STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CARE & REHABILITATION CENTER	**604 STOKES STREET EAST AHOSKIE, NC 27910**

(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 No deficiencies were cited as a result of the complaint investigation event ID# ED4V11.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on family and staff interview, grievance review and facility policy review, the facility failed to investigate missing clothing after being reported to staff for 1 (Resident #63) of 3 residents reviewed for personal property. The findings included: An undated facility policy entitled "Resident's Damaged of Missing Property" read in part: "When a resident or family member reports their personal property including eye glasses, hearing aids, dentures and /or personal clothing is damaged or missing, the following procedure should be followed: 1. Complete either a Grievance Report or 5 Day Report, whichever is applicable to your facility." "4. If the issue is in regard to missing or damaged clothing, confirm with the family how they want to handle the replacement, i.e., check made payable to the family member upon proof of sales receipt." During an interview for Resident #63 on 10/6/15 at 5:10 PM, the family member relayed that the resident was missing 2 long sleeved night gowns for about 3 weeks. The family member recalled reporting the missing gowns to laundry personnel	F 166	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding.	11/5/15

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

Electronically Signed | 10/23/2015

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F 166	Continued From page 1 (name unknown) upon realizing they were missing. The family member indicated the gowns had not been found yet, nor had the facility said if they were still looking for the gowns. Grievances submitted by or on behalf of Resident #63 in the last 6 months were reviewed. None were found pertaining to missing clothing. During an interview on 10/7/15 at 3:10 PM, Administrative Staff #3 stated if missing clothing was reported to staff on the hall a grievance should be written up by the hall nurse, who would in turn pass it on to Administrative Staff #3 or the Social Worker (SW). Administrative Staff #3 indicated she and the laundry personnel would immediately start searching for the missing item(s) and if not found within 2 weeks would then replace the item(s). During an interview on 10/8/15 at 3:30 PM, Housekeeping Staff (HS) #1 indicated if a resident or family reported a missing item to her, she would look for it immediately. If she was unable to find it, she would let the resident or family know right away but also tell them she would continue to look. HS#1 stated she did not write up a grievance or put anything in writing about the missing item. During a follow-up interview on 10/8/15 at 3:43 PM, Administrative Staff #3 indicated she encouraged staff to write down missing items and post them on the bulletin board in the laundry room. Administrative Staff #3 stated she was not aware that Resident #63 was missing any clothing. During an interview on 10/8/15 at 4:04 PM, Administrative Staff #1 stated the expectation is for a grievance to be written if the item is not found immediately.	F 166	1. Missing items of resident #63 were located and returned to resident's daughter during survey on 10/8/15. 2. All residents in the facility will have the opportunity to ensure that prompt efforts will be made to resolve grievances related to missing clothing/items. A meeting will be conducted on 10/27/15 with Resident Council to discuss any unresolved issues and progress toward resolution. 3. Laundry and Housekeeping staff re-educated on grievance procedure for missing clothing by the Behavioral Health Manager (BHM)/Director of Social Work. Staff were instructed that anytime missing clothing/items are reported a grievance form should be completed and given to the Director of Housekeeping or the BHM/Director of Social Work. This will be completed by 11/5/15. 4. Director of Social Work/Behavioral Health Manager (BHM) and Assistant will do random interviews to determine if any items missing and to ensure that issues have been addressed timely and a response to the resident/family has been given and documented appropriately. Director of Social Work/BHM and or her assistant will conduct interviews with 5 residents/ families of residents who are cognitively impaired per week for one month and then monthly for three months. Audits will be recorded on an audit tool and maintained in the Administrator¿s office. The findings of the audits will be brought to the monthly Quality Assurance	

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F 166	Continued From page 2	F 166	Performance Improvement (QAPI) Committee meeting by the Director of Social Work. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Assistant DONs, Staff Development Coordinator, Admissions Director, MDS Coordinator, Quality of Life Director, Medical Director, Director of Social Services/BHM, Director of Environmental Services, Dietary Manager and Maintenance Director. Other members may be assigned as the need arises.	
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observations, review of the Maintenance Request Log Books and staff interviews the facility failed to replace missing and burned out light bulbs in 2 of 32 sampled resident bathrooms (rooms 212 and 309) 1. During an observation on 10/6/15 at 10:57 AM in the bathroom of room 212 only 1 of 2 bulbs in the light fixture was working. During an observation on 10/7/15 at 2:50 PM only one of the light bulbs in the bathroom of room 212 was working. During an observation on 10/8/15 at 12:36 PM only one of the light bulbs in the bathroom of	F 256	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of	11/5/15

