STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345174	A. BUILDING: _____ B. WING _____	10/5/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE NURSING & REHABILITATION CENTER	91 VICTORIA ROAD ASHEVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 160	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH

(v) Conveyance upon discharge, eviction, or death.

Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on resident trust account review and staff interviews the facility failed to convey funds within 30 days for 1 of 3 sampled residents that expired (Resident #20).

The findings included:

A review of the facility policy and procedure for Conveyance of Funds Upon a Resident's Death with a revised date of December 2006 stated in part: Within thirty (30) days of the death of the resident, the facility will convey the deceased resident's personal funds and a final accounting of those funds to the probate jurisdiction administering the resident's estate.

Resident #20 was admitted to the facility on 11/17/15 and expired 06/18/17. Review of the resident trust account of Resident #20 noted the final fund amount for $290.00 was not sent to the Buncombe County Clerk of Court until 09/29/17.

On 10/04/17 at 3:56 PM the Business Office Manager explained the delay in conveyance of funds for Resident #20 was due to an expectation that Social Security would recoup the overpayment. The Business Office Manager stated she held off on sending the check because past experience when they sent the money back, the Social Security Office would recoup the money anyway leaving them with a negative balance. The Business Office manager acknowledged she should have sent the check within 30 days of the resident's expiration.

On 10/05/17 at 9:29 AM the Administrator stated her expectation was for the resident fund account to be closed and a check would be sent out within the 30 day timeframe to follow the regulation.

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

The above isolated deficiencies pose no actual harm to the residents

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F 000	INITIAL COMMENTS On 09/28/17 the State Agency initiated an investigation of an Immediate Jeopardy complaint investigation at the facility. This complaint investigation continued on 10/02/17 and was connected with the facility's Recertification survey event which concluded on 10/06/17. Event ID# LYJD11.	F 000		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to repair resident doors with broken wood and splintered laminate on 2 of 2 halls. 6 of 32 rooms were affected on 100 hall (Room #101, 103, 104, 105, 110, 126) and 1 of 30 rooms was affected on 200 hall (Room #210). The facility failed to repair and repaint scuffed or peeled walls on 2 of 2 halls. 3 of 32 rooms were affected on 100 hall (Room #110, 114, 126) and 1 of 30 rooms was affected on 200 hall (Room #220). The facility failed to replace rusted metal toilet paper holders on 2 of 2 halls. 4 of the 23 bathrooms were affected on 100 hall (Bathroom #110, 114, 117, 126) and 1 of the 21 bathrooms were affected on 200 hall (Bathroom #226). The facility failed to repair loosened toilet paper holder in 1 of 2 halls. 1 of the 23 bathrooms was affected on 100 hall (Bathroom #118). The facility also failed to repair holes found around the pipe going from the sink into the wall on 2 of 2 halls. 2 of 23 bathrooms were affected on 100 hall (Room #124, 125) and 1 of 21 bathrooms were affected	F 253	The plan of correcting the specific deficiency. The doors for rooms 101, 103, 104, 105, 110, 126, 210 will have a protective strip attached to cover the broken and splintering laminate by November 2, 2017. The toilet paper holders for rooms 110, 114, 117, 126, 226 were replaced on October 16, 2017. The toilet paper holder for room 118 was repaired on October 20, 2017, and is no longer loose. The holes around the pipes in bathrooms for rooms 124, 125 and 220 were patched on October 16, 2017. The area around the soap dispensers for rooms 110, 114 and 220 were repaired on	11/2/17

