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	345102	A. BUILDING _____ B. WING _____	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGGIE VALLEY NURSING AND REHABILITATION	75 FISHER LOOP MAGGIE VALLEY, NC 28751

(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 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the dignity of 1 of 20 residents by allowing a resident to be fed while staff was standing over her (Resident #13). The findings included: Resident #13 was admitted to the facility on 07/05/17 with diagnoses including history of stroke, difficulty swallowing and the inability to speak. The admission Minimum Data Set (MDS) dated 07/12/17 indicated Resident #13 had short and long term memory problems and had severely impaired decision making skills. The MDS also indicated Resident #13 was totally dependent for eating. During an observation of Resident #13 on 10/30/17 at 12:27 PM, Resident #13 was observed lying in bed, with the head of the bed elevated, while being fed by a nursing assistant (NA #1). NA #1 was observed to be standing at the side of the bed while assisting Resident #13 with her meal. During an interview with NA #1 on 10/30/17 at 12:37 PM, NA #1 was asked if she normally assisted the residents with their meals by standing at the side of the bed. NA #1 responded	F 241	All staff has been re-educated to treat each resident with respect and dignity while providing eating assistance. They are to be sitting at eye level and communicating with the resident while feeding the resident unless standing while feeding a resident is contraindicated. The process has been to educate the staff upon orientation and twice yearly. NA #1 has been educated and stated she had forgotten not to stand. Resident #13 was interviewed by the Director of Nursing and did not have any adverse outcomes. The Director of Nursing Services held mandatory in-services on all three shifts and educated the staff on the proper procedure of not standing while feeding a resident unless sitting is contraindicated. OT will evaluate any resident who is identified as being a resident that you would stand to feed for resident and staff safety OT will evaluate proper resident positioning, and make recommendations based on the resident needs. Administrative nurses will be monitoring staff to ensure the staff is sitting and communicating. All certified nursing assistants that are hired will continue to	11/27/17

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

Electronically Signed | 11/27/2017

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F 241	Continued From page 1 that she usually sat in a chair but she "just didn ' t think about it today." NA #1 stated she had been taught not to stand at the bedside for meals in school and she had training at the facility too, but she had forgotten. NA #1 stated there was a chair kept in the bathroom for Resident #13 that was used for staff to sit and assist Resident #13 with meals. During an interview with the Director of Nursing (DON) on 10/30/17 at 1:01 PM, the DON stated the NAs were trained at orientation and at least twice a year about not standing during meals. The DON further stated her expectation was for the NAs to be seated while assisting residents at mealtime as it can be intimidating to the residents if the NAs are standing over them. During an interview with the Staff Development Coordinator (SDC) on 11/02/17 at 9:25 AM, the SDC stated NAs are taught at least twice a year to sit while assisting residents with consuming a meal. The SDC verified on 6/27/17 NA #1 had been at a training that went over this information.	F 241	be educated upon hire, twice a year and as needed if feeding practice is identified as being deficient. Audits will be presented to monthly QAPI for any recommendations. The Administrative nursing staff will be doing audits of two meals daily of residents who require assistance with feeding Monday through Friday for four weeks, two meals each day twice a week, Monday through Friday for four weeks and then two meals weekly Monday through Friday for four weeks. The Director of Nursing or her designee is responsible for implementation of the plan for 3 months and if any additional issues are identified, further staff education will be initiated. The results of the audits will be taken to the QAPI meeting monthly for review and if any additional issues are identified, further staff education will be initiated and will continue with weekly audits. .	
F 248 SS=D	ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES CFR(s): 483.24(c)(1) (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 248		11/27/17