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F 256	Continued From page 3 room 212 was working. An interview was conducted at 2:30 PM on 10/8/15 with Housekeeper #2. She reported when she was cleaning rooms if she saw anything that needed to be fixed or replaced she would notify the maintenance worker. She stated any concerns such as broken items or lights not working would be reported to maintenance. During an observation on 10/8/15 at 2:35 PM with Housekeeper #2 in the bathroom of room 212 she was made aware of the burned out light. During an interview with Maintenance Worker #1 on 10/8/15 at 3:15 PM he reported the staff were to record any maintenance needs in the Maintenance Request Log Book located at each nurse's station. He stated the staff would also tell the maintenance workers but he would remind the staff to put the request in the log book. He stated that the log book was checked at least 3 times per day each day and the maintenance staff member who fixed the item documented in the log book when the repair was started and when the repair was completed. A review of the Maintenance Request Log Book for the 200 hall on 10/8/15 at 3:15 PM revealed no record of the bathroom light not working in room 212. On 10/8/15 at 4:03 PM the Director of Nursing (DON) stated that the facility had an Angel Rounds program where members of the management staff are required to visit residents on their assigned hall to discuss any concerns the resident may have and to make observations in the rooms for things that need to be fixed. On 10/8/15 at 4:15 PM during an observation of the light in bathroom of room 212 with the Administrator both of the lights were observed to be working. During an interview with Administrative Staff #1	F 256	civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. 1. Light bulbs in bathrooms for rooms 212 and 309 were replaced on 10/8/15. 2. An audit of all light bulbs in facility was conducted on 10/8/15 by maintenance staff and all lights needing to be replaced were replaced. A follow up audit of all light bulbs in facility will be conducted on 10/26/15 by maintenance staff. 3. All staff re-educated on procedure for reporting maintenance issues by Staff Development Coordinator, SDC, Director of Nurses (DON), Administrator, or Assistant Director of Nurses. Staff was educated that they are to report any maintenance issues including burned out light bulbs in the maintenance book at each nurse's station. This will be completed by 11/5/15. Maintenance staff have been educated by the administrator that they should be checking light bulbs during their rounds and while providing other maintenance in rooms and replace bulbs as needed. This was completed on 10/23/15. 4. Random audits of five rooms per week	

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F 256	Continued From page 4 on 10/8/15 at 4:15 PM she reported the Guardian Angel rounds were conducted by the management staff and the Quality of Life assistants to check on any concerns of the residents and to see how things were going. She stated that there was a Maintenance Request Log Book located at each nurse's station and that every staff member knew that any item that need to be fixed was to be recorded in the log book. She stated she expected the facility staff to observe for lights that needed to be replaced and to record the request in the log book on the unit. 2. On 10/6/15 at 11:39 AM an observation of the light fixture in the bathroom of room 309 revealed no light bulb was present in one of the four light sockets. During an observation on 10/7/15 at 2:55 PM there continued to be a missing light bulb in the bathroom fixture in room 309. During an observation on 10/8/15 at 12:40 PM there bathroom light fixture in room 309 continued to have one of the bulbs missing. An interview was conducted at 2:40 PM on 10/8/15 with Nursing Assistant (NA) #1. She stated she was responsible for room 309 today. She reported she would record any needed maintenance request in the Maintenance Request Log Book located at the nurse's station. She stated she had recorded a burned out light bulb over a resident's bed a few days ago but had not noticed any lights missing in any residents' bathrooms. During an observation on 10/8/15 at 2:43 PM with NA #1 in the bathroom of room 309 she was made aware of the missing light bulb. A review of the Maintenance Request Log Book for the 300 hall on 10/8/15 at 4:30 PM revealed no record of the missing light bulb for room 309.	F 256	for one month and then five rooms monthly for three months will be conducted by maintenance staff. Maintenance book will be checked for reports of any light bulbs needing to be replaced and any staff member found not to have appropriately reported burned out light bulbs in maintenance request book will receive education and counseling. Administrator, DON or ADONS will randomly follow up on rooms where maintenance has been provided to ensure maintenance is checking light bulbs. This will be done on five rooms weekly for three weeks, then monthly for three months. Audits will be documented on audit tool and maintained in the Administrator's office. Audits will be brought to monthly Quality Assurance Improvement (QAPI) Committee meeting by Maintenance Director. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Assistant DONs, Staff Development Coordinator, Admissions Director, MDS Coordinator, Quality of Life Director, Medical Director, Director of Social Services/BHM, Director of Environmental Services, Dietary Manager and Maintenance Director. Other members may be assigned as the need arises.	

