

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

PRINTED: 04/15/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345541	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2019
NAME OF PROVIDER OR SUPPLIER OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 13825 HUNTON LANE HUNTERSVILLE, NC 28078		
(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	
E 000	Initial Comments An unannounced recertification survey was conducted from 03/18/19 through 03/21/19. The facility is in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event URT611.	E 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		4/18/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/12/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	<p>Continued From page 1</p> <p>resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, family and staff interviews, and record review, the facility failed to have a privacy cover on the urine collection bag for 1 of 3 residents (Resident #76) reviewed for urinary catheters.</p> <p>Findings included:</p> <p>Resident #76 was admitted to the facility on 1/4/2019. Resident #76 had diagnoses that included chronic kidney disease stage 3, dementia without behavioral disturbance, chronic indwelling suprapubic catheter, and bladder spasms.</p> <p>Review of care plan dated 1/11/2019 revealed Resident #76 was admitted for short term rehab with a suprapubic catheter in place. The goal identified for Resident #76 was not to exhibit complications related to incontinence and signs or symptoms of Urinary Tract Infection. Interventions included providing catheter care as per facility policy, measure and empty catheter each shift.</p> <p>Review of the 30-day Minimum Data Set (MDS) dated 2/1/2019 revealed Resident #76 had</p>	F 550	<p>OLDE KNOX COMMONS' RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.</p> <p>F-550</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>A privacy bag has been placed on Resident #76's bed and this resident's urine collection bag is now placed in the privacy bag when the resident is in bed.</p> <p>Address how the facility will identify other residents having the potential to be</p>		

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F 550	<p>Continued From page 2</p> <p>severely impaired cognition and required extensive assistance for activities of daily living. Resident #76 had an indwelling urinary catheter in place.</p> <p>An observation was completed from the doorway of Resident #76's room on 3/18/2019 at 10:50 AM. Resident #76 was observed resting in bed. The urine collection bag was observed from the hallway, visibly hanging on the side of the bed, which contained amber colored urine with no privacy cover. A follow up observation was completed on 3/18/2019 at 12:22 PM. Resident #76 remained in bed resting. Resident #76's urine collection bag, which contained amber colored urine, continued to be observed from the hallway with no privacy cover.</p> <p>A telephone interview was completed on 3/19/2019 at 3:47 PM with the family of Resident #76. The family explained that Resident #76 was supposed to have a leg bag in place versus a urine collection bag. The family stated Resident #76 would have preferred a leg bag in place versus a urine collection bag, so that urine would be hidden under his pants.</p> <p>An observation was completed from the doorway of Resident #76's room on 3/20/2019 at 8:35 AM which revealed Resident #76 resting in bed. The urine collection bag, which contained amber colored urine, continued to be observed from the hallway. The urine collection bag was visibly hanging on the side of the bed with no privacy cover.</p> <p>An observation and interview were completed with the Director of Nursing (DON) on 3/20/2019 at 9:21 AM of Resident #76's room from the</p>	F 550	<p>affected by the same deficient practice :</p> <p>All residents with catheters have been reviewed and privacy bags have been added to each resident's bed for the urine collection bag to be placed in.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>All nursing staff will be inserviced on the need to have urine collection bags in privacy bags at all times unless the bag is being emptied or the resident is being showered. Unit Nurse Coordinators will conduct daily QA checks to ensure that urine collections bags are being maintained in privacy bags. These QA checks will be recorded on a QA forma and will be reviewed at the weekly QA Committee meeting. The review will be doe weekly for 4 weeks, then monthly for 2 months, then quarterly to ensure the deficient practice does not recur.</p> <p>Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:</p> <p>The Unit Nurse Coordinator's QA check logs will be reviewed at the weekly QA Committee meeting on a weekly basis for 4 weeks, then monthly for 2 months, then</p>		