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F 248	Continued From page 2 each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide an ongoing activity program during weekend to meet the individual needs from 05/01/17 through 10/31/17 for 1 of 2 residents reviewed for activities (Resident #47). Findings included: Resident # 47 was admitted to the facility on 01/16/17 with diagnoses which included anxiety, depression, muscle weakness, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated 10/03/17 revealed Resident #47 was cognitively intact with adequate hearing, clear speech and impaired vision. The facility did not provide any information for Section F (Preferences for Customary Routine and Activities) for both quarterly MDS assessments dated on 07/04/17 and 10/03/17. Record review of the Activity Evaluation dated 07/17/17 indicated Resident #47 enjoyed animals, arts/crafts, beauty/barber, and bingo. Review of the Care Area Assessment summary form (CAA) revealed activities did not trigger. Review of the care plan dated 07/17/17 revealed Resident #47 was independent of activity choice. She was alert and oriented. Enjoyed watching television, talking on her phone, and attending group activities of her interest. The goal was for Resident #47 to involve in activity of her choice ongoing through next review. Interventions included offering encouragement for out of room	F 248	The Activity Director and Social Services Director met with the Resident Council on 11/22/17 to discuss what activities they would like to have on the weekends. Resident #47, #34 and the Resident Council President attended the Resident Council Meeting. Resident #47 wanted games such as Old Maid, #34 did not have any input in the meeting and the Resident Council President stated she wanted to sleep on the weekends. Resident #155 was notified of the meeting and chose not to attend. Resident #6 is not on the sample list. Several activities were discussed. We will offer two activities daily on Saturday and Sunday as well as the current activities of BINGO and Devotions. The facility was not made aware that the residents had a concern about the weekend activities since they did not share their concerns with anyone or discuss concerns in resident council. The facility will offer two additional activities on the weekends with a designated employee available on the weekends to do activities. The residents will receive a copy of the monthly calendar, an announcement will be made prior to a activity announcing when, where and what activity The Social Services Director as well as the Activity Director will specifically ask during the Monthly Resident Council	

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F 248	Continued From page 3 involvement, providing in-room monthly activity calendar, and visiting 1 on 1 for conversation. Review of Monthly Activity Calendar from 05/01/17 through 10/31/17 revealed the following activities were scheduled during weekend: 05/06/17, Saturday - Bingo at 2:00 PM. 05/07/17, Sunday - Sunday school at 10:30 AM 05/13/17, Saturday - Bingo at 2:00 PM. 05/14/17, Sunday - Mother's day tea at 2:00 PM 05/20/17, Saturday - Time for family & friends at 2:00 PM. 05/21/17, Sunday - Rocky Branch Baptist Church at 3:00 PM 05/27/17, Saturday - Bingo at 2:00 PM and time for family & friends. 05/28/17, Sunday - Sunday school at 10:30 AM 06/03/17, Saturday - Bingo at 2:00 PM. 06/04/17, Sunday - Sunday school at 10:30 AM 06/10/17, Saturday - Bingo at 2:00 PM. 06/11/17, Sunday - Sunday school at 10:30 AM; Rocky Branch Baptist Church at 3:00 PM 06/17/17, Saturday - Bingo at 2:00 PM. 06/18/17, Sunday - Father's Day Pop. No activities scheduled 06/24/17, Saturday - Family & Friends - no activities scheduled. 06/25/17, Sunday - Sunday school at 10:30 AM 07/01/17, Saturday - Bingo at 2:00 PM. 07/02/17, Sunday - Sunday school at 10:30 AM 07/08/17, Saturday - Bingo at 2:00 PM. 07/09/17, Sunday - Sunday school at 10:30 AM 07/15/17, Saturday - Bingo at 2:00 PM. 07/16/17, Sunday - Sunday school at 10:30 AM; Rocky Branch Freewill Baptist at 3:00 PM 07/22/17, Saturday - Family & Friends - no activities scheduled. 07/23/17, Sunday - Sunday	F 248	Meetings if the residents are satisfied with the weekend activity schedule and document the response in the Resident Council Minutes. The Activity Director or Activity Assistant will document all attendance. Attendance Records and the Monthly Activity Calendar will be brought to QAPI and reviewed.	

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F 248	Continued From page 4 school at 10:30 AM 07/29/17, Saturday - Bingo at 2:00 PM. 07/30/17, Sunday - Sunday school at 10:30 AM 08/05/17, Saturday - Bingo at 2:00 PM. 08/06/17, Sunday - Sunday school at 10:30 AM 08/12/17, Saturday - Bingo at 2:00 PM. 08/13/17, Sunday - Sunday school at 10:30 AM 08/19/17, Saturday - Bingo at 2:00 PM. 08/20/17, Sunday - Sunday school at 10:30 AM; Rocky Branch Freewill Baptist at 3:00 PM 08/26/17, Saturday - Bingo at 2:00 PM. 08/27/17, Sunday - Sunday school at 10:30 AM 09/02/17, Saturday - Bingo at 2:00 PM. 09/03/17, Sunday - Sunday school at 10:30 AM 09/09/17, Saturday - Bingo at 2:00 PM. 09/10/17, Sunday - Sunday school at 10:30 AM 09/16/17, Saturday - Bingo at 2:00 PM. 09/17/17, Sunday -the Sunday school at 10:30 AM; Rocky Branch Baptist Church at 3:00 PM 09/23/17, Saturday - Bingo at 2:00 PM. 09/24/17, Sunday - Sunday school at 10:30 AM 09/30/17, Saturday - Bingo at 2:00 PM. 10/01/17, Sunday - Sunday school at 10:30 AM 10/07/17, Saturday - Bingo at 2:00 PM. 10/08/17, Sunday - Sunday school at 10:30 AM 10/14/17, Saturday - Bingo at 2:00 PM. 10/08/17, Sunday - Sunday school at 10:30 AM; Rocky Branch at 3:00 PM 10/21/17, Saturday - Bingo at 2:00 PM. 10/22/17, Sunday - Sunday school at 10:30 AM 10/28/17, Saturday - Bingo at 2:00 PM. 10/29/17, Sunday - Sunday school at 10:30 AM Record review of Activities Attendance Sheets from 08/01/17 through 09/08/17 revealed Resident #47 did not have any activities	F 248		

