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	345263	A. BUILDING _____ B. WING _____	C 04/13/2018

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MACON VALLEY NURSING AND REHABILITATION CENTER	245 OLD MURPHY ROAD FRANKLIN, NC 28734

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F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to honor food preferences for 1 of 5 residents reviewed for choices (Resident #10). Findings included:	F 561	ACKNOWLEDGEMENT DISCLAIMER Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually	5/11/18

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

Electronically Signed | 05/04/2018

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F 561	Continued From page 1 Resident #10 was admitted to the facility 11/14/08. The annual Minimum Data Set (MDS) dated 10/13/17 indicated Resident #10 had cognitive impairment. The MDS also indicated Resident #10 was edentulous (without teeth) and on a mechanically altered diet. During an observation on 04/10/18 at 1:55 PM, Resident #10 was seen eating from a plate that included an uneaten green substance in a puree consistency. Review of the meal tray card beside her plate indicated her diet was pureed and indicated her food dislikes included peas and green vegetables. An interview with the Dietary Manager (DM) on 04/10/18 at 2:08 PM in the room of Resident #10, the DM observed the tray for Resident #10 and stated the green substance on her plate was a mixture of pureed vegetables that included cauliflower, carrots and broccoli. The DM reviewed the meal tray card and stated she had accidentally overlooked that Resident #10 did not like green vegetables. The DM stated that sometimes things are missed in the kitchen and when staff on the hall gave Resident #10 her meal tray they should have noted the error and called the kitchen for a substitute. The DM also stated there were pureed carrots available for Resident #10 if they have been notified. During an interview with the Geriatric Care Attendant (GCA) on 04/10/18 at 2:22 PM, the GCA stated she had set the lunch meal tray for Resident #10. The GCA stated she had looked at the meal tray card for breakfast but had not looked at the meal tray card for lunch for Resident #10, but would pay attention to likes and dislikes listed on the tray card in the future.	F 561	correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The Plan of Correction is submitted as a written allegation of compliance. Macon Valley Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Macon Valley Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F561 The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to follow resident preference related to food choice- was failure to follow facility procedure. On 4/11/18, Resident #10 was interviewed by the dietary manager regarding food preferences. Resident #10 continued to express dislike for green vegetables and the facility will continue to honor residents□ preferences. The procedure for implementing the	

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F 561	Continued From page 2 During an interview with the Administrator on 04/13/18 at 6:19 PM, the Administrator stated her expectations were for the staff to give residents what they liked to eat and not to give them food they disliked.	F 561	acceptable plan of correction for the specific deficiency cited On 4/11/18, the dietary manager completed in-services for all dietary staff on how to read and follow tray cards including resident likes and dislikes. In-service to be completed by 5/11/18. This in-service will be added to the orientation for all newly hired dietary staff members. On 4/27/18, the director of nursing (DON) began an in-service with all nursing staff on reading tray cards to ensure residents do not receive food items from their dislike list. This in-service will be complete by 5/11/18. This in-service will be added to the orientation for all newly hired nursing employees. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, minimum data set (MDS) nurse, dietary manager, and/or quality improvement (QI) nurse will audit 20 resident meal trays weekly for 4 weeks, then 10 resident meal trays per week 8 weeks to ensure the resident is not served a food item from their dislike list. This audit will be documented on the Tray Audit Tool. The monthly QI committee will review the results of the resident Tray Audit Tool for 3 months for identification of trends, actions	

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F 561	Continued From page 3	F 561	taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly QAPI (Quality Assurance and Performance Improvement) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		5/11/18

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F 657	Continued From page 4 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to revise a care plan for 1 of 4 residents reviewed (Resident #49) for assistance with activities of daily living (ADL's). Findings included: Resident #49 was admitted to the facility on 4/14/09. Review of the annual Minimum Data Set (MDS) dated 03/09/18 indicated Resident #49 was alert and oriented with no mental health diagnoses listed. The MDS also indicated Resident #49 required only supervision with eating. The MDS further indicated Resident #49 had no problems chewing or swallowing and had no dental concerns. During an observation on 04/11/18 at 6:19 PM, Resident #49 was observed in her room with her dinner plate on her bed side table in front of her with a plastic spoon and fork resting on her plate. Resident #49 was observed independently using her plastic fork to eat with. Resident #49 stated she had been receiving plastic utensils for several years after a misunderstanding where they thought she tried to injure herself. Resident #49 also stated the kitchen staff send her regular	F 657	F657 The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency, failure to revise care plan- was staff failure to follow established policy and procedure. Resident #49□s ADL (assistance with daily living) care plan for eating was updated on 4/13/18 by MDS nurse. Resident # 49□s tray card was updated to remove plastic silverware on 4/13/18 by MDS nurse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/13/18, the MDS intervention nurse audited current resident care ADL care plan for eating for accuracy and to ensure the appropriateness of adaptive eating utensils. There were no further discrepancies identified.	

