STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 10/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		11/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/19/2018

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store a bath basin and urine collection containers off the bathroom floor on 1 of 4 resident hallways (resident room #215). The facility also failed to repair stains on bathroom floors around toilets on 2 of 4 resident hallways in 5 resident bathrooms (room #201, #204, #207, #215 and #315) and failed to repair and replace cove molding in the bathroom on 1 of 4 resident hallways (room #204). The facility further failed to clean debris on the floor behind a resident's bed and failed to clean a side rail with a dried substance on the side rail of a resident's bed on 2 resident rooms on 1 of 4 resident hallways (room #102 and #117). Findings included: 1. Observations on 10/22/18 10:52 AM in the bathroom of resident room #215 revealed a bath basin was lying on the floor uncovered beside the toilet and a urine collection container was lying on the floor behind the toilet. Observations on 10/24/18 11:20 AM in the bathroom of resident room #215 revealed a bath basin was lying on the floor uncovered beside the toilet and 2 urine collection containers were lying on the floor behind the toilet. Observations on 10/25/18 02:44 PM in the bathroom of resident room #215 revealed a bath basin was lying on the floor uncovered beside the toilet and 2 urine collection containers were lying on the floor behind the toilet. During an interview on 10/25/18 at 4:09 PM,	F 584	Element 1: The facility went and removed the bath basin and urine collection containers off the bathroom floor. The stains on the bathroom floors were scrapped and re-caulked. The cove base molding was replaced. The resident□s bed floor and bed rails were cleaned immediately. This inspection was completed by Maintenance Director/Environmental Services Director and the 100% was completed by 11/9/18. Element 2: The maintenance director and/or the environmental services manager completed a 100% audit to ensure there were no other rooms that had personal hygiene containers on the floors of bathrooms, all toilets were correctly caulked, and that there were no bathrooms with stains on the floors. The maintenance director and/or the environmental services manager audited other rooms to ensure that the beds were being moved away from the walls and that beds were being cleaned where residents grasp. Element 3: All staff were re-educated Director of Nursing and/or designee on the proper reporting procedures for maintenance/housekeeping concerns. Element 4: Maintenance Director and/or Environmental Service Director is responsible for implementing the	

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F 584	Continued From page 2 Nurse Aide #4 stated bed pans, bath basins and urine collection containers we supposed to be labeled and stored in plastic bags. She further stated items were not supposed to be stored on the bathroom floor. During a tour and interview on 10/26/18 at 3:08 PM, the Director of Nursing verified there were 2 urine collection containers on the floor behind the toilet and a bath basin on the floor next to the toilet. She stated it was her expectation for items such as bath basins and urine collection containers to be bagged, labeled and stored off the floor in the bathroom. She further stated items were not supposed to be stored on the floor in resident bathrooms. 2. a. Observations on 10/23/18 at 9:34 AM revealed in the bathroom of resident room #201 the floor around the base of the toilet was stained with dark brown stains. Observations on 10/24/18 at 3:19 PM revealed in the bathroom of resident room #201 the floor around the base of the toilet was stained with dark brown stains. Observations on 10/25/18 at 10:19 AM revealed in the bathroom of resident room #201 the floor around the base of the toilet was stained with dark brown stains. b. Observations on 10/22/18 at 4:01 PM revealed in the bathroom of resident room #204 the floor around the base of toilet had dark brown and black stains and there was no caulk around the base of toilet. Observations on 10/24/18 at 3:22 PM revealed in the bathroom of resident room #204 the floor around the base of toilet had dark brown and black stains and there was no caulk around the	F 584	acceptable plan of correction. Date of compliance will be 11/23/18. Maintenance Director will log all maintenance related issues into TELS and track the timeliness of items being fixed. Weekly auditing will be conducted by administrator to ensure that maintenance tickets are placed into TELS system will continue for 2 months, then every 2 weeks for 2 months, then monthly x2 months and taken care of in a timely manner. Maintenance Director will bring this to Quality Assurance and Performance Improvement Committee monthly, with the QAPI Committee responsible for ongoing compliance.	

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F 584	Continued From page 3	F 584		

base of toilet.
Observations on 10/25/18 at 10:20 AM revealed in the bathroom of resident room #204 the floor around the base of toilet had dark brown and black stains and there was no caulk at the base of toilet.

c. Observations on 10/23/18 at 09:47 AM revealed in the bathroom of resident room #207 the floor around the toilet had dark stains around the base of the toilet on the floor.
Observations on 10/24/18 at 3:24 PM revealed in the bathroom of resident room #207 the floor around the toilet had dark stains around the base of the toilet on the floor.
Observations on 10/25/18 at 10:21 AM revealed in the bathroom of resident room #207 the floor around the toilet had dark stains around the base of the toilet on the floor.

d. Observations on 10/22/18 at 10:52 AM revealed in the bathroom of resident room #215 there were dark brown stains on the floor around the base of the toilet.
Observations on 10/24/18 at 11:20 AM revealed in the bathroom of resident room #215 there were dark brown stains on the floor around the base of the toilet.
Observations on 10/25/18 at 2:44 PM revealed in the bathroom of resident room #215 there were dark brown stains on the floor around the base of the toilet.

e. Observations on 10/23/18 at 11:08 AM revealed in the bathroom of resident room #315 the caulk around the base of the toilet was black and there were brown and black stains between the tiles on the bathroom floor.
Observations on 10/24/18 at 11:23 AM revealed

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in the bathroom of resident room #315 the caulk around the base of the toilet was black and there were brown and black stains between the tiles on the bathroom floor.
Observations on 10/25/18 at 2:45 PM revealed in the bathroom of resident room #315 the caulk around the base of the toilet was black and there were brown and black stains between the tiles on the bathroom floor.

3. Observations on 10/22/18 at 4:01 PM revealed in the bathroom of resident room #204 the cove molding at the base of the floor was missing around the toilet.
Observations on 10/24/18 at 3:22 revealed in the bathroom of resident room #204 the cove molding at the base of the floor was missing around the toilet.
Observations on 10/25/18 at 10:20 AM revealed in the bathroom of resident room #204 the cove molding at the base of the floor was missing around the toilet.

