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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	07/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & RETIREMENT	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective	F 156	Please accept this Plan of Correction (POC) as Brian Center Health & Retirement – Winston Salem's credible allegation of compliance. Preparation and execution of this POC does not constitute admission or agreement with the findings of noncompliance. The POC is being provided pursuant to Federal and State requirements which require an acceptable Plan of Correction as a condition of continued certification. F156 1. Resident # 8 and Resident # 1 no longer reside in facility. Case worker reeducated by Business Office Manager 7/21/2017 on the process of presenting notices of non-coverage letters at least two days prior to the resident's skilled services being discontinued. 2. 100% audit of discharged residents was conducted 7/25/2017 reviewing discharges within the last 30 days. No other residents were identified as being affected by not being given notice of discharge.	8-19-17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMinistrator | (X6) DATE: 9-19-17

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 156	Continued From page 1 services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans	F 156	3. Case worker was reeducated by Business Office Manager 7/21/2017 on the non-coverage letters at least two days prior to the resident's skilled services being discontinued. Discharge meetings to be held each Monday and Thursday with Business office Manager and Case Worker confirming all planned discharges. The Business Office will review all signed NONMC letters daily and check for any missing letters. This double check will ensure all NONMC letters are in compliance. . Business Office Manager and/or Case Worker will conduct audits on residents with a planned discharge weekly times 12 weeks. 4. The results of this audit will be reported in the Quality Assurance Performance Improvement by the DON for 3 months. The committee will evaluate and make further recommendations as indicated.	

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F 156	Continued From page 2 Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not	F 156		

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F 156	Continued From page 3 limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 156		

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F 156	Continued From page 4 Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	F 156		

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F 156	Continued From page 5 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide Medicare non-coverage letter indicating resident was notified at least 2 days prior to Medicare coverage ending for 2 of 3 residents reviewed for Notice of Medicare non-coverage. (Resident # 8 and Resident # 1). Resident # 8 was admitted to the facility on 11/29/2016 with diagnoses that included gastro-esophageal reflux disease, chronic bronchitis, and pain in right shoulder. Review of the Notice of Medicare Non-coverage letter with services will end on 3/5/2017 revealed that Resident #8 signed it on 3/6/2017. Interview with Case Worker (CW) on 7/21/2017 at 2 PM revealed that she was aware that the Medicare non-coverage letter should be given to the resident at least 2 days prior to the services being discontinue.	F 156		

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F 156	Continued From page 6 Interview with the Administrator on 7/21/2018 at 2:30 PM indicated that her expectation was for the Medicare non-coverage letter to be given to the resident at least 2 days prior to the Medicare coverage ending. Resident #1 was admitted to the facility on 4/17/2017 with diagnoses of cellulitis, type 2 diabetes mellitus, muscle weakness and chronic obstructive pulmonary disease. Review of the Notice of Medicate Non-Coverage letter dated with services will end on 5/24/2017, revealed that Resident #1 signed the letter on 5/23/2017 Interview with Case Worker (CW) on 7/21/2017 at 2 PM revealed that she was aware that the Medicare non-coverage letter should be given to the resident at least 2 days prior to the services being discontinue. Interview with the Administrator on 7/21/2018 at 2:30 PM indicated that her expectation was for the Medicare non-coverage letter to be given to the resident at least 2 days prior to the Medicare coverage ending.	F 156		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		

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F 309	Continued From page 7 well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and interview with a Hospice representative the facility failed to coordinate services with the Hospice provider in 1 of 1 resident reviewed for Hospice services. (Resident #67). Findings included: Resident #67 has numerous diagnoses which included severe protein and calorie malnutrition.	F 309	F309 1. Hospice plan of care was faxed to facility on 7/21/2017 for resident # 67. When the plan was received, a meeting was scheduled to include the interdisciplinary team, Hospice representative and residents family members. Meeting took place on 7/27/2017 and care plan was updated. 2. All residents receiving Hospice services have the potential to be affected. DON re-educated the Case Manager and Social Services Assistant on ensuring Hospice plan of care is obtained and orders are obtained within 48 hours of initial Hospice Consult. Nurse # 5 was re-educated by the Director of Nursing on 8/8/2017 regarding communication with Hospice nurse when in the facility regarding any change in resident status. Case Manager and/or Social Services Assistant will initiate Hospice referral as requested by physician, resident and/or family members. Case Manager and/or Social Services Assistant will follow through with physicians orders for Hospice services. Case manager will follow up on coordination of plan of care and initial hospice orders if needed.	8-19-17

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F 309	Continued From page 8 Medical record review revealed Hospice services started on 6/27/17. The significant change Minimum Data Set Assessment was pending completion at the time of the survey. Review of the care plan updated 6/27/17 revealed a goal which stated Hospice services but there was no plan of care to indicate a coordination of services between the facility and the Hospice provider. Interview on 7/21/17 at 8:48 AM with Nursing Assistant (NA) #2 revealed Resident #67 required total care, needs to be turned and reposition, now trying to feed himself. Further interview revealed the resident was not in pain, was alert, oriented and very pleasant. Interview on 7/21/2017 at 9:15 AM with NA #3 revealed Resident #67 required feeding assistance, was incontinent of bladder and bowel, and no complaints of pain. Continued interview revealed the Hospice aide was assigned to the facility on Tuesdays and Thursdays. Interview on 7/21/17 at 9:22 AM with the facility Case Manager revealed the Hospice nurse was in the facility on 7/20/17 and spoke with the Unit manager and her. The Hospice nurse asked about the resident's pain management with the Unit Manager .Continued interview stated the Hospice nurse indicated that she noticed facial grimaces suggestive of pain and requested Tylenol to be administered to Resident #67. Schedule review revealed Nurse #5 was the nurse assigned to Resident #67 on 7/20/17 when the Hospice nurse was present.	F 309	3. Education provided to all licensed nursing staff by DON on communicating with Hospice nurse when in the facility regarding any change in resident status . Hospice role was to be a partnership with the facility to assist with the continuum of care. Hospice will speak with the family/resident and decide which optional disciplines were requested by the resident and/or family. Hospice will then notify facility of resident and family preferences. Hospice RN role is to provide efficient and safe end of life care. Hospice and supporting staff will make regular visits per patient specific plan of care. Hospice RN will document any new orders needed in the residents chart and communicate with the staff any changes during their visit. All facility licensed nursing staff will communicate with Hospice regarding the care of the resident and any new changes and /or orders obtained for resident. If any changes occur while Hospice is not present, the staff will contact Hospice to provide updates and notify the physician. The Director of Nursing and or Unit Manager will audit for any new Hospice Admissions daily times 2 weeks, then weekly times 2 weeks and then monthly times 3 months.	

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F 309	Continued From page 9 Interview on 07/21/2017 at 9:45 AM with Nurse #5 revealed she had not spoken with the Hospice nurse and did not administer any Tylenol to the resident on 7/20/17. Record review reviewed no evidence that Tylenol was administered or the assessment of the resident by the Hospice nurse. On 7/21/17 at 11:15 AM a telephone interview was held with the Director of Community Hospice Services who stated the Hospice initial plan of care and orders were faxed to the facility but could not provide a date. After the inquiry about the lack of coordination among the facility and Hospice, the plan of care and orders were sent to the facility from the Hospice provider on 7/21/17 via the fax machine. Interview on 07/21/17 3:22 PM with the Unit Manager revealed the Hospice nurse did not communicate with her on 7/20/17. Nor was she aware of any Tylenol administered. Nurse #5 joined the conversation and indicated that there was no communication with the Hospice nurse during her visit on 7/20/17 and was not aware of the Hospice nurse ' s name. Nurse #5 indicated the Resident #67 has not be assessed or complained of pain. Interview on 07/22/17 at 12:15 PM with the Administrator, Director of Nurses and Corporate Administrator was held. The Administrator indicated she expected Hospice staff and the facility staff to coordinate care and services for the resident.	F 309	4. The results of this audit will be reported in the Quality Assurance Performance Improvement by the DON for 3 months. The committee will evaluate and make further recommendations as indicated.	
F 315	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI,	F 315		

