

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/29/2015
NAME OF PROVIDER OR SUPPLIER MOUNTAIN HOME HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	
(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 The exit date for the facility's Recertification survey was extended from 12/10/15 to 12/29/15 due to a complaint investigation which occurred on 12/28/15 to 12/29/15 which resulted in deficiencies being cited at F-225 and F-226. Event ID # 6QJI11.	F 000	<p>The submission of the Plan of Correction does not constitute agreement on the part of Mountain Home Health and Rehabilitation Center that the deficiency cited with the report represent deficient practices on the part of Mountain Home Health and Rehabilitation Center. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.</p> <p>Tag: F225---Investigate/Report Allegations/Individuals</p> <p>Corrective action for identified residents: Allegation for resident #101 was investigated on June 6, 2015.</p> <p>Allegation for resident #39 was investigated on December 10, 2015. Allegation was reported to HCPR on February 1, 2016.</p> <p>Allegation for resident # 110 was investigated on December 1, 2015. Allegation was reported to HCPR on February 1, 2016.</p>	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

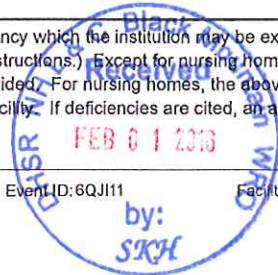
TITLE

Administrator

(X6) DATE

1-20-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of the abuse policy, review of an abuse investigation, review of incident investigations and staff interviews the facility failed to submit 1 of 1 abuse investigations in a timely manner to the North Carolina Health Care Personnel Registry (HCPR) and failed to file a 24 and 5 day report to the HCPR for 2 of 2 allegations of abuse. (Residents #39, #101 and #110)</p> <p>The findings included:</p> <p>The facility Abuse Prevention/Reporting Policy and Procedure dated 06/19/14 included under the heading "Reporting and Response" that the "Facility will report all allegations and substantiated occurrences of abuse, neglect, and misappropriation of property to the facility management, the Governing Body/Corporate Management, state agency and law enforcement officials as designated by this policy, state law, federal regulations and The Patient Protection and Affordable Care Act (Elder Justice Act)."</p> <p>1. On 12/29/15 at 9:15 AM the Director of Nursing (DON) stated the facility had one abuse investigation for the year 2015. This investigation occurred 06/05/15 and involved Resident #101</p>	F 225	<p>How other residents with the potential for deficient practice identified:</p> <p>All residents of the facility are at risk for abuse, neglect, mistreatment and misappropriation of property.</p> <p>Systematic changes made to ensure deficient practice does not reoccur:</p> <p>The Director of Nursing and Assistant Directors of Nursing were in-serviced by the Administrator on the Abuse policy and the guidelines for State reporting of the 24 hour and 5 day reporting to HCPR for allegations and substantiated occurrences of abuse, neglect, and misappropriation of property on January 15, 2016. All staff were in-serviced on the facility's Abuse Prevention/Reporting Policy and Procedure by January 26, 2016.. Policy states that all allegations and substantiated occurrences of abuse, neglect, and misappropriation of</p>	1-26-16	

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F 225	<p>Continued From page 2 and Medication Aide #1. The alleged incident was reported to the DON on 06/05/15 by Nurse #5.</p> <p>The 24 hour report for the 06/05/15 allegation was signed by the DON and dated as completed on 06/08/15 and transmitted to the North Carolina Health Care Personnel Registry (HCPR) on 06/09/15. The 24 hour report should have been submitted to the HCPR by 06/06/15. The 5 day working report was signed by the DON and dated as completed on 06/18/15 and transmitted to the HCPR on 06/18/15. The 5 day report should have been submitted to the HCPR by 06/12/15.</p> <p>On 12/29/15 at 12:00 PM the administrator stated the facility policy was to have all abuse investigations completed within 3 calendar days. The administrator stated she could not explain why the 24 hour and 5 day report for the investigation involving Resident #101 were submitted late and would expect them to be submitted within the required time frames. The administrator attempted to reach the DON for interview but was unsuccessful in her attempts.</p> <p>2. On 12/28/15 at 9:30 AM the Director of Nursing (DON) provided an investigation of an incident which involved Resident #39 and allegedly occurred 12/10/15. Review of the investigation revealed Hospitality Aide #1 reported she and another staff member were walking on the hall Resident #39 resided and heard Resident #39 hollering from inside her room, "your hurting me" and, as they walked by the room, saw Resident #39's legs "get slung and they hit each other very hard."</p> <p>The investigation noted the staff member that</p>	F 225	<p>property to the facility management. Facility management (Administrator, Director of Nursing, or Assistant Director of Nursing) will report allegations of abuse per state regulations. An Abuse Audit form will be utilized weekly x 8 weeks, then monthly x 2 ensuring that abuse is reporting to management timely, reported to the state within 24 hours, and then 5 day final report indicating substantiation or un-substantiation of abuse.</p> <p>Facility monitoring process:</p> <p>Administrator or Designee (Director of Nursing, Assistant Director of Nursing, or Social Services Director) will submit the findings of the Abuse Audit monthly x 4 months to the Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for further recommendations and/or follow up as needed.</p>		