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F 657	Continued From page 5 metal utensils sometimes and had recently received a regular knife to cut up her steak with during a monthly resident choice meal. Record review of the Care Area Assessment (CAA) for the 03/09/18 annual MDS revealed the following: "resident is very active in her care" and "typically only requires supervision/set up for ADL's." Record review of the ADL Care Plan for eating was originally initiated on 03/26/13. The care plan indicated Resident #49 required assistance with eating related to using plastic utensils. The care plan most recently revised on 03/22/18 continued to indicate Resident #49 required assistance with eating related to using plastic utensils. Record review of the Resident Care Guide used by the nursing assistants (NA's) to indicate information which including eating habits, special precautions, and ADL's revealed no listing of the use of plastic utensils for Resident #49. Record review of the meal tray card for Resident #49 indicated "plastic utensils for safety." During an interview on 04/12/18 at 3:08 PM, the psychiatric Nurse Practitioner (NP) stated Resident #49 would have been referred to her by facility staff if there was anything with her mood or behavior that concerned them. The NP stated she had not seen Resident #49 as a patient in several years and was unaware of any reason she would be on plastic utensils for safety. During an observation on 04/13/18 at 8:45 AM, Resident #49 was observed in her room with her breakfast plate on her bed side table in front of	F 657	On 4/13/18, the DON in-serviced the MDS coordinator on care plan revisions. Any newly hired MDS coordinator will be in-serviced by the DON on care plan revisions. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, QI nurse or administrator will audit 20 residents weekly x 4 weeks than 10 residents weekly x 8 weeks to ensure if the resident uses special silverware, including plastic, the intervention is appropriate and specified in the care plan. This audit will be documented on the Care Plan Audit tool. The monthly QI committee will review the results of the Care Plan Audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly QAPI committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing	

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F 657	Continued From page 6	F 657		

her. A plastic spoon was observed on her plate and the resident stated the spoon came with her tray and she had used it to eat her breakfast.

During an interview on 04/13/18 at 12:38 PM, a nurse who regularly worked with Resident #49 stated she had no concerns with her mood or behaviors and did not know why she had been using plastic utensils.

During an observation on 04/13/18 at 1:27 PM, Resident #49 was delivered her lunch meal tray by nurse assistant (NA) #1. When NA #1 removed the lid to her meal tray, plastic utensils in a sealed plastic bag were observed on the tray. During an interview with NA #1 as she exited the room, NA #1 stated she looked at the meal tray cards but had never noticed Resident #49 was to have plastic utensils. NA #1 also stated she did not know why Resident #49 was supposed to have plastic utensils.

During an interview on 04/13/18 at 1:31 PM, a 2nd nurse who regularly worked with Resident #49 stated there were no mood or behavior concerns and she did not know why she would be on plastic utensils for safety.

During an interview on 04/13/18 at 1:38 PM, the MDS Coordinator reviewed the care plan addressing eating for Resident #49 and confirmed it had remained the same without an update other than the date in the past year. The MDS Coordinator stated she had not updated the care plan herself, but she knew Resident #49 and the care plan did not accurately reflect her current mood and behavioral status.

During an interview on 04/13/18 at 1:49 PM, the

the acceptable plan of correction.

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F 657	Continued From page 7 Director of Nursing (DON) stated her expectation was for the care plan to be applicable to what was going on with a resident at the time of the review. The DON further stated the current care plan as written was not a current indication of what was happening with Resident #49.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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, and staff interviews the facility failed to stay in the presence of 1 of 1 resident observed with medication at the bedside without staff present. Resident #14 did not have physician orders or an assessment to self-medicate. Findings included: Resident #14 was admitted to the facility on 08/03/17. The admission Minimum Data Set (MDS) dated for 08/10/17 indicated Resident #14 had some mild cognitive impairment. The admission MDS and the most recent quarterly MDS dated 01/11/18 both indicated Resident #14 was being administered an anticoagulant (blood thinning medication). During an observation of Resident #14 in her room on 04/11/18 at 5:54 PM, 3 medications were noted in a plastic medication cup on her bedside table. Resident #14 was lying flat on her bed,	F 658	F658 The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency, failure to stay in the presence of Resident taking medication for a Resident not assessed to self-medicate was staff did not follow medication administration procedure. On 4/11/18, Nurse #3 administered medications to Resident #14 as prescribed. Nurse #3 remained at the resident□s bedside until medication administration was complete. The procedure for implementing the acceptable plan of correction for the specific deficiency cited	5/11/18

