STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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 and Compliant Investigation survey was conducted on 09/30/19 through 10/04/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 3CFN11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted on 09/30/19 through 10/04/19. A total of 17 allegations out of 62 were substantiated.	F 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.	F 550		10/25/19

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

Electronically Signed | 10/25/2019

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F 550	Continued From page 1 §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 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to ensure a resident's urine collection bag was covered for 1 of 1 resident reviewed for catheter care (Resident #143). Findings included: Resident #143 was admitted to the facility 01/01/19 with diagnoses including neurogenic bladder (a condition in which a person lacks bladder control due to a brain, spinal cord, or nerve condition). The significant change Minimum Data Set (MDS) dated 09/04/19 revealed Resident #143 was moderately impaired for cognition and had an indwelling urinary catheter. The care plan for suprapubic catheter last revised 09/11/19 revealed Resident #143 was to have a	F 550	1. Resident #143 has a dignity cover over their collection bag. 2. All residents with indwelling catheters have potential to be affected. 100% audit of all current residents with indwelling catheters was completed by the nursing leadership team to ensure all had dignity covers in place. In the stand-up meetings each morning, the Director of Nursing (DON) will review the orders and monitor for catheter orders on all residents. The Unit Managers and Central Supply Clerk will ensure all urine collection bags have a dignity cover. Additional dignity bags will be located on the treatment carts on each unit in case an admission occurs on nights/weekends. In addition, an order was placed on each resident's Medication Administration Record (MAR) to check for dignity bags on each shift.	

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F 550	Continued From page 2 privacy bag covering his catheter bag. An observation of Resident #143 on 09/03/19 at 4:58 PM revealed he was lying in bed and his catheter bag was hanging on the bed frame with no privacy bag in place. The catheter's urine collection bag was visible from the doorway of the room. An observation of Resident #143 on 10/01/19 at 8:13 AM revealed he was lying in bed and his catheter bag was hanging on the bed frame with no privacy bag in place. The catheter's urine collection bag was visible from the doorway of the room. An observation of Resident #143 on 10/01/19 at 2:24 PM revealed he was lying in bed and his catheter bag was hanging on the bed frame with no privacy bag in place. The catheter's urine collection bag was visible from the doorway of the room. An observation of Resident #143 on 10/02/19 at 6:29 AM revealed he was lying in bed and his catheter bag was hanging on the bed frame with no privacy bag in place. The catheter's urine collection bag was visible from the doorway of the room. An observation of Resident #143 on 10/02/19 at 8:24 Am revealed he was lying in bed and his catheter bag was hanging on the bed frame with no privacy bag in place. The catheter's urine collection bag was visible from the doorway of the room. Nurse #2 performed suprapubic catheter care for Resident #143 on 10/02/19 at 3:04 PM and did	F 550	3. Education was provided on 10/25/19 to the nursing staff by the DON and the Assistant Director of Nursing (ADON) regarding resident's right to privacy to include the use of dignity covers for all urine collection bags. During orientation, all new hires will receive education regarding the use of dignity covers over all urine collection bags during the clinical portion of orientation. 4. On 10/25/19, Unit Managers and ADON will audit will audit 5 times per week x 4 weeks; 3 times per week x 1 month; then one time per week x 1 month to ensure dignity bags are in place for all residents with indwelling catheters. Results of these audits will be brought before the Quality Assurance and Performance Improvement (QAPI) Committee by the DON monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance 10/25/19	

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F 550	Continued From page 3 not apply a privacy bag to the catheter bag. An interview with Nurse #2 on 10/02/19 at 3:06 PM revealed she thought catheter bags only needed dignity bags if residents were out of their rooms. An interview with the Director of Nursing (DON) on 10/04/19 at 9:19 AM revealed she expected all residents with an indwelling urinary catheter to have a privacy bag in place whether they were mobile or not. The DON stated nurses were responsible for applying privacy bags to catheter bags. An interview with the Administrator on 10/04/19 at 9:40 AM revealed she expected nurses to apply privacy bags to all catheter bags.	F 550		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review and resident and staff interviews, the facility failed to implement their abuse policy and procedures by	F 607	1. Resident #121 has had no further incidents of resident to resident altercations. Resident #121 moved to the	10/25/19

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F 607	Continued From page 4 not reporting or investigating 2 separate incidents of resident-to-resident abuse for 2 of 4 residents reviewed for abuse (Residents #121 and #144). Findings included: A review of the facility policy and procedure titled "Abuse Prohibition", with a revised date of March 2018, read in part: 6) Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Center Executive Director (CED) will perform the following: 6.2) Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made; 6.7) initiate an investigation within 24 hours of all allegation of abuse; and 6.8) the investigation will be thoroughly documented. 1. Resident #121 was admitted to the facility on 08/31/17 with diagnoses that included anxiety disorder and major depression. The quarterly Minimum Data Set (MDS) dated 08/16/19 assessed Resident #121 with intact cognition. Further review of the MDS revealed Resident #121 displayed physical and verbal behavior directed toward others 1 to 3 days during the 7-day assessment period. Resident #121's medical record revealed a Change in Condition (CIC) form dated 08/31/19 which read in part, "Resident #121 was verbally abusive to staff. Unable to redirect without yelling or cursing. Resident #121 was in the dining room, got into a disagreement with another resident, hit the other resident in the chin and pulled the resident's walker forward causing the resident to fall to their knees."	F 607	first floor on 5/13/19. Resident #144 has not had any other incidents. During audit, there were no further incidents identified with #144. 2. All residents have the potential to be effected. 100% audit of events started on 10/25/19 for the last 30 days was completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to determine if there had been any additional resident to resident events that had not been investigated or reported to the state. 3. Education was provided by the DON and ADON by Staff Development on 10/25/19 to the staff (education was given to nursing, dietary, housekeeping, rehabilitation and administration) on reporting resident to resident altercations immediately to DON and/or ADON so that an investigation can be initiated and report sent to the state. The incident is reported to the nurse assigned to the resident, who initiates the reporting process and documentation. The nurse assigned to the resident then reports the information to the DON and/or ADON. The DON and/or ADON are responsible for the investigation and filing the report to the state agency. 4. On 10/25/19, DON and ADON will audit events (documented in Risk Management Data Entry System, which is then reported to state agency) and nurses notes (to include all clinical documentation from the previous 24 hours) as part of the clinical	