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F 225	<p>Continued From page 3</p> <p>worked with Resident #39 on 12/10/15 (at the time of the reported incident) was suspended for two days. In addition, the DON interviewed residents that resided within the vicinity of Resident #39 to determine if they had any concerns with this staff member. A 24 hour and 5 day report were not included with the investigation.</p> <p>On 12/28/15 at 5:10 PM the DON stated she always completed a 24 hour and 5 day report for any allegations of abuse and didn't know why these had not been completed and submitted to the Health Care Personnel Registry (HCPR) for the 12/10/15 incident involving Resident #39.</p> <p>On 12/29/15 at 12:18 PM the administrator stated a 24 hour and 5 day report should have been completed and submitted to the HCPR for the alleged abuse involving Resident #39. The administrator could not explain why the reports had not been completed or submitted.</p> <p>3. On 12/29/15 at 2:15 PM Nurse Aide #3 stated she reported an incident of alleged abuse which involved Resident #110 and Medication Aide #2 which had occurred about a month prior. Nurse Aide #3 stated she and Nurse Aide #4 witnessed Medication Aide #2 being physically forceful with Resident #110 in an attempt to get the resident to agree to take a shower. Nurse Aide #3 stated she reported the incident to the Director of Nursing (DON) and the DON asked her to write a statement regarding what was witnessed.</p> <p>On 12/29/15 at 3:10 PM the administrator stated she was not aware of any allegations of abuse involving Resident #110. The administrator</p>	F 225			

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F 225	Continued From page 4 attempted to contact the DON but was unsuccessful in those attempts. The administrator provided an investigation that was located in the employee file of Medication Aide #2 which included an investigation of the incident reported by Nurse Aide #3. Included in the investigation was a statement by Nurse Aide #3 which read: I was attempting to help get Resident #110 to agree to a shower. He was adamant about not taking one. Nurse Aide #4 told the nurse on duty and Medication Aide #2 came down the hall into Resident #110's room. She (Medication Aide #2) began grabbing his arms pulling him say, get up you smell, you need a shower. Resident #110 began resisting pulling away she continued to pull, yanking his arms, grabbing his head. Nurse Aide #4 and I told her to stop several times and finally she did. A 24 hour and 5 day report were not included with the investigation. On 12/29/15 at 5:30 PM the administrator stated she was not aware of the incident involving Resident #110 and Medication Aide #2 until she reviewed the information in the employee file earlier that day at 3:10 PM. The administrator stated a 24 hour and 5 day report should have been completed and submitted to the HCPR for the alleged abuse involving Resident #110. The administrator stated continued attempts to contact the DON had not been successful and she could not explain why the she had not been informed of the allegation or why reports had not been completed or submitted.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226			

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F 226	<p>Continued From page 5</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of incident investigations and staff interviews, the facility failed to follow their abuse investigation policy and procedures by not thoroughly investigating allegations of abuse involving 2 of 2 sampled residents. (Resident #39 and #110)</p> <p>The findings included:</p> <p>The facility Abuse Prevention/Reporting Policy and Procedure policy dated 06/19/14 included under "Investigation" the following: -Skin will be assessed before leaving facility and upon return for bruising and/or other signs of injury -Interviews, clinical and physical assessments will be conducted to assist in the investigation -The Administrator and the Director of Nursing will conduct a comprehensive investigation of any and all allegations of abuse/neglect or misappropriation of resident property in accordance with state law, federal regulation and The Patient Protection and Affordable Care Act. -The investigating team will interview all parties concerned: witnesses, staff, the accused and the alleged victim as appropriate and obtain signed statements as possible. -The investigation will proceed and conclude by fact-finding, root cause analysis and comparison</p>	F 226	<p>Tag: F226---Develop/implement Abuse/Neglect, Etc. Policies</p> <p>Corrective action for identified residents:</p> <p>Director of Nursing completed a late entry on December 15, 2015, in the chart for resident #39 concerning a body assessment that had been completed during the investigation. Allegation for resident #39 was investigated on December 10, 2015. Allegation was reported to HCPR on February 1, 2016.</p> <p>Allegation for resident # 110 was investigated on December 1, 2015. Allegation was reported to HCPR on February 1, 2016.</p> <p>How other residents with the potential for deficient practice identified:</p> <p>All residents of the facility are at risk for abuse, neglect, mistreatment and misappropriation of property.</p>	<p>2-1-16</p> <p>2-1-16</p>

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F 226	<p>Continued From page 6 of information</p> <p>-The Administrator or Director of Nursing will report all allegations of abuse, alleged violations and substantiated incidents to the state agency and the Corporate Office or Governing Board as indicated by the Chain of Command.</p> <p>1. Resident #39 was admitted to the facility 11/10/11 with diagnoses which included dementia without behavioral disturbance. The latest Minimum Data Set assessment dated 11/25/15 assessed Resident #39 with severe cognitive impairment.</p> <p>The current care plan for Resident #39 included the following problem areas:</p> <ul style="list-style-type: none"> a. Decreased strength and weakness, all four extremities b. Potential for recurrent skin tears due to fragile skin turgor c. Self care deficit due to decline in cognition and independent mobility d. Behavior problem as evidenced by combativeness, resisting care, especially getting hair brushed and fingernails cut. <p>-if resident refuses care, return and attempt another time -if resident continues to refuse ask another aide or nurse to approach</p> <p>On 12/28/15 at 9:30 AM the Director of Nursing (DON) provided an investigation of an incident which involved Resident #39 and allegedly occurred 12/10/15. The DON stated the information provided was inclusive of the the entire investigation that had been done related to the incident which involved Resident #39. Review of the investigation revealed Hospitality Aide #1 reported she and another staff member</p>	F 226	<p>Systematic changes made to ensure deficient practice does not reoccur:</p> <p>All staff will be in-serviced on the in-servicing facility's Abuse Prevention/Reporting Policy and Procedure by 1-26-16. Policy states that all allegations and substantiated occurrences of abuse, neglect, and misappropriation of property to the facility management. Facility management (Administrator, Director of Nursing, or Assistant Director of Nursing) will report allegations of abuse per state regulations. Investigation guidelines and forms require the Charge Nurse, Director of Nursing Services, and Social Service Director to immediately evaluate all other potential abuse through physical assessment and interview of all residents who by similar cognition, diagnosis, physical ability or environmental location may be at risk for potential abuse. These assessments and resident statements are reviewed to implement interventions as needed to ensure resident safety is maintained. These Completed documents are then placed in the Investigation Folder for</p>	1-26-16	