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F 550	Continued From page 3 doorway. Resident #76 continued to be resting in bed. The urine collection bag, which contained amber colored urine, continued to be observed from the hallway. The urine collection bag was visibly hanging on the side of the bed with no privacy cover. The DON explained when resident's go out of the facility with family, leg bags were provided. The DON stated her expectation of nursing would be to ensure that Resident's urine collection bags were placed in a privacy bag, so they are covered and not visible to others. An interview was completed on 3/20/2019 at 9:28 AM with Nurse #3. Nurse #3 stated she checked Resident #76's urine collection bag each shift. Nurse #3 stated when Resident #76 was in bed, she checked for kinks in the tubing, the urine collection bag was positioned below the bladder, and the urine collection bag was not linked to any moveable part of the bed. Nurse #3 stated whatever side the securement lock was on, would be the side that she would hang the urine collection bag. Nurse #3 stated she liked to place the urine collection bag on the side towards the door, so she can have a visual of urine collection bag during rounds. Nurse #3 was not aware the urine collection bag needed a privacy cover. An interview was completed on 3/21/2019 at 4:51 PM with the Administrator. The Administrator stated her expectation was for resident dignity to be maintained and urine collection bags to be covered or in privacy bags.	F 550	quarterly. The results will also be reviewed at the Quarterly QAPI meetings to ensure the solutions are sustained.		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		4/18/19	

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F 641	<p>Continued From page 4</p> <p>The assessment must accurately reflect the resident's status.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and medical record review, the facility failed to code section A2100 of a discharge Minimum Data Set (MDS) assessment to accurately reflect discharge status for 1 of 3 closed records reviewed.</p> <p>The findings included:</p> <p>Resident #92 was admitted to the facility 2/5/19 and readmitted to the facility on 2/18/19 with plans to discharge home. Resident #92 discharged home on 2/28/19.</p> <p>Diagnoses included, in part, hypertension, urinary tract infection, pressure ulcers, wound infection, malnutrition, depression, acute osteomyelitis of right femur, sepsis, and cognitive communication deficit.</p> <p>Medical Record review revealed a nurse's progress note and a Post Discharge Plan of Care, both dated 2/27/19, which recorded a planned discharge to home on 2/28/19 for Resident #92.</p> <p>Review of a discharge MDS dated 2/28/19 coded Resident #92 discharged to an acute hospital and a return to the facility was not anticipated.</p> <p>The social worker stated in interview on 3/21/19 at 4:26 PM that Resident #92 was discharged to home with family on 2/28/19.</p> <p>An interview with the MDS Coordinator occurred on 3/21/19 at 5:00 PM and revealed Resident #92 went home as planned upon discharge from the</p>	F 641	<p>F-641</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Section A2100 of the MDS was modified on 03/21/2019 to indicate the resident discharging home.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The Corporate MDS Consultant and/r MDS Coordinator will conduct a Quality Review of current resident MDS' for accuracy of Section A2100. Any records found to be incorrect will be corrected at that time.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p>		

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F 641	Continued From page 5 facility. The MDS Coordinator further stated that the MDS nurse who completed Section A2100 of the Discharge MDS was not available for interview, but that the MDS was coded in error. She stated the MDS should have coded that Resident #92 was discharged home. During an interview on 3/21/19 at 5:30 PM, the Director of Nursing stated she expected the MDS to be accurately coded.	F 641	The Corporate MDS Consultant will inservice both facility MDS Nurses on the need for accuracy of MDS. The facility MDS Coordinator will conduct weekly QA checks of all discharge MDS to ensure accuracy for Section A2100. The QA checks will be recorded on an MDS QA log and will be submitted to the QA Committee each week for review for 4 weeks, then monthly for 2 months, and then quarterly. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained: Performance will be reviewed and discussed during the weekly QA Committee Meeting on a weekly basis for 4 weeks, then monthly for 2 months, then quarterly at the Quarterly QAPI Meeting to ensure solutions are sustained.		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		4/18/19	

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F 655	<p>Continued From page 6</p> <p>The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders.</p> <p>(B) Physician orders.</p> <p>(C) Dietary orders.</p> <p>(D) Therapy services.</p> <p>(E) Social services.</p> <p>(F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, resident and staff interviews, and record review, the facility failed to develop a base line care plan within 48 hours in</p>	F 655			
			F-655		