4. a. Observations on 10/22/18 at 11:41 AM in resident room #102 revealed food particles and debris on the floor behind the bed along the wall.
Observations 10/23/18 at 9:23 AM in resident room #102 revealed food particles and debris on the floor behind the bed along the wall.
Observations 10/24/18 at 3:40 PM in resident room #102 revealed food particles and debris on the floor behind the bed along the wall.

b. Observation on 10/24/18 at 1:32 PM in resident room #117 revealed the side rail on the left side of the bed on #117-B had dried debris along the upper and lower sections of the rail.
Observation on 10/24/18 at 3:17 PM in resident room #117-B revealed the side rail on the left side

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F 584	Continued From page 5	F 584		

of the bed on #117-B had dried debris along the upper and lower sections of the rail. Observation on 10/25/18 at 11:23 AM in resident room #117-B revealed the side rail on the left side of the bed on #117-B had dried debris along the upper and lower sections of the rail.

During an interview and environmental tour on 10/26/18 at 2:19 PM, the Maintenance Director explained they utilized a work order system in the facility and work orders were kept on the hallways. He stated he made rounds and picked up work orders and fixed things throughout the day. He further stated anyone could fil out work orders and he let new hires know about work orders and where they were located. He explained there were no major projects underway at the moment. He stated most of the toilets in resident bathrooms had caulk around the base of the toilet. He explained if the caulk was stained and could not be cleaned the caulk had to be stripped off and housekeeping staff were the first eyes to report stains on caulk or bathroom floors to maintenance. He verified during the tour stains on the bathroom floors in resident rooms # 210, #204, #207 and #215. He stated the floor needed to be stripped out and the tiles replaced in resident bathroom #315. He further stated he was unaware the cove molding was missing in the bathroom of resident room #204 and it should have been reported.

During an interview and tour on 10/26/18 at 2:56 PM, the Environmental Services Director explained it was housekeeping staff's job to keep the facility clean. He stated it was his expectation that housekeeping staff were responsibility to clean. During a tour he verified the floor in resident room #102 needed to be cleaned behind

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F 584	Continued From page 6 the resident's bed. He explained it was his expectation when a resident room was deep cleaned housekeeping staff should do a better job and pull furniture away from walls and they should clean under the bed. He also verified during the tour there was a dried substance on the side rail in resident room #117-B. He stated he was not sure what the substance was but it needed to be cleaned. During an interview on 10/26/18 at 6:11 PM, the Administrator stated it was his expectation to keep a home like environment. He stated they were working on improved reporting and if staff saw something they could not fix then they should fill out a work order so it could be fixed.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to accurately code a resident as having received insulin for 1 of 6 residents reviewed for unnecessary medications (Resident #37) and failed to accurately code the discharge location for 1 of 1 residents reviewed for discharge from the facility to a hospital (Resident # 116). The Findings Included: 1. Resident #37 was admitted to the facility on 06/10/18 with diagnoses that included type II diabetes mellitus, among others.	F 641	1. Resident # 37 Minimum Data Set (MDS) assessments, Section N0350A and Resident #116 Section A2100 were modified to reflect accurate coding. The changes were completed by 11/9/18. 2. The Center Reimbursement Coordinator shall audit MDS assessments Sections N0350A, Insulin injections and Section A2100, Discharge Status currently in progress for accuracy before completion/transmission. 3. The Clinical Reimbursement Manager will educate the Center Reimbursement Coordinator on the Resident Assessment	11/23/18

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F 641	Continued From page 7 A review of Resident #37's most recent Minimum Data Set (MDS) Assessment revealed resident to be moderately impaired cognitively. Resident was coded as receiving insulin 7 of 7 days during the look back period. A review of Resident #37's physician orders revealed no found physician order for insulin. Resident had a physician order for Trajenta Tablet 5mg to be given once a day related to diabetes mellitus. A review of Resident #37's care plan on 10/24/18 at 11:58 AM revealed a care plan area created on 07/04/18 which indicated Resident #37 had a diagnosis of diabetes and was non-insulin dependent. During an interview with Resident #37 on 10/22/18 at 11:02 AM she reported she did not take insulin, nor had she received insulin in the past. An interview with Hall Nurse #1 on 10/25/18 at 3:03 PM revealed Resident #37 has never been on insulin while a resident in the facility. During an interview with Hall Nurse #2 on 10/25/18 at 3:05 PM it was reported she had worked on Resident #37's hall since March 2018 and she had never given Resident #37 any insulin. An interview with MDS Nurse #2 on 10/26/18 at 2:30 PM revealed she made a mistake in coding Resident #37's quarterly MDS assessment as her having received insulin 7 of 7 days. She reported she may have looked at an order for Trajenta	F 641	Instrument (RAI) for Minimum Data Set (MDS) for Sections N0350A and A2100 on accuracy and completion. 4. Center Reimbursement Coordinator is responsible for implementing the acceptable plan of correction. Date of compliance will be 11/23/18. Audits to be conducted randomly by the Center Reimbursement Coordinator weekly for four weeks, monthly for two months, quarterly for three months and then annually for Minimum Data Set (MDS) for Sections N0350A and A2100 for accuracy prior to transmission to determine compliance. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, members complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

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F 641	Continued From page 8	F 641		

Tablet 5mg and mistook it for an insulin order. She reported she should have read through the entire physician order thoroughly to verify it was indeed insulin on the order.

During an interview with the Director of Nursing on 10/26/18 at 3:41 PM revealed it was her expectation that MDS Assessments are completed accurately.

During an interview with the Administrator on 10/26/18 at 4:56 PM he reported it was his expectation that MDS Assessments be completed accurately.

2. Resident #116 was admitted to the facility on 08/21/18 with diagnoses that included atrial fibrillation, congestive heart failure and muscle weakness among others and subsequently discharged on 09/21/18.