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F 658	Continued From page 8 with eyes closed and appeared to be sleeping. During an interview with Nurse #3 on 04/11/18 at 5:57 PM, she stated she had brought the 3 medications into the room for Resident #14 and had left them at the bedside table. Nurse #3 verified the medications were Xarelto (blood thinner), Lopressor (blood pressure) and Prilosec (antacid). Nurse #3 also stated she was not supposed to leave medications unattended at the bedside table. During an observation of Nurse #3 on 04/11/18 at 5:59 PM, Nurse #3 was observed to enter the room of Resident #14, wake her, and remain present while she swallowed her pills while Nurse #3 remained present in the room. During an interview with the Director of Nursing (DON) on 04/11/18 at 6:03 PM, the DON verified Resident #14 had no assessment to self-administer medications. The DON stated her expectation was for no medications to be left at the bedside of a resident unless they had a medication assessment indicating the resident could self-administer. The DON also stated the nurse or medication aide should observe the resident take the medication and swallow it before leaving the room.	F 658	On 4/12/18, the QI nurse and charge nurse completed a room audit to ensure no medications were left at a resident□s bedside for any resident not assessed to self-administer medications. No medications were found at the bedside during the audit. On 4/11/18, the DON began in-servicing all licensed nurses and medication aides, including agency staff, on medication administration. The in-service included observation of the resident through the entire process, unless assessed with physician order to self-administer medications. In-service to be completed by 5/11/18. This in-service will be included for the orientation of all new licensed nurses and medication aides, including agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, QI nurse, staff development, or administrator will audit 20 resident rooms weekly x 4 weeks then 10 resident rooms weekly x 8 weeks to ensure no medications are left at a resident□s bedside. This audit will be documented on the Resident Medication Audit Tool. The monthly QI committee will review the results of the Resident Medication Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make	

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F 658	Continued From page 9	F 658	recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly QAPI committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		5/11/18

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F 756	Continued From page 10 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and Pharmacy Consultant interview the Pharmacy Consultant failed to recognize 2 medications given at the same time had opposite orders 1) to take with food and 2) to take on an empty stomach for 1 of 6 residents reviewed for unnecessary medication review (Resident #14). Findings included: Resident #14 was admitted to the facility on 08/03/17. The admission Minimum Data Set (MDS) dated for 08/10/17 indicated Resident #14 had a diagnosis of atrial fibrillation (irregular heart rhythm) and had mild cognitive impairment. The admission MDS and the most recent quarterly MDS dated 01/11/18 both indicated Resident #14 was being administered an anticoagulant (blood thinning medication). Record review of the Medication Administration Record (MAR) for March and April 2018 indicated	F 756	F756 The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency, failure to recognize 2 medications given at the same time had opposite orders- was knowledge deficit. On 4/12/18, the licensed nurse received an updated physician order for Resident #14□s Prilosec to be given at bedtime on an empty stomach. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/25/18, the charge nurse audited all residents with a physician□s order for Prilosec to ensure the medication was scheduled at a time to be given on an empty stomach. During the audit no other	

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F 756	Continued From page 11	F 756		

the following:

Prilosec 20 milligram (mg) capsule by mouth every night - take on an empty stomach
Xarelto 20 mg tablet by mouth every night - take with food

The March and April 2018 MAR's both indicated the Prilosec and Xarelto were to be given at 5:00 PM. The February 2018 MAR indicated Prilosec was to be given at 8:00 PM. The March and April 2018 MAR's revealed the 8:00 PM administration time had a single written line through it with 5:00 PM written above it with no initials.

During an interview with Nurse #3 on 04/11/18 at 5:57 PM, Nurse #3 verified 3 medications to be administered to the resident at 5:00 PM with 2 of these medications being Xarelto (blood thinner) and Prilosec (antacid).

During an observation of Nurse #3 on 04/11/18 at 5:59 PM, Nurse #3 was observed in the room of Resident #14 and administering the Xarelto, Prilosec and the 3rd medication. Resident #14 was observed taking these medications whole with water.

Record review of the Monthly Medication Review (MMR) by the pharmacist for March and April 2018 indicated no notation or requested changes or concerns regarding the physician's orders for Xarelto or Prilosec.

During an interview with the Director of Nursing (DON) on 04/11/18 at 6:59 PM, the DON stated her expectations were for the Pharmacy Consultant to have caught this during the MMR as the first check and the nurses should have resident was found to be taking Prilosec that conflicted with meal times.

On 5/2/18, the charge nurse audited residents receiving Xarelto to ensure medication was scheduled at a time to be given with food. One other resident order was noted to be given at 2000. A clarification order was written so that the medication administration time was provided with food.

On 4/11/18, the DON began an in-service with all licensed nurses and medication aides, including agency staff, on administration of medications with food, including Xarelto, and medications to be given on an empty stomach, including Prilosec. This in-service will be complete by 5/11/18. This in-service will be included for the orientation of all new licensed nurses and medication aides, including agency staff.