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F 248	Continued From page 5	F 248		

documented on weekend. The Activity Director (AD) was unable to provide documentation for Resident #47's activity attendance beyond 09/09/17 and activity calendar from January through April 2017.

During an interview on 11/01/17 at 12:47 PM, the AD revealed she was responsible for the planning and implementation of monthly activity calendar. The AD stated she had medical issues since March 2017 and had been in and out of the facility while she worked as the AD. She had just come back to work full time about 2 months ago. Besides, she lost her only assistant about 6 weeks ago and the position was covered by an activity assistant who only work two days per week. The AD added there were about 60-70 % of the residents who did not have visitor during weekend and many residents did not attend the Sunday Church. The AD wanted to schedule more activities on weekend to cater the needs of the above residents and agreed the facility should have more activity during weekend. However, the AD stated she did not have enough activity staff to conduct more activities during weekend and to document residents' activity attendance on regular basis.

During an interview on 11/01/17 at 3:53 PM, the Administrator stated when the facility terminated the activity assistant's employment a few weeks ago, she took away most of the documentations from the activity department. That was why the AD could not provide most of the documents requested. In addition, the AD was having health related issues in the past few months. The facility planned to hire one full time activity assistant to assist the AD.

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F 248	Continued From page 6	F 248		

During an interview on 11/01/17 at 4:26 PM, the President of Resident Council stated even though there were no formal complaints voiced during the Residential Council meeting since January 2017 through October 2017, she had heard residents talked about lack of quality and quantity of weekend activity.

Interview on 11/01/17 at 4:38 PM with Resident #47 revealed the facility had failed to provide sufficient ongoing quality activity program during the weekend to satisfy her needs; especially when the AD was in and out of the facility due to personal health issues from March to August 2017. Resident #47 stated other than Bingo on Saturday afternoon and Sunday school on Sunday morning, the facility had no activities scheduled during weekend. She wanted to have more activity scheduled during the weekend.

Observation on 11/01/17 at 4:40 PM revealed Resident #47 was alert oriented and lying in her bed watching TV. There was a copy of November 2017 Activity Calendar posted on the bathroom entrance door.

Observation on 11/02/17 at 2:09 PM revealed Resident #47 was actively participating in the Bingo game in the main dining room. She was very excited and happy during the game that last approximately 1 hour.

During an interview on 11/02/17 at 3:09 PM, Resident #6 stated the facility should have more activity during the weekend. Even though he played Bingo on Saturday and attended the church on Sunday, he still felt boring during weekend.

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F 248	Continued From page 7 During an interview on 11/02/17 at 3:25 PM, Resident #155 wished there would be more activity scheduled during the weekend. She stated other than Saturday Bingo and Sunday Church that both lasted for about 1.5 hours, there were practically nothing going on during the weekend. During an interview on 11/02/17 at 3: 34 PM, Resident #34 stated the facility should have more activity during weekend. Other than playing Bingo game on Saturday, he would attend the Sunday Church. Resident #34 added sometimes the Pastor did not show up for Sunday Church in approximately 3 out of 10 times. Other than attending church, there was nothing to do during Sunday. During an interview on 11/02/17 at 5:27 PM, the Director of Nursing (DON) stated she never heard of any resident complained about lack of activity during weekend. The DON stated it would not hurt to have more activity during the weekend but she thought the quantity and quality of activities during the weekend in the past 6 months were adequate.	F 248		
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (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 label resident wash basins in a shared bathroom (Room #303) on 1 of 5 resident hallways; failed to maintain a clean bathroom	F 253	The facility policy and procedure is that wash basins in a shared bathroom are to be labeled with the resident's name. The resident had two wash basins she had	11/27/17