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

Electronically Signed | 10/27/2017

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 253	Continued From page 1 on 200 hall (Bathroom #220). The findings included: 1. The following observations were related to facility's failure to repair resident room doors with broken wood and splintered laminate: a. Observation of Room 101 on 10/02/17 at 1:28 PM revealed the door of the resident's room had broken wood with sharp edges on the front of the bottom half of the door. Subsequent observations made on 10/03/17 at 9:28 AM, 10/04/17 at 11:39 AM, and 10/05/17 at 8:57 AM revealed the door remained in disrepair. b. Observation of Room 103 on 10/02/17 at 1:30 PM revealed the door of the resident's room had broken wood with sharp edges and splintered laminate on the front of the bottom half of the door. Subsequent observations made on 10/03/17 at 9:30 AM, 10/04/17 at 11:41 AM, and 10/05/17 at 8:58 AM revealed the door remained in disrepair. c. Observation of Room 104 on 10/02/17 at 1:31 PM revealed the door of the resident's room had broken wood with sharp edges and splintered laminate on the front of the bottom half of the door. Subsequent observations made on 10/03/17 at 9:33 AM, 10/04/17 at 11:43 AM, and 10/05/17 at 9:00 AM revealed the door remained in disrepair. d. Observation of Room 105 on 10/02/17 at 1:33 PM revealed the door of the resident's room had broken wood with sharp edges and splintered laminate on the front of the bottom half of the door. Subsequent observations made on	F 253	October 20, 2017. The scuffed walls for rooms 110, 114, 126 and 220 will be repaired and painted by November 2, 2017. The process that led to the deficiency is that facility audits being completed didn't include structural damage to doors or walls and work orders were not being completed appropriately regarding all repairs needed. The procedure for implementing the acceptable plan of correction for the deficiency cited. All Staff will be in-serviced on completion of a work order by the Maintenance Director by November 2, 2017. A complete facility audit including, but not limited to, toilet paper holders, bathroom doors, resident room doors and walls will be completed by November 2, 2017. Walls will be patched and painted as needed. Toilet paper holders will be replaced as needed. Doors in need of repair will either be patched or replaced as needed. This audit will be completed by the Administrator. The Administrator will complete facility audits including, but not limited to, toilet paper holders, bathroom doors, resident room doors and walls bi-weekly X 2 months and monthly X 6 months. The monitoring procedure to ensure that	

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F 253	Continued From page 2 10/03/17 at 9:35 AM, 10/04/17 at 11:44 AM, and 10/05/17 at 9:01 AM revealed the door remained in disrepair. e. Observation of Room 110 on 10/02/17 at 1:38 PM revealed the door of the resident's room had broken wood with sharp edges and splintered laminate on the front of the bottom half of the door. Subsequent observations made on 10/03/17 at 9:38 AM, 10/04/17 at 11:49 AM, and 10/05/17 at 9:04 AM revealed the door remained in disrepair. f. Observation of Room 126 on 10/02/17 at 1:59 PM revealed the door of the resident's room had broken wood with sharp edges on the front of the bottom half of the door. Subsequent observations made on 10/03/17 at 9:58 AM, 10/04/17 at 12:08 AM, and 10/05/17 at 9:09 AM revealed the door remained in disrepair. g. Observation of Room 210 on 10/02/17 at 2:28 PM revealed the door of the resident's room had broken wood with sharp edges and splintered laminate on the front of the bottom half of the door. Subsequent observations made on 10/03/17 at 10:11 AM, 10/04/17 at 12:19 AM, and 10/05/17 at 9:12 AM revealed the door remained in disrepair. 2. The following observations were related to facility's failure to repair and repaint scuffed or peeled walls: a. Observation of Room 110 on 10/02/17 at 1:38 PM revealed a spot of peeled wall approximately 6 x 10 inches located next to the soap dispenser in the bathroom. Subsequent observations made on 10/03/17 at 9:38 AM, 10/04/17 at 11:49 AM,	F 253	the plan of correction is effective and that specific deficiency remains corrected and/or in compliance with the regulatory requirements. The Director of Maintenance will present the audit results of the facility to the Quality Assurance and Performance Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinator, Treatment Nurse, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge Nurse and a Certified Nursing Assistant X 8 months for follow up and/or recommendations. The person responsible for implementing the acceptable plan of correction is the Administrator.	