A review of Resident #116's most recent MDS Assessment dated 09/21/18 and coded as a discharge assessment revealed Resident to be cognitively impaired. Further review of the MDS Assessment revealed resident was coded as being discharged from the facility to an acute hospital.

Review of Resident #116's physician orders revealed and discharge order written 09/18/18 which indicated Resident #116 was to discharge home on 09/21/18 with family.

An interview with the facility Social Worker on 10/26/18 at 1:02 PM revealed she had handled the discharge planning for Resident #116. She reported he was sent home with home health, physical therapy and occupational therapy. She

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F 641	Continued From page 9 stated Resident #116 discharged home on 09/21/18 with his daughter. During an interview with MDS Nurse #1 on 10/26/18 at 2:30 PM, she reported that Resident #116's MDS Assessment was coded wrong and that it should be coded that he was discharged to the community. During an interview with the Director of Nursing on 10/26/18 at 3:41 PM revealed it was her expectation that MDS Assessments are completed accurately. During an interview with the Administrator on 10/26/18 at 4:56 PM he reported it was his expectation that MDS Assessments be completed accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		11/23/18

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F 656	Continued From page 10 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident and visitor interviews the facility failed to follow care plan interventions for 1 of 1 residents who were designated as requiring supervision while they smoked (Resident #40). The Findings Included: Resident #40 was admitted to the facility on 07/27/18 with diagnoses that included unspecified convulsions, neuromuscular dysfunction of bladder, adult failure to thrive and quadriplegia among others. A review of Resident #40's most recent Minimum Data Set (MDS) assessment	F 656	1. Resident # 40 was care planned for smoking with supervision and was seen outside smoking without proper supervision. This incident occurred because resident did not inform staff that she had resumed smoking. Resident is currently not smoking and has agreed to notify staff if she wishes to resume smoking in the future. 2. There are currently no residents in the facility who require supervised smoking. 3. All nursing management staff will be inserviced on the proper care planning of smokers by the Director of Nursing and/or	

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F 656	Continued From page 11 dated 08/30/18 revealed Resident #40 was cognitively intact. Further review of the MDS assessment revealed resident to require extensive assistance with bed mobility, dressing, toilet use and personal hygiene. Resident #40 was totally dependent upon staff for the completion of transfers and bathing. She was coded as requiring supervision with eating and locomotion on and off the unit. A review of Resident #40's care plan revealed a care plan area that reported Resident #40 could smoke with supervision from family, facility staff and her roommate. Interventions included monitoring Resident #40's compliance with the facility's smoking policy and to inform family and significant others that the patient needs supervision while smoking. A review of Resident #40's progress notes on 10/24/18 at 9:25 AM revealed a note dated 10/23/18 which detailed that Resident #40 had an apparent seizure while in the courtyard smoking. Further review of the progress note revealed she was seen by a family member of another resident in the facility. An interview with Resident #40 on 10/25/18 at 2:42 PM revealed she had a seizure while outside smoking on 10/23/18. She reported there was one other person who was outside at the time and described the person as someone she had met previously who had a loved one in the facility. She reported he was not family or a staff member. She stated the person was already out in the patio smoking area when she arrived. An interview on 10/25/18 at 11:23 AM with the visitor who was with Resident #40 at the time she	F 656	designee before they will be allowed to work again. Also, when a resident has decided to quit smoking and refuses to wear the patch nursing and/or social services will follow up with the resident for four weeks to ensure that they are still on plan for quitting or initiate a new care plan for smoking. 4. Director of Nursing and/or designee is responsible for implementing the acceptable plan of correction. Date of compliance will be 11/23/18. All new admissions will be reviewed for smoking and care plans will be created, reviewed and/or revised accordingly. This information will be presented and reviewed by QAPI team monthly.	

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MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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F 656	Continued From page 12	F 656		

had a seizure. He reported on the day of the incident he had gone out to smoke while visiting his loved one. He reported Resident #40 came out to the patio soon after and was reportedly alone. He stated that he had to assist Resident #40 with lighting her cigarette. He stated he was unaware if Resident #40 required supervision while smoking and reported the facility staff had said nothing to him about whether Resident #40 required some type of supervision while she smoked. He reported while he was with Resident #40 on the patio he noticed her head tilt to the side and Resident #40 go silent. He reported he deduced Resident #40 was having a medical emergency and he removed her cigarette from her hand and immediately went to search for a staff member. The visitor reported he was not a family member of Resident #40, nor was he a facility staff member or Resident #40's roommate.

An interview with Hall Nurse #3 on 10/26/18 at 2:01 PM revealed resident had a roommate at one time and that they would smoke together. She reported this was the first facility she had worked at where a staff member did not actively supervise smokers by being outside with the supervised smokers while they smoked. She stated she was not aware Resident #40 was a supervised smoker and always wondered how Resident #40 could manage to safely smoke with her diagnoses. She reported her understanding of a supervised smoker was any resident who needed assistance with some part of the smoking process. She stated if Resident #40's care plan specifically named persons who were to supervise Resident #40 while she smoked, then Resident #40 would only be considered to be supervised when those persons were with Resident #40 while she smoked. She indicated

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F 656	Continued From page 13 she was not aware of any assigned staff in the building that supervised residents while the smoked. During an interview with the Assistant Director of Nursing on 10/26/18 she reported if a resident was designated as a supervised smoker then the resident should be assigned to a nurse aide who would be responsible for supervising the resident while they smoked. She reported if the assigned nurse aide was busy then she expected another staff member to go out with the resident. She reported a visitor should not be supervising a designated supervised smoker. She reported she was unaware that Resident #40 had been designated as an unsupervised smoker. An interview with the Director of Nursing on 10/26/18 revealed she was unaware that Resident #40 was a smoker. She reported to her knowledge that Resident #40 committed to quitting once her roommate discharged from the facility. She reported she believed that Resident #40 was not properly supervised on 10/23/18 when Resident #40 had a medical emergency. She reported that per Resident #40's care plan, the only persons who should have supervised Resident #40 while she smoked were her family, facility staff or her roommate, who had recently been discharged from the facility.	F 656		
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.	F 657		11/23/18