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F 226	<p>Continued From page 7</p> <p>were walking on the hall Resident #39 resided and heard Resident #39 hollering from inside her room, "you are hurting me" and, as they walked by the room, saw Resident #39's legs "get slung and they hit each other very hard."</p> <p>The investigation noted the staff member that worked with Resident #39 on 12/10/15 (at the time of the reported incident) was suspended for two days. In addition, the DON interviewed six residents that resided within the vicinity of the room of Resident #39 to determine if they had any concerns with this staff member. A 24 hour and 5 day report were not included with the investigation. There was no indication Resident #39 had been assessed for injuries as part of the investigation. There was not a statement from the staff member that had been working with Resident #39 on 12/10/15. There was not a statement from the additional staff that was present with Hospitality Aide #1 on 12/10/15.</p> <p>On 12/28/15 at 5:10 PM the DON stated she always completed a 24 hour and 5 day report for any allegations of abuse and didn't know why these had not been completed and submitted to the Health Care Personnel Registry (HCPR) for the 12/10/15 incident involving Resident #39. The DON stated she knew she could not interview Resident #39 so she interviewed other residents that resided in close proximity to Resident #39 to see if they had any concerns with staff treatment. The DON stated she did look at the legs of Resident #39 and didn't see any evidence of injury but failed to document the observation. The DON stated she spoke to the nursing assistant that was working with Resident #39 on 12/10/15 but failed to obtain a written statement. The DON stated she spoke to the</p>	F 226	<p>the Nursing Home Administrator to review prior to completing a written Investigation summary as required by the Abuse Policy. New Policy and Procedure will be followed for all allegations of abuse, neglect or misappropriation. Investigations related to allegations of abuse, neglect or misappropriation will be reviewed by the Interdisciplinary team (Administrator, Nursing Director, Minimum Data Set Nurse, Rehabilitation Director, Social Worker, Staff Development Coordinator, Dietary Manager, Activity Manager, and Unit Manager) to ensure investigation is completed based on policy and procedure. New staff will be in-serviced during their orientation period. An Abuse Audit form will be utilized weekly x 8 weeks, then monthly x 2 ensuring that abuse is reporting to management timely, reported to the state within 24 hours, and then 5 day final report indicating substantiation or un-substantiation of abuse.</p>		

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F 226	<p>Continued From page 8</p> <p>nurse that had been on duty on 12/10/15 on the hall Resident #39 resided but failed to obtain a written statement. The DON stated she did not speak to the other staff member that was present with Hospitality Aide #1 on 12/10/15. The DON could not explain why the assessment of injuries of Resident #39, additional interviews and statements had not been obtained and/or documented.</p> <p>On 12/29/15 at 12:18 PM the administrator stated a 24 hour and 5 day report should have been completed and submitted to the HCPR for the alleged abuse involving Resident #39. The administrator could not explain why the reports had not been completed or submitted.</p> <p>2. Resident #110 was admitted to the facility 06/01/15 with diagnoses which included muscle weakness and hard of hearing. A quarterly Minimum Data Set dated 11/29/15 assessed Resident #110 with moderate cognitive impairment.</p> <p>On 12/29/15 at 2:15 PM Nurse Aide #3 stated she reported an incident of alleged abuse which involved Resident #110 and Medication Aide #2 which had occurred about a month prior. Nurse Aide #3 stated she and Nurse Aide #4 witnessed Medication Aide #2 being physically forceful with Resident #110 in an attempt to get the resident to agree to take a shower. Nurse Aide #3 stated she reported the incident to the Director of Nursing (DON) and the DON asked her to write a statement regarding what was witnessed.</p> <p>On 12/29/15 at 3:10 PM the administrator stated she was not aware of any allegations of abuse</p>	F 226	<p>Facility monitoring process:</p> <p>Administrator or Designee (Director of Nursing, Assistant Director of Nursing, or Social Services Director) will submit the findings of the Abuse Audit monthly x 4 months to the Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for further recommendations and/or follow up as needed.</p>		

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F 226	<p>Continued From page 9 involving Resident #110. The administrator attempted to contact the DON but was unsuccessful in those attempts. The administrator provided an investigation that was located in the employee file of Medication Aide #2 which included an investigation of the incident reported by Nurse Aide #3. Included in the investigation was a statement by Nurse Aide #3 which read:</p> <p>I was attempting to help get Resident #110 to agree to a shower. He was adamant about not taking one. Nurse Aide #4 told the nurse on duty and Medication Aide #2 came down the hall into Resident #110's room. She (Medication Aide # 2) began grabbing his arms pulling him say, get up, you smell you need a shower. Resident #110 began resisting pulling away she continued to pull, yanking his arms, grabbing his head. Nurse Aide #4 and I told her (Medication Aide #2) to stop several times and finally she did.</p> <p>A 24 hour and 5 day report were not included with the investigation. The investigation did include statements from Nurse Aide #3, Nurse Aide #4 and Medication Aide #2. In addition, the investigation included a statement from the nurse on duty at the time of the incident involving Resident #110. There was not an assessment of Resident #110 to determine if there were any injuries related to the incident.</p> <p>On 12/29/15 at 5:30 PM the administrator stated she was not aware of the incident involving Resident #110 and Medication Aide #2 until she reviewed the information in the employee file earlier that day at 3:10 PM. The administrator stated it would be impossible to get a statement from Resident #110 because of his hearing deficit. The administrator stated a 24 hour and 5</p>	F 226			

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F 226	Continued From page 10 day report should have been completed and submitted to the HCPR for the alleged abuse involving Resident #110. The administrator stated continued attempts to contact the DON had not been successful and she could not explain why there was not an assessment of Resident #110 to determine if there were any injuries after the alleged incident, why she had not been informed of the allegation or why reports had not been completed or submitted.	F 226			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interviews, the facility failed to allow residents to make choices regarding wake time and bath/shower preferences that were significant to the resident for 2 of 3 residents reviewed for choices (Resident #50 and Resident #132). The findings included: 1. Resident #50 was admitted to the facility on 10/19/12 with diagnoses which included high blood pressure, anxiety, and depression. The annual Minimum Data Set (MDS) for 07/28/15 revealed Resident #50 required extensive assistance with bed mobility, dressing, toileting, hygiene and bathing with 1 person physically	F 242	Tag: F242---Self-Determination-Right to Make Choices Corrective action for identified residents: Residents #50 and #132 were interviewed regarding their choices about aspects of their life in regards to their care on January 15, 2016. Their choices were incorporated into their daily care. How other residents with the potential for deficient practice identified: All residents have the potential to be adversely affected from the deficient practice of not allowing the resident to make choices about aspects of his or her life in the facility that are significant to the resident.		

