STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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 on 7/8/19 through 7/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #IH4D11.	E 000		
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 interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments for antidepressant medication use for 1 of 1 resident (Resident #29) reviewed for hospitalization. Findings included: 1. Resident #29 was admitted to the facility on 4/11/19 with diagnoses that included, in part, traumatic brain dysfunction. Resident #29 discharged to the hospital for a scheduled surgery on 5/8/19. A review of the admission Minimum Data Set (MDS) assessment dated 4/18/19 revealed Resident #29 had impaired cognition and required one-person extensive assistance for activities of daily living. It did not state that the resident received an antidepressant or have a diagnosis of depression. Review of Resident #29's hospital discharge summary revealed the resident was on chronic	F 641	1. Resident #29 was discharged from Brookridge Retirement Community on 05/08/2019. 2. Nursing management will audit 100% of MDS assessments completed in the last 90 days for antidepressant medication coding accuracy by 08/08/2019. Any assessments identified as having antidepressant medication coding inaccuracy for current residents will be modified by 08/08/2019 by nursing management. 3. The MDS Nurse will be in-serviced on antidepressant medication assessment coding accuracy by the Director of Nursing (DON) by 08/08/2019. 4. Nursing management will monitor antidepressant medication coding accuracy on all transmitted MDS assessments weekly x 3 months. All results will be brought to weekly review meetings by nursing management. All results will be brought to QAPI by Nursing Management for review quarterly.	8/8/19

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

Electronically Signed | 07/24/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 1 antidepressant therapy. Review of physician orders revealed an order for Resident #29 to take Prozac 20mg daily on his admission to the facility. Review of Resident #29's medication administration record revealed the resident received Prozac 20mg daily from 4/11/19 to 4/18/19. During an interview with the MDS Nurse on 7/9/19 at 3:41 PM she stated that Resident #29's MDS from 4/18/19 should have documented the 7 days of antidepressant medication administered and that would have triggered the system to alert the MDS nurse to initiate an antidepressant/psychotropic care plan. It is expected that both care plans and MDS assessments address antidepressant use. On 7/11/19 at 4:33 PM an interview was completed with the Administrator and the Director of Nursing. They both stated that it is their expectation that both MDS assessments and care plans both accurately address antidepressant use.	F 641	5. The titles of the persons responsible for implementing the acceptable plan of correction are MDS, RN Supervisor, DON.	
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	F 656		8/8/19

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F 656	Continued From page 2 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 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 staff interviews and record review, the facility failed to 1) develop a care plan that addressed discharge goals and plans for 1 of 1 resident (Resident #27) reviewed for discharge to the community and 2) develop a care plan that	F 656	1. Resident #27 discharged from Brookridge Retirement Community on 04/18/2019. Resident #29 discharged from Brookridge Retirement Community on 05/08/2019.	

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	345209	A. BUILDING _____ B. WING _____	07/11/2019

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F 656	Continued From page 3 addressed antidepressant medication use for 1 of 1 resident (Resident #29) reviewed for hospitalization. Findings included: 1. Resident #27 was admitted to the facility on 3/29/19 with diagnoses that included, in part, hypertension and heart block. Resident #27 discharged home on 4/18/19. A review of the admission Minimum Data Set (MDS) assessment dated 4/5/19 revealed Resident #27 had moderately impaired cognition. Further review of the MDS assessment revealed active discharge planning was in place for Resident #27. A review of the care plan updated 4/12/19 revealed there was no care plan that addressed discharge planning. On 7/10/19 at 10:20 AM an interview was completed with the Social Worker. She stated she assisted residents with the discharge planning process but typically had not completed any care plans that addressed discharge planning. The Social Worker said the MDS Nurse completed all the care plans. On 7/10/19 at 10:42 AM an interview was completed with the Former MDS Nurse. She said discharge planning information was documented in the interdisciplinary notes. She stated discharge planning was not included in the comprehensive care plan and said she was unaware of the regulation that discharge goals and plans were supposed to be addressed in the care plan.	F 656	2. Nursing management will audit 100% of all current residents' care plans for discharge goals by 08/08/2019. Any care plans identified as not having discharge goals will be modified to include discharge goals by nursing management by 08/08/2019. Nursing management will audit 100% of residents with a current physician order to receive antidepressant medications for care plans addressing antidepressant medication use by 08/08/2019. Any resident care plans identified as not addressing antidepressant medication use for residents with a current physician order for antidepressant medication will be modified to include antidepressant medication use by nursing management by 08/08/2019. 3. The MDS Nurse was in-serviced on care planning discharge goals by the DON on 07/15/2019. The MDS Nurse was in-serviced on care planning antidepressant medication use for residents with antidepressant medication physician orders by the DON on 07/15/2019. 4. Nursing management will monitor 100% of new admission care plans for discharge goals weekly x 3 months. All results will be brought to weekly review meeting by nursing management. All results will be brought to QAPI by Nursing Management for review quarterly.	