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F 657	Continued From page 14 (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 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 and staff interviews the facility failed to revise a care plan to include interventions for administration of oxygen for a resident who received oxygen for 1 of 3 sampled residents for respiratory care and oxygen (Resident #20). Findings included: Resident #20 was admitted to the facility on 11/16/16 with diagnoses which included heart disease, high blood pressure, diabetes and depression. A review of a physician's order dated 07/10/18	F 657	1. Resident # 20 had an order for Oxygen prn, and a care plan for oxygen as an intervention for a diagnosis of heart failure. Resident # 20□s care plan has been revised to reflect oxygen use as a respiratory focus plan of care. 2. All residents with a PRN order for oxygen have been reviewed and care plans updated as appropriate. 3. All Nursing leadership has been educated by DON on need for care plans to reflect prn O2 as a focus, not an intervention. 4. All new admissions or new orders for PRN O2 will be reviewed by clinical team	

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F 657	Continued From page 15 indicate oxygen by nasal cannula at 2 liters per minute as needed. A review of the most recent quarterly Minimum Data Set (MDS) dated 08/06/18 revealed Resident #20 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #20 required extensive assistance with bed mobility, transfers, dressing, toileting and hygiene and oxygen was indicated. A review of a care plan which was revised on 10/18/18 indicated Resident #20 was at risk for cardiovascular symptoms or complications related to diagnoses of cardiac murmur and fluid retention. The goal was Resident #20 would not experience any chest pain for 90 days and interventions indicated Lasix (to remove fluid) and oxygen but there were no interventions for the adminsitration of oxygen therapy. During an observation on 10/22/18 at 10:56 AM, Resident #20 was sitting in a wheelchair in her room with a nasal cannula in her nose and the tubing was connected to an oxygen tank on the back of her chair. Observations further revealed oxygen was turned on at 2 liters per minute. During an observation on 10/24/18 at 2:24 PM, Resident #20 was sitting in a wheelchair in her room with a nasal cannula in her nose and oxygen on at 2 liters per minute from an oxygen concentrator next to her bed. During an observation on 10/25/18 3:01 PM, Resident #20 was sitting in a wheelchair in her room with a nasal cannula in her nose and oxygen on at 2 liters per minute from an oxygen concentrator next to her bed.	F 657	for accurate care plans. Findings will be reported in monthly QAPI.	

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F 657	Continued From page 16 During an interview on 10/25/18 at 3:31 PM, Nurse #6 stated Resident #20 now required continuous oxygen because of heart disease. She further stated Resident #20 was short of breath when she talked and needed the oxygen because of her shortness of breath. During an interview on 10/26/18 at 9:52 AM, Nurse Practitioner #1 confirmed Resident #20 had drops in her oxygen saturation percentages and was ordered oxygen as needed. She explained Resident #20 now wore oxygen most of the time because of her decreased oxygen percentages and shortness of breath. During an interview on 10/26/18 at 4:52 PM, the Assistant Director of Nursing stated after review of Resident #20's care plan she would have expected to see a focus area for respiratory care and the care plan should have had specific interventions for oxygen. She confirmed Resident #20 needed oxygen because of heart disease and her oxygen saturation percentages were checked to determine her need for oxygen. During an interview on 10/26/18 at 5:47 PM, the Director of Nursing confirmed after review of Resident #20's care plans she would have expected for any resident who received oxygen they should have a focus area in their care plans for oxygen. She stated she also expected to see interventions to go with the focus area of oxygen and there were many things that needed to be considered.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		11/23/18

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F 677	Continued From page 17 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family, and staff interviews, the facility failed to provide showers twice weekly for 2 of 4 residents (Residents #17 and #41) reviewed for activities of daily living. The findings included: 1. Resident #17 was admitted to the facility on 04/10/18 and readmitted on 04/26/18. Her diagnoses included muscle weakness, Parkinson's disease, anxiety disorder, seizures, tremor, convulsions, repeated falls and osteoarthritis. A review of Resident #17's quarterly Minimum Data Set (MDS)dated 08/03/18 revealed she was cognitively intact for daily decision making and required total assistance of 2 persons with bathing and required extensive assistance of 1 with personal hygiene. A review of Resident #17's care plan dated 08/17/18 revealed she required extensive assistance to total dependence for personal hygiene and bathing related to her Parkinson's disease and seizures. Her goal was she would improve her current level of functioning or maintain functioning by next review as evidenced by improved activities of daily living (ADL) scores. The interventions included provide resident with extensive assistance of 1 person for bathing and personal hygiene.	F 677	1. Resident # 41 and # 17 were interviewed to determine their preference for shower schedule, and are currently receiving showers as indicated, or refusal of shower is being documented accordingly. 2. All current residents shower schedules have been reviewed and corrections made to times per resident preference. Nurses Aids will sign off each shift when showers are given and report to nurse any showers that were refused or not given for other reasons so that they can be rescheduled for another day/time. This will be completed by 11/23/18. 3. All nursing staff will be in-serviced Director of Nursing and/or Designee on the importance of showers following the facility policy of 2 times a week, when resident allows and properly documenting refusals. 4. DON or designee will complete daily observation audits of 20% of the resident population to determine if showers are being given as scheduled or proper documentation is completed until 100% compliance is achieved on 3 consecutive evaluations. Then weekly observation audits will be completed until 100% compliance is achieved on 3 consecutive evaluations, then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results will be reviewed	

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F 677	Continued From page 18 An interview on 10/22/18 at 2:59 PM with Resident #17 revealed she was supposed to get showers twice weekly on Wednesday and Saturday. Resident #17 went on to explain that she seldom got a shower on Saturday like she was supposed to and then did not get a shower until the following Wednesday. Resident #17 stated she mostly got bed baths or partial baths and it was her preference to shower twice weekly. A review of the shower schedule for Resident #17 revealed she had received only 3 showers and 1 bed bath in the last 30 days and had not received showers on Saturday as scheduled. An interview on 10/26/18 at 4:46 PM wit Nurse Aide (NA) #3 revealed there were mostly agency NAs working on the weekends and they had not always given the residents showers as scheduled. An interview on 10/26/18 at 5:07 PM with the Assistant Director of Nursing (ADON) revealed it was her expectation that all NAs give showers to the residents as scheduled and if the showers are not given as scheduled there should be a reason why the resident was not showered. An interview on 10/26/18 at 6:07 PM with the Director of Nursing (DON) revealed it was her expectation that residents received their showers as scheduled and if not that it was reported to the nurse. 2. Resident #41 was admitted to the facility on 09/01/17 with diagnoses which included hypertension, urine retention, cerebral infarction, dementia, Alzheimer's disease and others.	F 677	monthly with the Quality Assurance and Performance Improvement Committee, with the QAPI committee responsible for ongoing compliance.	