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and 10/05/17 at 9:04 AM revealed the wall remained in disrepair.

b. Observation of Room 114 on 10/02/17 at 1:43 PM revealed a spot of peeled wall approximately 6 x 10 inches located behind the soap dispenser in the bathroom. Subsequent observations made on 10/03/17 at 9:42 AM, 10/04/17 at 11:53 AM, and 10/05/17 at 9:05 AM revealed the wall remained in disrepair.

c. Observation of Room 126 on 10/02/17 at 1:59 PM revealed a spot of scuffed wall approximately 20 x 20 inches located behind Resident #41's bed. Subsequent observations made on 10/03/17 at 9:58 AM, 10/04/17 at 12:08 PM, and 10/05/17 at 9:09 AM revealed the wall remained in disrepair.

d. Observation of Room 220 on 10/02/17 at 2:43 PM revealed a spot of peeled wall approximately 6 x 10 inches located behind the soap dispenser in the bathroom. Subsequent observations made on 10/03/17 at 10:38 AM, 10/04/17 at 12:39 PM, and 10/05/17 at 9:13 AM revealed the wall remained in disrepair.

3. The following observations were related to facility's failure to replace rusted metal toilet paper holders or repair loosened toilet paper holders:

a. Observation of Room 110 on 10/02/17 at 1:38 PM revealed the metal toilet paper holder was badly rusted. Subsequent observations made on 10/03/17 at 9:38 AM, 10/04/17 at 11:49 AM, and 10/05/17 at 9:04 AM revealed the metal toilet paper holder remained in disrepair.

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b. Observation of Room 114 on 10/02/17 at 1:43 PM revealed the metal toilet paper holder was badly rusted. Subsequent observations made on 10/03/17 at 9:42 AM, 10/04/17 at 11:53 AM, and 10/05/17 at 9:05 AM revealed the metal toilet paper holder remained in disrepair.

c. Observation of Room 117 on 10/02/17 at 1:45 PM revealed the metal toilet paper holder was badly rusted. Subsequent observations made on 10/03/17 at 9:46 AM, 10/04/17 at 11:55 AM, and 10/05/17 at 9:06 AM revealed the metal toilet paper holder remained in disrepair.

d. Observation of Room 118 on 10/02/17 at 1:47 PM revealed the toilet paper holder was loosened and wiggled when it was used. Subsequent observations made on 10/03/17 at 9:48 AM, 10/04/17 at 11:58 AM, and 10/05/17 at 9:07 AM revealed the toilet paper holder remained loosened.

e. Observation of Room 126 on 10/02/17 at 1:59 PM revealed the metal toilet paper holder was badly rusted. Subsequent observations made on 10/03/17 at 9:58 AM, 10/04/17 at 12:08 PM, and 10/05/17 at 9:09 AM revealed the metal toilet paper holder remained in disrepair.

f. Observation of Room 226 on 10/02/17 at 2:59 PM revealed the metal toilet paper holder was badly rusted. Subsequent observations made on 10/03/17 at 10:48 AM, 10/04/17 at 12:50 AM, and 10/05/17 at 9:14 AM revealed the metal toilet paper holder remained in disrepair.

4. The following observations were related to facility's failure to repair the holes found around the pipe going from the sink to the wall in the

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bathroom:

a. Observation of Room 124 on 10/02/17 at 1:51 PM revealed there was a hole approximately 3 inches in diameter around the pipe going from the sink to the wall in the bathroom. Subsequent observations made on 10/03/17 at 9:52 AM, 10/04/17 at 12:02 PM, and 10/05/17 at 9:08 AM revealed the hole on the wall remained in disrepair.

b. Observation of Room 125 on 10/02/17 at 1:53 PM revealed there was a hole approximately 3 inches in diameter around the pipe going from the sink to the wall in the bathroom. Subsequent observations made on 10/03/17 at 9:53 AM, 10/04/17 at 12:03 PM, and 10/05/17 at 9:08 AM revealed the hole on the wall remained in disrepair.

c. Observation of Room 220 on 10/02/17 at 2:43 PM revealed there was a hole approximately 3 inches in diameter around the pipe going from the sink to the wall in the bathroom. Subsequent observations made on 10/03/17 at 10:38 AM, 10/04/17 at 12:39 PM, and 10/05/17 at 9:13 AM revealed the hole on the wall remained in disrepair.