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F 253	Continued From page 8 (Room #303) on 1 of 5 resident hallways; failed to paint patched areas and thick, dark marks along the middle of a bathroom wall (Room #303) on 1 of 5 resident hallways; failed to repair and paint multiple damaged areas of sheet rock and multiple black markings along the walls of a shared room and bathroom (Room 106) for 1 of 5 resident hallways and failed to paint black markings along the walls of a shared bathroom (Room 109) for 1 of 5 resident hallways. Findings included: 1. a. Observations in the shared bathroom (Room #303) on 10/30/17 at 2:42 PM revealed 3 unlabeled wash basins stored together in an unlabeled plastic bag hanging from a handrail. Observations in the shared bathroom (Room #303) on 10/31/17 at 11:36 AM revealed 3 unlabeled wash basins stored together in an unlabeled plastic bag hanging from a handrail. Observations in the shared bathroom (Room #303) on 11/02/17 at 12:36 PM revealed 3 unlabeled wash basins stored together in an unlabeled plastic bag hanging from a handrail. During an interview on 11/02/17 at 11:30 AM Nurse Aide (NA) #2 revealed wash basins stored in resident bathrooms were used when a bed bath was given to a resident. NA #2 acknowledged wash basins were to be labeled with the resident's name and to be stored in individual bags when not in use. During an interview on 11/02/17 at 12:45 PM the Director of Nursing (DON) stated when wash	F 253	brought with her from previous hospital admissions as well as one wash basin that was facility issued. The Facility staff failed to label the residents wash basin and misunderstood they are responsible for labeling the residents wash basins brought from other facilities. Resident Room #303's wash basin has had the residents name placed on it as well as her other personal wash basins. The staff have been re-educated on the policy and procedure for labeling wash basins in a shared bathroom both facility issued and non-facility issued. The staff will continue to be educated upon hire as well as twice each year and as needed by the Staff Development Coordinator. The Administrative Nurses have audited resident rooms to ensure residents wash basins are labeled with the residents name. The Administrative Nurses will be responsible for doing weekly rounds in 5 rooms twice a week to ensure that wash basins in a shared bathroom are labeled. If any items are found to be unlabeled. the Administrative Nurse will address the issue with the staff at that time and ensure that staff corrects the non-compliance. The Administrative Nurses will audit 5 rooms twice a week. Round sheets will be given to the Director of Nursing weekly, the Director of Nursing will bring the weekly audits to the monthly QAPI Meeting for review for 3 months and if any additional issues are identified, further staff education will be initiated. The Housekeepers have been educated	

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F 253	Continued From page 9 basins were used for resident care, she would expect for them to be labeled with the resident's name and stored separately in a plastic bag. Observation on 11/02/17 at 12:50 PM revealed NA #2 removing the bag containing the unlabeled wash basins from room #303 and disposing them into the trash container. During an interview on 11/02/17 at 5:06 PM the Administrator stated she would expect for wash basins to be labeled with the residents name and stored appropriately. 2. a. Observations in the shared bathroom (Room #303) on 10/30/17 at 2:49 PM revealed a spider web and spider hanging in between a potted plant and wall in the corner floor of the bathroom next to the door. Trash was also observed on the bathroom floor in the corner behind the potted plant. Observations in the shared bathroom (Room #303) on 10/31/17 at 11:35 AM revealed a spider web and spider hanging in between a potted plant and wall in the corner floor of the bathroom next to the door. Trash was also observed on the bathroom floor in the corner behind the potted plant. Observations in the shared bathroom (Room #303) on 11/01/17 at 11:36 AM revealed a spider web and spider hanging in between a potted plant and wall in the corner floor of the bathroom next to the door. Trash was also observed on the bathroom floor in the corner behind the potted plant. b. Observations in the shared bathroom (Room	F 253	on the facility policy and procedure of washing the walls of the facility when they see marks left from adaptive equipment and to clean corners and look for spider webs in all rooms. During cool weather, insects attempt to come into the facility, we have a pest control company that provides pest control. If the black marks do not come off with cleaning, the room is to be placed back on the schedule to be painted. The facility is in the process of painting all bathrooms in the facility. The toilet tissue dispensers have been changed and the walls patched where the old ones were located, however, the Maintenance Director misunderstood and thought that he could patch the walls and continue with his painting schedule without painting the patched wall until that room came up on the schedule. An employee has been hired, with painting as his primary job duties. The spider web has been removed. The Maintenance Department has started painting on 100 hall and all rooms identified as having marks or patches are on the schedule to be painted. The maintenance department has audited the bathrooms in the facility to identify bathrooms that have already been painted and the bathrooms that need painted. A painting schedule has been implemented and the bathrooms that have already been painted have been documented on the painting schedule. The maintenance department will then start on 100 hall and begin painting bathrooms on that hall then proceed to the other halls. As the	