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F 315 SS=D	Continued From page 10 RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 315	F315 1. Resident # 53 was provided with a method of stabilization for the Foley catheter on 7/22/2017. 2. A 100% audit of current residents having a Foley catheter was conducted to ensure they had a method of stabilization. 3. The Director of Nursing and/or designee provided education to all licensed nursing staff and non-licensed nursing staff on the stabilization of Foley catheters. All residents with Foley catheters will have orders to check methods of stabilization every shift. The DON and or designee will audit Foley catheters and ensure method of stabilization is in place on admission and weekly x 4 weeks. Any opportunities identified will be corrected by the DON and/or designee at that time. 4. The results of the audit will be reported to the Quality Assurance Performance Improvement meeting by the DON x 3 months. The committee will evaluate and make further recommendations as indicated.	8-19-17

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F 315	Continued From page 11 Based on observation, record review, staff and resident interview the facility failed to stabilize an indwelling urinary catheter to prevent injury or dislodgement. (Resident #53). This was evident in 1 of 3 residents in the sample with an indwelling urinary catheter. Findings included: Resident #53 has an indwelling urinary catheter inserted due to a neurogenic bladder. Review of the 5/25/17 quarterly Minimum Data Set Assessment revealed Resident #53 was alert and oriented Reviewed the care plan dated 6/27/17 included Resident #53 will have no complications from the indwelling urinary catheter thru the next review date. Observation on 7/19/17 at 2:30 PM revealed the indwelling urinary catheter did not have a method of stabilization. Interview with the resident at this observation time revealed her catheter was recently changed (within the last week) due to leaking urine. Observation on 7/20/17 at 1:30 PM revealed the indwelling urinary catheter did not have a method of stabilization. Continued observation on 7/21/17 at 8:30 AM revealed the indwelling urinary catheter did not have a method of stabilization. Observation on 07/22/17 at 10:44 AM revealed the indwelling urinary catheter continued to not have a method of stabilization. Interview on	F 315		

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F 315	Continued From page 12 7/22/17at 10:47 AM with Resident #53 who stated she had not had any type of stabilization device for the catheter. Interview on 07/22/17 at 12:15 PM with the Administrator, Director of Nurses (DON) and Corporate Representative was held. The DON indicated she expected the indwelling urinary catheter to have a method of stabilization. Interview on 07/22/17 at 2:10 PM with Nursing Assistant (NA) #1 stated sometimes the resident gets tangled in the catheter and drainage bag tubing. NA #1 indicated staff try to keep the catheter and tubing straight but we (referring to the nursing staff) do not use "anything" to stabilize the indwelling urinary catheter.	F 315		8-19-17
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 325	F325 1. Resident # 33 had new orders obtained from the MD on 7/21/2017. Registered Dietician was notified of the weight loss with new orders obtained on 7/22/2017. Nursing staff, to include Licensed Nurses and nursing assistants were educated on the importance of obtaining weights on admission and weekly for 4 weeks to ensure nutritional needs are met. 2. An audit was conducted on 8/8/2017 on all current residents admitted within the last 3 weeks to ensure they had weights on admission and were being monitored weekly for 4 weeks.	

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F 325	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to obtain weekly weights on a new admission to prevent significant weight loss for one of three Residents that were reviewed for nutritional status (Resident #33). Findings included: Resident #33 was admitted to the facility on 6/26/2017 with diagnoses that included cerebral infarction, muscle weakness, feeding difficulties, pressure ulcers and acute kidney failure. A care plan for Resident #33 was dated 7/9/2017 revealed "potential nutritional problem choking/aspiration, Skin breakdown, unplanned weight loss, dehydration, poorly controlled blood glucose levels, and abnormal labs r/t Diabetes Mellitus (DM). Dysphagia sepsis, Dementia, Anemia AKF, Poor intake (PO), thickened liquid, mechanically altered diet, pressure ulcers (PU). Resident #33 will maintain adequate nutritional status as evidence by (AEB) maintaining a stable weight with no significant changes through next review, no further signs and symptom skin breakdown, no signs and symptom choking/aspiration through next review maintain blood glucose (BG) level with baseline and maintain an adequate intake (PO) for wound healing and nutritional maintenance by consuming greater 50% of meals. Staff need to determine individual likes and dislikes, meal assistance-proper positioning, enteral feeds, observe/documentation/report as needed (PRN) and signs and symptom of dysphagia. Pocking, choking, coughing, drooling, holding food I mouth, several attempts at swallowing, refusing to eat,	F 325	3. The DON and/or designee will educate Licensed Nursing staff on the importance of obtaining weights on admission and monitoring the weights for 4 weeks. The DON and/or designee will monitor weights on admission and weekly for 4 weeks. Any opportunities identified will be corrected at this time by the DON or designee. 4. The results of this audit will be reported in the Quality Assurance Performance Improvement by the DON for 3 months. The committee will evaluate and make further recommendations as indicated.	

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F 325	Continued From page 14 appears concerns during meals, report to SLP, observed record report to physician (MD) as needed for signs and symptom of malnutrition: Emaciation (Cachexia) muscle wasting, significant weight loss, obtain and observe lab/diagnostic work as ordered. Report results to medical doctor and follow up as indicated. Provide and serve supplement as ordered: MVI(multivitamin) and Prostat for wound healing, provide serve diet as ordered, observed intake and record each meal PO diet pureed, supplemental enteral feedings of Osmolite 1.5 bolus 1 can if less than 50% of meals consumed and 1 can with HS: flush 150cc H20 6hrs. Registered Dietitian (RD) to evaluate and make diet change recommendations as needed, weight at same time of day and record. An admission minimum date set (MDS) for Resident # 33 revealed he required extensive to total assistance from staff, one person assist with eating. A review of medical record revealed the weight for Resident #33 were as follows: Admission weight on June 26, 2017 was 191, June 30, 2017 weight was 190 and July 19, 2017 weight was 187. A review of medical record reveled on July 21, 2017 at 7 PM Resident # 33 weight was 179.9. A weight loss of 11 pounds in 25 days. A review of the physician orders for June 2017 for Resident #33 revealed that he was on a pureed diet with supplemental enteral feedings of Osmolite 1,5 bolus 1 can if (less) <50% of meals consumed and 1 can with HS: flush 150cc H20q 6 hrs.	F 325		

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F 325	Continued From page 15 A review of the Nutrition Assessment done on July 8, 2017, all labs done on July 3, 2017. Summary/plan/progress note: Resident #33 was currently 72 and most recent weight was 190 on June 30, 2017 resulting in an IBW 178# IBWR R 160-196 and BMI of 25.8. Resident #33receives diet of pureed which intake are mostly 50% but resident in noted to refused breakfast 1 time and consumed less %50 two time within the last week. Enteral order for osmolite 1.5 1 can if less than 50% of meals consumed and at HS (Evening snack). During an interview with the Director of Nursing (DON) on July 21, 2017 at 11 AM, she revealed that the weight for Resident #33 on July 19, 2017 was not recorded on the right date. DON indicated that weight was for July 8, 2017 and that Resident #33 had not been weighted since July 8, 2017. DON indicated that the scale on that unit was broken. During a second interview with the DON on July 21, 2017 at 7 PM she revealed that Resident # 33 weight was done and weight was 179.9. DON indicated that she had called the medical doctor and new order was given. An interview with Nurse #6 on July 22, 2017 9 AM revealed that he weighed Resident # 33 on yesterday on the Hoyer scale not the standup scale. Nurse #6 indicated that the Hoyer scale had not been broken but the standup scale was for a day. Nurse #6 indicated he always get staff to assist him with Resident # 33. Resident #33 was a two person assisted with weights. Nurse #6 indicated that he does not recall getting the weight on Resident #33 last week at all. Nurse #6	F 325		

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indicated that with new admission weights are done weekly to help prevent weight loss. Nurse #6 also indicated that Resident #33 supplement enteral orders had never been used. However a new order from medical doctor was put in place on July 21, 2017.