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F 607	Continued From page 5 The facility's abuse investigations completed for the period August 2019 to October 2019 revealed no 24-hour initial or 5-day investigative reports were submitted to the State Agency (SA) related to the resident-to-resident altercation on 08/31/19 involving Resident #121. During a telephone interview on 10/03/19 at 4:10 PM, Nurse #5 confirmed she worked the evening of 08/31/19 when Resident #121 hit another resident but did not witness the incident. She explained when she entered the dining room to assess the situation, Resident #121 was sitting at the table and the other resident was on their knees on the floor. Nurse #5 recalled the other resident accused Resident #121 of hitting them in the chin and then pulled their walker away causing them to slide down to the floor. She added Resident #121 denied any knowledge of the incident when questioned. She indicated both residents were immediately separated and no other incidents occurred throughout the remainder of the shift. Nurse #5 stated she completed the CIC form related to the incident and notified the oncoming nurse during shift report but did not notify the Director of Nursing or Administrator. During an interview on 10/04/19 at 9:15 AM, the Administrator confirmed she was the facility's Abuse Coordinator and was notified of the resident-to-resident altercation involving Resident #121 on 08/31/19. She explained an investigation was not initiated since both residents were assessed by the nurse and immediately separated without further incident. The Administrator confirmed the incident on 08/31/19 was not reported to the State Agency	F 607	morning meeting 5 times per week x 4 weeks; then three times per week x 4 weeks; then weekly to determine if any resident to resident events have occurred to ensure appropriate investigation and reporting is completed. The residents involved would be interviewed and examined by social services and nursing after altercation is reported. Social services will also interview other alert and oriented residents as it pertains to the incident. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee (QAPI) monthly by the DON with the QAPI committee responsible for ongoing compliance. 5. Date of compliance 10/25/19	

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F 607	Continued From page 6	F 607		

and explained she was not aware they were required to report incidents of resident-to-resident altercations.

2. Resident #144 was admitted to the facility on 01/28/16 with multiple diagnoses that included hemiplegia (paralysis on one side of the body), anxiety disorder and depression.

The quarterly Minimum Data Set (MDS) dated 09/04/19 revealed Resident #144 had intact cognition and displayed no behaviors during the 7-day assessment period.

During an interview on 10/02/19 at 03:26 PM, Resident #144 revealed Resident #121 had once displayed inappropriate behavior toward him while they were roommates. Resident #144 was unable to recall the date this had occurred but indicated it happened during the early morning hours. Resident #144 explained he was lying in bed asleep when he woke up to Resident #121 putting his hand down the front of his brief, without touching his private area, and then quickly removed his hand, returned to his own bed and fell back asleep. Resident #144 stated although Resident #121's behavior "took me by surprise", he did not report it to anyone at the time because he felt Resident #121 might have been dreaming during the incident and wasn't sure what had caused it to happen. Resident #144 indicated he mentioned the incident to Social Worker (SW) #1 when he requested to move to another room but could not recall the exact date. Resident #144 denied being fearful of Resident #121 and confirmed no other incidents occurred with Resident #121 before or after the alleged incident.

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F 607	Continued From page 7 During an interview on 10/04/19 at 8:37 AM, SW #1 confirmed Resident #144 had reported to her that Resident #121 had put his hand down the front of Resident #144's brief. She was unable to recall the date Resident #144 reported the allegation but stated she immediately informed the Administrator and Director of Nursing (DON). During an interview on 10/04/19 at 9:15 AM, the Administrator confirmed she was the facility's Abuse Coordinator and explained she typically reported all allegations made by residents, especially when they were abuse related, to the State Agency (SA) and if applicable, the local police department. She did not recall being notified of the incident that occurred between Resident #121 and #144 and added staff were instructed to notify her immediately whenever an allegation of abuse was reported. The Administrator confirmed she had no documentation to support the incident was reported to the SA within the regulatory timeframe or that a facility investigation was conducted.	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		10/25/19

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F 610	Continued From page 8 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to investigate 2 separate incidents of resident-to-resident abuse for 2 of 4 residents reviewed for abuse (Residents #121 and #144). Findings included: 1. Resident #121 was admitted to the facility on 08/31/17 with diagnoses that included anxiety disorder and major depression. A nurse progress note dated 08/14/19 read in part, Resident #121's "behaviors are in the escalation phase for the past few weeks. He is confrontational daily with staff and other residents. He is not easily redirected and when redirected will often direct his verbal assaults to staff." The quarterly Minimum Data Set (MDS) dated 08/16/19 assessed Resident #121 with intact cognition. Further review of the MDS revealed Resident #121 displayed physical and verbal behavior directed toward others 1 to 3 days during the 7-day assessment period. Resident #121's medical record revealed a Change in Condition (CIC) form dated 08/31/19 which read in part, "Resident #121 was verbally abusive to staff. Unable to redirect without yelling	F 610	1. Resident #121 has had no further incidents of resident to resident altercations. Resident #121 moved to the first floor on 5/13/19. Resident #144 has not had any other incidents. During audit, there were no further incidents identified with #144. 2. All residents have the potential to be effected. 100% audit of events started on 10/25/19 for the last 30 days was completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to determine if there had been any additional resident to resident events that had not been investigated or reported to the state. 3. Education was provided by the DON and ADON by Staff Development on 10/25/19 to the staff (education was given to nursing, dietary, housekeeping, rehabilitation and administration) on reporting resident to resident altercations immediately to DON and/or ADON so that an investigation can be initiated and report sent to the state. The incident is reported to the nurse assigned to the resident, who initiates the reporting process and documentation. The nurse assigned to the resident then reports the information to	

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F 610	Continued From page 9	F 610		

or cursing. Resident #121 was in the dining room, got into a disagreement with another resident, hit the other resident in the chin and pulled the resident's walker forward causing the resident to fall to their knees."

During a telephone interview on 10/03/19 at 4:10 PM, Nurse #5 confirmed she worked the evening of 08/31/19 when Resident #121 hit another resident but did not witness the incident. She explained when she entered the dining room to assess the situation, Resident #121 was sitting at the table and the other resident was on their knees on the floor. Nurse #5 recalled the other resident accused Resident #121 of hitting them in the chin and then pulled their walker away causing them to slide down to the floor. She added Resident #121 denied any knowledge of the incident when questioned. She indicated both residents were immediately separated and no other incidents occurred throughout the remainder of the shift. Nurse #5 stated she completed the CIC form related to the incident and notified the oncoming nurse during shift report but did not notify the Director of Nursing or Administrator.