During an environmental tour and interview on 10/05/17 at 9:16 AM the maintenance manager verified there were 44 bathrooms and 62 bedrooms in the facility. He further confirmed resident doors, toilet paper holders, and walls were in disrepair and it needed to be fixed as soon as possible. According to the maintenance manager, he was the only maintenance staff in the facility. The work load was heavy but manageable. He stated he was not aware of

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F 253	Continued From page 6 some of the doors with broken chips of wood and splintered laminate, bathrooms with rusted and loosened toilet paper holder, rooms with scuffed or peeled wall, and holes on walls under the sink. He explained he made routine rounds at least twice daily to look for maintenance tasks that needed to be addressed for bed rooms, bath rooms, hallways, and other common areas. He relied on staff to report maintenance concerns via work orders or report verbally. The work orders were located at each nurse station and he checked periodically throughout the day. The maintenance manager added work was prioritized with safety concerns addressed first, equipment issues addressed second and cosmetic issues addressed third. During an interview on 10/05/17 at 12:45 PM, the Director of Nursing (DON) stated it was her expectation for residents' living environment to be in appropriate repair. She added the communication system set up for work orders needed to be reviewed and strengthened to ensure its effectiveness. During an environmental tour and interview on 10/05/17 at 1:21 PM, the Administrator stated it was her expectation for all the identified maintenance issues to be addressed accordingly and in a timely manner.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and	F 272		11/2/17

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preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with the resident, as well as communication with licensed and
non-licensed direct care staff members on all shifts.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and

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F 272	Continued From page 8 non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Care Area Assessment (CAA) to include contributing factors, risk factors and facility interventions that must be considered in developing an individualized care plan for 1 of 5 residents reviewed for behaviors (Resident #14). The findings included: Resident #14 was admitted to the facility 09/14/17 with diagnoses which included dementia with behaviors and an open wound to the forehead. Review of the resident's medical record included multiple nurses' notes describing behaviors. A nurse's note written 09/17/17 at 3:46 AM described Resident #14 as being combative with staff, by hitting, kicking, scratching at staff, screaming and cursing at staff. The note further included Resident #14 was standing over her roommate. On 09/17/17 an additional nurse's note written at 10:58 AM described the resident urinated on the floor instead of the commode. At 10:24 PM on 09/17/17 a nurse's note described behaviors of Resident #14 hitting staff, pulling down her pants at the nurse's station, and speaking gibberish. The note specified a nursing assistant was assigned to be with the resident 1 on 1. An admission Minimum Data Set (MDS) dated 09/20/17 indicated Resident #14's cognition was severely impaired as demonstrated by present and past memory loss and unable to make any	F 272	The plan of correcting the specific deficiency. Care Area Assessment for behaviors for resident #14 was no updated due to the fact the resident had already discharged from the facility. Process that led to the deficiency was the Social Services Director did not complete a thorough record review when completing the CAA for behavior. The procedure for implementing the acceptable plan of correction for the deficiency cited. The MDS nurses will audit all resident Care Area Assessments for Behavior to insure their behaviors have been captured appropriately. This will occur by November 2, 2017. The MDS Coordinators, Activity Director and Dietary Manager were in-serviced on completion of the Care Are Assessment by MDS Consultant on October 25, 2017. Care Area Assessments for Behaviors will be completed by the MDS Nurse Coordinator. The MDS Coordinator will audit Care Area Assessments for Behaviors with 2 weekly X 4 weeks, 1 weekly X 4 weeks, then 2 monthly X 6 months.	