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F 256	Continued From page 5 During an interview and observation with Administrative Staff #4 on 10/8/15 at 2:50 PM in the bathroom of room 309 he stated there was a bulb missing from the light fixture. During an interview with Administrative Staff #1 on 10/8/15 at 4:15 PM she reported the Guardian Angel rounds were conducted by the management staff and the Quality of Life assistants to check on any concerns of the residents and to see how things were going. She stated that there was a Maintenance Request Log Book located at each nurse's station and that every staff member knew that any item that need to be fixed was to be recorded in the log book. She stated she expected the facility staff to observe for lights that needed to be replaced and to record the request in the log book on the unit.	F 256		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		11/5/15

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F 329	Continued From page 6 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain a serum potassium level as ordered for 1 (Resident #63) of 5 residents reviewed for unnecessary medications. The findings included: Resident #63 was last readmitted to the facility on 5/14/15. Diagnoses included hypertension. Medications included furosemide (a diuretic used in the treatment of hypertension) 20 milligrams (mg) daily. According to "Lexi-Comp's Drug Information Handbook for Nursing" one of the adverse reactions to furosemide is a loss of potassium. Review of a laboratory report dated 6/18/15 revealed Resident #63 had a low serum potassium level of 3.3 mEq/L (milliequivalents per liter). The reference range was 3.5 - 5.5 mEq/L. The Consultant Pharmacist printed a "Note To Attending Physician/Prescriber" dated 9/24/15 which read in part: "This resident is receiving medications which need routine lab work. Please check all that you would like ordered: ( ) magnesium level now and every six months (magnesium oxide, omeprazole) ( ) vitamin D level now (50,000 units weekly since May)	F 329	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. 1. BMP was obtained for resident #63 on 10/9/15. Potassium was within normal limits. 2. A review of all September pharmacy	

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F 329	Continued From page 7 ( ) BMP (Basic Metabolic Panel which includes a potassium level) (potassium low at 3.3 on BMP dated 6/18, resident on furosemide 20 mg, no KCl ((potassium chloride)) supplement)." The note revealed one hand written check mark in the parenthesis preceding magnesium and two check marks in the parentheses preceding vitamin D. The Note included a section headed "Physician/Prescriber Response" consisting of 3 lines. The first line read "Agree"; the second "Disagree" and the third "Other". Each line began with a box for a check mark. The box preceding "Agree" was checked. Written on the form below the boxes was "Mg (magnesium) level, Vit (vitamin) D level, BMP." The form was signed by the physician on 9/30/15. A laboratory report dated 10/1/15 revealed results of Vitamin D and Magnesium but no BMP. During an interview on 10/8/15 at 11:05 AM, Nurse #3 indicated she could not find a record that the BMP was ordered and had checked with the laboratory just now and they had no record that the BMP was done. Nurse #3 stated she would request the BMP be done today. During an interview on 10/8/15 at 11:35 AM, the Director of Nursing (DON) reviewed the Note by the pharmacist and indicated the physician had ordered a BMP that was overlooked.	F 329	recommendation for completion of ordered labs will be completed by Assistant Directors of Nursing, Director of Nurses, Staff Development Coordinator, Restorative Nurse or Wound Nurse by 11/5/15. 3. All licensed Nursing staff re-educated on reviewing and ensuring that all orders obtained through pharmacy recommendations including physician prescriber responses are followed. Education will be conducted by Director of Nurses (DON), Assistant Director of Nurses (ADON) or Staff Development Coordinator(SDC). Education completed on 11/5/15. 4. Pharmacy reports will be audited by Director of Nursing (DON) or Assistant Director of Nursing (ADON) for three months to ensure that no orders are missed. Audits will be recorded on audit tool and maintained in the Administrator's office. Audits will be brought to the monthly Quality Assurance and Improvement (QAPI) meeting by the DON or ADON. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Assistant DONs, Staff Development Coordinator, MDS Coordinator, Quality of Life Director, Medical Director, Director of Social Services/BHM, Director of Environmental Services, Dietary Manager and Maintenance Director. Other members	