During an interview on 10/04/19 at 9:15 AM, the Administrator confirmed she was the facility's Abuse Coordinator and was notified of the resident-to-resident altercation involving Resident #121 on 08/31/19. She explained a facility investigation was not initiated or conducted since both residents were assessed by the nurse and immediately separated without further incident.

2. Resident #144 was admitted to the facility on 01/28/16 with multiple diagnoses that included hemiplegia (paralysis on one side of the body),

the DON and/or ADON. The DON and/or ADON are responsible for the investigation and filing the report to the state agency.

4. On 10/25/19, DON and ADON will audit events (documented in Risk Management Data Entry System, which is then reported to state agency) and nurses notes (to include all clinical documentation from the previous 24 hours) as part of the clinical morning meeting 5 times per week x 4 weeks; then three times per week x 4 weeks; then weekly to determine if any resident to resident events have occurred to ensure appropriate investigation and reporting is completed. The residents involved would be interviewed and examined by social services and nursing after altercation is reported. Social services will also interview other alert and oriented residents as it pertains to the incident. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee (QAPI) monthly by the DON with the QAPI committee responsible for ongoing compliance.

5. Date of compliance 10/25/19

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F 610	Continued From page 10	F 610		

anxiety disorder and depression.

The quarterly Minimum Data Set (MDS) dated 09/04/19 revealed Resident #144 had intact cognition and displayed no behaviors during the 7-day assessment period.

During an interview on 10/02/19 at 03:26 PM, Resident #144 revealed Resident #121 had once displayed inappropriate behavior toward him while they were roommates. Resident #144 was unable to recall the date this had occurred but indicated it happened during the early morning hours. Resident #144 explained he was lying in bed asleep when he woke up to Resident #121 putting his hand down the front of his brief, without touching his private area, and then quickly removed his hand, returned to his own bed and fell back asleep. Resident #144 stated although Resident #121's behavior "took me by surprise", he did not report it to anyone at the time because he felt Resident #121 might have been dreaming during the incident and wasn't sure what had caused it to happen. Resident #144 indicated he mentioned the incident to Social Worker (SW) #1 when he requested to move to another room but could not recall the exact date. Resident #144 denied being fearful of Resident #121 and confirmed no other incidents occurred with Resident #121 before or after the alleged incident.

During an interview on 10/04/19 at 8:37 AM, SW #1 revealed her part of the abuse investigation process consisted of interviewing residents and/or staff involved. SW #1 explained she documented who was interviewed, along with any concerns identified, and gave the information to the Administrator once completed. SW #1

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F 610	Continued From page 11 confirmed Resident #144 had reported to her that Resident #121 had put his hand down the front of Resident #144's brief. She was unable to recall the date Resident #144 reported the allegation but stated she immediately informed the Administrator and Director of Nursing. SW#1 explained she interviewed both Resident #121 and Resident #144 as well as other residents who had resided on the same hall at the time of the alleged incident and no other resident reported any concerns. SW #1 stated she did not have documentation that verified the date or name of the residents interviewed. SW #1 added after the allegation was reported, Resident #144 was moved to another room on a different floor at his request and there have been no further issues reported by Resident #144. During an interview on 10/04/19 at 9:15 AM, the Administrator confirmed she was the facility's Abuse Coordinator and explained she typically reported and investigated all allegations made by residents, especially when they were abuse related. She did not recall being notified of the incident that occurred between Resident #121 and #144 and added there was no documentation to support a facility investigation was conducted.	F 610		
F 641 SS=E	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 Minimum Data Set (MDS) reviewed for the areas of	F 641	1. Resident #19 effective hospice date 7/3/19, MDS (Minimum Data Set) dated 7/8/19 modified 10/2/19; 2. Resident #98	10/25/19

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F 641	Continued From page 12 Hospice to reflect prognosis (Resident #19, #98, #154, #159, #220, #219, and #118) and unnecessary medication for diagnosis (Resident # 121) for 8 of 15 sampled residents reviewed for MDS accuracy. Findings included: 1. Resident #19 was admitted to the facility on 07/01/19 with Cardiopulmonary Disease (COPD). A review of a Hospice Certification Statement with effective date of 07/03/19 and signed by the physician indicated Resident #19 had a terminal illness with a life expectancy of six months or less for diagnosis of cardiopulmonary disease (COPD). A review of an admission Minimum data Set (MDS) assessment dated 07/08/19 indicated under Section J1400. Prognosis that Resident #19 was not coded as having a chronic condition that might result in life expectancy of less than 6 months. On 10/02/19 at 1:31 PM an interview was conducted with MDS Nurse #1 who stated she was responsible for coding Section J1400. Prognosis on Resident #19's admission MDS assessment dated 07/08/19. MDS Nurse #1 revealed she did not code that Resident #19 had a life expectancy of less than 6 months because the Hospice Certification Statement was not available in the medical record at the time she completed the admission MDS assessment. On 10/02/19 at 2:16 PM an interview was conducted with MDS Nurse #2 who stated according to the Resident Assessment Instrument	F 641	hospice effective date 8/6/19, MDS dated 8/14/19 modified 10/2/19; 3. Resident #154 hospice effective date 9/5/19, MDS dated 9/11/19 modified 10/2/19; 4. Resident #159 hospice effective date 6/4/19, MDS quarterly dated 9/11/19 was reviewed and coded correctly on 9/23/19 with no modification needed, reviewed significant change MDS dated 6/11/19, modified on 10/2/19; 5. Resident #219 hospice effective 5/10/19, MDS dated 5/16/19 modified on 10/2/19; 6. Resident #220 hospice effective 6/4/19, MDS dated 6/7/19 modified 10/2/19; 7. Resident #118 hospice effective 5/9/17 with recertification on 6/28/19, MDS dated 8/1/6/19 modified 10/2/19. The facility failed to code MDS on 1 resident regarding current dx of GERD (Gastroesophageal Reflux Disease) on MDS. To correct this deficiency sited residents were modified. Resident #121 MDS dated 8/16/19, modified on 10/2/19. 2. The Clinical Reimbursement Coordinator (CRC) and the MDS Nurses will complete an audit of MDS Assessments for the period of June 1, 2019 through September 30, 2019 of all current residents for MDS Sections J1400 Prognosis and Section I I1200 GERD, I8000 GERD diagnosis to ensure accurate coding in place, and discrepancies will result in an modified MDS Assessment. Audit completed 10/24/19.	