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F 242	<p>Continued From page 11</p> <p>assisting in each care area. The most recent MDS for 10/20/15 indicated Resident #50 was cognitively intact with no behavioral concerns noted.</p> <p>Resident #50 was interviewed on 12/07/15 at 2:16 PM. Resident #50 verbalized he was not able to choose what time to get up in the morning. Resident #50 stated the nurse aides (NA's) came to get him up each morning 7:30 AM and 7:45 AM. The resident stated his preference was to get up at 8:30 AM or 9:00 AM in the morning. Resident #50 stated staff never asked him what his preference was for a time to get up in morning when he first came into the facility or since his admission. Resident #50 also indicated that he did not choose how many times a week he received a bath or a shower. Resident #50 indicated he received a shower on Tuesdays and Fridays each week. Resident #50 stated that he was used to taking a shower every day, but when he came to the facility he was told that he could only have a shower twice a week. Resident #50 stated he would prefer to have a shower every day, but if this wasn't possible, then at least three times a week.</p> <p>The admission packet was requested of the Admission Director (AD) and contents reviewed. There were no forms noted to have any indications or preferences for the resident, family member or power of attorney to make a choice of when the resident was to get up in the morning, go to bed at night, how many times a week the resident took a shower and whether to take a shower, tub or bed bath.</p> <p>An interview with the AD on 12/09/15 at 10:47 AM indicated that the admission packet information was reviewed with the residents and the responsible party or power of attorney. The AD indicated there was not a discussion about the</p>	F 242	<p>Systematic changes made to ensure deficient practice does not reoccur:</p> <p>All staff will be in-serviced on the right to make choices about aspects of his or her life in the facility that are significant to the resident by January 26, 2016.</p> <p>All residents or responsible parties will be interviewed regarding their choices about aspects of their life in regards to their care by January 26, 2016. These choices will be incorporated into their care plan and daily care guides for communication with the Certified Nursing Assistants.</p> <p>Residents/responsible parties will be interviewed upon admission regarding choices ongoing.</p> <p>A Resident's Choice Audit will be conducted weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 2 ensuring that new admissions are interviewed for choices and that this information is included in their plan of care and care guides for staff utilization.</p>	(-26-16)
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F 242	Continued From page 12 numbers of times the resident would like to shower or if a choice was available. The AD further indicated time preferences to get up in the morning and to go to bed at night were also not discussed as choices at the time of admission. An interview with Nurse #1 on 12/09/15 at 11:48 AM indicated no one was designated to complete the nursing admission assessment but a registered nurse. Nurse #1 stated that whoever was the admitting nurse would ask the resident about what time they got up in the morning and what time they went to bed at night. Nurse #1 also stated they explain to the resident there are showers twice a week and bed baths on all other days. Nurse #1 indicated that although this information was asked, it wasn't necessarily documented on the admitting nursing assessment, but was unable to identify where it was documented. An interview with Nurse #2 on 12/09/15 at 1:43 PM revealed that Resident #50 had a care plan indicating that he received 2 showers a week. Nurse #2 verified there was no documentation she could find where Resident #50 was asked how often he wanted to be bathed. Nurse #2 also validated there was no documentation for time preferences to get up in the morning and go to bed at night for Resident #50. During an interview with Nurse Aide (NA) #2 on 12/10/15 at 9:13 AM, NA #2 indicated that she told the residents when to get up in the morning. NA #2 validated she doesn't ask if they wanted to get up because it would be on their care guide if there was a certain time the resident had requested. NA #2 also stated that all residents received a shower twice a week. NA #2 stated she went into the residents rooms and told them it was time to shower. NA #2 verified she never asked the residents if their preference was a bath	F 242	Facility monitoring process: Administrator or Designee (Director of Nursing, Assistant Director of Nursing, or Social Services Director) will submit the findings of the Resident's Choice Audit monthly x 4 months to the Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson - Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for further recommendations and/or follow up as needed.	1-26-16

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F 242	<p>Continued From page 13</p> <p>or shower because she assumed they knew they got a shower.</p> <p>During an interview with the Director of Nursing (DON) on 12/10/15 at 6:03 PM, she stated when a resident came into the facility the number of showers and baths is discussed with them along with what time they get up in the morning and go to bed at night. The DON stated this was discussed during admission and then documented on the care plan after the interdisciplinary team met. The DON acknowledged it was her expectation that resident choices were followed.</p> <p>2. Resident #132 was admitted to the facility on 11/03/15 with diagnoses that included high blood pressure, lack of coordination, muscle weakness, and osteoarthritis. The admission Minimum Data Set (MDS) for 11/12/15 revealed Resident #132 required limited assistance with bed mobility, transfers, and dressing and required extensive assistance with hygiene, toileting and bathing. Further review of the MDS indicated that Resident #132 had indicated it was very important to her to choose a tub, bath, shower or sponge bath. The MDS also indicated the resident had mild cognitive impairment.</p> <p>Resident #132 was interviewed on 12/07/15 at 3:16 PM. Resident #132 stated that she did not get to choose whether to take a shower, tub or bed bath. Resident #132 stated she had to take showers but preferred to take a bath instead. Resident #132 also indicated she was never offered a bath since her admission. Resident #132 revealed she had never asked for a bath because she was "following the crowd" and "didn't want to rock the boat." Resident #132 stated she "feels more cleaner when I take a bath."</p>	F 242			