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F 253	Continued From page 10 #303) on 10/30/17 at 2:49 PM revealed thick, black scuff marks extending halfway down the length of the middle portion of the wall and 2 unpainted patched areas underneath the toilet paper holder. Observations in the shared bathroom (Room #303) on 11/01/17 at 11:36 AM revealed thick, black scuff marks extending halfway down the length of the middle portion of the wall and 2 unpainted patched areas underneath the toilet paper holder. Observations in the shared bathroom (Room #303) on 11/02/17 at 12:36 PM revealed thick, black scuff marks extending halfway down the length of the middle portion of the wall and 2 unpainted patched areas underneath the toilet paper holder. During an interview and tour on 11/01/17 at 3:53 PM the Environmental Services Director revealed housekeeping staff were responsible for cleaning resident rooms and bathrooms on a daily basis which included high/mid/low dusting, sweeping and mopping the floors. He added maintenance staff were responsible for the repairs and painting needed in resident rooms and bathrooms. The ERD stated they had started preparing resident rooms for repainting but the process had stalled when one of his employees went out of work on medical leave and another had been terminated. He confirmed there was no written plan currently in place that outlined which rooms were to be painted or when the work would be completed. He explained they tried not to inconvenience the residents and waited for the opportunity of when the resident would be out of the facility for the day in order to paint their rooms. The ERD agreed	F 253	Maintenance Director is auditing rooms, he will also identify bathrooms that have scuff marks from adaptive equipment and the housekeepers will then attempt to clean the scuff marks, the bathrooms that have scuff marks that will not wash off will be on the schedule for painting. The Administrator or designee will inspect the facility walls monthly to ensure that the painting schedule is being followed and is effective. The painting schedule form will be given to the Administrator each week to identify rooms that have been painted to ensure compliance. The Administrative Nurses will also identify any insect webs during rounds as well as scuff marks on the walls. The Maintenance Director is responsible for implementation and follow-up. The Administrator will audit 5 rooms twice a week for continued compliance, the Administrator will bring the weekly audits to the monthly QAPI Meeting for review for 3 months and if any additional issues are identified, further staff education will be initiated.	

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the trash on the floor behind the plant and the spider and cobweb in room #303's bathroom should have been removed and stated he would have expected for housekeeping staff to have cleaned the area more thoroughly. He stated the dark scuff marks along the middle of the bathroom wall couldn't be removed without painting the room. He added the holes in the bathroom of room #303 had been patched and sanded in preparation for painting but did not have a scheduled date for when the work would be started or completed.

During an interview on 11/02/17 at 5:06 PM the Administrator explained the ERD has had staffing challenges throughout the year and had to prioritize the painting and repairs needed by starting with the worst rooms first. She confirmed there was no current plan or timeline in place for the repainting of resident rooms or bathrooms.

3. a. Observations of a shared room (Room 106) on 10/31/17 at 9:34 AM revealed patches of torn sheet rock with gray and black scuff marks down the wall.

During an interview on 11/01/17 at 3:53 PM the ESD revealed when a room needed repaired or painted and was available maintenance would make the needed repairs. The ESD also revealed he did not use a tracking system to document information related to repairs needed or completed and indicated the areas in room 106 had not been address for a long time.

Observations of a shared room (Room 106) on 11/01/17 at 4:20 PM revealed patches of torn sheet rock with gray and black scuff marks down the wall.

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F 253	Continued From page 12 b. Observations of a shared room (Room106) on 10/31/17 at 9:34 AM revealed an area of peeling paint at the top area of the heating/air conditioner unit. Observations of a shared room (Room106) on 11/01/17 at 4:20 PM revealed an area of peeling paint at the top area of the heating/air conditioner unit. c. Observations of a shared bathroom (Room 106) on 10/31/17 at 9:34 AM revealed multiple large black scuff marks along the bathroom walls. Observations of a shared bathroom (Room 106) on 11/01/17 at 4:20 PM revealed multiple large black scuff marks along the bathroom walls. During an interview and tour on 11/01/17 at 4:20 PM the Environmental Service Director (ESD) revealed the repairs and painting were stopped when the resident returned from the hospital. 4. a. Observations of a shared bathroom (Room 109) on 10/31/17 at 10:16 AM revealed multiple black scuff markings on the bathroom walls. Observations of a shared bathroom (Room 109) on 11/01/17 at 4:20 PM revealed multiple black scuff markings on the bathroom walls. During an interview and tour on 11/01/17 at 4:20 PM the ESD) revealed the black marks on the bathroom walls were made by mobility devices and the walls needed repaired and painted. During an interview on 11/02/17 at 6:12 PM the Administrator revealed it was her expectation for	F 253		