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F 655	<p>Continued From page 7</p> <p>the area of intravenous antibiotic therapy for 1 of 4 residents reviewed for base line care plans (Resident #290).</p> <p>Findings included:</p> <p>Resident #290 was admitted to the facility on 3/13/2019. Diagnoses included wound infection, type 2 diabetes with foot ulcer, and MRSA (Methicillin-resistant Staphylococcus aureus).</p> <p>Review of the baseline care plan dated 3/13/2019 revealed Resident #290 was alert and cognitively intact. Resident #290 communicated verbally, was able to understand and be understood.</p> <p>Further review of the baseline care plan revealed that the following areas were addressed: dietary/nutritional needs, therapy services, safety, social services, ADL (activity of daily living), equipment, bowel and bladder, and skin concerns. Review of the Special Treatments/ Procedure section revealed Resident #290 had a wound vacuum to the left lower extremity. No information was indicated for Resident #290 receiving IV antibiotic therapy.</p> <p>Review of the March 2019 physician orders read in part: Unasyn 3 GM (gram) Vial- give 3 GM Intravenous every 6 hours for dx (diagnosis) of wound infection with start date of 3/13/2019.</p> <p>An observation and interview were completed on 3/18/2019 at 11:02 AM with Resident #290. Resident #290 was observed in his room, resting in bed eating grapes. Resident #290 stated he recently had amputations to his toes and ended up with an infection. Continued observation revealed a wound vacuum in place to his left foot</p>	F 655	<p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #290's Baseline Care Plan was corrected on 3/21/2019 to reflect intravenous antibiotic therapy.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The Corporate MDS Nurse and/or MDS Coordinator will conduct a review of all current resident Baseline Care Plans for accuracy and will correct any that need to be corrected.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>The Corporate MDS Nurse will inservice the facility MDS staff on the need for accurate Base Line Care Plans. All resident Base Line Care Plans will be reviewed by the facility MDS Coordinator within 24 hours of completion for</p>		

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F 655	<p>Continued From page 8</p> <p>and an IV pole present in the room. Resident #290 verbalized he would be receiving IV antibiotics for 6 weeks three times per day.</p> <p>An interview was completed with the MDS (Minimum Data Set) Nurse on 3/21/2019 at 3:01 PM. The MDS Nurse stated she completed the baseline care plan within 48 hours of a resident's admission to the facility. The MDS Nurse explained she used resident and family interviews, and record review for completion of the base line care plan. The MDS Nurse verbalized that she was aware Resident #290 was receiving IV antibiotics and should have included IV antibiotics in Resident #290's baseline care plan.</p> <p>An interview was completed on 3/21/2019 at 3:14 PM with the Regional MDS Nurse. The Regional MDS Nurse stated she expected for IV antibiotics to be included in Resident #290's baseline care plan.</p> <p>An interview was completed with the Administrator on 3/21/2019 at 4:45 PM. The Administrator stated her expectation would be for the MDS Nurse to complete the baseline care plan with all interventions and services per policy and regulation.</p>	F 655	<p>accuracy. These reviews will be recorded on a QA log and will be presented to the QA Committee for review weekly for 4 weeks, then monthly for 2 months, and then quarterly to ensure the deficient practice does not recur.</p> <p>Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:</p> <p>Performance will be reviewed and discussed during the weekly QA Committee meetings on a weekly basis for 4 weeks, then monthly for 2 months, and then quarterly at the quarterly QAPI Meeting to ensure solutions are sustained.</p>		
F 761 SS=E	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§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</p>	F 761		4/18/19	

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F 761	<p>Continued From page 9 applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, manufacturer's recommendations, and facility policy, the facility failed to 1) date medications after opening (Tuberculin Purified Protein Derivative (PPD), Inhaler, Nasal Spray, Eye Drops), 2) store medications per manufacturer's recommendations (Antianxiety, Nasal Spray), 3) remove expired medications/equipment (IV set, Insulin) and maintain medication carts free of loose pills, debris and non-medicinal items. This was observed in 1 of 2 medication storage rooms and 3 of 5 medication carts.</p> <p>The findings included:</p> <p>The facility policy, "Storage of Medications", undated, recorded in part:</p>	F 761	<p>F-761</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility had already identified an issue with the labeling and storing of biologicals prior to the survey and had developed an Action Plan to address the issue. On the first day of survey, the facility Vice President informed the survey team of the action plan and provided a copy of the plan to the surveyors. The facility</p>		