The times of administration of omeprazole (Prilosec) and rivaroxban (Xarelto) for Resident #14 were changed to 1700 for Xarelto and at bedtime for omeprazole, respectively, on 4/12/18.

The pharmacy's director of clinical services reviewed all current medication times of administration specified on the medication administration records (MARs) of all current residents on 5/4/18. Potential irregularities regarding medication times of administration were reported to the DON on 5/4/18. The DON and clarification orders obtained as

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F 756	Continued From page 12 caught it while reading the order as the second check. During a second interview with the DON on 04/12/18 at 11:48 PM, the DON stated she had been unable to find out who changed the administration time of the Prilosec from 8:00 PM to 5:00 PM. The DON also stated that the time had been changed from the February MAR to the March MAR but there were no physician's orders or nurses health status reports to indicate why the time change occurred. During an interview with the Pharmacy Consultant on 04/12/18 at 12:54 PM, she stated when the MAR is reviewed month to month, if should have been recognized that the medications were being given at the same time. The Pharmacy Consultant acknowledged that neither she or her colleague caught this and it was an oversight on their part.	F 756	appropriate. The pharmacy's Director of Clinical Services in-serviced the facility's consultant pharmacists regarding monitoring for potentially inappropriate times of medication administration on 5/4/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, QI nurse, or administrator will audit 20 resident medication administration records weekly x 4 weeks then 10 resident MARs weekly x 8 weeks to ensure medications are scheduled at correct times to be given with food and/or to be given on an empty stomach, as appropriate for the medication. This audit will be documented on the MAR Audit Tool. The monthly QI committee will review the results of the MAR Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly QAPI committee for further recommendations and oversight.	

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F 756	Continued From page 13	F 756	The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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, and staff interviews the facility failed to store 1 unused	F 761	F761	5/11/18

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F 761	Continued From page 14 Levemir FlexTouch in proper temperature and failed to discard 1 opened box of expired Bisac-Evac (Bisacodyl 10 Milligrams (mg) suppository), 1 tablet of expired Glyburide 5 mg, and 1 vial of expired insulin Lantus in 3 of the 4 medication carts in the facility. Findings included: A review of the facility's medication storage policy that was last revised on 10/01/10 revealed that all insulin products must be refrigerated at a temperature range between 36°F and 46°F prior to first use. Alternatively, insulin vials might be stored at room temperature in a secured location for up to 28 days after first use. All house stock medication provided in the manufacturer's original package should be considered expired when the manufacturer's expiration had been reached. Per manufacturer's package insert, all unopened Levemir should be kept in the refrigerator at a temperature range between 36°F and 46°F (2° and 8°C). 1. a. Resident #329 was admitted to the facility on 04/04/18 with diagnoses included diabetes mellitus (DM). On 04/12/18 at 09:21 AM an opened box of Bisac-Evac that contained 85 individually sealed Bisacodyl 10 mg suppository that expired on 03/31/18 was found in the 100 hall medication cart. In addition, one unused Levemir FlexTouch without opening date was found in the same medication cart. The Levemir FlexTouch was stored in the room temperature and it was found in the same bag with another used Levemir FlexTouch.	F 761	The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency, failure to store unused Levemir, and dispose of expired medications- was staff failure to follow policies for medication storage. On 4/12/18, the QI nurse discarded the unused Levemir stored incorrectly on the 100 hall medication cart according to the policy and a replacement was obtained. On 4/12/18, the QI nurse discarded the expired opened biscodyl 10mg suppository on the 100 hall medication cart according to the policy and a replacement was obtained. On 4/12/18, the QI nurse discarded the expired glyburide 5mg tablet on the 300 hall medication cart according to the policy and ensured medication was available. On 4/12/18, the QI nurse discarded the expired the Lantus vial on the 200 hall medication cart according to the policy and replacement was obtained. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/12/18, the DON, QI nurse, and charge nurse audited all medication carts and medication rooms to ensure all	