An interview with Registered Dietitian (RD) on July 22, 2017 at 10 AM indicated that her last assessment on Resident #33 was done, the weight was 190 on June 30, 2017. Weight Status was not an issues and that recommendation was based on that information. The RD added new admissions should be weighted weekly and resident with a 2-3 pounds weight loss in a week would be considered a significant weight loss and should be re-assessed for nutritional interventions. RD indicated that her expectation for new admissions for the facility to get weights weekly.

An interview with Nurse Practitioner (NP) on July 22, 2017 at 10:23 AM indicated that she had no knowledge of Resident # 33 weight loss issues unit she got a call from the facility on yesterday. NP indicated Resident #33 was last visit was July 5, 2017. NP indicated that new order was put in place on July 21, 2017. NP indicated that her expectation was that the facility completed weight on all new admissions weekly to help prevent significant weight loss and to put interventions in place to help with weight loss.

An interview with the DON on July 22, 2017 at 7PM indicated that her expectation for new admissions should be weighted weekly to help assessed the weight issues with residents.

An interview with the Administrator on July 22,

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F 325	Continued From page 17 2017 at 8 PM. Administrator indicated that her expectation was that the facility follow protocol for new admissions and report to the RD and MD any concerns with weight loss as soon as possible.	F 325		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the	F 329	F329 1. Resident # 34 was no longer resident in facility as of 7/2/17. Resident # 45 chart was audited to ensure that no other medication transcription errors were noted. MD notified immediately. 2. Licensed Nursing Staff will be re-educated by the DON and/or designee regarding the Month End Changeover process and Physician Orders. Licensed nursing staff was educated on ensuring that the orders were being transcribed appropriately to the medication administration record. To ensure that they are signing the physician's orders and that another licensed nurse also perform second checks.	8-19-17

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F 329	Continued From page 18 clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to discontinue a medication as ordered for 1 of 7 sampled residents reviewed for unnecessary medications (Resident #34). The facility administered the wrong dose of Lasix for 1 of 7 residents reviewed for unnecessary medications. (Resident #45) The findings included: 1. Resident #34 was admitted to the facility on 5/24/17 from a hospital. The resident ' s cumulative diagnoses included Type 2 diabetes, congestive heart failure, bacteremia (the presence of bacteria in the blood), and pneumonia. A review of Resident #34 ' s admission Minimum Data Set (MDS) dated 5/31/17 revealed the resident had severely impaired cognitive skills for daily decision making. She required limited assistance from staff for bed mobility, dressing, toileting, and personal hygiene. A review of Resident #34 ' s medical record revealed a magnesium blood level was drawn and reported on 6/13/17 as 1.3 milligram/deciliter (mg/dL). The resident ' s magnesium level was noted as low. The reporting laboratory indicated the normal magnesium range referenced by the lab was 1.8 - 2.4 mg/dL. A handwritten notation	F 329	3. The Director of Nursing and/or designee will audit physicians orders upon admission and daily times 4 weeks, then 2 times a week times 4 weeks and then weekly times 4 weeks. Any opportunities identified will be corrected by the Director of Nursing or designee at the time. Director of Nursing and / or designee will audit 6 random charts after month end change over to ensure Medication Administration Record is accurate per the Physician's orders monthly times 3 months. The consultant pharmacist audits charts monthly. If any issues identified and requires immediate actions, he/she will notify the nurse and request the attending physician or designee be notified of the issue and new orders obtained.	

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F 329	Continued From page 19 on the lab report read, "Magnesium oxide 400 mg po (by mouth) TID (three times a day); Recheck Mg (magnesium) on 6/26/17." The notation was signed by the Nurse Practitioner and dated 6/13/17. A review of Resident #34 ' s medical record included a Physician ' s Order (dated 6/13/17) to initiate giving the resident 400 mg magnesium oxide three times daily and to recheck her magnesium level on 6/26/17. A Physician ' s Order (dated 6/14/17) was also written on 6/14/16 to recheck the resident ' s magnesium level on 6/16/17. Results of Resident #34 ' s magnesium level from 6/16/17 was 2.0 mg/dL (the normal magnesium range referenced by this reporting laboratory was 1.8 - 2.5 mg/dL). Results of the resident ' s magnesium level drawn and reported on 6/26/17 was 2.4 mg/dL (the normal magnesium range referenced by the lab was 1.8 - 2.5 mg/dL). A review of Resident #34 ' s medical record revealed a Physician ' s Order was received on 6/30/17 to discontinue the previously prescribed magnesium oxide. A review of Resident #34 ' s medical record included the July 2017 Physician Order Summary and July 2017 Medication Administration Record (MAR). Both of these records were signed to indicate the "Meds (were) Reviewed By:" Medication Technician #2 (Med Tech #2) on 6/27/17 and the "Completed Entries (were) Checked By:" Med Tech #1 on 6/27/17. The July 2017 MAR included 400 mg magnesium oxide to	F 329	4. The results of these audits will be reported in the Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months. The committee will evaluate and make further recommendations as indicated.	

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be given three times daily. The July 2017 MAR indicated the resident continued to receive three doses of magnesium oxide on 7/1/17 and one dose at 9:00 AM on 7/2/17.

Resident #34 passed away at the facility on 7/2/17 at 12:15 PM.

An unsuccessful attempt was made to interview Med Tech #2 by telephone on 7/22/17 at 9:24 AM.

An unsuccessful attempt was made to interview Med Tech #1 by telephone on 7/22/17 at 9:28 AM.

On 7/22/17 at 10:08 AM, an interview was conducted with the facility ' s Director of Nursing (DON), accompanied by Corporate Administrator #1. Upon inquiry, the DON discussed the tasks assigned to Med Techs on the Skilled Nursing unit. The DON reported med techs were not allowed to receive or transcribe physician orders onto the MAR and stated the nurses were responsible for these tasks. When specifically asked about month-end changeover (a process completed at the end of each month when current orders were reviewed and transcribed onto residents ' Medication Administration Records for the upcoming month), the DON stated, "I like for everybody to help out, especially with month-ends." She added, "From here on forward, No." The DON identified Nurse #1 as the 3rd shift nurse who would have worked when the month-end changeover to the July 2017 MARs was completed. A request was made for the facility to assist in contacting Med Tech #1 and Med Tech #2 for a telephone interview. No return phone call was received from either of the medication technicians.

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F 329	Continued From page 21 On 7/22/2017 at 6:06 PM a telephone interview was conducted with Nurse #1. Nurse #1 reported the transition from June to July was the first time she was involved in the month-end changeover and stated she wasn't exactly sure of what the process involved. She recalled being the only 3rd shift nurse working the night month-end changeovers were completed and needing to review all of resident ' s orders and MARs herself. The nurse reported the med techs working that night helped her to tear the Physician Order Summaries and MARs apart. Nurse #1 stated she herself reviewed each one of the forms but did not sign all of them. When asked about the med techs signing the forms to indicate the completed entries were checked by them, the nurse stated, "I don't know if they just signed because they were helping with the process, but they shouldn't have signed them." The nurse indicated she must have missed the 6/30/17 discontinuation of Resident #34 ' s magnesium oxide during the month-end changeover review. A follow up interview was conducted on 7/22/17 at 8:15 PM with the DON in the presence of Corporate Administrator #1. Upon inquiry, the DON stated her expectation was, "The orders be transcribed accurately." 2. Resident #45 was admitted to the facility on 6/29/17 with cumulative diagnoses which included hypertension. Review of the admission physician orders included in part Lasix 20 milligram (2) tablets (total of 40 mg) by mouth (po) twice a day. Lasix is a drug used to treat excessive fluid accumulation and swelling (edema) of the body.	F 329		

