekeeping and Maintenance Services requirements were identified and corrected: a)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 6 was almost 2 weeks and systems have not been developed. The floor technician indicated that he was responsible for floor cleaning and buffs the floors each day and strips the floor once a year. Further environmental observations on Unit 2 revealed: 1. Stained floor tiles located across from the nurses station. 2. There was an accumulation of black substance in the corners of the floors under the water fountain. b. Observation on 8/4/15 at 2:30 PM revealed the paint on the door frames were chipped at the entrance of Resident Rooms #2, #3, #4, #5, and #6. Observation of the environment on 8/5/15 at 2 PM - 3:25 PM was conducted and revealed the paint on the door frames of Resident Rooms #2, #3, #4, #5, and #6 remained chipped. c. Observation on 8/5/15 at 2:15 PM with the infection control nurse revealed behind the activity cabinet located in the activity area was an accumulation of salt and paper packets, a writing pen, facial costume mask and playing cards on the floor covered with dust in the Secured unit. d. Observation on 8/5/15 at 3:35 PM on the Rehab Unit with the Maintenance/housekeeping and laundry supervisor revealed: 1. The bottom of the ice cart had an accumulation of a black colored substance on the surface. The inside of the ice cooler had a brown colored stain. During the observation the housekeeping /maintenance director indicated was no cleaning schedule for the ice cart or ice cooler and was not sure when the last time cleaning was performed. 2. The microwave in the nourishment room for resident use had an accumulation of dried food debris on the top and sides of the microwave. e. Observation of the environment on 8/5/15 at 2	F 253	Discolored, dirty and/or cracked floor tiles throughout the facility were identified, replaced (as needed), cleaned, stripped and waxed. Damaged over bed tables throughout the facility were identified, discarded and replaced (as needed). Lounge areas with dirty carpet were identified and cleaned (as needed) throughout the facility. b) door frames with chipped paint c) dust and trash on floor d) stained and dirty ice cart and ice cooler, e) soiled and discolored shower curtains. Cracked floor tiles were removed and replaced. Floors were stripped and waxed. Door frames were repainted. Housekeeping and Maintenance staff were re-educated on proper cleaning methods. Maintenance Supervisor and Administrator held an in-service with Housekeeping and Maintenance staff on 8/18/15 and 8/21/15 addressing all areas affecting F253 for Housekeeping and Maintenance Services. Maintenance Supervisor and Administrator audited facility to identify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 7 PM - 3:25 PM revealed the bottom of the bathroom shower curtain was soiled with a black and green colored stain in the bathing area on Unit 2. The shower curtain in the bathroom near room 224 had a brown colored stain. Interview on 8/5/15 at 2:20 PM with Housekeeper (HK #1) revealed she attempted to clean the shower curtain but the spray cleaner did not work. Interview on 8/5/15 at 3:15 PM with nursing assistant (NA) #1 and NA #2 revealed they had not noticed the stain on the shower curtain and housekeeping was responsible for cleaning the curtains. Interview on 8/6/15 at 4:22 pm with the corporate representative, interim administrator and director of nurses was held. The corporate representative and interim administrator indicated they expected staff to follow the policy and procedures for cleaning and follow the cleaning schedules cleaning schedules.	F 253	any additional repair or maintenance issues. Any repair or maintenance issues found were corrected to ensure compliance of all areas affecting F253 for Housekeeping and Maintenance Services. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The Administrator, Maintenance Supervisor, or designee will continue to assure compliance by completing Housekeeping and Maintenance audits and ensuring monitoring and training on a weekly basis. Formal QA meetings/processes will be completed monthly x 3 months and will include discussing in-services, audit outcomes, and any non-compliant issues to QA Committee/Maintenance Supervisor. #4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator, Maintenance Supervisor, or designee will monitor the results of the housekeeping and maintenance audits. The QA Committee will review the results of the audits and continue monitoring for evaluation and recommendation.