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F 761	<p>Continued From page 10</p> <ul style="list-style-type: none"> ·No discontinued, outdated, or deteriorated drugs or biological are available for use in this facility. All such drugs are returned to the issuing pharmacy or appropriately disposed of within 5 days. ·Antiseptics, disinfectants, and germicides used in resident care must have legible distinctive labels that identify the contents and the directions for such use. Such articles must be stored separately from regular medications. ·Drugs intended for topical use, except for ophthalmic, optic and transdermal medications, shall be stored in a designated area separate from the drugs intended for oral and injectable use. <p>1. An observation of the medication storage room on the 600/700 hall occurred on 03/20/19 at 11:18 AM with Unit Coordinator #1 (UC #1) and revealed the following:</p> <ul style="list-style-type: none"> ·2 vials of Tuberculin Purified Protein Derivative (PPD) diluted 1 ml/10 tests were opened without a date of opening. ·A secondary IV (intravenous) set with a universal spike and spin lock connector medihook with a volume capacity of 15 drops/ml and a manufacturer expiration date stamp of "11/2018" (November 2018). The IV set was available for use past its expiration. <p>UC #1 stated on 3/20/19 at 11:25 AM that she expected the nurses to date the vials of PPD once opened and that all nurses were responsible for monitoring the medication storage room for expired items. A follow up interview with UC #1 on 03/20/19 at 12:07 PM revealed she assumed the role of UC on Tuesday (3/19/19), and monitoring medication storage would be part of her role. She</p>	F 761	<p>Administrator, AIT, and a Pharmacy Consultant were in the process of cleaning the Medication Rooms and Medication Carts when the survey process began. However, all Medication Carts and both Medication Rooms have now been cleaned and checked to ensure that all medications are properly stored, dated, not expired, and that there are no loose pills or non-medicinal items on/in the carts or in the Medication Rooms.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>Any resident may be affected by this practice. All Medication Carts and both Medication Rooms have now been cleaned and checked to ensure that all medications are properly stored, dated, not expired, and that there are no loose pills or non-medicinal items on/in the carts or in the Medication Rooms. The Director of Nursing will inservice all facility nurses on the proper storage, dating and labeling of medications and the importance of keeping the Medication Carts and Medication Rooms free clean and free of loose pills, debris, expired medications, and non-medicinal items.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p>		

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F 761	<p>Continued From page 11</p> <p>further stated that she had not monitored the medication storage room yet since becoming the UC but that she would do so going forward.</p> <p>An interview with Nurse #1 occurred on 03/20/19 at 11:39 AM and revealed that she was trained to date the bottles of PPD and the box once opened.</p> <p>An interview with the Corporate Clinical Nurse (CCN) occurred on 03/20/19 at 12:01 PM and revealed that the medication storage rooms were last checked on 3/19/19 for expired/undated/unlabeled items and that these items may have been missed. The CCN stated that she expected nurses to date all medications on the bottle once opened (PPD). The CCN also stated that she expected the UC to check refrigerators daily that were used to store medications for any expired, unlabeled, or undated items.</p> <p>An interview with the Director of Nursing (DON) occurred on 03/20/19 at 12:56 PM and revealed that she expected nurses to date all opened medication. She also stated that the facility had an action plan in place regarding medication storage due to an increase in staff turnover. She further stated that the plan was to revise their system and identify who would be assigned the task for monitoring medication storage.</p> <p>The Administrator stated in interview on 03/20/19 at 1:26 PM that the facility identified concerns with medication storage resulting from staff turnover and so far that week, staff checked the medication storage rooms and cleaned them out. The Administrator further stated that the facility was still in the process of identifying how this task</p>	F 761	<p>The Director of Nursing will inservice all facility nurses on the proper storage, dating and labeling of medications and the importance of keeping the Medication Carts and Medication Rooms free clean and free of loose pills, debris, expired medications, and non-medicinal items. The Director of Nursing will conduct random weekly QA checks of the Medication Rooms and Medication Carts to ensure that all medications are dated/labeled/stored properly and that there are no expired medications, loose pills/debris, or non-medicinal items present. These QA checks will be recorded on a QA form and will be presented to the QA Committee for review weekly for 3 months, then monthly for 3 months, and then quarterly.</p> <p>Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:</p> <p>Performance will be monitored and discussed during the weekly QA Committee Meeting weekly for 3 months, monthly for 3 months, and quarterly at the Quarterly QAPI Meeting to ensure that solutions are sustained.</p>		