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F 329	Continued From page 22 Review of the 7/10/17 bloodwork results revealed a blood urea nitrogen (BUN) level was 61 milligrams/deciliters (mg/dl). The normal reference range was 5-25 mg/dl. The creatinine level was 2.24 mg/dl. The normal reference range was 0.50-1.30 mg/dl. Creatinine and BUN levels are important indexes to measure how well kidneys are functioning. The physician was notified and ordered to reduce Lasix 20 mg (2) tablets po twice a day to once a day. Review of the Medication Administration Record (MAR) indicated that a physician order was transcribed onto the form to reduce Lasix to 40 mg po daily. A line was noted to be drawn through this written entry. Review of the MAR revealed the original Lasix 20 mg po 2 tabs 40 mg order continued to be administered twice a day at 5 PM on 7/10/17 and 9 AM on 7/11/17. Interview on 07/22/17 at 4:45 PM via the phone with Nurse #2 who stated she had transcribed the 7/10/17 Lasix order onto the MAR. When an inquiry was made about initials indicating Lasix 40 mg continued to be given on 7/10/17 and 7/11/17 at 5 PM Nurse #2 indicated that she discontinued the order and had no other explanation. Nurse #4 was not able to be interviewed regarding the medication administration on 7/10/17 and 7/11/17. Interview on 7/22/17 at 7:59 PM with the Director of Nurses revealed her expectation was for medications to be administered as ordered.	F 329		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

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F 333	Continued From page 23 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to administer Resident #45 admission medications for 1 of 1 newly admitted resident reviewed. The facility failed to administer three scheduled medications and four medications ordered on an "as needed" basis over a period of 4 days after readmission for 1 of 7 sampled residents reviewed for unnecessary medications (Resident #61). Findings included: 1. Resident #45 was admitted to the facility on 6/29/17 with cumulative diagnoses which included gastroesophageal reflux disease (GERD), hypertension, congestive heart failure, diabetes and resolving infection from the hospital stay. Review of the 6/29/17 physician admission orders included: · Tylenol 650 milligrams (mg) 1 tablet by mouth (po) every 8 hours scheduled at 8 AM, 4 PM and 12 midnight. Tylenol is a pain reliever. · Coreg 6.25 mg twice a day po scheduled at 9 AM and 9 PM. Coreg is a beta blocker drug used for treating mild to severe CHF and hypertension. · Cipro 500 mg po every 12 hours for 7 days scheduled at 9 AM and 9 PM. Cipro is an antibiotic. · Docusate Sodium 100 mg po twice a day	F 333	F333 8-19-17 1. Resident # 45 physicians was notified resident did not receive medication. Nurse # 3 was reeducated by the DON regarding use of backup pharmacy, emergency kit and stock medications to ensure residents receive medications on admission as ordered. Resident # 61 no longer resides in facility. 2. DON and/or designee completed 100 % chart audits to ensure all records were accurate and complete. DON and/or designee will re educate Licensed Nursing staff regarding the use of backup pharmacy, the emergency kit and stock medications to ensure all residents receive medications as ordered. 3. DON or designee will audit new admissions to ensure medication availability and administration x 3 months. DON and/or designee will audit new admissions x 3 months to ensure medications were available and administered. The Consultant pharmacist audits charts monthly. If any issues identified and requires immediate action, he/she will notify the nurse and request the attending physician or designee be notified of the issue and new orders obtained. 4. The results of these audits will be reported in the Quality Assurance Performance Improvement meeting by the DON for 3 months. The committee will evaluate and make further recommendations as indicated	

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F 333	Continued From page 24 scheduled at 9 AM and 9 PM. Docusate Sodium is a stool softener. · Lasix 20 mg 2 tabs po twice a day scheduled for 9 AM and 5 PM. . Lasix is a drug used to treat excessive fluid accumulation and swelling (edema) of the body. · Neurontin 300 mg po at bedtime scheduled at 9 PM. Neurontin is used to treat nerve pain · Hydralazine 25 mg po three times a day scheduled at 9AM, 1 PM and 9 PM. Hydralazine is a medication used to treat high blood pressure and heart failure. · Levemir 3 units by subcutaneous injection at 9 PM. Levemir a long-acting insulin. · Lidocaine patch 5% q12 hours scheduled at 9 AM and 9 PM. Lidocaine patch is a medication used to numb tissue in a specific pain area. · Minocycline 100 mg scheduled at 9 AM and 9 PM. Minocycline is an antibiotic. · Protonix 40 mg twice a day scheduled at 9 AM and 9 PM. Protonix is a drug that prevents the production of acid in the stomach and used to treat. It is used to treat GERD. Review of the Medication Administration Record revealed the above medications were not administered to the resident on 6/29/17 during the evening shift. Review of the medication storage revealed Tylenol Review of the content list of the backup emergency kit revealed Coreg, Cipro, Lasix, Hydralazine and Protonix were available in the kit. Review of the over the counter stock medications revealed Docusate Sodium and Tylenol were available for administration. Interview on 07/22/17 at 12:15 PM with the	F 333		

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F 333	Continued From page 25 Administrator, Director of nurses (DON) and Corporate Administrator was held. The DON expected medication orders be faxed to the pharmacy, utilize the emergency back-up pharmacy, emergency kit or stock medications to ensure medications are administered as ordered. Interview on 07/22/2017 at 3:30PM with Nurse #3 (who admitted the resident and transcribed the admission orders) stated have a hard time getting medications from the pharmacy for new admissions.. "We have a late delivery" at the facility. When asked about the emergency backup pharmacy Nurse #3 indicated often the pharmacy will state that they never received the orders that were faxed. When inquiring about the backup emergency kit he indicated sometimes the medications are not available. When asked if he attempted to administer the admission meds there was no response. Nor had he made anyone aware of the above issues. 2. Resident #61 was admitted to the facility on 3/18/16. The resident ' s cumulative diagnoses included Type 2 diabetes, gastro-esophageal reflux disease (GERD), a history of cerebral infarction (stroke) and encephalopathy. Metabolic encephalopathy is temporary or permanent damage to the brain that happens when the body's metabolic processes are seriously impaired. Most cases occur when the liver cannot act normally to remove toxins from the bloodstream. A review of Resident #61 ' s most recent Minimum Data Set (MDS) dated 5/29/17 revealed the resident was assessed due to a significant change. The MDS assessment indicated the resident had severely impaired cognitive skills for daily decision making. He required extensive	F 333		

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F 333	Continued From page 26 assistance from staff for all of his Activities of Daily Living (ADLs) with the exception of requiring supervision only for eating. Section N of the MDS indicated Resident #61 received an insulin injection on 6 out of 7 days during the look back period. A review of the resident ' s medical record revealed he was sent out to the hospital on 6/14/17 and returned to the facility on 6/26/17. His current discharge medication list from the hospital included the following medications (in part): --5 Units of 100 Unit/ml insulin detemir (a long-acting insulin) to be injected into the skin at bedtime; --80 milligrams (mg) atorvastatin (an antilipemic medication used to lower cholesterol in the blood) to be given as one tablet by mouth at bedtime; --20 milliequivalents (mEq) potassium chloride (an electrolyte supplement) to be given as one tablet by mouth two times daily; --10 grams/15 milliliters lactulose (a medication used for the prevention and treatment of encephalopathy) to be given as 30 milliliters (ml) by mouth two times a day as needed (Take for signs of hepatic or liver encephalopathy); --500 mg acetaminophen (an over-the-counter pain reliever) to be given as one tablet by mouth as need for pain); --5 mg bisacodyl (a stimulant laxative) to be given as one tablet by mouth daily as needed for constipation; and, --20 mg famotidine (a medication used to reduce gastric acid secretions) to be given as one tablet by mouth at bedtime as needed. A review of Resident #61 ' s admission orders (dated 6/26/17) at the facility was completed.	F 333		