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 278	Continued From page 8 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment on 1 of 6 residents (Resident #17) for unnecessary medications, and 1 of 3 resident (Resident #57) for accidents. Findings included 1. Resident #17 was originally admitted to the facility on 6/30/2011 with diagnoses which included: vascular dementia with depressed mood, anxiety, and major depressive disorder. A review of the Quarterly MDS dated 4/2/15	F 278	Plan of Correction: Tag 278 ¿ Assessment Accuracy/Coordination/Certified #1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #17 MDS was reviewed by the Director of Nursing and MDS Coordinator and accurately reflects resident's status as of 8/6/15 regarding his diagnosis of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 278	Continued From page 9 revealed Resident #17 had diagnoses which included: dementia and depression. A review of the Quarterly MDS dated 7/2/15 revealed dementia and depression were omitted from Section I (the section of the MDS which addressed active diagnoses. A review of the physician orders dated 7/1/15 through 7/31/15 revealed medications which included: Donepezil (a medication used to treat symptoms of Alzheimer ' s disease such as confusion or dementia) 10 milligrams (mg) by mouth (PO) every night at bedtime (QHS), Klonopin (a medication used to treat symptoms of anxiety) 0.5mg - Give ½ tablet PO three times daily (TID), Quetiapine (a medication used to treat the symptoms of depression) 25mg PO QHS, and Namenda (a medication used to treat symptoms of dementia) 10mg PO twice daily (BID). A review of the Medication Administration Record (MAR) dated 7/1/15 through 7/31/15 for Resident #17 revealed Resident #17 received all medication doses as prescribed. A review of the care plans in effect for 7/1/2015 for Resident #17 revealed care planning related to: " At risk for social isolation related to impaired cognition " , " Alteration in cognition: Short and long term memory deficit with impaired decision making skills " , " At risk for nutritional decline due to diagnosis of dementia and depression " , and " Resident #17 is feeling depressed and has a decreased interest in doing things. " An interview was conducted on 8/6/15 at 10:30 AM with Nurse #4 and revealed Resident #17 was confused all the time. Nurse #4 stated Resident #17 took medications for depression, anxiety, and dementia. Nurse #4 also stated Resident #17 was diagnosed with anxiety, depression, and dementia.	F 278	dementia and depression. Resident #57 MDS was reviewed by the Director of Nursing and MDS Coordinator and accurately reflects the resident's status as of 8/6/15 regarding fall on 4/23/15. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice. The MDS Coordinator and Assistant MDS Coordinator will bring forward diagnoses from previous assessment and compare and ensure that they are accurate. The MDS team will refer to care plans for previous falls. The MDS team will triple check all MDS before closing. The MDS Coordinator will inservice the Assistant MDS Coordinator using the RAI manual and you-tube MDS 3-0 presentations for sections A-Z. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; A member of the Interdisciplinary Team (Admissions Coordinator) will audit all MDS's submitted from 8/1/15 to 8/31/15. IDT designee will review five (5) MDS assessments each week for four (4) weeks and the ten (10) MDS assessments will be reviewed each month for three (3) months. Identified issues will be corrected. #4. Indicate how the facility plans to monitor its performance to make sure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 278	Continued From page 10 An interview was conducted with Nurse #3 on 8/6/15 at 10:40 AM. Nurse #3 stated Section I (the active diagnosis section of the MDS) was completed based on information obtained from diagnoses in the computer, MARs, physician progress notes, and physician orders. Nurse #3 also stated Resident #17 should have depression, anxiety and dementia checked in Section I of the quarterly MDS dated 7/2/15 but they were not checked. An interview was conducted on 8/6/15 at 10:55 AM with the Director of Nurses (DON). The DON stated the expectation was for the MDS to be completed accurately. 2. Resident #57 was admitted to the facility on 3/15/2012 with a past medical history which included: gait ataxia (unsteady walking), osteoporosis, and Alzheimer ' s disease. A review of the quarterly Minimum Data Set (MDS) dated 4/29/2015 revealed Resident #57 had a brief interview for mental status (BIMS) score of 3, which indicated severe cognitive impairment, needed extensive assistance with all activities of daily living (ADLs) except eating, and was not steady walking without human assistance. Resident #57 had not displayed any behaviors or rejection of care, and had not exhibited wandering or exit seeking behaviors during the look back period. A review of the Care Area Assessment data (CAAs) data with an Assessment Reference Date (ARD) of 4/29/2015 revealed a CAA worksheet for falls. Resident "has had no falls since last assessment, needs minimum assistance with transfers but due to dementia often transfers self as she forgets to ask for assistance. Will proceed to care plan with interventions to prevent falls. " A review of the care plans dated 3/12/15 revealed	F 278	solutions are sustained. The Director of Nursing will monitor the results of the reviews and present them monthly for three (3) months to the Quality Assurance Committee for review and recommendations to sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 278	Continued From page 11	F 278		