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F 761	Continued From page 15 On 04/12/18 at 09:29 AM an interview was conducted with Nurse #4. She acknowledged that the opened box of Bisacodyl suppository was expired and it had to be discarded. She stated that when she checked the medication cart on Monday, the box of expired Bisacodyl suppository was not in the cart. She did not know that Levemir FlexTouch had to be refrigerated prior to first use and she called the pharmacy for verification. She was unable to determine how long this undated Levemir FlexTouch had been stored in the room temperature. She added she had been checking her medication cart for expired medication and proper labeling once every shift. On 04/12/18 at 09:54 AM an interview was conducted with Nurse #5. As a Quality Improvement (QI) nurse, she stated the facility had a system in place to ensure all medications were properly stored and free of expired medications. The administrative nursing team had been checking each medication cart at least once a week. She expected the floor nurses to check their respective cart once every shift and check each medication before administration. The nurse who started to use the insulin had to date the insulin and stored it in the medication cart. In addition, the pharmacist came once a month to check medication carts and storage rooms randomly. She acknowledged that the Levemir should be refrigerated prior to first use and the expired Bisacodyl should be removed from the medication cart. She attributed the incidents as an oversight. Review of Medication Administration Record (MAR) revealed Resident #329 had been	F 761	medications were in date, and insulins were stored according to the medication storage policy. No additional expired items or items stored incorrectly were identified at that point. On 4/12/18, an in-service was started by the DON on labeling of opened medications, storage of insulin, and removal disposal of expired medications per facility policy for all licensed nurses and medication aides. This in-service will be completed by 5/11/18. This in-service will be included with orientation for all newly hired licensed nursing staff and agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, staff facilitator, facility consultant, and/or MDS nurse will audit medication carts and medication rooms weekly x 4 weeks then bi-weekly x 8 weeks to ensure no expired medications are present and insulin is stored correctly. This audit will be documented on the Medication Storage Audit Tool. The monthly QI committee will review the results of the Medication Storage Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for	

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F 761	Continued From page 16 receiving Levemir FlexTouch subcutaneously as ordered and her blood glucose (BG) levels since admission had remained at the baseline. b. Resident #7 was admitted to the facility on 08/07/12 with diagnoses included type II DM, depression, and anxiety. On 04/12/18 at 10:35 AM one tablet of Glyburide 5 mg in unit dose packaging that expired on 02/28/18 was found in the 300 hall medication cart. This tablet was for Resident #7 and it was found in the same container with other Glyburide 5 mg tablets with different expiration dates. On 04/12/18 at 10:59 AM an interview was conducted with Nurse #1. She acknowledged that the expired tablet of Glyburide should be tossed. She stated that she checked the medication cart thoroughly for expired medications and proper labeling at least once per week. She denied she had ever administered the expired Glyburide to Resident #7 as she would check the medication each time before administration. She did not understand why the expired Glyburide was found in her medication cart along with other Glyburide tablets with different expiration dates. c. Resident #8 was admitted to the facility on 05/28/16 with diagnoses included DM and dementia. On 04/12/18 at 11:10 AM an expired vial of insulin Lantus opened on 03/07/18 and expired on 04/04/18 was found in 200 hall medication cart. This vial of insulin Lantus was for Resident #8. She received 5 units of Lantus subcutaneously once daily at bedtime.	F 761	continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly QAPI committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	

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F 761	Continued From page 17	F 761		

On 04/12/18 at 11:20 AM an interview was conducted with Nurse #2. She agreed that the expired vial of insulin Lantus should be discarded and confirmed the expired insulin Lantus had been administered to Resident #8 in the past few days. She stated that the expiration date look like 04/14/18 when she checked the medication cart this morning. Nurse #2 added she had been instructed to check the medication cart once every shift and each time before administration. Review of the MAR for Resident #8 revealed her BG has been checked 4 times daily in the past 2 weeks and it had remained at the baseline. This expired insulin Lantus was last administered to Resident #8 by Nurse #6 on 04/11/18 at 8:00 PM.

On 04/12/18 at 03:03 PM an interview was conducted with Nurse #6. She confirmed she had administered the expired insulin Lantus on 04/11/18 evening to Resident #8. She stated it was her second day working as a nurse in this facility. She added she checked each medication before administering to the residents and it was her oversight on the Lantus.

On 03/21/18 at 11:57 AM an interview was conducted with the Director of Nursing (DON). She stated the facility had a system in place to check for expired medication and to ensure proper labeling and storage for all medications. She added the plan was not fully executed as ordered and attributed the incidents as an oversight. It was her expectation for all the medication storage rooms and carts to be free from expired medication and all medication being stored as specified by manufacturer's guidelines.

On 04/13/18 at 01:08 PM an interview was conducted with the Administrator. She expected

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F 761	Continued From page 18 all the nursing staff to follow facility's medication storage policy to ensure all medication would be proper stored and free of expired medications.	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to ensure lab work was done as ordered by the physician for 2 of 12 sampled residents reviewed for labs. (Resident #63 and #74) The findings included: 1. Resident #63 was admitted to the facility 01/05/18 with diagnoses which included rhabdomyolysis, congestive heart failure, altered mental status, acute kidney disease, dementia without behavioral disturbance, lack of coordination, history of traumatic fracture, anxiety, osteoporosis, dorsalgia, disc degeneration and abnormal gait. Review of the medical record noted on 03/31/18 Resident #63 fell in her room and sustained a fracture of her right wrist. Resident #63 was seen by the Nurse Practitioner on 04/02/18 for	F 770	F770 The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency, failure to obtain laboratory test as ordered - was staff failure to follow procedures for laboratory process. Resident #63 had a vitamin D level and CMP drawn on 4/16/18. Results were communicated to the physician on 4/17/18 by the licensed nurse with no new orders received. Resident #74 needed no further intervention. The procedure for implementing the	5/11/18