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F 677	Continued From page 19	F 677		

A review of Resident #41's quarterly Minimum Data Set (MDS) dated 08/29/18 revealed she was severely cognitively impaired for daily decision making. The MDS also revealed Resident #41 required total dependence of one to two staff for personal hygiene and bathing.

A review of Resident #41's care plan dated 09/04/18 revealed she required assistance for ADL care in bathing, grooming, personal hygiene, etc., related to her Alzheimer's disease and dementia. The goal for Resident #41 was she would maintain the highest capable level of ADL ability throughout the next review period as evidenced by her ability to perform bathing, bed mobility, eating and dressing. The interventions included staff would anticipate resident's needs and provide whatever assistance from supervision to maximum assistance of two as needed due to fluctuations, monitor conditions that could contribute to a decline in ADL, monitor episodes of bizarre behavior that interfere with ADL performance, and implement established behavioral interventions or notify physician/provider of behavioral changes.

An interview on 10/26/18 at 11:50 AM with a family member revealed Resident #41 was supposed to get two showers per week but was not getting them. The family member stated the NAs never washed her face or brushed her teeth and stated her hair was often plastered to her head. The family member stated she was scheduled for showers on Tuesdays and Fridays.

A review of Resident #41's shower schedule for the past 30 days (09/27/18 through 10/25/18) reveled there was an entire week the resident

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F 677	Continued From page 20	F 677		

had not received a shower but instead had had a bed bath or sponge bath.

An interview on 10/26/18 at 4:46 PM with Nurse Aide (NA) #3 revealed Resident #41 cursed, screamed and would swing her hands at the NAs when they took her to the shower room for showers. NA #3 stated Resident #41 tried to grab the sprayer and spray the NAs and stated you could hear her throughout the building screaming in the shower. NA #3 stated once she was sitting on the shower chair she was not concerned about her falling but stated she was swatting at you and grabbing at you while trying to bathe her. NA #3 stated she would be difficult to shower for someone who did not know her well.

An interview on 10/26/18 at 5:07 PM with the Assistant Director of Nursing (ADON) revealed the NAs were supposed to give the residents showers as scheduled and if they were not giving them a shower there should be a reason why. The ADON stated if the resident was combative during showers, she would expect to see something documented in the resident's record about her behaviors during the shower. The ADON stated she would expect if there were behaviors they be charted or reported to the nurse and expected the nurse would document the behaviors. The ADON also stated she would expect them to try to make the shower fun and enjoyable for the resident.

An interview on 10/26/18 at 6:07 PM with the Director of Nursing (DON) revealed she expected the residents to receive their showers as scheduled and stated if the resident had behaviors she would expect the NAs to report the behaviors to the nurse and the nurse to document

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F 677	Continued From page 21 them. The DON also stated she expected the NAs to offer the residents other options for making the shower enjoyable for the resident.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident and visitor interviews the facility failed to provide supervision to prevent accidents for 1 of 1 residents who were designated as requiring supervision while they smoked (Resident #40). The Findings Included: Resident #40 was admitted to the facility on 07/27/18 with diagnoses that included unspecified convulsions, neuromuscular dysfunction of bladder, adult failure to thrive and quadriplegia among others. A review of Resident #40's most recent Minimum Data Set (MDS) assessment dated 08/30/18 revealed Resident #40 was cognitively intact. Further review of the MDS assessment revealed resident to require extensive assistance with bed mobility, dressing, toilet use and personal hygiene. Resident #40 was totally dependent upon staff for the completion of transfers and bathing. She was coded as requiring supervision with eating and	F 689	1. Resident # 40 had a care plan and smoking assessment that allowed her to be supervised by a previous roommate (friend). When that roommate was discharged on Resident # 40 said she would no longer be smoking. Staff was unaware that Resident # 40 was smoking. Need to say if she is currently smoking, and if so, whether or not she is supervised/ assessment/care plan. 2. There are currently no other residents that need supervision while smoking. 3. Social Service Director completed another smoking Assessment with Resident # 40 on 11/9/18, who again told SSD that she will no longer be smoking. Resident # 40 made aware that smoking without staff knowledge will violate the facilities smoking policy and will result in discharge. Also, when a resident has decided to quit smoking and refuses to wear the patch, nursing and/or social	11/23/18

