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	345381	A. BUILDING _____ B. WING _____	C 03/26/2019

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E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		4/16/19

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

Electronically Signed | 04/10/2019

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E 037	Continued From page 1 (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.	E 037		

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E 037	Continued From page 2	E 037		

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The

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E 037	Continued From page 3 CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide and maintain documentation of annual staff training on the facility emergency preparedness plan. Findings Included: Review of the facility ' s emergency preparedness plan revealed in-service education was provided on the facility emergency preparedness plan on 1/4/19. The in-service education only identified 29 employees had attended the training. An interview on 3/26/19 at 3:00 pm with the Administrator revealed the in-service education dated 1/4/19 did not include all the facility staff. He explained the in-service education materials were left at the nursing station to be completed by the third shift staff. The Administrator stated he could not confirm this was completed and he did not have any further evidence that all the facility staff had completed the annual training. He added it was his expectation that all facility staff would receive annual education on the facility emergency preparedness plan.	E 037	No resident was affected by the deficiency cited Immediate education for all staff including emergency preparedness policies, procedures and the core components of the facility□s Emergency Preparedness Plan was initiated on 04/03/2019. Completed 4/17/2019. To prevent this from recurring, all new hired employees will receive Emergency Preparedness Education during orientation process. All staff will receive Emergency Preparedness Plan training at the beginning of each calendar year. To monitor and maintain ongoing compliance, Human Resources Coordinator will report completed education for all newly hired employees monthly to the Administrator or designee. The Administrator or designee will audit all new hire personnel files weekly times 8	

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E 037	Continued From page 4	E 037	weeks to ensure compliance. The Administrator or designee will report the results of the monitoring to the QAPI committee for review and recommendation for the timeframe of the monitoring period.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636		4/17/19

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F 636	Continued From page 5 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the admission MDS (Minimum Data Set) assessment timely on 1 of 1 resident (Resident #286) reviewed as a new admission to the facility. Findings include: Resident #286 was admitted to the facility on	F 636	Resident #286 had a late Comprehensive Assessment completed on 4/8/19. To identify other residents that have the potential to be affected, MDS in progress list was reviewed/ prioritized to prevent further late MDS assessments. All assessments listed have been submitted timely as of 4/9/19.	

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F 636	Continued From page 6 3/11/19 with diagnoses that included status post right tibia fracture repair and acute cystitis. A review of Resident #286's admission MDS dated 3/18/19 revealed sections A (Identification Information), B (Hearing, Speech, and Vision), G (Functional Status), H (Bladder and Bowel), I (Active Diagnosis), J (Health Conditions), L (Oral/Dental Status), M (Skin Conditions), N (Medications), O (Special Treatments and Programs), P (Restraints), and V (Care Area Assessment Summary) had not been completed. An interview was conducted with the MDS nurse on 3/26/19 at 11:30 am. She reported she was responsible for completing all the MDS assessments. She reported an admission MDS assessment should be completed and locked within 14 days of admission. She reported she had not completed the admission MDS but could not give a reason why. An interview was conducted with the DON (Director of Nursing). She reported it was her expectation that all MDS assessments were completed and locked timely. She reported it was the responsibility of the MDS nurse to complete the MDS assessments.	F 636	To prevent this from recurring, the Regional Reimbursement Specialist has reeducated the nurses responsible for completing the MDS assessments in compliance with the guidelines on when a comprehensive assessment must be completed on 4/5/19. To monitor and maintain ongoing compliance, the MDS coordinator will create a list of MDS assessments in progress each week. The dates that each assessment are due will be listed. This will be presented to the Administrator for review each week for 12 weeks for review and follow up with any issues. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 637		4/17/19