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F 656	Continued From page 4 On 7/10/19 at 11:33 AM an interview was completed with the Administrator. She stated discharge planning had not been included in the electronic medical record care plan and said she expected discharge plans and goals be included in a resident's comprehensive care plan. 2. Resident #29 was admitted to the facility on 4/11/19 with diagnoses that included, in part, traumatic brain dysfunction. Resident #29 discharged to the hospital for a scheduled surgery on 5/8/19. A review of the admission Minimum Data Set (MDS) assessment dated 4/18/19 revealed Resident #29 had impaired cognition and required one-person extensive assistance for activities of daily living. It did not state that the resident received an antidepressant or have a diagnosis of depression. Review of Resident #29's hospital discharge summary revealed the resident was on chronic antidepressant therapy. Review of physician orders revealed an order for Resident #29 to take Prozac 20mg daily on his admission to the facility. Review of Resident #29's medication administration record revealed the resident received Prozac 20mg daily from 4/11/19 to 4/18/19. Review of Resident #29's care plan revealed there was no care plan that addressed antidepressant or psychotropic medications.	F 656	5. The titles of the persons responsible for implementing the acceptable plan of correction are MDS, RN Supervisor, DON.	

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F 656	Continued From page 5 During an interview with the MDS Nurse on 7/9/19 at 3:41 PM she stated that Resident #29's MDS from 4/18/19 should have documented the 7 days of antidepressant medication administered and that would have triggered the system to alert the MDS nurse to initiate an antidepressant/psychotropic care plan. It is expected that both care plans and MDS assessments address antidepressant use. On 7/10/19 at 4:33 PM an interview was completed with the Administrator and the Director of Nursing. They both stated that it is their expectation that both MDS assessments and care plans both accurately address antidepressant use.	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. (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	F 657		8/8/19

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F 657	Continued From page 6 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, resident and staff interviews and record review, the facility failed to update the care plan with appropriate interventions in the area of fall prevention for 3 of 4 residents (Resident #15, Resident #19 and Resident #17) reviewed for accidents. Findings included: 1. Resident #15 was admitted to the facility on 3/14/18 with diagnoses that included, in part, Alzheimer's disease. Resident #15's quarterly Minimum Data Set (MDS) assessment dated 5/31/19 revealed resident had severe cognitive impairment. She required one person limited assistance for transfers and walking. Further review of the MDS revealed Resident #15 had one fall with injury in the look back period of the assessment. A review of the current care plan revealed a problem of, "At risk for falls related to poor safety awareness and dementia," and a stated goal of, "Will not experience any major fall related injuries." Care plan approaches included, "Observe for unsteady/unsafe transfers or ambulation and provide stand-by or balance support as needed, monitor resident for signs of	F 657	1. The fall care plan for resident #15 was reviewed and updated by nursing management to reflect appropriate fall intervention on 08/01/2019. The fall care plan for resident #17 was reviewed and updated by nursing management to reflect appropriate fall intervention on 08/01/2019. The fall care plan for resident #19 was reviewed and updated by nursing management to reflect appropriate fall intervention on 08/01/2019, 2. A 100% audit of fall care plans for residents having falls in the month of July will be reviewed by nursing management for appropriate intervention by 08/08/2019. Any resident care plans identified as not addressing appropriate fall intervention for residents with falls during the month of July will be updated to include appropriate fall intervention by nursing management by 08/08/2019. 3. The MDS nurse was in-serviced by the DON on 07/15/2019. 4. 100% of falls will be reviewed for appropriate intervention placement on the	