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F 761	<p>Continued From page 12</p> <p>would be divided for monitoring amongst administrative staff.</p> <p>2a. An observation of the 600 Hall medication cart with Nurse #1 occurred on 03/20/19 at 11:44 AM and revealed the following:</p> <p>·A bottle of Lorazepam (antianxiety medication) 2mg/ml oral concentration was observed stored on the cart and not refrigerated. The manufacturer recommendations stamped on the box recorded "Store at cold temperature, refrigerate 2 degrees to 8 degrees Celsius, 36 degrees to 46 degrees Fahrenheit."</p> <p>Nurse #1 stated in interview on 3/20/19 at 11:46 AM that Lorazepam should be refrigerated. She further stated that she checked her medication cart that morning around 7:00 AM and saw the bottle of Lorazepam stored on the 600 Hall medication cart when she received it from the prior nurse, but that she forgot to put the Lorazepam in the refrigerator.</p> <p>An interview with the Corporate Clinical Nurse (CCN) occurred on 03/20/19 at 12:01 PM and revealed that medications should be stored according to manufacturer guidelines.</p> <p>An interview with the Director of Nursing (DON) occurred on 03/20/19 at 12:56 PM and revealed that she expected nurses to store medications per manufacturer recommendations. She also stated that the facility had an action plan in place regarding medication storage due to an increase in staff turnover. She further stated that the plan was to revise their system and identify who would be assigned the task for monitoring medication storage.</p>	F 761			

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F 761	<p>Continued From page 13</p> <p>The Administrator stated in interview on 03/20/19 at 1:26 PM that the facility had previously identified concerns with medication storage resulting from staff turnover and so far that week, staff checked the medication storage rooms and cleaned them out, but had not addressed the medication carts yet. The Administrator further stated that the facility was still in the process of identifying how this task would be divided for monitoring amongst administrative staff.</p> <p>2b. An observation of the 100 Hall medication cart with Nurse #2 occurred on 03/20/19 at 12:17 PM and revealed the following:</p> <ul style="list-style-type: none"> ·Humalog Insulin Injection 100 units/ml, with a facility open date of "2/18/19" and manufacturer instructions to "Throw away any medicine that remains 28 days after first use." The bottle of insulin was open and available for use for 31 days without being discarded. ·Azelastine HCl Antihistamine Nasal Solution 0.1%, 137 mcg/spray 200 metered sprays stored on its side instead of upright with manufacturer instructions to "Store upright at 20 - 25 degrees Celsius, 68 - 77 degrees Fahrenheit, keep bottle upright." ·Albuterol Sulfate Inhalation Solution 0.083% 2.5 mg/3ml opened and stored without a date of opening. ·Spartan Airlift Air Freshener 16 ounce can, a non-medicinal item stored on the medication cart. ·2 unidentified loose pills, white and blue, ·The bottom drawer of the cart was observed with an excessive amount of loose powder, debris and human hair. <p>An interview with Nurse #2 occurred on 3/20/19 at</p>	F 761			

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F 761	<p>Continued From page 14</p> <p>12:20 PM and revealed that the medication cart was last checked on the 11 P - 7A shift on 3/14/19, but these items found were not noticed. Nurse #2 further stated that the insulin was expired and should be discarded, the nasal spray should be stored upright and the air freshener should not be stored on the medication cart.</p> <p>An interview with the Corporate Clinical Nurse (CCN) occurred on 03/20/19 at 12:26 PM and revealed that medications should be stored according to manufacturer guidelines and the air freshener should not be on a medication cart mixed with medications.</p> <p>An interview with the Director of Nursing (DON) occurred on 03/20/19 at 12:56 PM and revealed that she expected nurses to store medications per manufacturer recommendations and date medicines once opened. She also stated that the facility had an action plan in place regarding medication storage due to an increase in staff turnover. She further stated that the plan was to revise their system and identify who would be assigned the task for monitoring medication storage.</p> <p>The Administrator stated in interview on 03/20/19 at 1:26 PM that the facility had previously identified concerns with medication storage resulting from staff turnover and so far that week, staff checked the medication storage rooms and cleaned them out, but had not addressed the medication carts yet. The administrator further stated that the facility was still in the process of identifying how this task would be divided for monitoring amongst administrative staff.</p> <p>2c. An observation of the medication cart for the</p>	F 761			