the resident had a care plan in place for falls risk. Interventions included: quarterly fall risk assessment; keeping the room well lit and clutter free; wearing non-skid shoes when out of bed; ensure the bed was in lowest position. The care plan was reviewed 4/23/15 after a fall.

A review of the 'incident reports' for a fall on 4/23/15 revealed the fall resulted in no injuries, the appropriate assessments were completed, interventions were in place and being followed at the time of the fall, care plans were reviewed and updated as needed after the fall, and family members/physicians were notified.

An additional review of the quarterly MDS dated 4/29/15 revealed Section J of the MDS (the section related to falls) did not reflect the resident had a fall on 4/23/15. The MDS was coded no falls since admission or prior assessment.

An interview was conducted on 8/6/15 at 10:55 AM with the Director of Nurses (DON). The DON stated the expectation was for the MDS to be completed accurately.
An interview was conducted on 8/6/15 at 2:20 PM with Nurse # 2. Nurse #2 stated, "We get our falls information by reading the nursing notes in the chart, daily morning meetings, and interdisciplinary team meetings every Friday. The look back period is 7 days. So if the ARD is 4/29/15 the look back period goes back to 4/23/15." After reviewing the resident's chart, Nurse #2 also stated the resident had a fall on 4/23/15 at 4:04 PM and should have been reflected in the 4/29/15 MDS. After looking at the 4/29/15 MDS, Nurse #2 stated, "It says zero falls."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 371	Continued From page 12	F 371		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the facility: a. Failed to have a dietary staff wear a hair restraint on a beard. b. The facility failed to have soap in 1 of 2 soap dispenser. c. The facility failed to have splash guard, burners on the stove, hood filter sections and butcher block wood shelf on front of the steam table free from a builid up of dirt, grease and dried food debris. d. The facility failed to date opened food items of sugar, swiss cheese, salad mix, dill hamburger pickle slices, and celery stalks. This was evident in 2 of 2 days of dietary observations. The findings included: a. Record review of the Hair Restraints Policy, undated, revealed in part that any employee directly working with food, either working on the food line, or preparing food, shall wear hair restraints (hair nets), beard restraints, and clothing that covers body hair, that are designed and worn effectively to keep their hair from contacting exposing food. Observations on 8/3/15 at 9:35 AM revealed	F 371	Plan of Correction: Tag 371 Food Procure, Store/Prepare/Serve - Sanitary #1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; All areas affecting F371 for Dietary Services requirements were identified and corrected: a) failure to wear a hair restraint on a beard, b) failure to have soap in a soap dispenser, c) build-up of dirt, grease and dried food debris on splash guard, stove burners, hood filters and steam table shelf, d) failure to date open food items. a) All dietary employees were provided hair, beard restraints. Dietary staff were re-educated about wearing beard guards in the kitchen area.	9/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 371	Continued From page 13 Dietary Aide #1 had no beard restraint to cover his beard. Observations on 08/04/2015 at 9:46:14 AM revealed that Dietary Aid #1 had no beard restraint to cover his beard. b. Observations on 8/3/15 9:35 AM and 11:40 AM revealed no soap in the soap dispenser located at the entrance from the dining room into the kitchen. Interview on 8/3/15 at 3:30 PM with Cook #1 revealed that the soap dispenser by the dining room was always out of soap. The employees used the sink by the outside door on the other side of the kitchen. c. Observations on 8/4/14 at 11:30 AM revealed discoloration ranging from black to brown to yellow on the back of the stove splash guard. The three front burners on the stove were covered with white chalky color buildup and the three back burners were black and crusty. Interview with Dietary Manager #1 on 8/4/15 at 11:30 AM revealed that burnt area on the shelf above the stove was greasy and dusty. Interview with Cook #1 on 8/5/15 at 1:47 PM revealed he did not know who cleaned the stove. Cook #1 continued to indicate he wiped down the shelf above the stove every night. Someone came in and cleaned the filters (was not able to identify the individual). He did not know when the last time the filters were cleaned. Further interview revealed Cook #1 did not know what the weekly cleaning schedule was. There was a schedule on the board but it was not made like Cook #1 said. Cook #1 indicated he gave a schedule to Dietary Manager #1 that checked off	F 371	b) Soap was installed in the soap dispenser located at the entrance from the dining room into the kitchen. c) Dirt, grease and dried food debris on splash guard, stove burners, hood filters and steam table shelf were cleaned and sanitized. d) Dietary Supervisor, Administrator and Dietary staff audited all kitchen food items. Any opened food item found not to be labeled/dated was immediately labeled/dated or discarded. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All other areas throughout the kitchen affecting F371 for Dietary Services requirements were identified and corrected: a) failure to wear a hair restraint on a beard, b) failure to have soap in a soap dispenser, c) build-up of dirt, grease and dried food debris on splash guard, stove burners, hood filters and steam table shelf, d) failure to date open food items. a) Dietary staff were re-educated about wearing beard guards in the kitchen area. Dietary Manager and Administrator reviewed and updated the following policies with Dietary staff on 8/12/15: ¿Food Storage Policy¿, ¿Hair Restraint	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 371	Continued From page 14 that the range top back splash, shelf, drip pan, front and sides of ovens were cleaned on 7/27/15. Observations on 8/4/15 at 11:30 AM revealed the butcher block wood shelf on the front steam table had an accummulation of black areas throughout the shelf. Interview with Cook #2 on 08/05/2015 at 2:00:15 PM revealed that the stove had not been cleaned in a couple of weeks. Dietary Manager #1 checked the weekly sheets when the cleaning was done. Cook #2 continued that Sunday morning Dietary Aid #2 cleaned the small oven. Interview with Dietary Manager #1 on 8/4/15 at 11:30 AM revealed that the butcher block shelf on the steam table always looked like that. d. Observations on 8/4/15 at 10:20 AM with Dietary Manager #1 revealed 2 pounds (lbs.) of sugar, with 1 lb. opened and undated, 2 lbs. of Swiss cheese, with 2 lbs. opened and undated, 2 packages of salad mix 5 lbs. with 2.5 lbs undated and opened, dill hamburger slices, 128 ounces (oz) with about ¼ of the jar remaining, opened and undated and a package of celery stalks with ½ of the celery opened and undated. Interview with Dietary Manager #1 on 8/4/15 at 10:30 AM revealed that she did not know why the dietary staff, when they placed open food in the cooler, did not date it. Her expectation was that the dietary staff would date the opened package of food at the time they placed it in the cooler. Interview on 8/5/15 at 1:47 PM with Cook #1 revealed the person that was the last to use the product was responsible for dating it. Interview on 08/05/2015 5:16:14 PM with the	F 371	Policy¿. Dietary Supervisor held an in-service on 8/12/15 on the following: following cleaning schedules, dating and labeling food items, taking and recording sanitation and temperature logs, hair restraint use, adhering to break times, appropriate break areas, attendance policy, soap and towel dispensers. b) All soap dispensers throughout the kitchen were inspected and soap was installed or replaced as needed. ¿Sanitation Assignments¿ checklists were re-vamped and instituted on 8/5/15 to encompass all areas of F371. The ¿Sanitation Assignments¿ implemented ensures a clean and sanitary kitchen environment by assigning specific cleaning tasks and duties to individual dietary employees. Dietary Supervisor held an in-service on 8/12/15 on the following: following cleaning schedules, dating and labeling food items, taking and recording sanitation and temperature logs, hair restraint use, adhering to break times, appropriate break areas, attendance policy, soap and towel dispensers. c) Dietary Supervisor, Administrator and Dietary staff audited kitchen to ensure all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 371	Continued From page 15 Corporate Representative revealed her expectation was that the kitchen be clean and sanitary. Interview with the Director of Nursing on 8/5/15 at 5:18 PM revealed his expectation was to follow the procedures that had been put in place.	F 371	equipment, floors, walls, shelving, fridges, freezers, etc. were thoroughly cleaned and sanitized. Any equipment, floors, walls, shelving, fridges, freezers, etc. found with dirt, grease, dried food debris, etc. was immediately cleaned and sanitized. ¿Sanitation Assignments¿ checklists were re-vamped and instituted on 8/5/15 to encompass all areas of F371. The ¿Sanitation Assignments¿ implemented ensures a clean and sanitary kitchen environment by assigning specific cleaning tasks and duties to individual dietary employees. Dietary Supervisor held an in-service on 8/12/15 on the following: following cleaning schedules, dating and labeling food items, taking and recording sanitation and temperature logs, hair restraint use, adhering to break times, appropriate break areas, attendance policy, soap and towel dispensers. d) Dietary Supervisor, Administrator and Dietary staff audited all kitchen food items. Any opened food item found not to be labeled/dated was immediately labeled/dated or discarded. ¿Sanitation Assignments¿ checklists were re-vamped and instituted on 8/5/15 to encompass all areas of F371. The ¿Sanitation Assignments¿ implemented ensures a clean and sanitary kitchen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 371	Continued From page 16	F 371	environment by assigning specific cleaning tasks and duties to individual dietary employees. Dietary Supervisor and Administrator reviewed and updated the following policies with Dietary staff on 8/12/15: ¿Food Storage Policy¿, ¿Hair Restraint Policy¿ Dietary Supervisor held an in-service on 8/12/15 on the following: following cleaning schedules, dating and labeling food items, taking and recording sanitation and temperature logs, hair restraint use, adhering to break times, appropriate break areas, attendance policy, soap and towel dispensers. ¿¿¿¿#3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; ¿Sanitization Assignments¿ will be completed by Dietary staff on a daily basis. Dietary Supervisor, Administrator, or designee will conduct and document kitchen audits as follows: daily x 5 and weekly until QA Committee evaluates and makes recommendations. Any deficiencies noted from the audits will be corrected. #4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 371	Continued From page 17	F 371	Dietary Supervisor, Administrator, or designee will review the audits on a weekly basis. Audit information will be presented to the QA Committee for review and recommendation.