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F 641	Continued From page 13 (RAI) manual the admission MDS assessment dated 07/08/19 should have been coded under Section J1400. Prognosis to reflect Resident #19 had a life expectancy less than 6 months. MDS Nurse #2 revealed a modification of the admission MDS assessment dated 07/08/19 would need to be submitted to accurately reflect Resident #19 had a life expectancy less than 6 months. MDS Nurse #2 revealed she had been confused with the interpretation of the RAI manual on how to code Section J1400. Prognosis. On 10/02/19 at 2:48 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the admission MDS assessment would have been accurately coded to reflect Resident #19 had a life expectancy less than 6 months. The DON stated if the Hospice certification was not located in the medical record than she would have expected the MDS Nurse to have obtained the certification from Hospice. The DON indicated there may have been confusion of the interpretation of the RAI manual for the MDS nurse to code Section J1400. Prognosis on the admission MDS assessment. On 10/02/19 at 3:02 PM an interview was conducted with the Administrator who stated her expectation was that the MDS assessment would have been accurately coded to reflect Resident #19 had a life expectancy less than 6 months. The Administrator stated she felt the inaccurate coding of Section J1400. Prognosis was related to the MDS Nurse misinterpretation of the RAI manual for coding prognosis. 2. Resident #98 was admitted to the facility on	F 641	3. The Clinical Reimbursement Coordinator and MDS Nurse were educated by the regional MDS Consultant on 10/23/19 on: MDS RAI Manual 1.17,1: Education included the following: RAI Manual 1.17.1 Section J. Other Health Conditions, Section J1400 Prognosis was reviewed and inserviced with the CRC / MDS Nurses regarding coding guidelines per RAI Manual. RAI Manual 1.17.1 Section I. Active Diagnosis, Section I I1200 Comprehensive, I8000 Additional Active Diagnoses were reviewed and inserviced with the CRC / MDS Nurses regarding the coding guidelines per RAI Manual. 4. On 10/25/19, Clinical Reimbursement Coordinator and/or MDS Nurse will perform MDS audit for 100% of current residents weekly for a period of 4 weeks until 100% compliance for MDS Sections J1400 Prognosis then monthly x 2 monthly until 100% compliance and quarterly x 3 quarters until 100% compliance, then yearly or until pattern of compliance is achieved. Prior to locking and transmitting MDS the Clinical Reimbursement Coordinator and/or MDS Nurse will review and verify for accuracy MDS Sections J1400 Prognosis. Section I - I1200 and I8000 regarding GERD - audits will be preformed weekly for period	

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F 641	Continued From page 14 07/24/19 with tonsillar cancer. A review of a Hospice Certification Statement with effective date of 08/06/19 and signed by the physician indicated Resident #98 had a terminal illness with a life expectancy of six months or less for diagnosis of tonsillar cancer. A review of a significant change Minimum data Set (MDS) assessment dated 08/14/19 indicated under Section J1400. Prognosis that Resident #98 was not coded as having a chronic condition that might result in life expectancy of less than 6 months. On 10/02/19 at 1:31 PM an interview was conducted with MDS Nurse #1 who stated she was responsible for coding Section J1400. Prognosis on Resident #98's significant change MDS assessment dated 08/14/19. MDS Nurse #1 revealed she did not code that Resident #98 had a life expectancy of less than 6 months because the Hospice Certification Statement was not available in the medical record at the time she completed the admission MDS assessment. On 10/02/19 at 2:16 PM an interview was conducted with MDS Nurse #2 who stated according to the Resident Assessment Instrument (RAI) manual the significant change MDS assessment dated 08/14/19 should have been coded under Section J1400. Prognosis to reflect Resident #98 had a life expectancy less than 6 months. MDS Nurse #2 revealed a modification of the significant change MDS assessment dated 08/14/19 would need to be submitted to accurately reflect Resident #98 had a life expectancy less than 6 months. MDS Nurse #2 revealed she had been confused with the	F 641	of 4 weeks until 100% for MDS section I1200 & I8000, then monthly x2 until 100% compliance and quarterly x 3 quarters until 100% compliance, then yearly or until pattern of compliance is achieved. Results of these audits will be brought before the Quality Assurance and Performance Improvement (QAPI) Committee by the MDS Coordinator monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/25/19	

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interpretation of the RAI manual on how to code Section J1400. Prognosis.

On 10/02/19 at 2:48 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the significant change MDS assessment would have been accurately coded to reflect Resident #98 had a life expectancy less than 6 months. The DON stated if the Hospice certification was not located in the medical record than she would have expected the MDS Nurse to have obtained the certification from Hospice. The DON indicated there may have been confusion of the interpretation of the RAI manual for the MDS nurse to code Section J1400. Prognosis on the admission MDS assessment.

On 10/02/19 at 3:02 PM an interview was conducted with the Administrator who stated her expectation was that the MDS assessment would have been accurately coded to reflect Resident #98 had a life expectancy less than 6 months. The Administrator stated she felt the inaccurate coding of Section J1400. Prognosis was related to the MDS Nurse misinterpretation of the RAI manual for coding prognosis.

3. Resident #154 readmitted to the facility on 9/4/2019. His diagnoses included malignant neoplasm of the bladder, urinary outlet obstruction requiring left nephrostomy tube and foley catheter, and gross hematuria.

A Hospice contract dated 9/1/2019 certified Resident #154 was admitted under the care and services of Hospice for end of life.

Review of the significant change Minimum Data

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Set (MDS) dated 9/11/2019 revealed Resident #154 had intact cognition. Review of Section J1400 (Prognosis-Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded as Resident #154 not having less than 6 months to live.

An interview was completed with MDS Nurse #2 on 10/2/2019 at 2:16 PM. MDS Nurse #2 indicated Section J1400 (Prognosis) should have been coded on the MDS assessment to reflect a life expectancy of less than 6 months. MDS Nurse #2 revealed a modification assessment would be completed to accurately reflect prognosis of life expectancy of less than 6 months for Resident #154. MDS Nurse #2 revealed she had been confused with the interpretation of the RAI (Resident Assessment Instrument) manual on how to code Section J1400 (Prognosis).

An interview was completed with the Director of Nursing (DON) on 10/2/2019 at 2:48 PM. The DON stated her expectation was for the significant change MDS assessment to be accurately coded. The DON explained if the Hospice certification was not located in the medical record then she would have expected the MDS Nurse to have obtained the certification from Hospice. The DON indicated there may have been confusion regarding the interpretation of the RAI manual for the MDS nurse's to code Section J1400 (Prognosis) on the MDS assessment.