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F 761	<p>Continued From page 15</p> <p>400/500/200 halls and rooms 101, 301 - 303 occurred with Nurse #3 on 03/20/19 at 12:34 PM and revealed the following:</p> <ul style="list-style-type: none"> ·2 opened, undated vials of Acetylcysteine 20% Solution 30 ml ·An opened, unlabeled Multi-use vial of Normal Saline 20 ml for injection opened on "2/27/18" ·An opened, undated, unlabeled foil pouch of Budesonide inhalation suspension 0.5 mg/2 ml ·An opened, undated bottle of Latanoporst solution 0.005% eye drops ·An opened bottle of Desenex 2% miconazole nitrate antifungal powder (topical use) was stored on the medication cart next to over the counter ingestible liquids (oral use) ·An opened, undated bottle of Refresh Liquid 1% Eye Drops ·An opened, undated bottle of Ipratropium Solution Albuterol Inhalation ·54 unidentified loose pills of various shapes, sizes and colors found in all drawers of the cart <p>During an interview with Nurse #3 on 03/20/19 at 12:35 PM, she revealed that this medication cart was last checked for medication storage concerns on the previous Friday or Saturday. Nurse #3 also stated that she had not noticed the condition of the cart related to its cleanliness and there were some medicines she opened but forgot to date them. Nurse #3 further stated that she monitored the cart for cleanliness as time permitted, but usually ran out of time. She stated all medicines should be dated once opened.</p> <p>An interview with the Director of Nursing (DON) occurred on 03/20/19 at 12:56 PM and revealed that she expected nurses to date all medications once opened. She also stated that the facility had</p>	F 761			

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F 761	Continued From page 16 an action plan in place regarding medication storage due to an increase in staff turnover. She further stated that the plan was to revise their system and identify who would be assigned the task for monitoring medication storage. The Administrator stated in interview on 03/20/19 at 1:26 PM that the facility had previously identified concerns with medication storage resulting from staff turnover and so far that week, staff checked the medication storage rooms and cleaned them out, but had not addressed the medication carts yet. The Administrator further stated that the facility was still in the process of identifying how this task would be divided for monitoring amongst administrative staff.	F 761			
F 812 SS=F	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.	F 812		4/18/19	

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F 812	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and an interview with a contract employee, the facility failed to maintain and monitor the kitchen's the dish machine to ensure the machine's wash cycle temperature reached a minimum temperature of 150 degrees Fahrenheit (F) that was utilized to clean the dish ware and eating utensils during 1 of 1 observation of the dish machine in use.</p> <p>Findings included:</p> <p>An observation of the kitchen's dish machine, with the Dietary Manager (DM) and Certified Dietary Manager (CDM) on 3/20/2019 at 9:50 AM revealed one employee, Dietary Aide (DA) #1, was working at the dish machine, pre-rinsing and feeding dirty kitchenware, which included 62 plates, 31 bowls, 14 trays, and 4 saucers, into the dish machine, who was not monitoring the machine's temperature gauges. Observations of the machine's wash temperature gauge as DA #1 washed 3 different racks of kitchenware in the dish machine, revealed the machine's wash temperature gauge was fixed on a registered temperature of 138 degrees F.</p> <p>On 3/20/2019 at 10:00 AM the CDM instructed DA #1 to stop using the dish machine and to get the Maintenance Director (MD).</p> <p>An interview and observation were completed on 3/20/2019 at 10:06 AM with the MD. The MD used a calibrated thermometer to check the dish machine's water temperature. The first internal wash temperature reached 146 degrees F. At 10:08 AM on 3/20/2019 a second internal wash temperature was observed reaching 152 degrees</p>	F 812	<p>F-812</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility dish machine was checked at the start of the day and was found to be working at the proper temperature as required. This temperature was recorded on the temperature log per facility policy. Once it was noted by the surveyor that the dish machine was no longer operating at the proper temperature, the facility immediately switched to using disposable dishware and contacted Hobart to fix the dish machine. The dish machine was repaired by Hobart on 3/22/2019. The facility used disposable dishware until the machine could be repaired and all dishware could be re-washed at the proper temperature to ensure complete cleaning and sanitizing of the dishware.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p>		