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F 272	Continued From page 9 decisions. The MDS described the resident's speech was slurred, words were mumbled, and she rarely understood others. The MDS further described behaviors of having continuous difficulty focusing attention, not easily distracted, and disorganized thinking by demonstrating unclear or illogical flow of ideas. Additional behavior specified in the MDS was wandering that was intrusive to others. The MDS coded the resident required supervision for bed mobility, transfers, walking in room or corridor on and off the unit, and eating. The resident required extensive assistance of 1 staff for dressing, toilet use, and personal hygiene. A CAA associated with the admission MDS and related to behaviors contained Resident #14 has shown wandering behaviors and seemed unaware of safety needs that may be related to cognitive status and a diagnosis of dementia. Wandering behaviors were not easily redirected or altered. An interview was conducted with the MDS Coordinator on 10/04/17 at 9:23 AM. The MDS Coordinator stated the behavioral CAA did not reflect the resident's actual behaviors. She added the CAA should tell a story which included the resident's diagnoses, contributing and risk factors, and interventions the facility was utilizing to monitor the behaviors. She stated this CAA did not contain the needed information and was not complete. The MDS Coordinator stated the facility Social Worker (SW) was responsible for MDS behavior assessments. An interview with the SW on 10/05/17 at 10:04 AM revealed when he gathered information for the behavioral CAA for Resident #14, he looked	F 272	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency remains corrected and/or in compliance with the regulatory requirements. The MDS Coordinator will audit Care Area Assessments for Behaviors with 2 weekly X 4 weeks, 1 weekly X 4 weeks, then 2 monthly X 6 months. The findings will be reported by the MDS Coordinator to the Quality Assurance and Performance Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records Charge Nurse and a Certified Nursing Assistant meeting X 8 months for follow up and/or recommendations. The person responsible for implementing the acceptable plan of correction is the Administrator.	

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F 272	Continued From page 10 for contributing factors, read nurse's notes. He added he found out what the nurses thought about this resident. He explained he could look back 7 days from 09/20/17 and include any behaviors the resident demonstrated in that time period. The SW stated 09/17/17 was included in that 7 day look back period. The SW further explained this was the first job he had in long term care that he was responsible for behavior assessments and care plans. He added this CAA did not totally include Resident #14's behaviors and he did not give the facility credit for interventions implemented.	F 272		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain laboratory values as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #48). The findings included: Resident #48 was admitted to the facility 09/14/14 and readmitted 09/02/17. The resident's diagnoses included congestive heart failure, stroke, and vascular dementia.	F 281	The plan of correcting the specific deficiency. The lipid panel blood draw was drawn on October 9, 2017, for resident #48 following multiple refusals. The process that led to the deficiency cited was that chart audits were not completed for all charts of readmitting residents to verify the orders. The procedure for implementing the	11/2/17

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F 281	Continued From page 11 A review of the physician's monthly recap orders dated 09/01/17 through 09/30/17 revealed an order for blood tests which included a lipid panel every 6 months in March/September. The recap orders were signed by the physician on 09/06/17. A review of the resident's medical record revealed no results for a lipid panel were found. An interview was conducted with the Director of Nursing (DON) on 10/04/17 at 2:58 PM. The DON stated the facility did not do the lipid panel the month of September. She explained the resident was in the hospital and did not return to the facility until 09/02/17. On the first day of each month, the monthly lab tests were set up to be drawn that month. Since Resident #48 was not in the facility that day, the lipid panel ordered for the month of September was overlooked. When the resident reentered the facility on 09/02/17 the lipid panel continued to be overlooked. An interview was conducted with the Nurse Supervisor (NS) on 10/04/17 at 5:05 PM. The NS confirmed the physician did want the lipid panel to continue to be obtained every 6 months. She added the physician gave a verbal order to obtain the September lipid panel 10/05/17.	F 281	acceptable plan of correction for the deficiency cited. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Treatment Nurse or Unit Coordinator will audit all current residents for lab compliance by November 2, 2017. All licensed staff will be in-serviced on proper transcription of lab orders and the verification of the orders upon readmission by November 2, 2017, by the Director of Nursing, Assistant Director of Nursing, Treatment Nurse or Unit Coordinator. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Treatment Nurse or Unit Coordinator will audit all lab orders for proper transcription monthly X 4 months and bi-monthly X 4 months. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Treatment Nurse or Unit Coordinator will audit all charts of readmitting residents to verify the orders within 72 hours X 6 months. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Treatment Nurse or Unit Coordinator will audit all lab orders for	

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F 281	Continued From page 12	F 281	proper transcription monthly X 4 months and bi-monthly X 4 months. The findings will be reported by the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator to the Quality Assurance and Performance Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinator, Social Services Director, Treatment Nurse, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Maintenance Director, Environmental, Services Supervisor, Restorative Nurse, Medical Records, Charge Nurse and a Certified Nursing Assistant meeting x 8 months for follow up and/or recommendations. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Treatment Nurse or Unit Coordinator will present the audit results of the charts of readmitting residents for verification of the orders to the Quality Assurance and Performance Committee meeting consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinator, Treatment Nurse, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge Nurse and a Certified Nursing Assistant X 6 months for follow up	