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F 253	Continued From page 13 maintenance to have a system in place to track the repairs needed and when completed and for the repairs to be completed in a timely manner.	F 253		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (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 observations, record review, staff, and physician interviews, the facility failed to follow physician's orders to discontinue a medication (Resident #24) and to follow prescribed dietary orders (Resident #60) for 2 of 2 residents reviewed. The findings included: 1. Resident #24 was admitted to the facility on 05/08/17 with diagnoses including high blood pressure, high cholesterol and muscle weakness among others. Medical record review of the lab results for Vitamin B-12 drawn on 7/19/17 indicated Resident #24 had a level that was outside the normal range. Resident #24 had elevated results of 1448 with a normal range being 180-914. Medical record review of medication orders revealed a physician's order noted on 09/15/17 to	F 281	All orders are being audited Monday through Friday in the clinical morning meeting for any physicians order written from the day before. The physician orders are then compared with the electronic MAR to ensure accuracy. Previously the orders were reviewed but not compared with the electronic MAR. The night shift nurses are responsible for doing 24 hour chart checks to ensure physicians orders are initiated or changed on the electronic MAR in a timely manner, Due to an oversight, the nurses failed to properly perform a 24 hour chart check and the nurse who received the order failed to discontinue the order on the electronic MAR. The night shift nurses have been re-educated that 24 hour chart checks are to be done on each chart on each resident in their assigned group. Resident #24 and #60 have been monitored with no adverse outcome noted.	11/27/17

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F 281	Continued From page 14 discontinue Vitamin B-12 and to attain a Vitamin B-12 level in 3 months. Medical record review of the Medication Administration Record (MAR) for September, October and November of 2017 indicated the Vitamin B-12 was originally ordered 05/08/17 and had a stop date of 05/08/27. The dosage was 1000 micrograms (mcg) under the tongue each day at 8:00 AM. Review of the MAR from 09/16/17 through 11/02/17 indicated the medication had not been discontinued and Resident #24 had continued to be receiving it daily. Review of physician's progress notes from 9/27/17 from the MD and 10/29/17 from the General Nurse Practitioner (GNP) both indicated a medical history of Vitamin B-12 deficiency. During an interview with Nurse #2 on 11/02/17 at 2:48 PM, she stated she had signed off on the physician's order to discontinue the Vitamin B-12 for Resident #24. Nurse #2 stated there was a process with the medical orders to come to her after they have been faxed to the pharmacy, then they are reviewed in morning meeting the next day. Nurse #2 acknowledged she was not sure how the medication got overlooked but it should have been discontinued for Resident #24. During an interview with the Director of Nursing (DON) on 11/02/17 at 3:13 PM, the DON stated they have a triple check on medication orders and she thinks a Family Nurse Practitioner (FNP) who actually wrote the order did not place it where it was flagged to be noted as a new order for Resident #24. Therefore, it would not have been faxed to the pharmacy, reviewed the next day in	F 281	All nurses have been educated on the proper procedure for receiving orders and adding and discontinued orders on the electronic MAR. The nurse Practitioner was temporary and is no longer coming to the facility. All orders are being audited Monday through Friday in the clinical morning meeting for any physicians order written from the day before. The physician orders are then compared with the electronic MAR and diet card to ensure accuracy. The Director of Nursing, QA Nurse or Assistant Director of Nursing will monitor each order in the clinical morning meeting. All diet orders have been compared to the physicians orders, the electronic MAR and the diet cards to ensure accuracy. A diet communication sheet was misplaced and did not get to the dietary personnel to change the diet. A clip board has been placed on the dietary door to place communication forms on to ensure they are not misplaced. All diet orders will be reviewed in the clinical morning meeting and compared to the electronic MAR. The diet order will then be sent to the Administrator and Dietary Manager to review and ensure the diet order is placed on the diet card. The Dietary Manager as well as the Administrator will compare the Physician Diet Order, Electronic MAR, and the diet	