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F 812	<p>Continued From page 18</p> <p>F, with the wash temperature gauge observed to be in a fixed position of 138 degrees F. A third internal wash temperature was obtained at 10:12 AM on 3/20/2019, which registered an internal wash temperature of 152 degrees F, with the wash temperature gauge remaining in a fixed position of 138 degrees F.</p> <p>During a continued interview with the MD on 3/20/2019 at 10:12 AM, he stated the dish machine needed a new wash temperature gauge. The MD explained that the wash cycle temperature should reach 150 degrees F or higher. The MD was concerned with the wash temperature due to the gauge not working properly and registering accurate wash temperatures. The MD verbalized even though running the wash cycle through several times and it reaching temperature, the wash gauge had the capability to get stuck again. The MD stated the dish machine was last serviced the end of 2018 with no repairs indicated. The MD expressed he would order a new gauge for the dish machine and have the contract vendor service the dish machine.</p> <p>An interview was completed on 3/20/2019 at 10:16 AM with Dietary Aide (DA) #1. DA #1 stated she had worked at the facility for approximately 14 to 16 months. DA #1 explained she monitored the temperatures (wash and rinse) while she prepared items to go through the dish machine. DA #1 stated that earlier in the morning, the gauges were working fine. DA #1 verbalized that wash temperatures needed to be at 150 degrees Fahrenheit or higher, and rinse temperatures needed to be at 180 degrees Fahrenheit or higher. DA #1 stated she would monitor about every couple of racks that went</p>	F 812	<p>All residents have the potential to be affected by this practice. The dish machine was repaired on 3/22/2019 and the facility used disposable dishware until the machine was repaired and all dishware was re-washed at the proper cleaning and sanitizing. The facility will begin monitoring and recording the dish machine temperature at each wash cycle to ensure that dishware is cleaned and sanitized at the proper temperature.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>The facility dish machine temperature will be monitored and recorded at each wash cycle to ensure that the dishware is washed at the proper temperature. The Dietary Manager will be responsible for monitoring the recording of the temperatures at each wash cycle and will present the results of her monitoring and the temperature log to the QA Committee for review weekly for 4 weeks, monthly for 2 months, and then quarterly.</p> <p>Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:</p> <p>The Dietary Manager will monitor the</p>		

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F 812	<p>Continued From page 19</p> <p>through the dish machine to ensure that temperatures were appropriate. DA #1 expressed that she had not checked the last few racks that went through the dish machine. DA #1 stated she should have stopped the dish machine when she noticed the temperature of 150 degrees F. was not being reached for the wash cycle. DA #1 did not realize the wash temperature was not reaching a wash temperature until it was brought to her attention by the surveyor. DA #1 verbalized she would do better. Review of the dish machine temperature log revealed no temperatures were recorded for 3/20/2019.</p> <p>An interview was completed on 3/20/2019 at 10:17 AM with the CDM. The CDM stated her expectation of staff would be to monitor temperatures throughout the wash and rinse process and the aide did not.</p> <p>An interview was completed on 3/20/2019 at 12:52 PM with a service technician from the company contracted by the facility to service the kitchen's dish machine. The service technician stated he checked the dish machine for proper function and found the machine had three (3) bad heating elements, as well as, both the wash gauge and rinse gauge were bad and needed to be replaced. The service technician stated the gauges, for both the wash and rinse cycles, could have gone out at any given time. The service technician explained the gauge for the rinse cycle maintained the hot water temperature for the wash cycle; both gauges worked in unison. If one gauge was not working properly, then the other gauge would not work properly. The service technician communicated to the MD and Administration that parts needed to be ordered and then repairs could be completed.</p>	F 812	<p>recording of the dish machine temperatures to ensure that they are being checked and recorded at each wash cycle. The Dietary Manager will present the results of her monitoring and the temperature logs to the QA Committee for review weekly for 4 weeks, monthly for 2 months, and quarterly at the Quarterly QAPI meeting to ensure that the solution is sustained.</p>		

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F 812	Continued From page 20 A follow up interview was completed with the CDM on 3/20/2019 at 6:51 PM. The CDM revealed that the process for monitoring the wash/ rinse temperatures on the dish machine was the responsibility of the DA assigned to the dishes. The CDM stated several empty racks would go through the dish machine, so that the water could reach temperature for washing and rinsing. Once the water reached the appropriate temperature for washing (150 or higher) and rinsing (180 or higher), the DA would record that temperature on the temperature log and start the dishwashing process with actual used kitchenware. An interview was completed with the Administrator on 3/21/2019 at 4:42 PM. The Administrator stated her expectation would be for dietary staff to monitor the wash/ rinse cycle temperatures while the dish machine was in use per policy and regulation.	F 812			
F 867 SS=F	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, staff interviews and review of the facility policy, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put	F 867	F-867 How the corrective action will be	4/18/19	