An interview was completed with the Administrator on 10/2/2019 at 3:02 PM. The Administrator stated her expectation was for the

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MDS assessment to be accurately coded. The Administrator stated she felt the inaccurate coding of Section J1400 (Prognosis) was related to the MDS Nurse's misinterpretation of the RAI manual for coding prognosis.

4. Resident #159 admitted to the facility on 2/28/2019. Her diagnoses included chronic kidney disease- stage 4, new lung nodules and pancreatic lesions with bilateral pleural effusions, and abdominal ascites.

A Hospice contract dated 6/4/2019 certified Resident #159 was admitted under the care and services of Hospice for end of life.

Review of the significant change Minimum Data Set (MDS) dated 9/11/2019 revealed Resident #159 had moderate cognitive impairments. Review of Section J1400 (Prognosis-Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded as Resident #159 not having less than 6 months to live.

An interview was completed with MDS Nurse #2 on 10/2/2019 at 2:16 PM. MDS Nurse #2 indicated Section J1400 (Prognosis) should have been coded on the MDS assessment to reflect a life expectancy of less than 6 months. MDS Nurse #2 revealed a modification assessment would be completed to accurately reflect prognosis of life expectancy of less than 6 months for Resident #159. MDS Nurse #2 revealed she had been confused with the interpretation of the RAI (Resident Assessment Instrument) manual on how to code Section J1400 (Prognosis).

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An interview was completed with the Director of Nursing (DON) on 10/2/2019 at 2:48 PM. The DON stated her expectation was for the significant change MDS assessment to be accurately coded. The DON explained if the Hospice certification was not located in the medical record then she would have expected the MDS Nurse to have obtained the certification from Hospice. The DON indicated there may have been confusion of the interpretation of the RAI manual for the MDS nurse's to code Section J1400 (Prognosis) on the MDS assessment.

An interview was completed with the Administrator on 10/2/2019 at 3:02 PM. The Administrator stated her expectation was for the MDS assessment to be accurately coded. The Administrator stated she felt the inaccurate coding of Section J1400 (Prognosis) was related to the MDS Nurse's misinterpretation of the RAI manual for coding prognosis.

5. Resident #219 was admitted to the facility on 10/25/15 and discharged on 07/25/19. Her diagnoses included vascular dementia and chronic obstructive pulmonary disease (COPD).

A Hospice contract dated 05/10/19 certified Resident #219 was admitted under the care and services of Hospice for end of life.

Review of the significant change Minimum Data Set (MDS) dated 05/10/19 revealed Resident #219 was moderately impaired for daily decision making. Review of Section J1400 (Prognosis - Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded as Resident #219 not having less than 6 months to live.

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An interview was completed with MDS Nurse #2 on 10/02/19 at 2:16 PM. MDS Nurse #2 indicated Section J1400 (Prognosis) should have been coded on the MDS assessment to reflect a life expectancy of less than 6 months. MDS Nurse #2 revealed a modification assessment would be completed to accurately reflect prognosis of life expectancy of less than 6 months for Resident #219. MDS Nurse #2 revealed she had been confused with the interpretation of the Resident Assessment Instrument (RAI) manual on how to code Section J1400 (Prognosis).

An interview was completed with the Director of Nursing (DON) on 10/02/19 at 2:48 PM. The DON stated her expectation was for the significant change MDS assessment to be accurately coded. The DON explained if the Hospice certification was not located in the medical record then she would have expected the MDS Nurse to have obtained the certification from Hospice. The DON indicated there may have been confusion regarding the interpretation of the RAI manual for the MDS nurse's to code Section J1400 (Prognosis) on the MDS assessment.

An interview was completed with the Administrator on 10/02/19 at 3:023 PM. The Administrator stated her expectation was for the MDS assessment to be accurately coded. The Administrator stated she felt the inaccurate coding of Section J1400 (Prognosis) was related to the MDS Nurse's misinterpretation of the RAI manual for coding prognosis.

6. Resident #120 was readmitted to the facility on 01/11/19 and discharged on 06/30/19. Her

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diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD) and failure to thrive.

A Hospice contract dated 06/04/19 certified Resident #220 was admitted under the dare and services of Hospice for end of life.

Review of the significant change Minimum Data Set (MDS) dated 06/07/19 revealed the resident was moderately cognitively impaired for daily decision making. Review of Section J1400 (Prognosis - Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded as Resident #220 not having less than 6 months to live.

An interview was completed with MDS Nurse #2 on 10/02/19 at 2:16 PM. MDS Nurse #2 indicated Section J1400 (Prognosis) should have been coded on the MDS assessment to reflect a life expectancy of less than 6 months. MDS Nurse #2 revealed a modification assessment would be completed to accurately reflect prognosis of life expectancy of less than 6 months for Resident #220. MDS Nurse #2 revealed she had been confused with the interpretation of the Resident Assessment Instrument (RAI) manual on how to code Section J1400 (Prognosis).

An interview was completed with the Director of Nursing (DON) on 10/02/19 at 2:48 PM. The DON stated her expectation was for the significant change MDS assessment to be accurately coded. The DON explained if the Hospice certification was not located in the medical record then she would have expected the MDS Nurse to have obtained the certification

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from Hospice. The DON indicated there may have been confusion regarding the interpretation of the RAI manual for the MDS nurse's to code Section J1400 (Prognosis) on the MDS assessment.

An interview was completed with the Administrator on 10/02/19 at 3:023 PM. The Administrator stated her expectation was for the MDS assessment to be accurately coded. The Administrator stated she felt the inaccurate coding of Section J1400 (Prognosis) was related to the MDS Nurse's misinterpretation of the RAI manual for coding prognosis.

7. Resident #118 was admitted to the facility on 04/01/17 with multiple diagnoses that included Parkinson's disease, cerebrovascular accident (stroke), hemiplegia (paralysis on one side of the body), seizure disorder, and depression.

The Hospice Recertification Statement, with an effective date of 06/28/19, indicated Resident #118 had a terminal illness with a life expectancy of six months or less and was recertified to receive Hospice services for end of life care.

The quarterly MDS dated 08/16/19 indicated Resident #118 received Hospice care; however, under section J 1400 for Prognosis, Resident #118 was not coded as having a chronic condition that might result in a life expectancy of less than six months.

During an interview on 10/02/19 at 2:16 PM MDS Nurse #2 explained she had been confused with the interpretation of the Resident Assessment Instrument (RAI) manual on how to code prognosis under Section J for MDS assessments.

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She confirmed the quarterly MDS assessment dated 08/16/19 should have been coded to reflect Resident #118 had a life expectancy of less than six months and verified a modification would be submitted to accurately reflect Resident #118's prognosis.