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F 281	Continued From page 15 morning meeting, and the Quality Assurance (QA) Nurse would not have been able to make sure the order was discontinued from the MAR. The DON acknowledged the medication should have been discontinued on the date the physician's order was written. During an interview with the Medical Doctor (MD) on 11/02/17 at 5:57 PM, the MD stated he had no concern that harm was done to Resident #24 since there had not actually been an increase in the dosage of the medication. The MD also stated he did not feel it necessary to repeat lab work until Resident #24 had actually been off the Vitamin B-12 for 3 months because if it was repeated now the level would probably be close to what it had been on the previous lab work. The MD stated his only concern was that a medication error had occurred. 2. Resident #66 was admitted to the facility on 02/25/14 with the diagnoses of Parkinson's, heart failure, and dementia. The most current quarterly Minimum Data Set (MDS) dated 10/03/17 indicated Resident #60 had moderately intact cognition and usually understood others. The MDS also indicated	F 281	card to ensure continued compliance weekly for three months with the results of the audits brought to the monthly QAPI meeting for review and recommendations for three months. .	

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Resident #60 needed supervision with eating.

Review of the care plan revised on 10/03/17 focused on a nutritional problem or potential for a nutritional problem related to a diagnosis of dysphagia. The approach was to provide puree foods with full range liquids as ordered and for speech therapy to evaluate and treat. The goal was to maintain an adequate nutritional status.

During an observation on 11/02/17 at 8:20 AM, Resident #60 was resting in bed and had refused to eat breakfast and the meal card read mechanical soft.

During an interview on 11/02/17 at 3:33 PM, the cook revealed Resident #60 had been on a mechanical soft diet for a long time. The cook also explained a communication slip was provided to the kitchen when a new diet order was received and the information was entered into the computer system by the Dietary Manager. The cook revealed Resident #60's diet was mechanical soft and the kitchen staff had been sending mechanical soft food for each meal until today when a new diet order was received.

During an interview on 11/02/17 at 5:58 PM, the Dietary Manager revealed there had been no change to the diet for Resident #60 since her last day on 10/03/17. The DM also revealed she was responsible for changing the diet orders in the computer.

During an interview on 11/02/17 at 3:47 PM, the Speech Therapist (SLP) revealed a dysphagia evaluation was done and the diet was changed to puree on 10/4/17. The SLP revealed a communication slip with the new diet order was

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F 281	Continued From page 17 provided to the kitchen staff on 10/03/17. The SLP indicated the goal was to get Resident #60 back to a mechanical soft diet and SLP continued to do trials of mechanical soft foods to see if the consistency was tolerated. The SLP revealed according to their records Resident #60 was never upgraded to a mechanical soft diet. A review of the progress note dated 11/01/17 by the SLP revealed Resident #60 was demonstrating varied levels of physical function which limited the ability to tolerate upgraded food consistency and in order to keep the patient safe it would benefit to remain with a puree consistency and on 11/2/17 wrote an order for puree foods and nectar thick liquids. During an interview on 11/02/17 at 5:25 PM, Nurse #2 revealed she attempted to feed Resident #60 breakfast of a mechanical soft consistency. Nurse #2 also revealed she did not know how long Resident #60 had been on a mechanical soft diet, but the diet was being changed today to puree. Nurse #2 confirmed when a diet changes, a communication slip was provided to the kitchen. During an interview on 11/02/17 at 6:06 PM, the Administrator revealed her expectations were for the kitchen staff to follow the diet orders as written and for the DM or the cook to change the diet card and the for nursing department to change the diet order on the MAR.	F 281		
F 371 SS=D	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or	F 371		11/27/17

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F 371	Continued From page 18 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and date multiple portion food items in the kitchen walk in freezer. Findings included: During the initial tour of the kitchen on 10/30/17 at 9:30 AM an observation of the kitchen walk-in freezer revealed 3 clear plastic bags of frozen chicken breast, which were not dated or labeled, lying on top of a box on one of the shelves. One of the 3 bags had been opened with 4 chicken breasts remaining in the bag.	F 371	The Dietary Manager/Cook has re-educated all Dietary Personnel in labeling and dating foods stored in the cooler when opened. The previous policy and procedure has not changed with the exception of communicating "USE BY" date instead of the date opened on the product. The employee responsible for placing unlabeled food in the cooler was re-educated per the facility policy and procedure for opening and labeling food items by the Dietary Manager as well as the Director of Nursing.	