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F 329	Continued From page 8	F 329	may be assigned as the need arises.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F 334		11/5/15

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F 334	Continued From page 9 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assess the status of the pneumococcal vaccine for 1 (Resident #45) of 5 residents reviewed for immunizations. The findings included: An undated facility policy entitled "Vaccination of	F 334	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings.	

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F 334	Continued From page 10 Resident" read in part, "All new residents shall be assessed for current vaccinations status upon admission." Resident #45 was admitted to the facility on 5/1/15. Diagnoses included end stage renal disease and anemia. Record review revealed no history on file regarding the resident's pneumococcal vaccine. During an interview on 5/7/15 at 5:15 PM, the Staff Development Coordinator (SDC) stated she had review the records and could find nothing about the pneumococcal status for Resident #45. She added vaccination status should have been obtained on admission.	F 334	This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding 1. Resident #45 legal guardian was informed via telephone by two Registered Nurses of the risk and benefits of the pneumococcal vaccine on 10/20/2015. Resident #45 received the pneumococcal vaccine on 10/20/2015. 2. All active resident records have been reviewed by the Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), the Director of Nursing (DON), or Wound Nurse to determine if resident¿s had been offered and/or received the pneumococcal vaccine. All residents requesting the pneumococcal vaccine will have vaccine administered by 11/5/15 unless contraindicated. 3. All Licensed staff will be educated by the SDC, DON or ADONs on the pneumococcal vaccine procedure for offering upon admission. This will be	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CARE & REHABILITATION CENTER	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 11	F 334	completed by 11/5/2015. New residents admitted to the facility will be reviewed by the Nurse Management Team (DON, ADONs, SDC, Restorative Nurse or Wound Nurse) to assure residents are offered and/or administered the pneumococcal vaccine per policy. 4. Ongoing audits are being completed by the DON, SDC, and/or ADONs for offering and administration of the pneumococcal vaccine to new residents upon admission. These audits will be conducted 5 days a week for two weeks, then monthly for three months. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Audits will be documented on the audit tool and will be maintained in the Administrator¿s office. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, Medical Director, DON, SDC, ADON, Environmental Service Director, Social Services Director, Admissions Coordinator, Plant OP¿s, and Dietary Supervisor. Other members may be assigned as the need arise.	
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	F 431		11/5/15

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F 431	Continued From page 12 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, manufacturer specification and facility policy, the facility failed to discard expired medications on 1 of 4 medication carts (West Annex Medication Cart #1) and store unopened insulin and latanoprost eye drops in the refrigerator on 1 of 4 medication carts (West Annex Medication Cart	F 431	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or	

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F 431	Continued From page 13 #2). The findings included: A facility policy dated 9/10 entitled "Storage of Medication" read in part, "Insulin products should be stored in the refrigerator until opened." "Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists." 1. On 10/8/15 at 10:05 AM, the West Annex Medication Cart #1 was observed with Nurse #3. One vial of Humalog insulin with an opened date of 6/30/15 and one bottle of Liquid Pain Relief with an expiration date of 9/15 were on the cart. Nurse #3 was interviewed at this time and stated the Humalog and Liquid Pain Relief were expired and should have been discarded or sent back to the pharmacy. During an interview on 10/8/15 at 10:43 AM, the Director of Nursing (DON) indicated insulin was good for 28 days after being opened and should be discarded after 28 days, and all expired medications should be removed from the cart. 2. On 10/8/15 at 10:18 AM, the West Annex Medication Cart #2 was observed with Nurse #4. One unopened vial of Levemir insulin and one bottle of latanoprost (Xalatan) eye drops were observed on the medication cart. Each had a sticker affixed that read, "Keep in refrigerator". Nurse #4 indicated at this time that the Levemir should be stored in the refrigerator until opened.	F 431	any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. 1. Education was started on 10/08/2015 with Licensed Nurses that are employed by Creekside on appropriate medication storage. This education was provided by the Staff Development Coordinator (SDC) and Director of Nurses (DON). Medications noted on Medication Cart #1 was one OTC, a bottle of Liquid Pain Relief ,that was replaced with a current dated bottle and a vial of Humalog insulin that was immediately removed from the cart and reordered from Pharmacy. Medication Cart #2 was noted to have one vial of unopened Levemir insulin and one bottle of latanoprost (Xalatan) eye drops both unrefrigerated. Both medications were removed from the cart immediately on 10/08/2015, discarded and Pharmacy notified. Education was provided to Licensed Nurses #3 and #4 on medication storage on 10/08/2015 and 10/14/15.	