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 431	Continued From page 18 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to discard expired medications in 1 of 5 medications carts (200 Hall) and 1 of 4 medication store rooms (100 Hall); and failed to securely store a medication for 1 of 1 residents (Resident #33) observed with a medication left at bedside for self-administration. The findings included: 1) An observation of the 200 Hall medication cart on 8/6/15 at 7:35 AM revealed an opened vial of Humalog insulin labeled for Resident #83 and dated as opened on 7/2/15 was stored on the cart. The manufacturer's product information indicated, "Once punctured (in use), vials may be stored under refrigeration or at room temperature; use within 28 days." A review of Resident #83's August 2015 Physician Orders revealed there was a current order for the insulin to be used on a sliding scale basis (which indicated the insulin was to be used only as needed and that the insulin dose used was dependent on the resident ' s blood glucose level). A review of the Medication Administration Records (MARs) for July 2015 and August 2015 revealed 12 doses of insulin were given to Resident #83 after the insulin ' s calculated expiration date of 7/30/15. An interview was conducted on 8/6/15 at 7:40 AM	F 431	Tag 0431 - 483.60(b), (d), (e) Drug Records, Label/Store Drugs & Biologicals #1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Humalog insulin labeled for Resident #83 an opened vial of insulin stored on the cart was discarded on 8/6/15. The opened vial of Lantus insulin labeled for Resident #3 stored in the refrigerator on 100 hall medication store room was discarded on 8/6/15. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the same deficient practice. All medication storage rooms and medication carts were thoroughly checked for undated or expired medications on 8/7/15 by the IDT team members which included the MDS Coordinator, Admissions Coordinator and Infection Preventionist and none were located. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The MDS Coordinator provided in-service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 431	Continued From page 19 with Nurse #4. Nurse #4 was the hall nurse assigned to the 200 Hall medication cart. During the interview, Nurse #4 acknowledged the insulin was outdated and stated, "We ' ll get a new one." An interview was conducted on 8/6/15 at 11:25 AM with the facility's Director of Nursing (DON). During the interview, the DON reported his expectation was for nursing staff to follow the facility's policy and procedures, and to dispose of expired medications as directed. 2) An observation of the 100 Hall medication store room on 8/6/15 at 7:05 AM revealed an opened vial of Lantus insulin labeled for Resident #3 and dated as opened on 7/4/15 was stored in the refrigerator. The manufacturer's product information indicated, "Once punctured (in use), vials may be stored under refrigeration or at room temperature; use within 28 days." A review of Resident #3's August 2015 Physician Orders revealed there was a current order for the insulin to be given as 23 units injected subcutaneously (under the skin) every morning and 19 units injected subcutaneously every night at bedtime. A review of the Medication Administration Record (MAR) for August 2015 revealed 8 doses of insulin were given to Resident #3 after the insulin's calculated expiration date of 8/1/15. An interview was conducted on 8/6/15 at 7:10 AM with Nurse #5. Nurse #5 was one of the hall nurses assigned to the 100 Hall medication store room. During the interview, Nurse #5 acknowledged the insulin was outdated and stated, "That's old." She indicated the insulin vial would need to be replaced.	F 431	training to licensed staff and Medication Aides on dating vials when opening and discarding if undated and to check for expiration dates on vials. The in-services were completed by 8-20-15. All new licensed staff and Medication Aides will receive training by the Staff Development Coordinator specific to the requirements for labeling, dating, and discarding multi-dose vials of medications on orientation. The Director of Nursing has implemented weekly audits of medication Storage Rooms and Carts as follows: beginning 8/10/15 the Medication Storage Rooms and carts will be audited by MDS Coordinator weekly times four weeks then monthly times three months. Variances will be corrected if observed. In addition, the facility's consulting pharmacist will audit medication carts and medication rooms monthly. #4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will monitor the results of the med storage audits and report the results and any trends or patterns to the Quality Assurance Committee monthly for four months. The Quality assurance Committee will determine if further interventions or systemic changes are needed to sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 431	Continued From page 20	F 431		