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F 657	Continued From page 7 fatigue during ambulation, observe cognitive deficits and accommodate forgetfulness regarding safety devices and environmental risks." A care plan approach updated 10/25/18 revealed, "Education provided to staff and spouse on signs and symptoms of agitation and how to handle certain behaviors, and to be alert while resident is awake to avoid falls and/or injuries." On 7/8/19 at 2:03 PM an observation of Resident #15 revealed she was in her bed resting. Fall prevention floor mats were placed on either side of the bed. An interview with Resident #15's family member revealed the resident fell a couple of months ago and fractured her wrist but the family member was unable to recall the circumstances that surrounded the fall. A review of an incident report dated 5/1/19 revealed, "Certified Nursing Assistant (CNA) reported to this writer that she was walking this resident down the hall and this resident pulled away from her, lost her balance and fell. CNA stated this resident hit the back of her head on the hall banister. This writer assessed this resident. No raised areas found at this time. Has a small skin tear just below the left elbow. Cleansed with normal saline, applied anti-biotic ointment, and covered with bandaid. Notified responsible party. In doctor communication book. Staff to do frequent checks. Will continue to monitor." Further review of the care plan revealed no additional fall prevention interventions were added to the care plan after Resident #15 fell on 5/1/19. On 7/11/19 at 1:09 PM an interview was	F 657	residents' care plans weekly x 3 months by nursing management. All results will be brought to weekly review meeting by nursing management. All results will by brought to QAPI by nursing management for review quarterly. 5. The titles of the persons responsible for implementing the acceptable plan of correction are MDS, RN Supervisor, DON.	

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	345209	A. BUILDING _____ B. WING _____	07/11/2019

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F 657	Continued From page 8	F 657		

completed with Nurse Aide (NA) #1. She witnessed Resident #15's fall on 5/1/19. NA #1 said she walked with Resident #15 in the hallway and when the resident tried to go into another resident's room NA #1 attempted to redirect Resident #15 who then pulled away from NA #1 and fell. NA #1 said she could not remember if Resident #15 fell into the wall, door or on the floor but recalled the resident used her arm to break the fall. NA #1 reported she immediately notified the nurse after Resident #15 fell.

On 7/10/19 at 1:51 PM an interview was completed with Nurse #1. She said Resident #15 typically walked around the unit with a steady gait most days but had times when she became unbalanced and required supervision. Nurse #1 stated when she arrived for her shift the day after Resident #15 fell she assessed the resident's wrist as swollen, notified the physician and obtained an x-ray. Nurse #1 said the x-ray revealed a fractured wrist. Resident #15 was scheduled for treatment of the wrist fracture at an orthopedic rehabilitation office but was instead sent to the emergency room since she complained of pain.

On 7/10/19 at 8:22 AM an interview was completed with the Director of Nursing (DON). She stated whenever a resident fell, an investigation of the fall was completed at the time of the incident. She said the interdisciplinary team met daily and discussed falls from the previous day and fall prevention interventions were added to the resident's care plan within 24 hours of a fall.

On 7/10/19 at 11:30 AM an interview was completed with the Administrator. She said when

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F 657	Continued From page 9	F 657		

a resident fell the care plan was updated within 24-48 hours by the MDS nurse, nurse supervisor or DON.

On 7/10/19 at 3:29 PM a follow up interview was completed with the DON. She said the facility had several different MDS nurses in the past eight months and the current MDS nurse had been in her role for only a few weeks. The DON stated Resident #15's care plan should have been updated after the fall on 5/1/19. She acknowledged care plans had been an issue the facility had identified in their Quality Assessment and Performance Improvement process.