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F 333	Continued From page 27 The admission orders included each of the hospital discharge medications as listed and included (in part): insulin detemir, atorvastatin, potassium chloride, lactulose, acetaminophen, bisacodyl, and famotidine. These seven medications were all listed on page 3 (of 3 pages) of the Admission Orders to the facility. The Admission Orders to the facility were signed by the Unit Manager and dated 6/26/17. A review of Resident #61 ' s June 2017 Medication Administration Record (MAR) was completed. Each page of the MAR was a duplicate form of the Admission Orders. For example, page 1 of the MAR corresponded with page 1 of the resident ' s Admission Orders. The June 2017 MAR revealed medications listed on pages 1 and 2 of the MAR (and Admission Orders) were documented as having been administered to the resident as ordered. However, there was no documentation on page 3 of the June 2017 MAR to indicate any of the seven medications listed on that page were administered upon the resident ' s re-admission to the facility. No doses of insulin detemir, atorvastatin, potassium chloride, lactulose, acetaminophen, bisacodyl, or famotidine were documented as having been administered between 6/26/17 to 6/30/17. A review of the resident ' s medical record included results of his blood glucose (sugar) checks from 6/26/17 to 6/30/17: 6/27/17 at 11:30 AM Blood glucose = 176; 6/27/17 at 4:30 PM Blood glucose = 182; 6/29/17 at 6:00 AM Blood glucose (illegible); 6/29/17 at 11:15 AM Blood glucose = 130; 6/29/17 at 4:30 PM Blood glucose = 125; 6/30/17 at 6:00 AM Blood glucose = 149;	F 333		

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F 333	Continued From page 28 6/30/17 at 11:30 AM Blood glucose = 148; 6/30/17 at 4:30 PM Blood glucose = 132; 6/30/17 at 9:00 PM Blood glucose = 157. A blood sugar level less than 140 is consider to be normal. Further review of the resident ' s medical record included Progress Notes from 6/26/17 - 6/30/17. The notes did not indicate the resident experienced signs/symptoms of metabolic encephalopathy, constipation, or stomach acid reflux. No pertinent labs from that period of time were available for review. An interview was conducted on 7/22/17 at 10:08 AM with the facility ' s Director of Nursing (DON), accompanied by Corporate Administrator #1. During the interview, Resident #61 ' s Admission Orders from 6/26/17 were reviewed, along with the corresponding June 2017 MAR. Upon review, the DON identified Nurse #2 by her handwriting as having written the Admission Orders. She also identified the Unit Manager (by her signature) as the nurse who verified the Admission Orders. The DON recalled the Unit Manager was the nurse working on the med cart at the time Resident #61 was readmitted to the facility. When asked how the DON interpreted the absence of documentation on page 3 of the June 2017 MAR, the DON indicated she was not sure if the medications listed on that page of the MAR had been given. An interview was conducted on 7/22/17 at 2:15 PM with the Unit Manager. Upon review of Resident #61 ' s Admission Orders, the Unit Manager reported she signed the Physician ' s Orders only to indicate she faxed the orders to the physician ' s office for approval. Upon inquiry,	F 333		

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F 333	Continued From page 29 the Unit Manager stated Nurse #2 had written the Admission Orders and was responsible to ensure these were transcribed onto the resident ' s MAR. A telephone interview was conducted on 7/22/17 at 4:48 PM with Nurse #2. During the interview, inquiry was made in regards to the process employed when recording admission medications for Resident #61 on 6/26/17. The nurse reported she typically used the hospital discharge medication list to initiate admission orders for a resident. Upon further inquiry, the nurse stated the top copy of the orders (the Admission Orders) were placed in the resident ' s medical record and the bottom copy (the MAR) of each page was put into the MAR book to record medication administration. Nurse #2 stated she could not recall specifics about the readmission of Resident #61 on 6/26/17. A follow up interview was conducted on 7/22/17 at 8:15 PM with the DON in the presence of Corporate Administrator #1. Upon inquiry, the DON stated her expectation was, "On admission, all MARs be placed in the MAR book."	F 333		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	F 431		

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F 431	Continued From page 30 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	F431 1. Nurse # 1, Nurse # 2, Nurse # 3 , Nurse # 4 and Unit Manager were re-educated on the procedures for the administration and accounting of controlled substance medications. Resident # 22, # 98 and # 28 medications were discarded immediately and re-ordered from pharmacy. Nurse # 1 was re-educated on the labeling of medications with a shortened expiration date. Medication carts were audited on 7/22/17 for correct labeling on medications with shortened expiration dates. Medication storage room was audited to ensure all medications were being stored per manufacturer's recommendations. 2. All Medication carts were audited for correct labeling on medications with shortened expiration dates. All Medication storage room were audited to ensure all medications were being stored per manufacturer's recommendations.	8-9-17

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F 431	Continued From page 31 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility: 1) Failed to consistently follow established procedures for the administration and accounting of controlled substance medications for 3 of 3 sampled residents (Residents #58, #39, and #79) receiving controlled substances prescribed on an as needed basis; 2) Failed to store medications in accordance with the manufacturer ' s recommendations in 1 of 1 medication room; and, 3) Failed to label medications with a shortened expiration date on 1 of 2 medication carts (the Back Med Cart). The findings included: 1a) Resident #58 was admitted to the facility on 6/29/17. A review of Resident #58 ' s medication orders included an order for 10 milligrams (mg) oxycodone (an opioid pain reliever) to be given as one tablet by mouth every 6 hours as needed. Oxycodone is a controlled substance medication. A review and comparison of Resident #58 ' s Controlled Medication Utilization Record (a declining inventory record) for oxycodone with the corresponding Medication Administration Record (MAR) from 7/7/17 to 7/19/17 was completed. This comparison identified the following documentation discrepancies for the oxycodone administered to Resident #58: 7/8/17 Controlled Medication Utilization Record: 1 tablet was removed at 1:00 AM; July 2017 MAR: No tablets were documented as given on this date.	F 431	The DON and/or designee will educate Licensed nursing staff on the storage of medication in accordance with the manufacturer's recommendation. The DON and /or designee will educate Licensed Nursing staff on the procedures for the administration and accounting of controlled substance medications, to ensure that signatures are present on the narcotic declining inventory sheet, the front of the medication administration record and the effectiveness documented on the back of the medication administration record. The DON and/or designee will educate the Licensed Nursing Staff on the labeling of medications with shortened expiration date, to ensure there is a date opened present on the medication with shortened expiration dates and that they are checking the dates before the medication is administered. The role of the Medication Aide is to administer medications as per physician orders. They are to check the dates on the medication before administration and are not allowed to give Injections. They are to report to the charge nurse any issues that arise with or during medication administration.	

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F 431	Continued From page 32 7/8/17 Controlled Medication Utilization Record: 1 tablet was removed at 1:03 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/8/17 Controlled Medication Utilization Record: 1 tablet was removed at 10:00 PM; July 2017 MAR: No tablets were documented as given on this date. 7/9/17 Controlled Medication Utilization Record: 1 tablet was removed at 7:00 AM; July 2017 MAR: No tablets were documented as given on this date/time. 7/9/17 Controlled Medication Utilization Record: 1 tablet was removed at 1:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/11/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:45 AM; July 2017 MAR: No tablets were documented as given on this date/time. 7/11/17 Controlled Medication Utilization Record: 1 tablet was removed at 6:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/12/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/13/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/14/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:45 AM; July 2017 MAR: No tablets were documented as given on this date. 7/14/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:00 PM; July 2017 MAR: No tablets were	F 431	The pharmacy consultant audits charts monthly. If an issue is identified and requires immediate action, he/she will notify the nurse and request the attending physician or designee be notified of the issue and new orders obtained. 3. The Director of Nursing and/or designee will complete a random audit on 10 residents to compare the documentation of narcotic administration on controlled medication utilization record against documentation on the medication administration record weekly times 4 weeks and then monthly times 2 months. The DON and/or designee will audit the storage of medications twice weekly times 4 weeks, weekly for 4 weeks and then monthly times 2 months. The DON and/or designee will audit the labeling of medications with shortened expiration date on admission and 2 times weekly for 4 weeks, weekly times 4 weeks and then monthly times 2 months. 4. The results of these audits will be reported in the Quality Assurance Performance Improvement meeting by the DON for 3 months. The committee will evaluate and make further recommendations as indicated.	