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F 867	<p>Continued From page 21</p> <p>into place in April 2018. This was for a recited deficiency, F761 Label/Store Drugs and Biologicals, which was originally cited during a recertification and complaint survey completed March 2018. 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.</p> <p>Findings included:</p> <p>This tag is cross referred to:</p> <p>F761: Label/Store Drugs and Biologicals: Based on observations, staff interviews, manufacturer's recommendations, and facility policy, the facility failed to 1) date medications after opening (Tuberculin Purified Protein Derivative (PPD), Inhaler, Nasal Spray, Eye Drops), 2) store medications per manufacturer's recommendations (Antianxiety, Nasal Spray), 3) remove expired medications/equipment (IV set, Insulin) and maintain medication carts free of loose pills, debris and non-medicinal items. This was observed in 1 of 2 medication storage rooms and 3 of 5 medication carts.</p> <p>During the recertification and complaint survey of March 2018, the facility was cited for failure to remove expired medications, label opened medications, and discard a single use injection after use. During the current recertification survey of March 2019, the facility was recited for failure to remove expired medications, date opened medications, store medications per manufacturer recommendations and maintain medication carts clean.</p> <p>An interview on 03/21/19 at 5:49 PM with the</p>	F 867	<p>accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility had already identified an issue with the labeling and storing of biologicals prior to the survey and had developed an Action Plan to address the issue. On the first day of survey, the facility Vice President informed the survey team of the action plan and provided a copy of the plan to the surveyors. The facility Administrator, AIT, and a Pharmacy Consultant were in the process of cleaning the Medication Rooms and Medication Carts when the survey process began. However, all Medication Carts and both Medication Rooms have now been cleaned and checked to ensure that all medications are properly stored, dated, not expired, and that there are no loose pills or non-medicinal items on/in the carts or in the Medication Rooms.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>Any resident may be affected by this practice. All Medication Carts and both</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345541	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2019
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F 867	Continued From page 22 Administrator revealed that the agenda items discussed during the facility's quarterly QAA meetings was determined based on concerns identified during previous QAA meetings. The Administrator stated that after 6 months to 1 year of monitoring, though monitoring did not continue daily, the facility kept the identified concerns as part of the quarterly QAA monitoring process. The Administrator further stated that she attributed a repeat deficiency related to labeling/storing drugs and biologicals to a turnover in staff since August 2018 which the facility had identified. The Administrator stated that the Pharmacy Consultant assisted the facility the prior week to ensure all medications were available for administration. The Pharmacy Consultant also tried to remove expired medications, but the focus was the availability of medications. Then the facility cleaned the medication storage rooms, but had not had a chance to monitor medications stored on the carts. The Administrator stated that since the facility identified systemic concerns with their medication storage, monitoring by the QAA committee had not yet begun because the facility was still organizing and identifying leadership roles for monitoring.	F 867	Medication Rooms have now been cleaned and checked to ensure that all medications are properly stored, dated, not expired, and that there are no loose pills or non-medicinal items on/in the carts or in the Medication Rooms. The Director of Nursing will inservice all facility nurses on the proper storage, dating and labeling of medications and the importance of keeping the Medication Carts and Medication Rooms free clean and free of loose pills, debris, expired medications, and non-medicinal items. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing will inservice all facility nurses on the proper storage, dating and labeling of medications and the importance of keeping the Medication Carts and Medication Rooms free clean and free of loose pills, debris, expired medications, and non-medicinal items. The Director of Nursing will conduct random weekly QA checks of the Medication Rooms and Medication Carts to ensure that all medications are dated/labeled/stored properly and that there are no expired medications, loose pills/debris, or non-medicinal items present. These QA checks will be		

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

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F 867	Continued From page 23	F 867	<p>recorded on a QA form and will be presented to the QA Committee for review weekly for 3 months, then monthly for 3 months, and then quarterly.</p> <p>Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:</p> <p>Performance will be monitored and discussed during the weekly QA Committee Meeting weekly for 3 months, monthly for 3 months, and quarterly at the Quarterly QAPI Meeting to ensure that solutions are sustained.</p>		