During an interview on 10/02/19 at 2:48 PM, the Director of Nursing (DON) stated she would expect for MDS assessments to be accurately coded. The DON stated she felt there may have been confusion regarding the interpretation of the RAI manual related to the coding of Section J Prognosis and would have expected for the MDS Nurse to obtain clarification from Hospice if the information was not available in the resident's medical record when completing MDS assessments.

During an interview on 10/02/19 at 3:02 PM, the Administrator stated she would expect for MDS assessments to be accurately coded.

8. Resident #121 was admitted to the facility on 08/31/17 with multiple diagnoses that included Gastroesophageal Reflux Disease (GERD; chronic condition where the liquid content of the stomach flows back into the esophagus).

The August 2019 Medication Administration Record (MAR) for Resident #121 revealed a physician's order dated 09/01/17 for Protonix (medication used to treat stomach and esophagus problems) 40 milligrams daily for GERD related to gastrointestinal hemorrhage. Further review of the MAR revealed the medication was administered daily as ordered.

The quarterly MDS dated 08/16/19 revealed

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F 641	Continued From page 23 Resident #121 was not coded under Section I, Active Diagnosis as having a diagnosis of GERD. During an interview on 10/02/19 at 1:45 PM MDS Nurse #2 explained she reviewed the resident's diagnoses list and the physician's and/or Nurse Practitioner's (NP) progress notes to determine the active diagnoses to code on the MDS assessment. MDS Nurse #2 reviewed Resident #121's medical record and stated she overlooked the diagnosis of GERD on the NP progress note dated 07/07/19. She confirmed the diagnosis of GERD should have been marked under Section I as an active diagnosis on Resident #121's MDS assessment dated 08/16/19 and verified a modification would be submitted. During an interview on 10/02/19 at 2:45 PM, the Director of Nursing stated she would expect all active diagnoses were coded to accurately reflect the patient's condition at the time of the MDS assessment, especially when they received medication to treat the condition. During an interview on 10/02/19 at 3:02 PM the Administrator stated she would expect for MDS assessments to be accurately coded.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to	F 677	1. Resident #111 has had their fingernails trimmed and cleaned appropriately.	10/25/19

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F 677	Continued From page 24 provide nail care to 1 of 12 sampled residents who were dependent on staff for assistance with activities of daily living (Resident #111). Findings included: Resident #111 was admitted to the facility on 09/01/17 with multiple diagnoses that included left-sided hemiplegia (paralysis on one side of the body), epilepsy (neurological disorder that causes seizures), and dementia. The quarterly MDS dated 08/15/19 indicated Resident #111 had moderate impairment in cognition and required extensive staff assistance with personal hygiene and bathing. The MDS noted Resident #111 had an impairment on one side of both the upper and lower extremities. Resident #111's medical record revealed a physician's order dated 09/25/19 that read in part, new diagnosis of diabetes. Check blood glucose 3 times a week for diabetes. During an observation and interview on 10/01/19 at 1:00 PM, Resident #111's fingernails on the thumb, middle finger and pinky finger of his right hand were observed to extend approximately one inch beyond his fingertips. Resident #111 indicated he was unable to trim his own nails due to not being able to use his left hand and relied on staff to trim his nails when they got too long. He was unable to recall when his fingernails were last trimmed and stated they bothered him when they were this long because "they get stuck on things." Subsequent observations conducted on 10/02/19 at 4:30 PM, 10/03/19 at 5:09 PM and 10/04/19 at	F 677	2. All residents have the potential to be effected. 100% of current residents were audited by the clinical leadership team on 10/21/19 to ensure that nails are trimmed and cleaned appropriately. 3. Education provided to nursing staff on 10/25/19 by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on appropriate nail care. 4. On 10/21/19, Unit Managers and ADON will randomly audit 10 residents per week x 4 weeks; then 3 times per week x 4 weeks; then one time per month to ensure that nail are is provided. Results of these audits will be brought before the Quality Assurance and Performance Improvement (QAPI) Committee by the DON with the QAPI committee responsible for ongoing compliance. 5. Date of compliance 10/25/19	

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F 677	Continued From page 25 9:55 AM revealed the fingernails on Resident #111's right hand remained untrimmed. During an interview on 10/04/19 at 10:08 PM Nurse #4 confirmed nurses were responsible for trimming the fingernails of residents who had a diagnosis of diabetes or received anticoagulant (medication used to thin the blood) medication. Nurse #4 stated she had noticed Resident #111's fingernails had grown too long and needed to be trimmed. She stated she had offered to trim them on 10/03/19 but he had refused. She explained she usually did not make multiple attempts to provide nail care when he refused but did ask him each morning if he would allow her to trim his nails. She added she had not offered to trim his nails this morning but would check with him to see if he would allow her to provide nail care. During an interview on 10/04/19 at 11:02 AM, the Director of Nursing (DON) explained if a resident was a diabetic and/or received anticoagulant medication, nurses were responsible for checking, cleaning and cutting the resident's fingernails. The DON was unaware that on multiple observations Resident #111's fingernails were observed to extend approximately one inch past his fingertips and indicated she was surprised since Resident #111 was usually compliant with personal care. The DON stated she would have expected for the nurse to have cut his nails prior to them growing that long and when he refused, they should have continued their attempts until he allowed them to provide nail care.	F 677		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		10/25/19

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F 761	Continued From page 26 §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, record review, and staff interviews the facility failed to discard 2 opened and undated Lantus insulin prefilled pens and 1 opened and undated multi-dose vial of 1% Lidocaine (anesthetic) on 2 of 5 medication carts and 1 opened and undated NovoLog insulin vial and 1 opened and undated Lantus insulin vial in 2 of 2 medication refrigerators. Findings included:	F 761	1. All unlabeled/undated medications were disposed of appropriately and reordered. 2. All medication carts and medication rooms were audited by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to ensure no other unlabeled/undated items present. 3. Education provided by the DON and	