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F 770	Continued From page 19 assessment and noted, " I have assessed the course of this patient's history of falls and the patient has recently demonstrated recurrence of instability with fall. Risk of injury is high and the patient is being monitored closely for complications. Fall prevention measures are to continue and the patient will be monitored closely for changes suggestive of increased fall risk or recurrence. Vitamin D and CMP (complete metabolic package) level ordered." A physician's order was written on 04/02/18 for Vitamin D level, CMP next lab draw. On 04/13/18 the results of the Vitamin D level and CMP for Resident #63 were not located in the resident's medical record. On 04/13/18 at 3:00 PM the medical records director called the lab service and verified the 04/02/18 lab order for Vitamin D and CMP for Resident #63 was not done as ordered. The medical records director reviewed the system in place for processing lab orders which included the nurse that noted the handwritten order in the resident's medical record was supposed to place a copy of the order in a box at the central nursing station. The medical records director stated the phlebotomist/ward clerk received a copy of the order and would draw the blood and provide the specimen to the lab company for processing. The medical records director stated the results came back electronically and were printed off and placed in the physician book for review. On 04/13/18 at 3:30 PM the phlebotomist/ward clerk stated when the physician wrote an order for a lab the nurse taking the order was responsible to place a copy of the order in a box located at the central nursing station. The	F 770	acceptable plan of correction for the specific deficiency cited On 4/23/18, the DON audited all resident orders for the past 14 days to ensure all laboratory testing was completed as ordered. There were no identified missed laboratory orders noted at that time. On 4/13/18, the DON started an in-service for all licensed nurses, including agency, on the procedure for receipt of physician orders, and diagnostic services related to laboratory testing to ensure laboratory orders are transcribed and completed per order, including reviewing the discharge summary for physician ordered laboratory tests. This in-service will be completed by 5/11/18. This in-service will be added to the orientation for all newly hired licensed nurses and agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, QI nurse, and/or MDS nurse will audit 20 residents□ orders weekly for 4 weeks then 10 residents□ orders weekly per week for 8 weeks to ensure laboratory testing was completed as ordered. This audit will be documented on the Laboratory Monitoring Audit Tool. The monthly QI committee will review the results of the Laboratory Monitoring Audit Tool monthly for 3 months for identification	

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F 770	Continued From page 20 phlebotomist/ward clerk stated the nurse would then record the order for the lab in the facility lab book. The phlebotomist/ward clerk stated a copy of the lab order (placed in the box at the central nursing station) was reviewed in the staff morning meeting by management staff and she used the order to requisition a lab slip from the lab electronic system to attach to the specimen for testing. The phlebotomist/ward clerk stated she typically checked to verify the nurse documented the lab in the facility lab book. The phlebotomist/ward clerk stated the results came back electronically and, after printing the labs, she highlighted the order in the facility lab book (to note the result was back) and placed the lab results in the physician book for review. The phlebotomist/ward clerk stated the need for the vitamin D and CMP for Resident #63 was not placed in the facility lab book and could not explain what happened. On 04/13/18 at 5:30 PM the Director of Nursing (DON) stated she kept a copy of all ordered lab work (obtained from the box at the central nursing station) to ensure lab work was done as ordered. The DON indicated on a weekly basis she reviewed the labs (using the copy of the order) to ensure labs were all done as ordered. The DON stated it was the responsibility of the nurse that noted the order for lab work to place a copy of the order in the box at the central nursing station. The DON stated the nurse would then enter the lab order in the facility lab book and the ward clerk/phlebotomist would obtain a lab requisition from the electronic lab system. The DON stated she did not have a copy of the order and the order was not placed in the facility lab book. The DON stated if the copy was not put in the box, the order was not entered in the lab book and a	F 770	of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly QAPI committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	

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requisition was not filled out then the lab would not have been done. The DON identified Nurse #4 as the nurse that was on duty 04/02/18 and processed the order for the Vitamin D and CMP for Resident #63. The DON stated it was her expectation that labs were done as ordered and stated she could not explain what happened.

On 04/13/18 at 6:05 PM the physician of Resident #63 reported he expected labs to be done as ordered.

Attempts to contact Nurse #4 were unsuccessful.

On 04/13/18 at 6:41 PM the Administrator reported she expected labs to be done as ordered.

2. Resident #74 was admitted to the facility 07/06/15 with diagnoses which included hypothyroidism, dementia and chronic kidney disease.