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F 242	<p>Continued From page 14</p> <p>The admission packet was requested of the Admission Director (AD) and contents reviewed. There were no forms noted to have any indications or preferences for the resident, family member or power of attorney to make a choice of how many times a week the resident may take a shower and whether to take a shower, tub or bed bath.</p> <p>An interview with the AD on 12/09/15 at 10:47 AM indicated that the admission packet information was reviewed with the residents and the responsible party or power of attorney. The AD indicated there was not a discussion about the numbers of times the resident would like to shower or if a choice of tub, shower, sponge or bed bath was available.</p> <p>An interview with Nurse Aide (NA) #1 on 12/09/15 at 11:22 AM indicated that NA #1 had been employed by the facility full-time for several years. NA #1 indicated that no regular baths or a whirlpool bath had been given to anyone on the A hall since NA #1 had worked here. NA #1 escorted Resident #132 to view both shower rooms on the A hall to see the regular bathtub and the whirlpool bath. NA #1 asked Resident #132 if she was "a bath person" and Resident #132 stated, "oh yeah, that's what I like."</p> <p>An interview with Nurse #1 on 12/09/15 at 11:48 PM indicated only a registered nurse is responsible for completing the nursing admission assessment. Nurse #1 also stated the admitting nurse explained to the resident there are showers twice a week and bed baths on all other days. Nurse #1 indicated that although this information is asked, it wasn't necessarily documented on the admitting nursing assessment.</p> <p>An interview with Nurse #2 on 12/09/15 at 1:43 PM revealed the care plan for Resident #132 indicated the resident required 1-2 person assist</p>	F 242			

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F 242	Continued From page 15 with shower or tub bath per facility schedule. Nurse #2 verified there was no written documentation that she could find where the resident was asked how often she wanted to be bathed and whether she preferred a shower, bath, sponge or bed bath. During an interview with Nurse Aide (NA) #2 on 12/10/15 at 9:13 AM, NA #2 verbalized that all residents receive a shower twice a week. NA #2 stated she went into the resident rooms and told the resident when it was time to shower. NA #2 verified that she had never asked the residents if they preferred a bath because she just assumed they knew they get a shower. NA #2 stated she did not think the whirlpool bath or tub bath was working as she had never see either of them used since she started working at the facility. Review of the NA shower book on 12/10/15 at 9:46 AM indicated there was no choice listed but a shower. The resident care guide was also reviewed and only had indicators for shower days and shifts that showers were given. No baths were listed as choices in the shower book or on the resident care guide. During an interview with the Director of Nursing (DON) on 12/10/15 at 6:03 PM, she stated when a resident came into the facility the number of showers and baths was discussed with the resident. The DON stated that this was discussed during admission and then documented on the care plan after the interdisciplinary team met. The DON acknowledged that it was her expectation for resident choices to be followed.	F 242			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253			

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F 253	<p>Continued From page 16</p> <p>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and interviews with residents and staff the facility failed to address maintenance concerns in 6 resident rooms on 2 of 2 halls in the facility. (Residents #117, #132, #105, #30 , #122 and #27)</p> <p>The findings included:</p> <p>1. Resident #117 was assessed on the current Minimum Data Set dated 10/16/15 with no cognitive impairment or memory issues.</p> <p>On 12/08/15 at 11:02 AM Resident #117 stated she shared her room with a family member. A light string pull was observed above the bed of the family member of Resident #117 and the pull extended down from the overbed light approximately 4 inches, rendering it difficult to access from the prone position in the bed. Resident #117 stated she had reported the concern to staff approximately 2 weeks prior but could not recall the specific staff member the issue had been reported to. Resident #117 also stated one of two bulbs in the overbed light above her bed was burned out and the call light for the family member was not working for approximately 2 weeks and also had been shared with staff.</p> <p>On 12/10/15 from 10:00 AM-11:15 AM during a tour of the facility the maintenance director stated he relied on staff to report any maintenance concerns via work orders (located at each nurses</p>	F 253	<p>Tag: F253---Housekeeping & Maintenance Services</p> <p>Corrective action for identified residents:</p> <p>All concerns mentioned from resident interview and facility tour during survey will be corrected by January 26, 2016.</p> <p>How other residents with the potential for deficient practice identified:</p> <p>All residents have potential for deficient practice.</p> <p>All resident rooms will be audited for maintenance concerns and repaired by January 26, 2016.</p> <p>Systematic changes made to ensure deficient practice does not reoccur:</p> <p>All staff will be in-serviced on completion and process for work orders by January 26, 2016.</p> <p>Director of Maintenance or designee will complete monthly audits of all resident rooms for maintenance concerns for three months until receiving further direction form Quality Assurance and Performance Improvement Committee.</p>	1-26-16	1-26-16