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F 371	Continued From page 19 An interview on 10/30/17 at 9:30 AM with the Dietary Cook (DC), who was present during the observation, revealed all the bags of chicken breast should have been labeled and dated when they had been removed from the original shipping carton. An interview on 11/01/17 at 11:38 AM with the Certified Dietary Manager (CDM) revealed dietary staff were responsible for dating and labeling food items when opened. The CDM stated she would have expected for the bags of chicken breast to have been dated and labeled when placed in the freezer. An interview on 11/02/17 at 5:06 PM with the Administrator revealed she would expect for all food items placed in the freezer to be labeled and dated.	F 371	A check off sheet will be provided for the Dietary Manager/Cook to monitor the cooler daily to ensure that no unlabeled food is placed in the cooler. The facility has purchased baggies that are labeled "Use BY" with a place to write the date to use the product by. The Dietary Manager/Cook will monitor the cooler for unlabeled food items daily and provide a check off sheet for monitoring. If unlabeled foods are identified, The Dietary Manager/Cook will be responsible for further education of staff. All new employees as well as current employees will be educated upon hire, as needed and yearly. The cooler monitoring tool will be brought to the monthly QAPI meeting for review and follow-up.	
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) 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.	F 431		11/27/17

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F 431	Continued From page 20 (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 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431		

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F 431	Continued From page 21 Based on observations, staff interviews and manufacturer's specifications, the facility failed to remove two unopened bottles of expired 0.25% acetic acid from 1 of 2 medication storage rooms. Findings included: During an observation on 11/01/17 at 2:55 PM, two unopened bottles of 0.25% acetic acid with expiration date of 07/01/17 were found on the shelf in the South medication storage room. Each bottle of acetic acid contained 250 milliliter (ml) and both bottles had not been used by any resident in the facility. According to the manufacturer's package insert, the 0.25% acetic acid solution contained no antimicrobial agent or added buffer and it was intended only for use as a single-dose irrigation. When smaller volumes were required, the unused portion should be discarded. The solution was an acidifying agent used for irrigation of the urinary bladder by the transurethral route. Review of the facility's medication storage policy that was last updated on May 2016 revealed: "Outdated, contaminated, discontinued or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy, if a current order exists." During an interview on 11/01/17, Nurse #3 confirmed the two unopened bottles of acetic acid were expired on 07/01/17 and should be removed from the medication storage room. Nurse #3 stated all the nurses were ordered to check their	F 431	The Central Supply Clerk will continue with monthly audits of all OTC medications. Previously, the Central Supply Clerk placed unopened boxes of OTC medications on the shelf. The OTC medications will be removed from the original container and the expiration date reviewed by the Central Supply Clerk when placed on the shelf. The acetic acid found in the medication room that had expired was located among unexpired medications and was an oversight that it was not discarded. It has been discarded and all other OTC Medications have been audited and no other expired medications were found. The floor nurse assigned to each unit where OTC medications are stored will audit the OTC medications twice each day and the RN Supervisor as well as the Quality Assurance Nurse will audit all OTC medications weekly on a separate audit sheet. The Central Supply Clerk will continue with monthly audits of all OTC medications. The OTC medications will be removed from its container and the expiration date reviewed by the Central Supply Clerk when placed on the shelf. The floor nurse assigned to each unit where OTC medications are stored will audit the OTC medications twice each day and the RN Supervisor as well as the Quality Assurance Nurse will audit all OTC medications weekly on a separate audit sheet . All OTC Medication audits will be completed and given to the Director of	

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F 431	Continued From page 22 respective medication cart and medication storage room for expired medications two times daily. Upon completion of the medication audit, the nurses had to sign off the medication audit sheet and submitted the document to the Director of Nursing (DON) daily. Nurse #3 added each nurses had been instructed to check for medication expiration date before administration. Besides, the consultant pharmacist would conduct expired medication audit at least once monthly or as needed. In an interview conducted on 11/01/17 at 3:09 PM, the Assistant DON (ADON) stated all the nurses were ordered to conduct medication audit for their medication cart or storage room twice daily and documented it in the daily medication audit sheet. The nurse who received the medication from the pharmacy had to put the medications up onto the shelf, rotated the medications, and removed expired medications from the shelf. The facility required the nurse to check each medication before administration. In addition, the ADON stated she and the other Unit manager would conduct weekly random medication audit for expired medication. It was her expectation to ensure the facility free of expired medication either in storage rooms or in medication carts. The ADON attributed the incident as a human error. During an interview on 11/01/17 at 4:57 PM, the DON stated that the facility had a system in place to check for expired medication. The oversight was mainly due to human error. She expected the nurses to audit their respective medication carts and storage rooms twice daily with submission of the medication audit sheet. It was her expectation for the nursing staff to check for expired	F 431	Nursing for review on a weekly basis to ensure continued compliance with the policy and procedures. The audits will be reviewed monthly for recommendations in the monthly QAPI Meeting for three months and follow QAPI Committee recommendations for continued review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING _____ B. WING _____	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 23 medication as ordered and remove expired medications in a timely manner.	F 431		