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F 637	Continued From page 7 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change assessment within 14 days of the initiation of hospice care. This was evident for 1 of 1 resident that was reviewed for hospice (Resident #56). Findings Included: Resident #56 was admitted to the facility on 1/31/19 and diagnoses included chronic kidney disease, dementia and diabetes. Review of the medical record for Resident #56 revealed she was started on hospice services 2/20/19. A significant change minimum data set (MDS) dated 2/28/19 was identified as being in progress. Sections A, B, G, H, J, L, M, N, O and P were not completed. An interview on 3/26/19 at 12:07 pm with the MDS nurse revealed the significant change MDS dated 2/28/19 for Resident #56 should have been completed by 3/13/19. The MDS nurse stated she was behind and in the process of getting the MDS ' s completed. An interview on 3/26/19 at 2:07 pm with the Director of Nursing revealed it was her expectation that significant change assessments	F 637	Resident #56 had a late Comprehensive Significant Change Assessment completed 4/1/19. To identify other residents that have the potential to be affected, MDS in progress list was reviewed/ prioritized to prevent further late MDS assessments. All assessments listed have been submitted timely as of 4/9/19. To prevent this from recurring, the Regional Reimbursement Specialist has reeducated the nurses responsible for completing the MDS assessments in compliance with the guidelines on when a comprehensive significant change assessment must be completed. Education completed on 4/5/19. To monitor and maintain ongoing compliance, the MDS coordinator will create a list of MDS assessments in progress each week.The dates that each assessment are due will be listed. This will be presented to the Administrator for review each week for 12 weeks for review and follow up with any issues. The Administrator will report the results of the monitoring to the QAPI committee for	

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F 637	Continued From page 8 were completed within the required timeframes.	F 637	review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a minimum data set (MDS) assessment every 3 months. This was evident for 1 of 1 resident that was reviewed for dialysis (Resident #9). Findings Included: Resident #9 was admitted to the facility on 8/24/17 and diagnoses included end stage renal disease with dependence on renal dialysis, adult failure to thrive, schizophrenia, diabetes, dementia and chronic pain. A quarterly MDS dated 2/28/19 for Resident #9 identified Sections A, B, G, H, J, L, M, N, O and P were in progress. The last completed MDS was dated 12/1/18. An interview on 3/26/19 at 12:05 pm with the MDS Nurse revealed the MDS dated 2/28/19 for Resident #9 was past due and should have been completed by 3/14/19. The MDS Nurse stated she was in the process of getting the MDS ' s completed.	F 638	Resident #9 had a late Quarterly Assessment completed 3/29/19. To identify other residents that have the potential to be affected, MDS in progress list was reviewed/ prioritized to prevent further late MDS assessments. All assessments listed have been submitted timely as of 4/9/19. To prevent this from recurring, the Regional Reimbursement Specialist has reeducated the nurses responsible for completing the MDS assessments in compliance with the guidelines on when a quarterly assessment must be completed. Education completed on 4/5/19. To monitor and maintain ongoing compliance, the MDS coordinator will create a list of MDS assessments in progress each week. The dates that each assessment are due will be listed. This will be presented to the Administrator for review each week for 12 weeks for review	4/17/19

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F 638	Continued From page 9 An interview on 3/26/19 at 2:05 pm with the Director of Nursing revealed it was her expectation that quarterly assessments were completed by the assessment reference date.	F 638	and follow up with any issues. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
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 interviews, the facility failed to accurately code the MDS (Minimum Data Set) on 1 of 5 residents (Resident #47) reviewed for unnecessary medications reviewed for unnecessary medications. Findings include: Resident #47 was admitted to the facility on 10/24/18 with diagnoses that included recent Cerebrovascular Accident and encephalopathy. A review of Resident #47's most recent MDS coded as a quarterly assessment and dated 3/6/19 coded the resident as cognitively impaired. Active diagnoses included hypertension, anxiety, depression, chronic obstructive pulmonary disease, and encephalopathy. The MDS coded Resident #47's medication 7 day look back as resident having had injectable 1 out of 7 days, antidepressant 7 out of 7 days, anticoagulant 2 out of 7 days, and opioid 2 out of 7 days.	F 641	Resident #47 had a late inaccurate MDS Assessment completed. Correction completion 3/27/19. To identify other residents that have the potential to be affected, an audit was completed of 3 MDS assessments including section N. Audit sample was for the three weeks prior to 4/12/19. No inaccuracies were found. Completed 4/12/19. To prevent this from recurring, the Regional Reimbursement Specialist has reeducated the nurses responsible for completing the MDS assessments in compliance with the guidelines concerning the expectation that all assessments are accurate on 4/5/19. To monitor and maintain ongoing compliance, the MDS nurses will audit 3 completed MDS's, section N every week	4/17/19