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F 281	Continued From page 13	F 281	and/or recommendations. The person responsible for implementing the acceptable plan of correction is the Director of Nursing.	
F 431 SS=D	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 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	F 431		11/2/17

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F 431	Continued From page 14 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 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, staff interviews, and manufacturer specifications, the facility failed to remove an expired vial of NovoLog insulin from 1 of 4 medication carts. Findings included: Manufacturer specifications for NovoLog insulin per the package insert included, "Unused NovoLog should be stored in a refrigerator between 2° and 8°C (36° to 46°F). After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or light. Opened vials may be refrigerated." During an observation on 10/04/17 at 10:56 AM,	F 431	The plan of correcting the specific deficiency. The expired insulin was disposed of at time of discovery. The medication carts were checked by staff for expired medications on October 4, 2017. The process that led to the deficiency cited was that carts audits were not being completed regularly for expired medications. The procedure for implementing the acceptable plan of correction for the deficiency cited. All licensed staff will be in-serviced on the Medication Storage Policy and	

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F 431	Continued From page 15 an opened vial of NovoLog insulin marked with an open date of 09/02/17 with an expiration date of 07/31/19 was found in the medication cart for Lower 100 Hall. This opened vial of NovoLog insulin was supposed to be removed from the medication cart after it had been opened for 28 days. Review of physician order dated 04/11/17 indicated Resident #22 had an order to receive NovoLog insulin 5 units subcutaneously 3 times daily with meals for diagnosis of Diabetes Mellitus. Review of Electronic Medication Administration Record (eMAR) for October 2017 indicated Resident #22 had received 5 units of NovoLog insulin 3 times daily from 10/01/17 to 10/03/17. Resident #22 had refused the morning dose of NovoLog on 10/04/17. Further review of eMAR revealed Resident #22's blood glucose level remained at the baseline from 10/01/17 to 10/04/17. During an interview on 10/04/17, Nurse #1 confirmed the opened vial of NovoLog insulin in the medication cart was for Resident #22 and it was the only vial of NovoLog insulin for Resident #22. Nurse #1 acknowledged that she had administered this expired vial of NovoLog insulin to Resident #22 on 10/01/17 for 3 times as she had forgotten to check the expiration date before administration. During an interview on 10/04/17, the Unit Manager stated the facility had a system set up to check for expired medications. Other than requiring all the nurses to check for expiration before administration, the facility had scheduled	F 431	completion of the Medication Cart Audit procedure which includes the proper disposal of expired medications and checking expiration dates prior to administering medications to residents by November 2, 2017. Weekly audits for expired medications in medication carts will be completed by licensed staff X 6 months. Monthly audits for expired medications in medication carts will be completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Treatment Nurse, Unit Coordinator or Pharmacy Representative X 8 months. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Treatment Nurse or Unit Coordinator will present the audit results of the medication carts to the Quality Assurance and performance Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Maintenance Director, Environmental Services Supervisor,	

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F 431	Continued From page 16 the third shift nurses to check their respective medication cart and storage room every Sunday. In addition, the consultant pharmacist would visit the facility at least once monthly to audit for expired medications. The last pharmacist visit to audit for expired medication was conducted on 09/19/17. The Unit Manager stated that the above vial of NovoLog should be removed from the medication cart after it had opened for 28 days. During an interview on 10/04/17 at 5:24 PM, the Director of Nursing (DON) stated that the facility had a system in place to check for expired medication. It was her expectation for the nursing staff to check for medication expiration before administration and to remove expired medications from the carts and storage rooms in a timely manner. During an interview on 10/05/17 at 11:38 AM, the Administrator stated that it was her expectation for all the staff to follow facility's medication storage policy to ensure all the expired medications would be removed accordingly and in a timely manner.	F 431	Restorative Nurse, Treatment Nurse, Medical Records, Charge Nurse and a Certified Nursing Assistant meeting X 8 months for follow up and/or recommendations. The person responsible for implementing the acceptable plan of correction is the Director of Nursing.	