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F 689	Continued From page 22 locomotion on and off the unit. A review of Resident #40's care plan revealed a care plan area that reported Resident #40 could smoke with supervision from family, facility staff and her roommate. Interventions included monitoring Resident #40's compliance with the facility's smoking policy and to inform family and significant others that the patient needs supervision while smoking. A review of Resident #40's progress notes on 10/24/18 at 9:25 AM revealed a note dated 10/23/18 which detailed that Resident #40 had an apparent seizure while in the courtyard smoking. Further review of the progress note revealed she was seen by a family member of another resident in the facility. An interview with Resident #40 on 10/25/18 at 2:42 PM revealed she had a seizure while outside smoking on 10/23/18. She reported there was one other person who was outside at the time and described the person as someone she had meet previously who had a loved one in the facility. She reported he was not family or a staff member. She stated the person was already out in the patio smoking area when she arrived. An interview on 10/25/18 at 11:23 AM with the visitor who was with Resident #40 at the time she had a seizure. He reported on the day of the incident he had gone out to smoke while visiting his loved one. He reported Resident #40 came out to the patio soon after and was reportedly alone. He stated that he had to assist Resident #40 with lighting her cigarette. He stated he was unaware if Resident #40 required supervision while smoking and reported the facility staff had	F 689	services will follow up with the resident for four weeks to ensure that they are still on plan/goal for quitting or initiate a new care plan for smoking. All residents who smoke are routinely assessed for safe smoking according to policy. All nursing management staff will be inserviced on the proper care planning of smokers by the Director of Nursing and/or designee before they will be allowed to work again. 4. Social Work Director and/or designee is responsible for implementing the acceptable plan of correction. Date of compliance will be 11/23/18. Social Work Director or designee will follow up with Resident # 40 to verify that she is no longer smoking weekly x 4 weeks. Results will be reviewed monthly with the Quality Assurance and Performance Improvement Committee, with the QAPI committee responsible for ongoing compliance.	

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F 689	Continued From page 23	F 689		

said nothing to him about whether Resident #40 required some type of supervision while she smoked. He reported while he was with Resident #40 on the patio he noticed her head tilt to the side and Resident #40 go silent. He reported he deduced Resident #40 was having a medical emergency and he removed her cigarette from her hand and immediately went to search for a staff member. The visitor reported he was not a family member of Resident #40, nor was he a facility staff member or Resident #40's roommate.

An interview with Hall Nurse #3 on 10/26/18 at 2:01 PM revealed resident had a roommate at one time and that they would smoke together. She reported this was the first facility she had worked at where a staff member did not actively supervise smokers by being outside with the supervised smokers while they smoked. She stated she was not aware Resident #40 was a supervised smoker and always wondered how Resident #40 could manage to safely smoke with her diagnoses. She reported her understanding of a supervised smoker was any resident who needed assistance with some part of the smoking process. She indicated she was not aware of any assigned staff in the building that supervised residents while the smoked.

During an interview with the Assistant Director of Nursing on 10/26/18 she reported if a resident was designated as a supervised smoker then the resident should be assigned to a nurse aide who would be responsible for supervising the resident while they smoked. She reported if the assigned nurse aide was busy then she expected another staff member to go out with the resident. She reported a visitor should not be supervising a designated supervised smoker. She reported

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F 689	Continued From page 24 she was unaware that Resident #40 had been designated as a supervised smoker. An interview with the Director of Nursing on 10/26/18 revealed she was unaware that Resident #40 was a smoker. She reported to her knowledge that Resident #40 committed to quitting once her roommate discharged from the facility. She reported she believed that Resident #40 was not properly supervised on 10/23/18 when Resident #40 had a medical emergency.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		11/23/18

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F 690	Continued From page 25 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to empty a urinary catheter for a resident (Resident #63) and failed to prevent an indwelling urinary catheter tubing from resting on the floor for resident (Resident #267) for 2 of 3 residents reviewed for indwelling urinary catheters. The findings included: A review of a policy entitiled Care of Indwelling Urinary Catheter dated 06/01/96 with a revision date of 01/02/14 read in part "11. Empty the catheter drainage bag at least once every eight hours, and as necessary". 1. Resident #63 was readmitted on 9/18/17 with diagnoses which included neuromuscular bladder dysfunction with supra-pubic indwelling urinary catheter, anoxic brain damage, and others. A review of Resident #63's care plan dated 07/06/18 revealed she had a care plan for her indwelling supra-pubic catheter. The focus stated the resident required indwelling supra-pubic catheter due to her neurogenic bladder. The goal was that resident would have no signs or	F 690	1. Resident # 63□s Foley bag was emptied when staff was made aware. Staff involved with Resident # 267, including therapy were reminded about foley bag and tubing not touching the ground. Resident # 267 was changed to a leg bag when out of bed. 2. All residents with foleys were checked for placement and emptying by Director of Nursing and/or designee by 11/9/18. 3. All residents with catheters will have records reviewed for proper orders and POC/Kardex will prompt C.N.As to empty foley at the end of their shift. The TAR will alert the nurse to check that the foley has been emptied before they leave for their shift as well. All licensed clinical staff will be in-serviced Director of Nursing and/or designee on the use of leg bags while out of bed, and the importance of the bag or tubing not touching the floor and they need to empty the foley and document that it was completed. 4. The DON or designee will audit all residents with foleys weekly on random shifts, until 100% compliance is achieved on 3 consecutive observations, then	

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F 690	Continued From page 26 symptoms of urinary tract infection through 90 days. The interventions included monitor output for odor, color, consistency and amount, provide privacy and comfort, monitor urine for sediment, cloudy, odor, blood and amount and provide skin care after each incontinent episode and apply a moisture barrier. A review of Resident #63's quarterly Minimum Data Set (MDS) dated 9/27/18 revealed Resident #63 was severely impaired for daily decision making, was totally dependent on staff for all activities of daily living (ADL), upper and lower impairment on both sides, had suprapubic catheter and colostomy. A review of Resident #63's October, 2018 physician orders read in part "change bedside foley drainage bag when occluded or when foley catheter is changed, dry dressing to be placed around foley cath every day and as needed, perform foley cath care - cleanse area with soap and water and pat dry, change foley catheter when occluded, leaking or to obtain urine specimen, and empty foley catheter drainage bag every shift and as needed." An observation on 10/24/18 at 11:26 AM of Resident #63's catheter bag revealed it was almost full and there was only approximately 1/2 of an inch at the top of the bag that did not contain urine. An observation on 10/24/18 at 1:32 PM of Resident #63's catheter bag revealed it was almost full and there was approximately 1/2 of an inch at the top of the bag that did not contain urine.	F 690	weekly audits on 50% of foley residents, on different shifts until 100% compliance is achieved on 3 observations in a row, then monthly random audits will be completed for 3 months. Results of these audits will be brought before the Quality Assurance and Performance Improvement committee monthly, with QAPI Committee responsible for ongoing compliance.	