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F 641	Continued From page 10 A review of Resident #47's MAR (Medication Administration Record) for February 28, 2019 - March 6, 2019 revealed the resident received Paxil, an antidepressant, for the 7 days, Tuberculin PPD injection one day, Buspar, an anxiety, for the 7 days, Cipro, an antibiotic, for 2 of the 7 days, Pradaxa, an anticoagulant, for 4 of the 7 days, and Tramadol, an opioid, for 4 of the 7 days. An interview was conducted with the MDS nurse on 3/26/19 at 11:30 am. The MDS nurse reported it was her responsibility to code all MDS assessments. She reported she did not correctly code Resident #47's quarterly MDS dated 3/6/19 in the medication section. An interview was conducted on 3/26/19 at 2:30 pm with the DON (Director of Nursing) and Administrator. The DON reported it was the responsibility of the MDS nurse to correctly code all MDS assessments. The DON and Administrator reported it was their expectation that the MDS assessments are coded accurately.	F 641	for 12 weeks. Nurses will not audit their own work. The MDS nurses will report the results of the audit to the Administrator each week for review. The MDS Coordinator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		4/16/19

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F 732	Continued From page 11 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to post daily nurse staffing information during one (1) of four (4) days and the facility failed to post the correct resident census on the daily nurse staffing information for three (3) of four (4) days during the recertification survey. Finding included; An observation on 3/23/2019 at 3:15 PM revealed the daily nurse staffing information for 3/22/2019 was posted in the facility's front lobby in a plastic sleeve on the wall. The staffing information was	F 732	No resident was affected by the deficiency cited. A new Nurse Staffing Information form was developed and implemented on 3/27/2019. To prevent this from recurring, the nurse scheduler and the weekend receptionist were educated on the regulatory requirements regarding Nurse Staffing Information. Education completed on	

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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
F 732	Continued From page 12 not posted for 3/23/2019. An observation on 3/24/2019 at 10 AM revealed daily nurse staffing information was posted in the facility's front lobby and was dated 3/24/2019. The facility's census sheet revealed the resident census was 110 on 3/24/2017. The posted nurse staffing included the assisted living census. An observation on 3/25/ 2019 at 11:30 PM revealed the daily nurse staffing information was posted in the facility's front lobby and was dated 3/25/2019. The facility's census sheet revealed the resident census was 108. The census number on the posting continued to combine assisted living census with the skilled nursing census. An observation on 3/26/2019 at 10:30 AM revealed the daily nurse staffing information was posted in the facility's front lobby and was dated 3/26/2019. The census number on the posting continued to combine assisted living census with the skilled nursing census. An interview with the Facility Scheduler (FS) on 3/26/2019 at 11:36 AM revealed she has been trained to compete the daily staff posting to included assisted living census. The FS indicated she had only been in this job for three months. An interview with the Director of Nursing on 3/26/2019 at 11:42 AM revealed the census was 90 for the skilled nursing and 17 for the assisted living on 3/26/2019. She stated that she was not aware the posting included the assisted living census. An interview with the Administrator on 3/26/2019 at 11:42 AM revealed the census for skilled nursing was 91 on 3/26/2019 and that the census posted which was 108 was the total for the whole facility. He indicated he was not aware that the assisted living residents should not be included. He stated it was his expectation that the posted	F 732	04/15/2019 To monitor and maintain ongoing compliance, Director of Nursing or designee will monitor Posted Nurse Staffing Information. This will be documented daily for 7 days, 2 times a week for 3 weeks, and then 1 time a week for 5 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 03/26/2019

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F 732	Continued From page 13 daily staffing be correct and not combine the nursing home and assisted living census per state regulations.	F 732		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and resident interview the facility failed to (1a) properly dispose of 5 Eswab collection and transport systems that had expired in 1 of 2 medication rooms (Medication room for the 100	F 761	Peroxide and flu swabs that were out of date were immediately discarded when identified on 3/25/2019. The out of date Zyrtec on the 100 hall cart	4/17/19