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F 253	<p>Continued From page 17 station) or report verbally. The maintenance director stated both he and the assistant maintenance director were available at all times to address any concerns. The maintenance director stated work is prioritized with safety concerns addressed first, equipment issues addressed second and cosmetic issues addressed third. The maintenance director stated there were no outstanding work orders that needed to be addressed. During the tour the room of Resident #117 was observed. The maintenance director stated he was not aware of the shortened light string pull, burned out bulb and non functioning call light. At the time of the observation Resident #117 also reported the wall clock in the room was not working correctly. Resident #117 stated several staff had attempted to fix the clock but they were not successful. The top portion of an outlet cover of a cable box between the two beds in the room was observed to extend out from the wall, approximately 1 1/2". The maintenance director stated he was not aware of the broken clock or loose cable box.</p> <p>2. Resident #132 was assessed on an admission assessment dated 11/12/15 with mild cognitive impairment.</p> <p>On 12/07/15 at 3:34 PM Resident #132 reported a strong "sewer-like" smell came from the heat pump in the room when it was turned off at night. Resident #132 stated the concern had been reported to several staff but could not recall which specific staff members.</p> <p>On 12/10/15 from 10:00 AM-11:15 AM during a tour of the facility the maintenance director stated he relied on staff to report any maintenance concerns via work orders (located at each nurses</p>	F 253	<p>Administrator or designee will audit at least ten resident rooms monthly for verification of monthly audits by maintenance for three months until receiving further direction form Quality Assurance and Performance Improvement Committee.</p> <p>Facility monitoring process:</p> <p>Administrator or Designee will monitor for continued compliance monthly for three months. Audit findings will be reported to the Quality Assurance and Performance Improvement Committee for further recommendation or follow-up as needed.</p>		

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F 253	<p>Continued From page 18</p> <p>station) or report verbally. The maintenance director stated both he and the assistant maintenance director were available at all times to address any concerns. The maintenance director stated work is prioritized with safety concerns addressed first, equipment issues addressed second and cosmetic issues addressed third. The maintenance director stated there were no outstanding work orders that needed to be addressed. During the tour the maintenance director stated he was aware of concerns with regulating the heat in the room of Resident #132 but had not been informed of the "sewer-like" smell from the heat pump. The maintenance director reported filters from all the heat pumps had been removed the week prior by the assistant maintenance director and cleaned. At the time of the tour the filters were removed from the heat pump in the room of Resident #132 and the filter on the left hand side was observed with black dotted matter covering the majority of the surface area. The maintenance director was unable to identify the source of the matter on the filter and stated he could not understand how the filter could have gotten so dirty when it was just cleaned the week prior.</p> <p>3. On 12/07/15 at 12:14 PM the escutcheon plate on the interior door knob, on the room door of Resident #105 was loose from the door frame which resulted in exposed metal edges.</p> <p>On 12/10/15 from 10:00 AM-11:15 AM during a tour of the facility the maintenance director stated he relied on staff to report any maintenance concerns via work orders (located at each nurses station) or report verbally. The maintenance director stated both he and the assistant maintenance director were available at all times</p>	F 253		

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F 253	<p>Continued From page 19</p> <p>to address any concerns. The maintenance director stated work is prioritized with safety concerns addressed first, equipment issues addressed second and cosmetic issues addressed third. The maintenance director stated there were no outstanding work orders that needed to be addressed. During the tour the maintenance director stated he was not aware of the concern and the escutcheon plate was immediately repaired.</p> <p>4. On 12/07/15 at 2:02 PM in the room of Resident #30 the top portion of an outlet cover of a cable box between the two beds in the room was observed to extend out from the wall, approximately 1/2". A drywall screw (with a sharp, pointed end) was hanging from the top portion of the outlet cover where it was extended out from the wall. The outlet cover of the cable box was in close proximity to the area of the head of the bed of Resident #30. A metal toilet paper holder in the shared bathroom of Resident #30 (shared by 4 residents) was loose from the wall, on the left hand side. Two screws were observed to loosely hold the left hand side of the metal toilet paper holder in place and it pulled from the wall when toilet paper was pulled from the roll holder.</p> <p>On 12/10/15 from 10:00 AM-11:15 AM during a tour of the facility the maintenance director stated he relied on staff to report any maintenance concerns via work orders (located at each nurses station) or report verbally. The maintenance director stated both he and the assistant maintenance director were available at all times to address any concerns. The maintenance director stated work is prioritized with safety concerns addressed first, equipment issues addressed second and cosmetic issues</p>	F 253			

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F 253	<p>Continued From page 20</p> <p>addressed third. The maintenance director stated there were no outstanding work orders that needed to be addressed. At the time of the tour the maintenance director stated he was not aware of the loose outlet cover of the cable box or the loose toilet paper holder. During the tour the squared off hard plastic kick plate on the outside of the room door was observed to be loose on the right upper corner. The kick plate covered approximately the lower third of the door with the right upper corner at wheelchair height and the area which a resident would come in contact with when entering the room. The maintenance director stated he was not aware of the loose kick plate on the room door.</p> <p>5. On 12/08/15 at 9:53 AM and 12/09/15 at 8:30 AM the squared off hard plastic kick plate on the outside of the room door of Resident #122 was observed to be loose on the right upper corner and pulled out approximately 6"-7". The kick plate covered approximately the lower third of the door with the right upper corner at wheelchair height and the area which a resident would come in contact with when entering the room. A phone jack cover at floor level was broken on the right upper corner with exposed jagged edges which affected approximately 1/4 of the upper cover. The phone jack cover was located on a wall between the left hand side of the bed of Resident #122 and a bedside table (where the television was located). During the observations Resident #122 watched television while seated in a wheelchair in the area where the phone jack cover was located.</p> <p>On 12/10/15 from 10:00 AM-11:15 AM during a tour of the facility the maintenance director stated he relied on staff to report any maintenance</p>	F 253			