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F 761	Continued From page 27 1. a. A review of the manufacturer's recommendations indicated Lantus insulin 3 ml prefilled pen had to be discarded 28 days after opening. On 10/02/19 at 9:41 AM an observation of South One medication cart B was conducted with Nurse #1 and revealed an opened and undated Lantus insulin 3 ml prefilled pen that was available for resident use. On 10/02/19 at 9:45 AM an interview was conducted with Nurse #1 who stated the Lantus insulin prefilled pen should have been dated when opened per facility policy and because the insulin had not been dated when opened there was no way to determine when the insulin had expired. Nurse #1 immediately removed the Lantus insulin prefilled pen from the medication cart. On 10/02/19 at 9:45 AM an interview was conducted with the Assistant Director of Nursing (ADON) who verified the Lantus insulin prefilled pen was opened and undated and was available for resident use. The ADON shared that the Lantus insulin prefilled pen should have been dated when opened and because the insulin had not been dated then there was no way to determine when the insulin had expired. On 10/02/19 at 10:46 AM a further interview was conducted with the ADON who revealed there was no structured system in place to check the medication carts for outdated and expired medication. On 10/02/19 at 10:51 AM an interview was conducted with the Director of Nursing (DON)	F 761	ADON to the licensed nursing staff on 10/25/19 on appropriate medication storage to include labeling and dating accordingly. 4. On 10/25/19, ADON and Unit Managers will audit medication rooms and medication carts 5 times per week ; then 3 times per week x 4 weeks; then weekly for 4 weeks, to ensure appropriate storage and labeling/dating of medications. Results of these audits will be brought before the Quality Assurance and Performance Improvement (QAPI) Committee by the DON monthly with the QAPI committee responsible for ongoing compliance. 5. Date of compliance 10/25/19	

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who stated insulin should be dated when opened per facility policy. The DON shared it had been the responsibility of the night shift nurse to check the medication carts for outdated and expired medication and the process had not been monitored or enforced.

On 10/02/19 at 11:30 AM an interview was conducted with the Administrator who stated her expectation was that staff would have followed the facility policy and dated the insulin when opened. The administrator revealed there was no current system in place for checking for outdated and expired medication on the medication carts.

b. A review of the manufacturer's recommendations indicated Lantus insulin 3 ml prefilled pen had to be discarded 28 days after opening. A review of manufacturer's recommendations indicated Lidocaine (anesthetic) 1 % multi-dose vial 200 (milligram) mg/20 ml vial had to be discarded 28 days after opening.

On 10/02/19 at 9:52 AM an observation of South One medication cart A was conducted with Nurse #2 and revealed an opened and undated Lantus insulin 3 ml prefilled pen and open and undated Lidocaine 1 % multi-dose vial 200 (milligram) mg/20 ml vial that were available for resident use.

On 10/02/19 at 9:53 AM an interview was conducted with Nurse #2 who stated the Lantus insulin prefilled pen and Lidocaine 1 % multi-dose vial should have been dated when opened per facility policy and because they had not been dated when opened there was no way to determine when the Lantus insulin and Lidocaine 1 % multi-dose vial had expired. Nurse #2

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immediately removed the Lantus insulin prefilled pen and multi-dose vial of Lidocaine 1 % from the medication cart.

On 10/02/19 at 10:22 AM an interview was conducted with the Assistant Director of Nursing (ADON) who verified the Lantus insulin prefilled pen and Lidocaine 1 % multi-dose vial were opened and undated and available for resident use. The ADON shared because the Lantus insulin prefilled pen and Lidocaine 1 % multi-dose vial were not dated when opened then there was no way to determine when they expired.

On 10/02/19 at 10:46 AM a further interview was conducted with the ADON who revealed there was no structured system in place to check the medication carts for outdated and expired medication.

On 10/02/19 at 10:51 AM an interview was conducted with the Director of Nursing (DON) who stated Lantus insulin and Lidocaine 1 % multi-dose vial should have been dated when opened per facility policy. The DON shared it had been the responsibility of the night shift nurse to check the medication cart for outdated and expired medication and the process had not been monitored or enforced.

On 10/02/19 at 11:30 AM an interview was conducted with the Administrator who stated her expectation was that staff would have followed the facility policy and dated the Lantus insulin and Lidocaine 1 % multi-dose vial when opened. The administrator revealed there was no current system in place for checking for outdated and expired medication on the medication carts.

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F 761	Continued From page 30	F 761		

c. A review of the manufacturer's recommendations indicated NovoLog insulin vial had to be discarded 28 days after opening.

On 10/02/19 at 10:11 AM an observation of South One medication refrigerator was conducted with Nurse #2 and revealed an opened and undated NovoLog insulin 10 milliliter (ml) vial.

On 10/02/19 at 10:15 AM an interview was conducted with Nurse #2 who stated NovoLog insulin vial was in the medication refrigerator ready for resident use. Nurse #2 stated the facility policy was to date insulin when opened and discard when expired. Nurse #2 immediately removed the NovoLog insulin vial from the medication refrigerator.

On 10/02/19 at 10:17 AM an interview was conducted with the Assistant Director of Nursing (ADON) who verified the NovoLog insulin 10 ml vial was opened and undated and was available for resident use. The ADON shared because the NovoLog insulin vial had not been dated when opened there was no way to determine when it expired.

On 10/02/19 at 10:46 AM a further interview was conducted with the ADON who revealed there was no structured system in place to check the medication refrigerator for outdated and expired medication.

On 10/02/19 at 10:51 AM an interview was conducted with the Director of Nursing (DON) who stated NovoLog insulin vial should have been dated when opened per facility policy. The DON shared it had been the responsibility of the night shift nurse to check the medication

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F 761	Continued From page 31	F 761		

refrigerator for outdated and expired medication and the process had not been monitored or enforced.

On 10/02/19 at 11:30 AM an interview was conducted with the Administrator who stated her expectation was that staff would have followed the facility policy and dated the NovoLog insulin vial when opened. The administrator revealed there was no current system in place for checking for outdated and expired medication in the medication refrigerator.

d. A review of the manufacturer's recommendations indicated Lantus insulin vial had to be discarded 28 days after opening.

On 10/02/19 at 10:28 AM an observation of South Two medication refrigerator was conducted with Nurse #3 and revealed an opened and undated Lantus insulin 10 milliliter (ml) vial.

On 10/02/19 at 10:30 AM an interview was conducted with Nurse #3 who stated Lantus insulin vial was in the medication refrigerator ready for resident use. Nurse #3 stated the facility policy was to date insulin when opened and discard when expired. Nurse #3 immediately removed the Lantus insulin vial from the medication refrigerator.

On 10/02/19 at 10:32 AM an interview was conducted with the Assistant Director of Nursing (ADON) who verified the Lantus insulin 10 ml vial was opened and should have been dated when opened and was available for resident use. The ADON shared because the Lantus insulin vial had not been dated when opened there was no way to determine when it expired.