2. Resident #19 was admitted to the facility on 2/24/18 with diagnoses that included, in part, anemia and Parkinson's disease.

Resident #19's quarterly Minimum Data Set (MDS) assessment dated 6/14/19 revealed resident was cognitively intact. She required one person limited assistance for transfers and used a wheelchair. Further review of the MDS revealed Resident #19 had two or more falls with no injury in the look back period of the assessment.

A review of the current care plan revealed a problem of, "At risk for falls related to history of falls," and a stated goal of, "Will not have any major fall related injuries." A care plan approach updated 7/31/18 revealed, "Staff to remind resident to not bend over while sitting in the wheelchair, to call for assistance to retrieve dropped items." A care plan approach updated 8/12/18 revealed, " ...Items that are most often used will be kept within resident's reach." The care plan was last updated on 3/23/19 with an

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	345209	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 10	F 657		

approach that stated, "Reminded and re-educated resident to always call for assistance prior to transferring or standing."

On 7/8/19 at 3:47 PM an interview was completed with Resident #19. She reported she fell a couple of weeks ago when she attempted to pick something up off the floor while she sat in her wheelchair.

A review of an incident report dated 6/26/19 revealed, "Certified Nursing Assistant (CNA) answered resident's call light and located resident sitting upright in the floor in front of her wheelchair. 'I was bending over trying to pick a book up off the floor.' Staff action at time of incident: Head to toe assessment administered. Large raised area to the left side of resident's forehead noted. Resident refuses to go to the hospital. Neuro checks initiated. Resident reminded not to bend over in wheelchair and to use call light for assistance with toileting and transfers ..."

Further review of the care plan revealed no additional fall prevention interventions were added to the care plan after Resident #19 fell on 6/26/19.

On 7/10/19 at 8:51 AM an interview was completed with Nurse #1. She said she was the nurse on duty 6/26/19 when Resident #19 fell. She reported Resident #19 was in her wheelchair, bent over to pick up a book, fell out of the chair and hit her head.

On 7/10/19 at 8:22 AM an interview was completed with the Director of Nursing (DON). She stated whenever a resident fell, an

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F 657	Continued From page 11	F 657		

investigation of the fall was completed at the time of the incident. She said the interdisciplinary team met daily and discussed falls from the previous day and fall prevention interventions were added to the resident's care plan within 24 hours of a fall.

On 7/10/19 at 11:30 AM an interview was completed with the Administrator. She said when a resident fell the care plan was updated within 24-48 hours by the MDS nurse, nurse supervisor or DON.

On 7/10/19 at 3:29 PM a follow up interview was completed with the DON. She said the facility had several different MDS nurses in the past eight months and the current MDS nurse had been in her role for only a few weeks. The DON stated Resident #19's care plan should have been updated after the fall on 6/26/19. She acknowledged care plans had been an issue the facility had identified in their Quality Assessment and Performance Improvement process.

3. Resident #17 was admitted to the facility on 2/22/19 with diagnoses that included, in part, Alzheimer's disease and dementia.

Resident #17's quarterly Minimum Data Set (MDS) assessment dated 6/6/19 revealed resident was cognitively impaired. She required one-person extensive assistance for transfers and used a wheelchair. Further review of the MDS revealed Resident #17 had two or more falls with no injury in the look back period of the assessment.

Review of incident reports revealed that the resident fell on 3/11/19, 3/12/19, 3/27/19, and

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	345209	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 12	F 657		

5/31/19.

A review of the current care plan revealed a problem of, "At risk for falls related to frequent fall history and decrease in mobility," and a stated goal of, "resident will remain free of injuries and falls through next review." A care plan approach updated 3/21/19 revealed, "instructed on how to use the call bell for assistance". A care plan approach updated on 3/27/19 revealed " ...to be monitored by staff at all times due to confusion". A care plan approach updated 6/2/19 revealed a problem of, "At risk for falls related to non-compliance with assistance to the bathroom" with the intervention of "re-educated resident on the importance of requesting assistance for ADL's".