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F 253	<p>Continued From page 21</p> <p>concerns via work orders (located at each nurses station) or report verbally. The maintenance director stated both he and the assistant maintenance director were available at all times to address any concerns. The maintenance director stated work is prioritized with safety concerns addressed first, equipment issues addressed second and cosmetic issues addressed third. The maintenance director stated there were no outstanding work orders that needed to be addressed. The maintenance director stated he was not aware of the loose kick plate and broken phone jack cover in the room of Resident #122.</p> <p>6. On 12/07/15 at 3:33 PM and 12/09/15 at 8:30 AM a wire, with an attached phone jack plate was draped on a hook, on the wall, beside the right hand side of the bed of Resident #27. A drywall screw (with a sharp, pointed end) was exposed and visible from the phone jack plate. The phone jack plate was at head height of Resident #27 and Resident #27 was observed ambulating in the room at the time of the observations.</p> <p>On 12/10/15 from 10:00 AM-11:15 AM during a tour of the facility the maintenance director stated he relied on staff to report any maintenance concerns via work orders (located at each nurses station) or report verbally. The maintenance director stated both he and the assistant maintenance director were available at all times to address any concerns. The maintenance director stated work is prioritized with safety concerns addressed first, equipment issues addressed second and cosmetic issues addressed third. The maintenance director stated there were no outstanding work orders that needed to be addressed. The maintenance</p>	F 253			

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F 253	Continued From page 22 director stated he was not aware of the concern and could not explain why the phone jack plate would have been stored on a wall hook.	F 253		
F 406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to provide rehabilitation services as ordered for 1 of 3 sampled residents. (Resident #133)</p> <p>The findings included:</p> <p>Resident #133 was admitted to the facility 11/11/15 with diagnoses which included cerebrovascular disease, hemiplegia, diabetes and hypertensive kidney disease. The admission diet order for Resident #133 was puree.</p> <p>The admission Minimum Data Set dated 11/20/15 assessed Resident #133 as unable to complete the assessment of cognition, with short and long term memory and without a swallowing disorder.</p>	F 406	<p>Tag: F406---Provide/Obtain specialized Rehab Services</p> <p>Corrective action for identified residents:</p> <p>Resident #133 was treated by Speech Therapy on December 10, 2015, and was found to be unsafe for a diet upgrade.</p> <p>How other residents with the potential for deficient practice identified:</p> <p>All residents have potential for deficient practice.</p> <p>Systematic changes made to ensure deficient practice does not reoccur:</p> <p>All new admissions and current residents with orders for therapy will be brought to morning meeting for Interdisciplinary Care Team to review and verify appropriate follow through on therapy orders.</p>	1-26-16

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F 406	<p>Continued From page 23</p> <p>The dental Care Area Assessment (CAA) completed 11/23/15 and associated with the annual Minimum Data Set noted, At risk for mouth pain and problem chewing due to edentulous. Resident has well fitting upper and lower dentures in which he wears. Denies any pain or problem chewing. Resident is on a puree diet and eats 50-75% of meals.</p> <p>The care plan for Resident #133 included the following problem areas: -Potential for alteration in nutrition-resident requires mechanically altered diet. Approaches to this problem area included occupational therapy/physical therapy/restorative program per facility protocol as indicated. -Self care deficit due to debility and right hemiparesis related to late effect of cerebrovascular accident. Approaches to this problem area included occupational therapy/physical therapy/speech therapy as needed or ordered to evaluate and treat</p> <p>Review of physician/nurse practitioner progress notes in the medical record of Resident #133 included the following: 11/12/15-Resident #133 presents for ongoing rehabilitation post devastating cerebrovascular accident with right hemiparesis on 09/14/15. He was at another skilled nursing facility 10/14/15-11/10/15 and will resume physical therapy/occupational therapy/speech therapy here. His goal is to return home. 11/20/15-Seen in follow-up, admitted 11/11/15 for rehab after cerebrovascular accident 9/14/15 with right hemiparesis. Difficulty obtaining review of symptoms/history related to word finding difficulty/cognitive. Patient very upset about diet but unable to say what in particular-probably</p>	F 406	<p>Director of Nursing or designee will audit all new admission records and records of current residents with rehab orders weekly x 3 months for continued compliance and to ensure therapy is carried out as ordered and appropriate.</p> <p>Facility monitoring process:</p> <p>Administrator or Designee (Director of Nursing, Assistant Director of Nursing, or Social Services Director) will submit the findings of the Rehab Audit monthly x 3 months to the Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for further recommendations and/or follow up as needed.</p>	1-26-16	

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F 406	<p>Continued From page 24 related to puree diet. Speech therapy consult to evaluate advance diet.</p> <p>A physician's order was written on 11/16/15 for Resident #133 which included, Speech therapy consult to change diet (advance from puree if possible).</p> <p>On 12/09/15 at 12:00 PM the speech therapist and rehab manager were asked about the 11/16/15 order for speech therapy consult. Both the speech therapist and rehab manager stated they were unaware of the 11/16/15 order and a speech therapy consult had not been done for Resident #133. The rehab manager stated physician orders were given to him by the nurse that processed the order and was passed on to the therapist. The rehab manager stated he did not recall ever receiving the order for a speech therapy consult for Resident #133 on 11/16/15.</p> <p>On 12/09/15 at 1:12 PM the Director of Nursing (DON) stated Nurse # 1 processed the order on 11/16/15 for a speech therapy consult on 11/16/15. The DON stated Nurse # 1 should have made a copy of the order and given it to the rehab manager/speech therapist. The DON stated she recalled the 11/16/15 order for the speech therapy consult was written because Resident #133 did not like the texture of the puree diet. The DON stated all orders are reviewed on a daily basis in the morning staff meetings and, because of the pay source of Resident #133 the decision was made to put the order on hold. The DON stated because the need for speech therapy was not life threatening she felt it was okay to put the order on hold. The DON stated typically the rehab manager is present in the morning staff meetings and should</p>	F 406			