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An observation on 1024/18 at 3:00 PM of Resident #63's catheter bag revealed it was still almost full and there was approximately 1/2 of an inch at the top of the bag that did not contain urine.

An interview on 10/24/18 at 3:17 PM with Nurse Assistant (NA) #2 revealed she was almost done for the day with and she just had to finish her documentation.

An observation and interview on 10/24/18 at 3:21 PM with NA #2, Unit Manager (UM) #2 and Nurse #4 revealed Resident #63's indwelling supra-pubic urinary catheter was almost full and had approximately 1/4 inch at the top of the catheter bag that did not have urine in it. Nurse #4 and UM #2 both stated the catheter bag should have been emptied at the end of the shift and stated all indwelling catheters should be emptied at the end of each shift and as needed.

An interview on 10/24/18 at 3:35 PM revealed Nurse #4 was not aware of the amount of urine that was emptied from the catheter bag because they did not keep up with the output but stated the bag was almost full and it should have been emptied at the end of the shift.

An interview on 10/24/18 at 5:46 PM with the Assistant Director of Nursing (ADON) revealed "monitor" on Resident #63's care plan meant for the NA to let the nurse know if there was no urine or an abnormally small amount of urine in the bag at the end of an eight hour period.

An interview on 10/26/18 at 5:07 PM with the ADON revealed it was her expectation that all indwelling catheters be emptied at the end of

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each shift and as needed.

10/25/18 10:49 AM An interview on 10/26/18 at 6:07 PM with the Director of Nursing (DON) revealed it was her expectation that all indwelling catheters be emptied at the end of each shift and as needed.

The policy and procedure for the Care of Indwelling Urinary Catheter with a revision date of 01/04/14 revealed in part to "keep the catheter tubing off of the floor.....".

2. Resident #267 was admitted to the facility on 10/11/18 with diagnoses which included obstructive uropathy and urinary tract infections (UTI's).

Review of Resident #267's admission Minimum Data Set (MDS) assessment dated 10/18/18 revealed she had severe cognitive impairment, required extensive assistance with transfers and had an indwelling urinary catheter.

Review of Resident #267's Care Area Assessment (CAA) for Urinary Catheters dated 10/18/18 indicated in part that she has had a urinary catheter for 5 years due to a bladder outlet obstruction and bladder prolapse. The CAA also stated since the use of a catheter could cause complications, catheter care would be provided to prevent complications such as a UTI.

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Review of Resident #267's Care Plan dated 10/23/18 indicated she was at risk for infection due to the use of the urinary catheter. The goal was to prevent infections by giving cranberry capsules, monitoring for signs and symptoms of infections, changing the catheter every 2 weeks and as needed and by providing the appropriate care for the urinary catheter.

10/22/18 at 02:59 PM an observation was made of the urinary catheter tubing on the floor.
10/23/18 at 11:51 AM an observation was made of the urinary catheter tubing on the floor.
10/24/18 at 04:03 PM an observation was made of the urinary catheter tubing on the floor.
10/24/18 at 05:54 PM an observation was made of the urinary catheter tubing on the floor.
10/25/18 at 10:32 AM an observation was made of the urinary catheter tubing on the floor.

On 10/25/18 at 10:53 Nurse Aide #1 who was assigned to Resident #267 was shown Resident #267's urinary catheter tubing which was on the floor. During an interview with NA #1 she stated care rounds were made on the residents with urinary catheters about every 2 hours or as often as needed to ensure the catheter bags were kept below the resident's bladder and the tubing was not on the floor to prevent urinary tract infections.

On 10/25/18 at 11:24 AM during an interview with Nurse #1 who was assigned with Resident #267 stated she made rounds on residents with urinary catheters about every 15 to 20 minutes to make sure the catheter tubing is not on the floor.

On 10/26/18 at 09:25 AM during an interview with Unit Manager #1 she stated rounds should be

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F 690	Continued From page 30 made on the residents with urinary catheters about every 2 to 3 hours to assure the catheter bag was below the resident's bladder and the tubing was not on the floor. On 10/26/18 at 6:28 PM during an interview with the Director of Nursing she stated it was her expectation that the urinary catheter tubing not be on the floor.	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		11/23/18

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F 755	Continued From page 31 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to refrigerate unopened insulin and remove expired medications from one of three medication carts (100 Hall Medication Cart) reviewed for Medication Storage. The findings included: The facility's Pharmacy Services Policies and Procedures revision date of 12/15/18 revealed in part "a pharmacy representative will perform regular nursing unit inspections to assist the Center with compliance with obligations pursuant to applicable law relating to medication expiration dates and proper storage of drugs in medication carts and refrigerators". According to the manufacture's recommendations: Novolin insulin used to treat diabetes mellitus should be refrigerated until opened. Levemir insulin used to treat diabetes mellitus should be discarded in 42 days after opening. Latanoprost eye drops used to treat glaucoma should be discarded in 42 days after opening. On 10/26/18 at 02:52 PM during the inspection of the 100 hall medication cart with Unit Manager(UM) #2 the following medications were found:	F 755	Element 1: The nursing administrative staff went and removed the unopened insulin and the 100 Hall Medication Cart was inspected for expired medication and removed immediately. All items were discarded in Drug Buster. Element 2: The nursing administrative staff went and inspected the rest of the medication carts for expired medications and discarded any medication that was either undated or expired. Element 3: All licensed nurses were inserviced by Director of Nursing and/or designee on insulin storage and checking expirations on medications on a monthly basis. Element 4: Director of Nursing and/or designee are responsible for implementing the acceptable plan of correction. Date of compliance will be 11/23/18. Director of Nursing and/or designee will complete an audit of all medication carts daily until three consecutive audits at 100% compliance has been completed. Then weekly audits will be conducted until three consecutive audits at 100% compliance has been achieved. Then monthly random medication cart audits will be completed	