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F 431	Continued From page 14 She was unsure if the latanoprost should be stored in the refrigerator when unopened. On 10/8/15 at 11:10 AM the facility provided a manufacturer specification sheet for latanoprost which read in part, "Store intact bottles under refrigeration". "Once opened, the container may be stored at room temperature". During an interview on 10/8/15 at 11:10 AM, the Director of Nursing (DON) stated that unopened insulin and unopened latanoprost should be stored in the refrigerator.	F 431	2. Medication Carts and storage areas have been inspected and reviewed by the DON or Assistant Director of Nurses (ADON), Staff Development Coordinator (SDC), Restorative Nurse, or Wound Nurse on 10/30/2015 to insure all medications are within date range for administration and all medications are stored properly. Any concerns were addressed and corrected by the Licensed Nurse immediately. Any outdated or improperly stored medications were immediately removed from the medication carts. The DON, ADONs, SDC, Restorative Nurse, Wound Nurse or other licensed nurse will audit three medication carts and one storage area at various times on all shifts to ensure medication cart compliance is met. At least one of the audits will occur on every shift. The assigned team member will come in on the assigned shift to conduct the audit. These audits will be ongoing weekly for one month and then monthly for three months. 3. All Licensed Nurses will be educated by SDC or DON regarding proper storage and dating of medications on the medication cart. This education will be completed by 11/5/2015. This training will also be provided to all Licensed Nurses upon hire during orientation and at least annually through a skills review. 4. Ongoing audits will be performed by the DON, SDC, ADONs, Restorative Nurse, Wound Nurse, or other licensed nurse to ensure compliance with proper	

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F 431	Continued From page 15	F 431	storage and dating of medications on the medication carts and storage areas. Three medication carts and one storage area will be audited weekly for one month, then monthly for three months. At least one of these audits will occur on each shift. The assigned team member will come in on the shift assigned to conduct the audit. All data will be summarized and presented to the facility Quality Assurance Performance Improvement (QAPI) Committee meeting monthly by the DON or SDC. Any area of trends will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, ADON, Environmental Services Director, Medical Director, Admissions Coordinator, Social Services Director, Plant Op's, and Dietary Supervisor. Other members may be assigned as the need arise.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		11/5/15

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F 441	Continued From page 16 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, manufacturer specifications and facility policy, the facility failed to disinfect the glucometer after use for 2 of 3 sampled residents (Residents #48 and # 79) observed getting a blood glucose check. The findings included: The undated facility policy entitled, "Glucometer, Cleaning and Disinfecting," read in part: "General guidelines" "1. Per Centers for Disease Control and Prevention guideline (CDC), if glucometer is shared, clean as needed and disinfect the device after every use according to manufacturer's	F 441	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible	