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F 431	Continued From page 33 documented as given on this date. 7/16/17 Controlled Medication Utilization Record: 1 tablet was removed at (time was not legible); July 2017 MAR: No tablets were documented as given on this date. 7/16/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:00 PM; July 2017 MAR: No tablets were documented as given on this date. 7/16/17 Controlled Medication Utilization Record: 1 tablet was removed at 11:30 PM; July 2017 MAR: No tablets were documented as given on this date. 7/19/17 Controlled Medication Utilization Record: 1 tablet was removed at 8:50 AM; July 2017 MAR: No tablets were documented as given on this date. 7/19/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:00 PM; July 2017 MAR: No tablets were documented as given on this date. An interview was conducted on 7/22/17 at 2:15 PM with the Unit Manager. The Unit Manager was identified by her initials on the Controlled Medication Utilization Record as having pulled oxycodone from the med cart for Resident #58 on 7/8 at 1:03 PM. During the interview, the Unit Manager was asked what procedures the facility required for the administration and documentation when a controlled substance medication was given to a resident. The Unit Manager reported that if a nurse gave a controlled substance medication, the nurse would need to sign out the medication on the narcotic log (Controlled Medication Utilization Record) when the medication was pulled from the medication cart. After the medication was given, the nurse would need to sign on the front of MAR,	F 431		

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F 431	Continued From page 34 on the back of the MAR (along with the time of the medication administration and its effectiveness), and on the resident ' s pain sheet. Upon request, the Unit Manager assisted in identifying some of the nursing staff by his/her initials on the Controlled Medication Utilization Record. Not all of the nursing staff signatures were identified. An interview was conducted on 7/22/17 at 2:41 PM with Nurse #3. Nurse #3 was identified by his initials on the Controlled Medication Utilization Record as having pulled oxycodone from the med cart for Resident #58 on 7/8 at 1:00 AM, 7/8 at 10:00 PM, 7/12 at 9:00 PM, 7/13 at 9:00 PM, 7/16 at 1:30 PM, and 7/19 at 9:00 PM, without documenting administration of the medication on the resident ' s MAR. During the interview, Nurse #3 was asked what procedures the facility required for the administration and documentation when a controlled substance medication was given to a resident. Nurse #3 reported when a controlled substance medication was given to a resident, he needed to keep a count of the medication(s) and the time it was given. The nurse stated he documented the administration of a controlled substance medication on both the MAR and the narcotic log immediately after the patient had taken it (at the same time). Nurse #3 also reported he also made notes on the 24-hour nursing report that the resident had taken the medication. An unsuccessful attempt was made to contact Nurse #4 on 7/22/17 at 5:30 PM for a telephone interview. Nurse #4 was identified by her initials on the Controlled Medication Utilization Record as having pulled oxycodone from the med cart for Resident #58 on 7/9 at 1:00 PM without	F 431		

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F 431	Continued From page 35 documenting administration of the medication on the resident ' s MAR. A message was left for the nurse requesting a return telephone call. A telephone interview was conducted on 7/22/17 at 6:06 PM with Nurse #1. Nurse #1 was identified by her initials on the Controlled Medication Utilization Record as having pulled oxycodone from the med cart for Resident #58 on 7/9 at 7:00 AM without documenting administration of the medication on the resident ' s MAR. During the interview, Nurse #1 was asked what procedures the facility required for the administration and documentation when a controlled substance medication was given to a resident. The nurse reported she documented administration of a controlled substance medication on both the narcotic log and on the front of the MAR after the medication was given to the resident. Nurse #1 also stated she documented the med administration on the resident ' s pain sheet, the 24-hour report, and the back of the MAR (in regards to the effectiveness of the medication). An interview was conducted on 7/22/17 at 8:15 PM with the facility ' s Director of Nursing (DON), accompanied by Corporate Administrator #1. During the interview, the DON discussed the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported a nurse would be expected to sign off on the declining inventory record as soon as the controlled substance was taken out of the med cart and to sign off on the resident ' s MAR after the medication was administered to the resident. Upon further inquiry, the DON indicated she expected information from the residents' MARs	F 431		

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F 431	Continued From page 36 and Controlled Medication Utilization Records to be consistent with one another. 1b) Resident #39 was admitted to the facility on 6/22/17. A review of Resident #39 ' s medication orders included an order for 5/325 milligrams (mg) hydrocodone/acetaminophen (a combination opioid pain reliever) to be given as one tablet by mouth every 8 hours as needed; and an order dated 7/6/17 for 0.5 mg lorazepam to be given as ½ tablet (0.25 mg) to be given by mouth every day as needed for anxiety for 14 days. Hydrocodone/acetaminophen and lorazepam are controlled substance medications. A review and comparison of Resident #39 ' s Controlled Medication Utilization Record (a declining inventory record) for lorazepam with the corresponding Medication Administration Record (MAR) from 7/7/17 to 7/19/17 was completed. This comparison identified the following documentation discrepancies for the lorazepam administered to Resident #39: 7/10/17 Controlled Medication Utilization Record: 1 tablet was removed at 8:00 PM; July 2017 MAR: No tablets were documented as given on this date. 7/12/17 Controlled Medication Utilization Record: 1 tablet was removed at 8:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/15/17 Controlled Medication Utilization Record: 1 tablet was removed at 8:00 AM; July 2017 MAR: No tablets were documented as given on this date. A review and comparison of Resident #39 ' s Controlled Medication Utilization Record for 5/325 mg hydrocodone/acetaminophen with the	F 431		

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F 431	Continued From page 37	F 431		

corresponding MAR from 7/7/17 to 7/19/17 was completed. This comparison identified the following documentation discrepancies for the hydrocodone/acetaminophen administered to Resident #39:
7/7/17 Controlled Medication Utilization Record: 1 tablet was removed at 6:00 PM;
July 2017 MAR: No tablets were documented as given on this date/time.
7/8/17 Controlled Medication Utilization Record: 1 tablet was removed at 10:00 AM;
July 2017 MAR: No tablets were documented as given on this date.
7/10/17 Controlled Medication Utilization Record: 1 tablet was removed at 10:00 PM;
July 2017 MAR: No tablets were documented as given on this date.
7/12/17 Controlled Medication Utilization Record: 1 tablet was removed at 8:00 PM;
July 2017 MAR: No tablets were documented as given on this date/time.
7/13/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:10 AM;
July 2017 MAR: No tablets were documented as given on this date/time.
7/14/17 Controlled Medication Utilization Record: 1 tablet was removed at 3:00 PM;
July 2017 MAR: No tablets were documented as given on this time.
7/15/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:00 AM;
July 2017 MAR: No tablets were documented as given on this date.
7/15/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:00 PM;
July 2017 MAR: No tablets were documented as given on this date.
7/16/17 Controlled Medication Utilization Record: 1 tablet was removed at 6:00 AM;

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F 431	Continued From page 38 July 2017 MAR: No tablets were documented as given on this date/time. 7/17/17 Controlled Medication Utilization Record: 1 tablet was removed at 6:00 AM; July 2017 MAR: No tablets were documented as given on this date. 7/17/17 Controlled Medication Utilization Record: 1 tablet was removed at 2:30 PM; July 2017 MAR: No tablets were documented as given on this date. 7/17/17 Controlled Medication Utilization Record: 1 tablet was removed at 3:30 PM; July 2017 MAR: No tablets were documented as given on this date. 7/17/17 Controlled Medication Utilization Record: 1 tablet was removed at 11:30 PM; July 2017 MAR: No tablets were documented as given on this date. 7/18/17 Controlled Medication Utilization Record: 1 tablet was removed at 5:00 PM; July 2017 MAR: No tablets were documented as given on this date. 7/19/17 Controlled Medication Utilization Record: 1 tablet was removed at 3:15 AM; July 2017 MAR: No tablets were documented as given on this date. 7/19/17 Controlled Medication Utilization Record: 1 tablet was removed at 4:52 PM; July 2017 MAR: No tablets were documented as given on this date. An interview was conducted on 7/22/17 at 2:15 PM with the Unit Manager. During the interview, the Unit Manager was asked what procedures the facility required for the administration and documentation when a controlled substance medication was given to a resident. The Unit Manager reported that if a nurse gave a controlled substance medication, the nurse would	F 431		