Review of physician orders in the medical record noted Resident #74 was ordered 137 micrograms (mcg) of Synthroid daily. On 10/26/17 the Synthroid was increased to 150 mcg after results were received from lab work noting a high TSH (thyroid stimulating hormone) level. In addition, the nurse practitioner ordered a recheck of the TSH level in 4 weeks. Review of the November 2017 Medication Administration Record (MAR) for Resident #74 noted "TSH in 4 weeks" was handwritten on the MAR with the date 11/26/17 blocked off on the MAR as the due date for the TSH level.

Review of the monthly consultant pharmacist notes revealed the need for the TSH level was

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F 770	Continued From page 22	F 770		

mentioned on 11/22/17, 12/28/17 and 01/31/18. On 02/22/18 a TSH level for Resident #74 was done with a level of 32 (with the normal range of .45-4.5.) In response, the physician increased the Synthroid for Resident #74 from 150 mcg to 175 mcg.

On 04/13/18 at 5:35 PM the Director of Nursing (DON) stated a different system for lab work was in place 11/26/17 and the nurse that noted the order at that time was supposed to place the need for the lab on the resident's MAR, filled out a lab requisition slip and placed the need for the lab in the facility lab book. The DON stated the nurse that noted the lab on 10/26/17 no longer worked at the facility. The DON stated the requisition slip would have been placed in the facility lab book for the day the blood work should have been drawn. The DON stated at that time, the nurses drew labs and the lab company picked up the specimens for testing. The DON stated a copy of the order was supposed to be sent to her and she kept those to follow-up to ensure labs were done as ordered. The DON stated the order for the TSH level blocked off on the November MAR for Resident #74 should have been a reminder to the nurse that the lab needed to be drawn. The DON stated it appeared an agency nurse was working that day with Resident #74 and noted agency nurses had been oriented on the lab process. The DON called the lab and verified the TSH level due 11/26/17 for Resident #74 was not done as ordered. The DON stated the copy of the order was not sent to her, the need for the order was not put on the facility lab book and the lab requisition for the TSH was not completed. The DON could not explain what happened but said it was her expectation that labs be done as ordered.

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F 770	Continued From page 23 On 04/13/18 at 6:05 PM the physician of Resident #74 stated he expected labs to be done as ordered. On 04/13/18 at 6:41 PM the Administrator reported she expected labs to be done as ordered.	F 770		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide a barrier between bare hands and ice ready for distribution to residents and failed to store 13 milkshakes in a nourishment pantry to ensure use within guidance provided by the manufacturer.	F 812	F812 The plan of correcting the specific deficiency The position of Macon Valley Nursing and	5/11/18

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F 812	Continued From page 24 The findings included: 1. During an initial brief kitchen tour on 4/10/2018, at 9:45AM, the dietary manager was observed to reach in and remove the ice bend from the machine with bare hands. She then pointed out the cleanliness of the piece of equipment and attempted to reinsert the ice bend back into the machine. At this time the ice had accumulated and restricted the ability to place the bend flat into the machine. The dietary manager was observed to reach into the machine with bare hands; no gloves or other coverings, and pushed the ice toward the back of the machine. During an interview on 4/10/18 at 2:55 PM the Dietary manager, stated, "Yes, I touched it, I should not have done that. I will empty the machine and clean with bleach solution and then rinse with hot water." During an interview with the Registered Dietician on 4/10/2018 at 3:05 PM, the Registered Dietician stated, "I would expect they would completely empty and clean the machine". During an interview with the Administrator on 4/10/2018 at 3:10PM, the Administrator stated, "My expectations would have been for her to wear gloves, and to have changed the gloves after checking the shield prior to touching the ice." 2. On 04/12/18 at 7:20 AM thirteen thawed, 4 ounce manufactured milkshakes were observed in the subacute nourishment refrigerator. Of the thirteen milkshakes, 11 were were vanilla and 2 were chocolate and none of the milkshakes were labeled to indicate the date they were thawed or the expiration date. Each milkshake had a manufacturer stamped date of expiration which	F 812	Rehabilitation center regarding the process that lead to this deficiency, facility failed to provide a barrier between hands and ice and failed to store milkshakes in a nourishment pantry according to manufacturer guidelines- was lack of knowledge. On 4/10/18, dietary manager cleaned the ice machine in the kitchen with bleach solution and rinsed it with hot water. On 4/13/18, the dietary manger discarded the milkshakes in the nourishment pantry. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/13/18, the dietary manager audited all nourishment rooms to ensure nourishment products, inclusive of milkshakes, were stored according to manufacturer guidelines. No other items were found stored improperly within any nourishment room. By 5/11/18, the dietary manager in-serviced all dietary staff on handling of ice and proper food storage, inclusive of milkshakes, according to manufacturing guidelines. This in-service will be part of the orientation process for all newly hired dietary employees. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 812	Continued From page 25 indicated the expiration of the product in a frozen state. The manufacturer label on each carton indicated the milkshakes were good for 14 days after thawed. On 04/12/18 at 2:15 PM a dietary aide was observed entering the subacute nourishment pantry with a cart of various food items. The dietary aide explained that the nourishment pantry refrigerator was stocked on a daily basis and included stocking beverages likes juices, milk and milkshakes. The dietary aide stated the 4 ounce milkshakes were placed in the pantry refrigerator for resident use. The dietary aide explained he was responsible for checking all food in the pantry for expiration and noted the manufacturer stamped date on the thawed milkshake cartons was the date he used for expiration. The stamped date on the thawed milkshakes stored in the subacute nourishment pantry was March 2019. On 04/13/18 at 4:23 PM the Food Service Director stated the manufactured 4 ounce milkshakes were not supposed to be stocked or stored in any of the nourishment pantries. The Food Service Director stated the manufactured milkshakes were typically sent with resident trays as a supplement and explained the process used in the kitchen to ensure the milkshakes were used within 14 days after thawed. The Food Service Director stated she was not aware that dietary aides were stocking the milkshakes in the nourishment pantry and would re-educate staff on the handling of milkshakes and the difference between the stamped date of expiration in a frozen state and expiration once thawed. On 4/13/18 at 6:32 PM the Administrator stated	F 812	requirements The administrator/dietary manager will audit nourishment rooms weekly x 12 weeks to ensure food products are stored according to manufactures guidelines. The administrator/dietary manager will observe 3 occurrences of ice handling weekly x 12 weeks to ensure proper procedure is followed. These audits will be documented on the dietary audit tool. The monthly QI committee will review the results of the dietary tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly QAPI committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	