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F 441	Continued From page 17 instructions." "3. Follow manufacturer's instructions on germicidal product/wipe contact time." "Procedure" "5. To disinfect the meter or lancing device: a. Use (brand name) germicidal bleach wipes." "c. Allow the surface of the meter or lancing device to remain wet at room temperature for five (5) minutes." Manufacturer specifications for (brand name) included, #5. " A 5 minute contact time is required to kill HIV and other organisms listed on the label. Reapply as necessary to ensure that the surface remains wet for the entire contact time. #6. Allow surface to air dry and discard used wipe. " The following micro-organisms were listed and included in part, "Hepatitis B Virus, Hepatitis C Virus, Human Immunodeficiency Virus Type 1 (HIV-1), and Methicillin Resistant Staphylococcus aureus (MRSA)." 1. On 10/7/2015 at 4:32 PM, Nurse #1 was observed wiping glucometer with the (brand name) bleach wipe in advance of a blood sugar check, then she set the glucometer down to air dry. At 4:33 PM, the nurse entered the room of Resident # 48, donned gloves and performed the blood sugar check. At 4:36 PM, the nurse went back out to her medicine cart and wiped the glucometer with the (brand name) bleach wipe for 10 seconds, and set the glucometer on a clean paper towel to air dry. At 4:37 PM, the nurse put the dried glucometer in a container in the medicine cart. An interview was conducted with Nurse #1 on 10/7/2015 at 4:41 PM. The nurse stated she cleaned the glucometer the same as where she worked before. She indicated she was told that if she had to do 2 blood sugar checks back to back, she should put one glucometer in a cup and when she was finished with both blood sugar checks	F 441	contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceedings. 1. Nurse # 1 and #2 were re-educated on 10/08/15 on Glucometer Cleaning and Disinfecting Guidelines per policy which include General Guidelines per Centers for Disease Control and Prevention following the manufacturer's instructions on germicidal product wipe/contact time. 2. Observational audits of Licensed Nurse cleaning and disinfecting blood glucose meters according to the manufactures instructions on germicidal product wipe/contact time began on 10/08/2015 by the Staff Development Coordinator and the Director of Nurses to ensure proper cleaning and disinfecting blood glucose meters following the manufacturer instructions on germicidal product wipe/contact time. 3. Reeducation was conducted by the Staff Development Coordinator for Licensed Nurses on the proper cleaning and disinfecting of the blood glucose meter following the manufactures instructions on germicidal product	

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F 441	Continued From page 18 she should clean both glucometers at the same time. 2. On 10/7/2015 at 5:07 PM, Nurse #2 was observed performing a blood sugar check. The nurse gathered her supplies, donned gloves and performed a blood sugar check on Resident #79. At 5:10 PM the nurse wiped the glucometer with the (brand name) bleach wipe for 10 seconds, then threw the wipe away and set the glucometer on a paper towel to dry. She indicated she would let the glucometer dry for 5 minutes. An interview was conducted with Nurse #2 on 10/7/2015 at 5:11 PM. The nurse stated she was given an in-service by the Staff Development Coordinated (SDC), and was told to wipe the glucometer and then let it air dry for 5 minutes. On 10/7/2015 at 5:18 PM, an interview was conducted with the SDC, who stated she had given an in-service to the nursing staff on cleaning glucometers, according to the facility policy. She indicated that all parts of the glucometer must be cleaned with the (brand name) bleach wipe, then it was to be air dried for 5 minutes to kill the blood borne pathogens. On 10/8/2015 at 9:29 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she previously thought 5 minutes was required for drying time, but now understood the glucometer should have been wet for 5 minutes and then air dried.	F 441	wipe/contact time. Inservice sheets will be compared to licensed nurse roster to ensure 100% compliance. This will be completed by 11/5/15. Any Licensed nurse not receiving education by 11/5/15 will receive education prior to working a shift. 4. Observational audits of Licensed Nurses cleaning and disinfecting blood glucose meters following the manufactures instructions on germicidal product wipe/contact time will be conducted by the Staff Development Coordinator, Assistant Director of Nurses, Wound Nurse, Restorative Nurse, the Director of Nurses or licensed nurse. Six glucometer cleaning and disinfecting audits will be conducted per week for 12 weeks to ensure proper cleaning and disinfecting blood glucose meters following the manufacturer instructions on germicidal product wipe/contact time. At least one audit will be conducted on each shift each week and at least one will be conducted on each unit each week. Audits will be completed on the audit tool and will be maintained in the Administrator's office. Any issue identified will be immediately addressed, corrected and the identified staff member will receive immediate re-education. Any other issue or trends identified in these audits will be addressed and the plans will be adjusted to ensure continued compliance. The Director of Nurses will report to the Quality Assurance Performance Improvement (QAPI) Committee any findings, identified trends or patterns. QAPI consists of the	

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F 441	Continued From page 19	F 441	Administrator, Director of Nurses, Staff Development Coordinator, Assistant Director of Nurses, Environmental Services Director, Medical Director, Admissions Coordinator, Social Services Director, Director of Plant Operations, and Dietary Supervisor. Other members may be assigned as the need arises	