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F 431	Continued From page 39 need to sign out the medication on the narcotic log (Controlled Medication Utilization Record) when the medication was pulled from the medication cart. After the medication was given, the nurse would need to sign on the front of MAR, on the back of the MAR (along with the time of the medication administration and its effectiveness), and on the resident ' s pain sheet. Upon request, the Unit Manager assisted in identifying some of the nursing staff by his/her initials on the Controlled Medication Utilization Record. Not all of the nursing staff signatures were identified. A telephone interview was conducted on 7/22/17 at 4:48 PM with Nurse #2. Nurse #2 was identified by her initials on the Controlled Medication Utilization Record as having pulled hydrocodone/acetaminophen from the med cart for Resident #39 on 7/13 at 9:10 AM without documenting administration of the medication on the resident ' s MAR. Upon inquiry as to where (and when) she documented the withdrawal of controlled substance medications for administration to a resident, the nurse stated, "You document on the back of the MAR or the nursing notes." When asked if she also documented on the front of the MAR and on the declining inventory sheet, she stated, "You have to." Upon further inquiry as to when she documented on each of these, she stated, "It depends." An unsuccessful attempt was made to contact Nurse #4 on 7/22/17 at 5:30 PM for a telephone interview. Nurse #4 was identified by her initials on the Controlled Medication Utilization Record as having pulled lorazepam from the med cart for Resident #39 on 7/10, 7/12, and 7/15 without	F 431		

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F 431	Continued From page 40 documenting administration of the medication on the resident ' s MAR. She was also identified by her initials on the Controlled Medication Utilization Record as having pulled hydrocodone/acetaminophen from the med cart for Resident #39 on 7/7 at 6:00 PM, 7/10 at 10:00 PM, 7/12 at 8:00 PM, 7/15 at 9:L00 AM, 7/17 at 3:30 PM, and 7/17 at 11:30 PM without documenting administration of the medication on the resident ' s MAR. A message was left for the nurse requesting a return telephone call. A telephone interview was conducted on 7/22/17 at 6:06 PM with Nurse #1. Nurse #1 was identified by her initials on the Controlled Medication Utilization Record as having pulled hydrocodone/acetaminophen from the med cart for Resident #39 on 7/15 at 9:00 PM, 7/16 at 6:00 AM, and 7/17 at 6:00 AM without documenting administration of the medication on the resident ' s MAR. During the interview, Nurse #1 was asked what procedures the facility required for the administration and documentation when a controlled substance medication was given to a resident. The nurse reported she documented administration of a controlled substance medication on both the narcotic log and on the front of the MAR after the medication was given to the resident. Nurse #1 also stated she documented the med administration on the resident ' s pain sheet, the 24-hour report, and the back of the MAR (in regards to the effectiveness of the medication). An interview was conducted on 7/22/17 at 8:15 PM with the facility ' s Director of Nursing (DON), accompanied by Corporate Administrator #1. During the interview, the DON discussed the facility ' s procedures for documenting the	F 431		

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F 431	Continued From page 41 administration of a controlled substance medication to a resident. The DON reported a nurse would be expected to sign off on the declining inventory record as soon as the controlled substance was taken out of the med cart and to sign off on the resident ' s MAR after the medication was administered to the resident. Upon further inquiry, the DON indicated she expected information from the residents' MARs and Controlled Medication Utilization Records to be consistent with one another. During the interview, a request was made for the facility to assist in contacting Nurse #4 for a telephone interview. No return phone call was received from Nurse #4. 1c) Resident #79 was admitted to the facility on 3/21/17. A review of Resident #79 ' s medication orders included an order for 5/325 milligrams (mg) oxycodone/acetaminophen (a combination opioid pain reliever) to be given as one tablet by mouth every 4 hours as needed for pain. An additional order was written for a scheduled dose of 5/325 mg oxycodone/acetaminophen to be given once daily at 6:00 AM. Oxycodone/acetaminophen is a controlled substance medication. A review and comparison of Resident #79 ' s Controlled Medication Utilization Record (a declining inventory record) for oxycodone/acetaminophen with the corresponding Medication Administration Records (MAR) from 7/7/17 to 7/19/17 was completed. This comparison identified the following documentation discrepancies for the oxycodone/acetaminophen administered to Resident #79: 7/8/17 Controlled Medication Utilization Record:	F 431		

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F 431	Continued From page 42 1 tablet was removed at 6:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/12/17 Controlled Medication Utilization Record: 1 tablet was removed at 9:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/13/17 Controlled Medication Utilization Record: 1 tablet was removed at 12:30 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/13/17 Controlled Medication Utilization Record: 1 tablet was removed at 6:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. 7/16/17 Controlled Medication Utilization Record: 1 tablet was removed at 6:00 PM; July 2017 MAR: No tablets were documented as given on this date/time. An interview was conducted on 7/22/17 at 2:15 PM with the Unit Manager. During the interview, the Unit Manager was asked what procedures the facility required for the administration and documentation when a controlled substance medication was given to a resident. The Unit Manager reported that if a nurse gave a controlled substance medication, the nurse would need to sign out the medication on the narcotic log (Controlled Medication Utilization Record) when the medication was pulled from the medication cart. After the medication was given, the nurse would need to sign on the front of MAR, on the back of the MAR (along with the time of the medication administration and its effectiveness), and on the resident ' s pain sheet. Upon request, the Unit Manager assisted in identifying some of the nursing staff by his/her initials on the Controlled Medication Utilization	F 431		

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F 431	Continued From page 43 Record. Not all of the nursing staff signatures were identified. An interview was conducted on 7/22/17 at 2:41 PM with Nurse #3. Nurse #3 was identified by his initials on the Controlled Medication Utilization Record as having pulled oxycodone/acetaminophen from the med cart for Resident #79 on 7/8 at 6:00 PM, 7/13 at 6:00 PM, and 7/16 at 6:00 PM, without documenting administration of the medication on the resident ' s MAR. During the interview, Nurse #3 was asked what procedures the facility required for the administration and documentation when a controlled substance medication was given to a resident. Nurse #3 reported when a controlled substance medication was given to a resident, he needed to keep a count of the medication(s) and the time it was given. The nurse stated he documented the administration of a controlled substance medication on both the MAR and the narcotic log immediately after the patient had taken it (at the same time). Nurse #3 also reported he also made notes on the 24-hour nursing report that the resident had taken the medication. An interview was conducted on 7/22/17 at 8:15 PM with the facility ' s Director of Nursing (DON), accompanied by Corporate Administrator #1. During the interview, the DON discussed the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported a nurse would be expected to sign off on the declining inventory record as soon as the controlled substance was taken out of the med cart and to sign off on the resident ' s MAR after the medication was administered to the resident.	F 431		