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F 812	Continued From page 26 she expected staff to follow the manufacturer guidelines and to use the 4 ounce manufactured milkshakes within 14 days after thawed.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to one recited deficiency that was originally cited following the 01/27/17 recertification and complaint survey and recited again on the current recertification and complaint survey. The recited deficiency was in the area of food procurement, store/prepare/serve - sanitary. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: 1.a. 483.35 Food procurement, store/prepare/serve - sanitary: Based on observations and staff interviews the facility failed to provide a barrier between bare hands and ice	F 867	867 The plan of correcting the specific deficiency The position of Macon Valley Health and Rehabilitation center regarding the process that lead to this deficiency, failed to maintain implemented procedures and monitor interventions- was failure to follow established facility policy related to QAPI. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/2/18, the facility QAPI Committee held a meeting to review the purpose and function of the QAPI committee and review on-going compliance issues. The medical director, administrator, DON, MDS nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend quarterly QAPI committee	5/11/18

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F 867	Continued From page 27 ready for distribution to residents, and failed to provide dates for Mighty Shakes (dietary supplement) after removal from the freezer. During the recertification and complaint survey of 01/27/17 the facility was cited for failure to remove 1 container of expired chocolate pudding for resident use in 1 of 3 nourishment room refrigerators and failed to date or label 3 bags of sliced cheese for resident use in 3 of 3 nourishment room refrigerators. During an interview on 04/13/18 at 6:51 PM the Administrator stated she was not with the facility until June 2017. The QAA committee had been functional and the correction plans that included in-services were all completed in August 2017. Monitoring for the above plan of correction was ongoing until August 2017 as well. The Administrator stated the Dietary Manager had been performing managerial role in the kitchen for 20 years. She could not understand why the Dietary Manager used her bare hand to touch the ice ready for distribution to residents. The Administrator added the repeated areas of concern would be reviewed by the QAA committee and a performance improvement plan would be developed to correct the deficiencies.	F 867	meetings on an ongoing basis and will assign additional team members as appropriate. On 5/1/18, the corporate facility consultant in-serviced the DON related to the appropriate functioning of the QAPI committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F812. On 5/2/18, the DON in-serviced the department heads related to the appropriate functioning of the QAPI committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F812. As of 5/2/18, after the facility consultant in-service, the facility QAPI committee will begin identifying other areas of quality concern through the QA review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, and review of regional facility consultant recommendations. The facility QI committee will meet at a minimum of monthly and the QAPI committee will meet at a minimum of quarterly to identify issues related to quality assessment and assurance activities and will develop and implement appropriate plans of action for identified	

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F 867	Continued From page 28	F 867	facility concerns. Corrective action has been taken for the identified concerns related to F812. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The monthly QI committee will meet at a minimum of monthly and the QAPI committee will meet at a minimum of quarterly with oversight by a corporate staff member. The QAPI committee, including the medical director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The QAPI committee will validate the facility□'s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the acceptable plan of correction.	