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F 755	Continued From page 32 One unopened Novolin insulin vial with the delivery date of 10/04/18 One used Levemir FlexPen with an open date of 08/19/18 Two opened Latanoprost eye drop bottles both dated 08/29/18 During the interview with the UM she stated the pharmacy was responsible to check the medication carts on a monthly basis and the cart checks had already been done for the month of October 2018. On 10/26/18 at 06:32 PM an interview with the Director of Nursing revealed the pharmacist checked the medication carts on a monthly basis and since he had already reviewed the medication carts for October 2018 he should have caught the expired medications.	F 755	until 5 consecutive audits at 100% compliance has been achieved. Director of Nursing will bring this to QAPI on a monthly basis for six months.	
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.	F 812		11/23/18

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F 812	Continued From page 33 §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, record review and staff interviews the facility failed to remove ice buildup on the floor of a walk in freezer in the kitchen, failed to ensure sheet pans were dry when stored on the shelf in the kitchen and failed to store an ice scoop for an ice chest in a container. Findings included: 1. Observations during the initial tour in the kitchen on 10/22/18 at 9:44 AM revealed ice buildup on the floor in the back of the walk in freezer. During an observation and interview on 10/16/18 at 1:45 PM, there were icicles hanging down from a rubber hose in the back of the walk in freezer and there were patches of ice buildup on the floor in the back of the freezer. The Dietary Manager confirmed she had made requests for maintenance to repair the freezing water in the freezer but it had not been repaired. She stated she tried to clean the ice off the floor of the freezer but it was constant work to keep it off the floor. During an interview on 10/26/18 at 11:46 PM, the Administrator stated the ice on the floor in the walk in freezer was related to the condenser cycle and when it defrosted it dripped water down onto the floor. He stated the Dietary Manager had been trying to keep the ice off the floor in the freezer but they needed to find a solution to the	F 812	Element 1: The dietary staff immediately removed the ice buildup on the floor in the walk-in freezer in the kitchen. Also, the sheet pans that were wet nested were removed from service and sent back through the dishwasher to ensure cleanliness/sanitation standards were being met. The ice chest were removed immediately from service returned to the kitchen and sanitized for infection control purposes. Element 2: The dietary manager inspected the freezer at the end of the shift to verify that there was no further ice buildup on the floor in the freezer. The dietary manager inspected the rest of the pans that were removed during the same time to ensure that no further wet nesting was identified. The dietary manager removed the rest of the ice chests and sanitized to ensure safety for the residents. Element 3: All dietary staff were in-serviced Director of Dining Services on the on the inspection of the freezer for ice buildup and removing any excess water from the floor to ensure safety and/or sanitary standards. Also, maintenance department was involved in isolating/installing a catch pan for the condenser unit when it is in defrost mode.	

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F 812	Continued From page 34 problem to resolve it. 2. Observations during the initial tour in the kitchen on 10/22/18 at 9:51 AM with the Dietary Manager present revealed sheet pans were stored on shelving in the kitchen. The observations further revealed there was moisture on the edges of the sheet pans and when the sheet pans were lifted there was moisture between the pans. During an interview on 10/26/18 12:43 PM, Cook #1 stated pans were supposed to be put on the big rack in the kitchen after they were washed and they were supposed to be dry before they stored them on shelves. She further stated pans were not supposed to stored wet. . During an interview on 10/26/18 at 12:50 PM, Dietary Aide #1 stated they were supposed to stand pans up to air dry. She explained after the pans were air dried then they could be stacked on the wire shelves in the kitchen. During an interview on 10/26/18 at 1:45 PM, the Dietary Manager confirmed the sheet pans observed during the initial kitchen tour had not been air dried properly. She stated sometimes staff were quick to put things away but they needed to understand the corner lip on the pans could harbor moisture and if the pans were put away without being properly dried it caused moisture between the pans. She explained the sheet pans had not been left on a rack to dry but it was her expectation for pans to be left on the drying rack until they were dry. She further stated she was not sure who had stored the sheet pans on the shelves before they were dry.	F 812	All dietary staff will receive training and re-education by Director of Dining Services on proper air drying of all dishes/pots/pans that are washed. Extra racks have been ordered to provide more space to allow dishes to air dry. All licensed staff will receive training and re-education by Director of Nursing and/or designee on using and/or dispensing ice to the residents on the hallway from portable coolers Element 4: Director Dietary Services and/or designee are responsible for implementing the acceptable plan of correction. Date of compliance will be 11/23/18. Director Dietary Services and/or designee will complete the audit by completing a daily audit for the 30 days on the freezer, wet-nesting, and ice scoop use on the hallway. The 2nd month of audits will be completed on every other day to ensure compliance. A weekly check will be completed during the 3rd month and a bi-weekly audit for the 4th □ 6th month. Director Dietary Services will bring this to QAPI on a monthly basis for six months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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During an interview on 10/26/18 at 11:46 PM, the Administrator stated it was his expectation there was no moisture between pans stored on shelves in the kitchen.

3. During an observation on 10/22/18 at 11:04 AM at the nurse's station for 200 and 600 halls revealed there was an ice chest on a cart in the pantry. Observations inside the ice chest revealed an ice scoop was floating in water and ice.
Observation on 10/22/18 at 12:45 PM at the nurse's station for 200 and 600 halls revealed there was an ice chest on a cart in the pantry. Observations inside the ice chest revealed an ice scoop was floating in water and ice.
Observation on 10/22/18 at 3:49 PM at the nurse's station for 200 and 600 halls revealed there was an ice chest on a cart in the pantry and a scoop was lying on top of the cart uncovered.

During an interview on 10/26/18 at 1:45 PM the Dietary Manager confirmed kitchen staff managed ice chests that were sent to nursing halls. She stated they put scoops in a zip lock bag or in a pitcher that was on the cart. She stated it was her expectation that scoops were not supposed to be left in water and ice and they were not supposed to be left on top of the cart.

During an interview on 10/26/18 at 11:46 PM, the Administrator stated scoops used in ice chests were not to be stored in ice and water because of infection control reasons. He further stated they had provided a pitcher for the scoop to be placed in when not in use and the scoop should have been stored in the pitcher.