An interview was conducted on 8/6/15 at 11:25 AM with the facility's Director of Nursing (DON). During the interview, the DON reported his expectation was for nursing staff to follow the facility's policy and procedures, and to dispose of expired medications as directed.

3) Resident #33 was admitted to the facility on 3/21/05 with diagnoses which included asthma. A review of the most recent quarterly Minimum Data Set (MDS) dated 5/13/15 revealed the resident had intact cognitive skills for daily decision making. She required extensive assistance to total dependence on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring supervision only for eating.

A review of Resident #33's current physician orders included the following: Advair Diskus 250/50 micrograms (mcg) inhaler to be given as one puff (inhalation) by mouth twice daily. Advair Diskus inhaler is a combination medication containing a steroid (fluticasone) to reduce inflammation and a long-acting beta-2 agonist (salmeterol) to relax bronchial smooth muscle for the treatment of asthma.

On 8/4/15 at 11:12 AM, Resident #33 was observed to have an Advair Diskus 250/50 mcg inhaler on the bedside table in front of her. The hall nurse was not in her room at the time of the observation. Upon inquiry about the Advair inhaler, the resident stated the nursing staff would leave the inhaler for her so she could use it when she was ready to do so. Resident #33 stated she had not yet used the Advair that morning. The resident reported she would give the Advair to a nursing assistant after she had used it so the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 431	Continued From page 21	F 431		

inhaler could be returned to the hall nurse for storage.

A review of Resident #33's medical record revealed it did not include either an assessment of the resident's abilities to self-administer medications or a physician's note/order in regards to the resident's ability to self-administer the inhaler.

An interview was conducted on 8/4/15 at 2:08 PM with Nurse #1. Nurse #1 was the first shift nurse assigned to care for Resident #33. During the interview, inquiry was made in regards to the Advair Diskus inhaler observed to be left on Resident #33's bedside table. Nurse #1 reported if Resident #33 was busy at the time of the medication pass, they (the nursing staff) may leave the Advair Diskus with her to self-administer and pick it up later.

An interview was conducted on 8/5/15 at 2:07 PM with the Director of Nursing (DON). During the interview, the DON stated his expectation was for staff to follow the facility ' s policy and procedures for the storage of the Advair Diskus inhaler and to "use it (the medication) and then secure it."