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F 761	Continued From page 14 and 200 halls), (1b) 2 bottles of Hydrogen Peroxide that had expired in 1 of 2 medication rooms (Medication room for the 300 and 400 halls) and (2) 1 bottle of prescription medication that had expired from 1 of 4 medication carts (medication cart for the 100 hall). Findings included: 1a. An observation of the medication storage room for halls 100 and 200 occurred on 3-25-19 at 9:30am with the Assistant Director of Nursing. There were 4 Eswab collection and transport systems (Flu swab) that expired on 2-28-19 and 1 that expired on 1-31-19. The Assistant Director of Nursing removed the swabs and discarded them. 1b. An observation of the medication storage room for halls 300 and 400 occurred on 3-25-19 at 9:45am with the Assistant Director of Nursing. There was 1- 32-ounce bottle of Hydrogen Peroxide in the cabinet that had expired on 1-2019 and another bottle that had expired on 12-2018. The Assistant Director of Nursing removed the 2 bottles of Hydrogen Peroxide and discarded them. During an interview with the Assistant Director of Nursing on 3-25-19 at 10:00am, she stated central supply would check for out of date supplies, but the unit managers also check for out of date supplies weekly. She also stated there had not been a unit manager for halls 100 and 200 till "a few days ago." Unit manager #2 was interviewed on 3-25-19 at 10:50am. The unit manager stated she did check the medication storage room for halls 300 and 400 weekly and had "just missed" seeing the	F 761	was immediately discarded as soon as it was identified on 3/26/2019. All medication rooms and carts were inspected for any further medication storage issues on 3/27/19. No other issues were identified. All Licensed nurses have completed reeducation in-servicing concerning medication storage and labeling expectations per facility policy by 4/17/19. Medication rooms and medication carts will be inspected for compliance with the medication storage and labeling expectations by the Director of Nursing or designee. This will be documented for all areas daily for 7 days, then all areas 5 days a week for 3 weeks, and then all areas weekly for 8 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period.	

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F 761	Continued From page 15 expired Hydrogen Peroxide. 2. A review of the medication cart on hall 100 occurred on 3-26-19 at 11:00am with nurse #2. A bottle of Cetirizine 10mg (milligrams) (allergy medication) was noted to have an expiration date of 10-2018 and to have approximately 20 pills out of 100 left. During an interview with nurse #2 on 3-26-19 at 11:05am, she stated she was not sure if any medication had been given out of the Cetirizine bottle because another nurse was helping her but was able to review the medication record and revealed one resident had received one dose of Cetirizine 10mg earlier in the morning of 3-26-19. The Administrator and Director of Nursing was interviewed on 3-26-19 at 1:30pm. The Director of Nursing stated she expected medications to be stored properly and to be within correct date range.	F 761		
F 867 SS=D	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, record review and staff interviews the facility's Quality Assurance and Assessment Committee failed to maintain implemented procedures and monitor the interventions put in place following the	F 867	There was a repeat citation for MDS assessment accuracy. To identify other residents that have the potential to be affected, the Administrator	4/16/19

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F 867	Continued From page 16 recertification survey of 2/28/18. One deficiency in the area of Minimum Data Set coding was recited on the recent recertification/complaint survey of 3/26/19. The two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance and Assessment program. Findings included: This tags is cross referred to: F 641 Based on record review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) on 1 of 5 residents (Resident #47) reviewed for unnecessary medications reviewed for unnecessary medications. During the recertification and complaint survey of February 28, 2018 the facility was cited F641 failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 (Resident #54) sampled for tube feedings. During an interview with Director of Nurses and Administrator on 3/26/2019 at 2:36 revealed they acknowledged understanding of F 641 Minimum Data Set accurately coded. Both indicated that they would take this concern to QA (Quality Assurance) and monitor it monthly to assure that staff was correcting these concerns. Their expectation was to address and monitor any tags to be in compliance with the state regulation.	F 867	reviewed the schedule of the MDS assessments and verified that there were no more late assessments in the active list. To prevent this from recurring, the Regional Director of Clinical Services has reeducated the Administrator concerning the components of the QAPI program. Completed 04/08/2019 To monitor and maintain ongoing compliance, the Regional Vice President of Operations or the Regional Director of Clinical Services will review the minutes of each QAPI committee meeting that is not attended by one of them for the next 3 monthly scheduled meetings. The review will look at the progress of each plan and goal to see if monitoring is effectively showing change in the outcomes or the committee is guided by the Administrator to reevaluate the plan. The Administrator will report the results of the feedback from the regional team to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	