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F 406	<p>Continued From page 25</p> <p>have been aware of the order when it was discussed. The DON stated there had been a few meetings the rehab manager was not able to attend in recent months but did not recall if it was the meeting when the 11/16/15 order for Resident #133 was discussed.</p> <p>Interdisciplinary notes in the medical record of Resident #133 included the following: 11/15/15-Nurses notes in the medical record included, Resident became very upset at lunch today stated he was not going to eat anything pureed. Stated there was no reason for him to eat that. Unable to redirect. Attempted three times. Resident's wife called she states that she would like her husband looked at regarding his diet. She stated that he did okay on a regular diet. Note was put in the nurse practitioner book. 11/19/15-A Social Worker note in the medical record included, Resident #133 was not able to complete the assessment of cognition. He is not able to find words and complete thoughts. He does best with yes/no questions. Speech therapy is involved. 11/22/15-A consultant dietitian note in the medical record included, Noted resident is dissatisfied with diet texture. Speech therapy consult to review for upgraded diet texture ordered. Follow-up with speech therapy evaluation, labs and intake. Resident's attitude/expected compliance to diet-fair.</p> <p>Review of weights recorded in the medical record of Resident #133 included: 11/11/15-194 11/19/15-194 11/30/15-187 12/07/15-187</p>	F 406			

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F 406	Continued From page 26 On 12/09/15 at 2:55 PM the nurse practitioner for Resident #133 stated when a order is written the expectation is that it will be followed. The nurse practitioner stated if there was a problem with an order staff should have discussed it with the practitioner that wrote the order. The nurse practitioner stated she was unaware Resident #133 had not been assessed by the speech therapist as ordered on 11/16/15. On 12/09/15 at 3:02 PM Nurse # 1 stated her practice was to make a copy of an order and provide it to the appropriate department. Nurse # 1 stated the 11/16/15 order for speech therapy for Resident #133 would have been given to the rehab director. Nurse # 1 stated she could not recall the specific order for speech therapy for Resident #133 and was not aware Resident #133 had not been seen by the speech therapist.	F 406			
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.	F 431	Tag: F431---Drug Records, Label/Store Drugs & Biologicals Corrective action for identified residents: A-2 cart medication was disposed of on December 8, 2015. A-1 medication cart was cleaned on December 8, 2015. Two boxes of expired nasal decongestant in medication room were disposed of on December 8, 2015.		

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F 431	<p>Continued From page 27</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired stock medications from an over the counter medication room, properly store medications requiring refrigeration, remove expired stock medications from a medication cart and to maintain a clean medication cart on 1 of 2 units (Unit A). The finding included: On 12/08/15 at 4:14 PM, medication cart A-2 was observed on A unit and checked for medication storage. This medication cart contained one bottle of a medication administered to assist in determining if a resident had a specific, contagious respiratory disease. This medication was required per manufacturer's indications on the packaging to "store between 2 degrees and 8 degrees Celsius (36 degrees and 46 degrees Fahrenheit)". During an interview with Nurse #3 on 12/08/15 at</p>	F 431	<p>Medication carts and medication room were checked for expired, improperly stored or improperly labeled medications on December 8, 2015.</p> <p>How other residents with the potential for deficient practice identified:</p> <p>All residents have potential for deficient practice.</p> <p>Medication carts and medication room were checked for expired, improperly stored or improperly labeled medications on December 8, 2015.</p> <p>Systematic changes made to ensure deficient practice does not reoccur:</p> <p>All licensed nurses were in-serviced on proper storage of medications and on verifying a medication is not expired. In-servicing was initiated on December 8, 2015 and completed by January 26, 2016. In-servicing of the Storage of Medications policy included:</p> <ol style="list-style-type: none"> 1. Nursing Staff will be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 		

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F 431	<p>Continued From page 28</p> <p>4:40 PM, Nurse #3 indicated she was assigned to cart A-2 for her shift and did not administer medication from the bottle requiring refrigeration during her shift.</p> <p>On 12/08/15 at 4:50 PM, medication cart A-1 was observed on the A unit and checked for medication storage. This medication cart was noted to have 8 large circles of a reddish, dried substance on the bottom of the 3rd drawer on the left. There was also a liquid medication available for indigestion that had an expiration date of 11/15.</p> <p>During an interview with Nurse #4 on 12/08/15 at 4:50 PM, Nurse #4 indicated the night shift checks the medication carts for expired meds and cleanliness of the cart at least every 30 days. Nurse #4 stated all nurses should be looking at the medications to make sure they haven't expired before administering the medication. Nurse #4 was unsure of the last time the medication cart had been checked for cleanliness and expired meds.</p> <p>On 12/08/15 at 5:27 PM, the over the counter (OTC) medication room was reviewed for medication storage. Two boxes of a nasal decongestant spray were discovered, each with an expiration date of 11/15. Each box had an intact seal across the top.</p> <p>During an interview with DON on 12/08/15 at 5:49 PM, DON stated she and both Assistant Director of Nursing (ADON's) checked the medication cart and medication storage rooms every 30 days to 6 weeks for expired medications.</p> <p>During a 2nd interview with DON on 12/10/15 at 6:03 PM, DON acknowledged that medication requiring refrigeration should be properly stored, no expired medications should be on the medication carts or in the medication storage rooms, and the medication carts should be clean.</p>	F 431	<p>2. Discontinued, outdated, or deteriorated drugs or biologicals will not be used. These medications shall be returned to the dispensing pharmacy or destroyed.</p> <p>3. Medication requiring refrigeration must be stored in a refrigerator located in the medication room at the nurses' station and must be stored separately from food and must be labeled appropriately. Narcotics requiring refrigeration should be secured to the inside of the refrigerator in a locked box.</p> <p>Medication carts will be audited 1-2 times per week for expired and improperly stored medication by the first shift licensed nurse staff on Tuesday and Thursday ongoing. Any expired or undated medication will be returned pharmacy or discarded. Carts will also be audited for cleanliness.</p> <p>Central Supply will audit the Over the counter Medication room at least monthly ongoing and will dispose of expired or improperly stored medications.</p>	1-26-16

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			<p>Facility monitoring process:</p> <p>Administrator or Designee (Director of Nursing, Assistant Director of Nursing, or Social Services Director) will submit the findings of the Med Cart and Medication Room Audit monthly ongoing to the Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for further recommendations and/or follow up as needed.</p>		