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F 761	Continued From page 32 On 10/02/19 at 10:46 AM a further interview was conducted with the ADON who revealed there was no structured system in place to check the medication refrigerator for outdated and expired medication. On 10/02/19 at 10:51 AM an interview was conducted with the Director of Nursing (DON) who stated Lantus insulin vial should have been dated when opened per facility policy. The DON shared it had been the responsibility of the night shift nurse to check the medication refrigerator for outdated and expired medication and the process had not been monitored or enforced. On 10/02/19 at 11:30 AM an interview was conducted with the Administrator who stated her expectation was that staff would have followed the facility policy and dated the Lantus insulin vial when opened. The administrator revealed there was no current system in place for checking for outdated and expired medication in the medication refrigerator.	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide fluids consistent with the Physician's order for 1 of 2 residents reviewed for nutrition	F 805	1. Resident #28 is receiving thickened liquids per physician's order. 2. All residents with orders for thickened	10/25/19

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F 805	Continued From page 33 (Resident #28). Findings included: Resident #28 was admitted to the facility 06/22/18 with diagnoses including anemia and hypertension (high blood pressure). Review of the quarterly Minimum Data Set (MDS) dated 07/08/19 revealed Resident #28 was cognitively intact, was able to independently eat, and coughed or choked when swallowing medications or during meals. Review of Resident #28's Physician's orders revealed a diet order dated 08/07/19 for a regular diet with chopped meat and nectar thickened liquids. Review of the nutrition care plan last updated 09/20/19 revealed Resident #28 was to receive thickened liquids related to a diagnosis of dysphagia. An observation of Resident #28's bedside table on 10/02/19 at 6:15 AM revealed a styrofoam cup of ice and regular water sitting on top. An interview with Resident #28 on 10/02/19 at 6:16 AM revealed staff gave him the water and ice and he had been drinking the water. An interview with nurse aide (NA) #1 on 10/02/19 at 6:18 AM revealed she had passed ice at 4:30 AM on 10/02/19 and she gave Resident #28 ice in his cup. NA #1 stated she knew Resident #28 was to receive nectar thickened liquids and she just forgot. NA #1 also stated residents receiving thickened liquids should not receive ice because	F 805	liquids have potential to be effected. 100% audit of all current residents with orders was completed by the Registered Dietitian to ensure that orders were being followed by the kitchen and nursing staff. 3. Education completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10/25/19 with the Certified Nursing Assistants and Licensed Nurses on providing thickened liquids per order and an updated list of residents with thickened liquids was provided for the staff. 4. On 10/21/19, ADON and Unit Managers randomly audit residents with thickened liquids 5 times per week; then 3 times per week x 4 weeks; then weekly to ensure that they are served thickened liquids per order. Results of these audits will be brought before the Quality Assurance and Performance Improvement (QAPI) committee monthly by the DON with the QAPI committee responsible for ongoing performance. 5. Date of compliance 10/25/19	

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F 805	Continued From page 34 it can melt. An interview with the Speech Therapist (ST) on 10/01/19 at 9:55 AM revealed Resident #28 had a fiberoptic evaluation of swallowing (FEES) test on 01/10/19 that showed he was aspirating (sucking food or liquids into the airway) thin liquids. A follow-up FEES test on 03/20/19 revealed Resident #28 could have thin liquids with a 10 milliliter (ml) cup, needed to take small sips, and avoid straws. The ST stated on 04/08/19 Resident #28 was referred to speech therapy due to noncompliance with liquids and he was showing overt signs and symptoms of aspiration and was diagnosed with new onset pneumonia. The ST explained Resident #28 received speech therapy from 04/08/19 to 05/05/19 and his liquids were switched to nectar thickened liquids. Resident #28 was screened on 07/02/19 by speech therapy and he was observed coughing after drinking thin liquids so it was recommended to continue him on nectar thickened liquids. An interview with the Director of Nursing (DON) on 10/02/19 at 2:52 PM revealed Resident #28 should not have received ice from staff because he was to receive nectar thickened liquids. The DON stated if the NA was not sure what type of liquids Resident #28 was to receive she should have asked the nurse for clarification. An interview with the Administrator on 10/04/19 at 9:52 AM revealed she expected staff to follow the Physician's order for consistency of liquids. The Administrator stated Resident #28 should not have received ice from staff.	F 805		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		10/25/19

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F 812	Continued From page 35 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to remove expired honey thickened milk from 1 of 1 kitchen storage rooms. Findings included: An initial observation of the kitchen storage room on 09/30/19 at 10:03 AM revealed six 32 ounce containers of honey thickened milk were available for use and had an expiration date of 09/21/19. An interview with the Registered Dietician (RD) on 09/30/19 at 4:12 PM revealed the honey thickened milk expired 09/21/19 and should have been used or discarded on or before 09/21/19. An interview with the Dietary Manager on	F 812	1. Expired thickened milk was removed and discarded upon discovery during survey. 2. All residents with thickened liquid diet orders have the potential to be affected. Dietary Manager (DM) completed an audit of all food/beverage storage in the kitchen on 10/1/19 to ensure that no other food products had expired. 3. Registered Dietitian (RD) provided education to the DM and Assistant Dietary Manager (ADM) on 10/21/19 on the procedure for checking for expired products.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 36 10/02/19 at 8:36 AM revealed the honey thickened milk expired 09/21/19 and should not have been available for use. The Dietary Manager stated the honey thickened milk was sent to the facility from the food supplier 09/16/19 but the kitchen staff should have recognized the milk was expired and either used or discarded the milk on or before 09/21/19. The Dietary Manager stated he and the Executive Chef were constantly checking expiration dates and it just got missed. The Dietary Manager also stated there were 10 residents out of 159 that received honey thickened liquids. An interview with the Administrator on 10/04/19 at 9:38 AM revealed she expected food and drink items to be used or discarded on or by the expiration date. She also stated she expected the kitchen staff to have discovered the milk was expired and removed it from use.	F 812	4. Upon delivery of food from food supplier, the DM and the Assistant Dietary Manager (ADM) will weekly check the expiration dates of thickened beverage products to ensure they have not been delivered after the product expiration dates. On 10/21/19, the DM will audit 5 times per week x 4 weeks; then 3 times per week x 4 weeks; then once per month to ensure proper rotation of thickened beverages to ensure outdated beverages are not left in storage. Results of these audits will be brought before the Quality Assurance and Performance Improvement (QAPI) committee by the Registered Dietitian monthly with the QAPI committee responsible for ongoing compliance. 5. Date of compliance 10/25/19	