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F 431	Continued From page 44 Upon further inquiry, the DON indicated she expected information from the residents' MARs and Controlled Medication Utilization Records to be consistent with one another. 2a) Accompanied by the Unit Manager, an observation was made on 7/22/17 at 8:52 PM of the medication room. The observation revealed a 250/50 micrograms (mcg) Advair Diskus inhaler (a medication used for the treatment of asthma and chronic obstructive pulmonary disease) was stored in the refrigerator. The inhaler was dispensed from the pharmacy on 7/13/17 and labeled for use by Resident #22. The temperature of the med room refrigerator was 38o Fahrenheit (F). Manufacturer labeling on the Advair Diskus box indicated the inhaler should be stored between 68o-77oF (controlled room temperature); Store in a dry place. A review of Resident #22 ' s July 2017 Physician Orders revealed there was a current order for 250/50 mcg Advair Diskus inhaler to be used as 1 puff inhaled by mouth every 12 hours. An interview was conducted on 7/22/17 at 9:00 PM with the Unit Manager. When asked if the Advair Diskus inhaler was supposed to be stored in the refrigerator, she stated, "No." An interview was conducted on 7/22/17 at 9:05 PM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for the medications to be stored properly according to the manufacturer ' s directions. 2b) Accompanied by the Unit Manager, an observation was made on 7/22/17 at 8:52 PM of	F 431		

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F 431	Continued From page 45 the medication room. The observation revealed a bottle of 50 micrograms (mcg) fluticasone nasal spray (a corticosteroid medication) was stored in the refrigerator. The nasal spray was dispensed from the pharmacy on 7/13/17 and labeled for use by Resident #22. The temperature of the med room refrigerator was 38o Fahrenheit (F). Manufacturer labeling on the fluticasone bottle indicated the nasal spray should be stored between 68o-77oF (controlled room temperature). A review of Resident #22 ' s July 2017 Physician Orders revealed there was a current order for 50 mcg fluticasone nasal spray to be used as 1 spray into each nostril every day. An interview was conducted on 7/22/17 at 9:00 PM with the Unit Manager. When asked if the fluticasone nasal spray was supposed to be stored in the refrigerator, she stated, "No." An interview was conducted on 7/22/17 at 9:05 PM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for the medications to be stored properly according to the manufacturer ' s directions. 2c) Accompanied by the Unit Manager, an observation was made on 7/22/17 at 8:52 PM of the medication room. The observation revealed two bottles of 20 milliequivalents/15 milliliters (mEq/ml) potassium chloride solution were stored in the refrigerator. Both bottles of the potassium chloride solution were dispensed from the pharmacy on 7/5/17 and labeled for use by Resident #98. The temperature of the med room refrigerator was 38o Fahrenheit (F).	F 431		

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F 431	Continued From page 46 Manufacturer labeling on each bottle of potassium chloride indicated the solution should be stored between at 77oF with excursions permitted to 59o-86oF. A review of Resident #98 ' s July 2017 Physician Orders revealed there was a current order for 20 mEq/15 ml potassium chloride solution to be given as 30 milliliters via gastrostomy tube (a tube inserted into the stomach through an opening in the abdominal wall for the administration of fluids and/or nutrition) twice daily. An interview was conducted on 7/22/17 at 9:00 PM with the Unit Manager. When asked if the potassium chloride was supposed to be stored in the refrigerator, she stated, "No." An interview was conducted on 7/22/17 at 9:05 PM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for the medications to be stored properly according to the manufacturer ' s directions. 3) An observation was made on 7/22/17 at 8:35 PM revealed an opened bottle of 0.005% latanoprost ophthalmic solution (a medication used to treat glaucoma) was stored on the cart. The latanoprost eye drops were labeled as having been dispensed from the pharmacy on 6/5/17 and labeled for use by Resident #28. The bottle was not dated as to when it had been opened and/or placed in the med cart at room temperature. A pharmacy auxiliary sticker placed on the bottle read, "For the eye. Refrigerate until opened. Discard 6 weeks after opening."	F 431		

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F 431	Continued From page 47 Manufacturer labeling for latanoprost ophthalmic solution indicated intact bottles of the solution should be stored under refrigeration. Once opened, the solution may be stored at room temperature for 6 weeks. A review of Resident #28 ' s July 2017 Physician ' s Orders revealed there was a current medication order for 0.005% latanoprost ophthalmic solution to be given as one drop into both eyes every night at bedtime. An interview was conducted on 7/22/17 at 8:40 PM with Nurse #1. Nurse #1 was assigned to the Back Medication Cart. After reviewing the medication labeling on the latanoprost solution, the nurse acknowledged there was a shortened expiration date that needed to be observed for this medication. However, she did not know when the eye drops had been opened. An interview was conducted on 7/22/17 at 9:05 PM with the facility ' s Administrator. During the interview, the Administrator stated her expectation would be for medications to be dated when opened and thrown away when expired.	F 431		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		

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F 514	Continued From page 48 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to document treatments performed to Resident #61 ' s pressure sore. This was evident in 1 of 3 residents reviewed with pressure sores. Findings included: 1) Resident #61 was readmitted to the facility on 6/26/17 after a hospitalization with cumulative diagnoses which included a cerebral vascular accident. Review of the medical record revealed the	F 514	F514 1. Resident # 61 no longer resides in the facility. 2. 100 % audit of all treatment administration records was completed and any issues noted were corrected. 3. Licensed nursing staff were reeducated by the Director of Nursing and/or designee on the policy and procedure for accurate and complete documentation. Medication aides may assist with the positioning of a resident during treatment procedures but do not perform treatments. The DON and/or designee will audit the treatment administration record daily x 2 weeks, then 3 x week x 4 weeks and then weekly x4 weeks. 4. The results of these audits will be reported in the Quality Assurance Performance Improvement meeting by the DON for 3 months. The committee will evaluate and make further recommendations as indicated.	8-19-17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 49 resident developed a pressure sore on the left hip that progressed to a Stage 4. A Stage 4 pressure sore is described as full thickness tissue loss with exposed bone, tendon or muscle. Review of the physician orders revealed: On 6/26/17 to apply Santyl ointment topically and Allevyn dressing to left hip sore twice a day. Apply Dakin ' s solution to the dressings. On 7/6/17 to cleanse the pressure sore with normal saline. Apply skin barrier around the wound. For the next 2 weeks pack the wound with Dakin ' s soaked 2 inch gauze Review of the Treatment Administration Record (TAR) revealed on 7/5/17 and 7/8/17 during the 3 PM to 11 PM shift a blank space without a staff ' s initial. Interview on 7/22/17 at 4 PM with Nurse #3 indicated that treatments were always completed. Interview on 7/22/17 at 4 PM with the Unit Manager revealed the treatments to the pressure sores were always done. Interview on 7/22/17 at 7 PM with the Director of Nurses revealed she expected her staff to document care rendered.	F 514		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	07/22/2017

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F 520	Continued From page 50 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place on 8/2016. This was for F431 recited deficiency, which was originally cited in August 2016 on a Recertification Survey and on the Current Recertification and Complaint Survey.	F 520	F520 8-19-17 1. A QAPI meeting was held on 8/10/2017 to discuss F431 – (Drug Records, label and store Drugs and Biological) and develop a plan for improvement and to ensure practices are being maintained. 2. The administrator will provide education to the QAPI team members. This education was completed on 8/10/2017. 3. The District Director of Clinical Services will randomly review QAPI minutes and will attend when possible. The QAPI committee will meet more frequently than the required quarterly meeting, meeting at least monthly. We will discuss F431 and develop a plan for process improvements and deficiency correction as needed. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 51 The deficiency was in the area of medication storage. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Finding Included: This tag is cross referenced to F 431 Based on observations, record review and staff interviews, the facility: 1) Failed to consistently follow established procedures for the administration and accounting of controlled substance medications for 3 of 3 sampled residents (Residents #58, #39, and #79) receiving controlled substances prescribed on an as needed basis; 2) Failed to store medications in accordance with the manufacturer's recommendations in 1 of 1 medication room; and, 3) Failed to label medications with a shortened expiration date on 1 of 2 medication carts (the Back Med Cart). F520 was originally cited during the August 2016 Recertification Survey. Based on record review and staff interview the facility failed to follow established procedures to provide for an accurate count and verification of all controlled substances on 2 of 2 medication carts (Front I medication cart and back II medication cart.) An interview was conducted on 7/22/2017 at 7 PM with the Administrator. The Administrator indicated that her expectation was not to get recited deficiency.	F 520		