During an interview with Nurse Aide #2 on 7/10/19 at 4:12 PM she stated that Resident #17 was confused, she tried to get up from her wheelchair frequently, and that she has to be monitored more closely. She stated that the resident did not use her call bell often, if at all.

During an interview with Nurse #1 on 7/10/19 at 4:16 PM she stated that Resident #17 was not oriented and was confused. She stated that she tried to go to the bathroom on her own at times and staff have to monitor her closely.

On 7/11/19 at 4:32 PM an interview was completed with the Director of Nursing (DON). She stated whenever a resident fell, an investigation of the fall was completed at the time of the incident. She said the interdisciplinary team met daily and discussed falls from the previous day and fall prevention interventions were added to the resident's care plan within 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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 657	Continued From page 13 hours of a fall. She stated that she expected the interventions to be individualized to each resident and that providing education to a confused resident was not an appropriate intervention. She also stated that the only way a resident can be monitored by staff at all times was if they had a one on one sitter, Resident #17 had not had a one on one sitter, so that intervention was not appropriate either. On 7/11/19 at 4:40 PM an interview was completed with the Administratorand and DON. They said when a resident fell, it was their expectation the care plan was updated within 24-48 hours by the MDS nurse, nurse supervisor or DON with appropriate interventions for each resident.	F 657		
F 761 SS=D	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	F 761		8/8/19

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F 761	Continued From page 14 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications and blood glucose test strips, date and label multi-dose eye ointment when opened, and ensure there were no loose pills in medication/treatment cart for one of one medication/treatment carts and one of one medication rooms observed. The findings included: Observations on 7/11/19 at 10:20 AM of the medication/treatment cart used for 600 Hall residents revealed the following expired medications: 1 - Miralax powder bottle (Expired 11/2018), 1 - Vaseline gauze (Expired 7/2018), and 1 - opened bottle of blood glucose strips (Expired 9/30/2018). In the top drawer of the cart, there was a loose white oblong pill, and an opened multi-use Lubrifresh PM eye ointment tube that was not labeled or dated. Observations of the medication room for 600 Hall residents at 7/11/19 at 10:32 AM revealed 15 expired Triple Antibiotic Ointment Packets (0.9g weight), and 1 - Bacitracin Zinc Ointment Packet (Expired 5/2017). During an interview with the Treatment Nurse on 7/11/19 at 10:25 AM she stated that third shift	F 761	1. The expired Miralax powder bottle, expired Vaseline gauze, open bottle of blood glucose strips, white oblong pill and open multiuse Lubifresh PM eye ointment tube were removed from the 600 hall medication care and disposed of by nursing management on 07/11/2019. The 15 expired triple ointment packets and expired bacitracin zinc ointment packet were removed from the 600 hall medication room and disposed of by nursing management on 07/11/2019. 2. A 100% audit of all medication carts, treatment carts and medication rooms was completed by nursing management on 07/15/2019. Any medications/ treatment supplies identified as loose, expired or open without proper labeling or dating was removed and disposed of by nursing management on 07/15/2019. 3. A 100% in-service of nurses and medication aides will be completed by nursing management on the proper labeling and storage of drugs and biologicals by 08/08/2019. 4. Nursing management will complete a 100% of medication carts, treatment carts	

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F 761	Continued From page 15 nursing staff was responsible for checking carts and the medication room for expired medications and supplies. During an interview with the Administrator on 7/11/19 at 11:20 AM, she stated that it was her expectation that there were no expired medications or supplies in the carts or medication rooms. She stated that a pharmacy company was hired to audit medication storage and had been signing off weekly for the last few weeks that they were checked for expired medications and supplies. She stated that in between those audits, it was her expectation that third shift employees were auditing the carts and medication rooms.	F 761	and medication storage rooms will be reviewed for proper labeling and storage of drugs and biologicals weekly x 3 months. All results will be brought back to weekly review by nursing management. All results will be brought to QAPI by nursing management for review quarterly. 5. The title of the persons responsible for implementing the acceptable plan of correction are supervisors.	