STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD GASTONIA, NC 28054**

(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 unannounce recertification and complaint survey was conducted on 11/12/19 through 11/15/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 3Z5211.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted 11/12/19 through 11/15/19. A total of 6 allegations were investigated and none were substantiated. Event ID # 3Z5211.	F 000		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to	F 661		12/13/19

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

Electronically Signed | 12/06/2019

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

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F 661	Continued From page 1 adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a recapitulation of stay for 1 of 1 closed records reviewed for a planned discharge to the community (Resident #51). The findings included: Resident #51 was admitted to the facility on 8/3/19 for rehab following an ankle fracture. Additional diagnoses included Parkinson's disease, mild cognitive impairment, muscle weakness, lack of coordination and abnormalities of gait and mobility. A review an admission Minimum Data Set (MDS) dated 8/10/19 indicated Resident #51 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #51 required extensive assistance with bed mobility, transfers and toileting. Resident #51's care plan revealed that Resident #51 had a care plan in place with the intention to discharge to another facility after completing rehabilitation services. A review of a facility document titled Post Discharge Plan of Care dated 9/9/19 revealed Resident #51 was to discharge to an assisted living facility with orders for home health nursing, physical therapy and occupational therapy.	F 661	Alexandria Place’s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law. A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice. It is the policy of Alexandria Place to ensure a recapitulation of stay for all discharged residents is documented appropriately and accurately. All nurse managers were immediately re-trained and re-educated on 12/4/19. The Electronic medical record system, American Health Tech, used by Alexandria Place generated a recapitulation of stay by the medical records nurse on 12/4/19 for resident #51 for the dates of 8/03/19 through 9/09/2019. The recapitulation of stay generated with American Health Tech by the medical records nurse was added to the closed records of resident #51 on 12/4/19. B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same	

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F 661	Continued From page 2 Review of handwritten orders in Resident #51's physical chart revealed handwritten orders to discharge resident from physical therapy and occupational therapy services signed 9/9/19. Further review of the medical chart showed the resident discharged from the facility on 9/9/19 and no recapitulation of the resident's stay at the facility was found in the resident's closed medical record. An interview with the Director of Nursing (DON) was conducted at 3:37 PM on 11/14/19 who revealed that a discharge order was not placed by the facility physician and the DON was unsure if he had written a Recapitulation of Stay for Resident #51. The DON was unable to provide a Recapitulation of Stay for Resident #51. The DON further explained that the physician was not good at submitting documents in a timely manner and was no longer employed by the facility. The DON further explained that it was within her responsibilities to obtain a discharge order and Recapitulation of Stay from the physician and that this was missed. The DON confirmed Resident #51 was discharged as planned to an assisted living facility on 9/9/19. During an interview on 11/15/19 at 9:52 AM, the Administrator explained that the previous facility physician would often neglect to turn things in. She further reported that the missing discharge order and Recapitulation of Stay for Resident #51 should have been noticed by management staff, and it was not.	F 661	deficient practice. All residents have the potential to be affected by this deficient practice. The Director of Nursing and the Medical Records nurse audited all recapitulations of residents discharged to the community from January 1, 2019 to December 1, 2019 on 12/5/19. No other residents were found to be affected. C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. All licensed nurses will receive an in-service by the Director of Nursing on 12/9/19 on the proper completion and documentation of discharge summaries and the appropriate recapitulation of stay for residents discharging from the facility. Any licensed nurse not present on 12/9/19 will be in-serviced by the Director of Nursing before the start of their shift. All new hires will receive training, during the initial classroom orientation that is conducted prior to new staff being assigned to the floor, on discharge documentation and accurate recapitulations of stay. Furthermore, the medical records nurse will be assigned to audit and confirm all recapitulations of stay are in place upon the discharge of all residents. The medical records nurse will present all discharges for review monthly to the Quality Assurance Committee.	
F 761	Label/Store Drugs and Biologicals	F 761		12/13/19

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F 761 SS=D — Continued From page 3
CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility failed to date opened multi use insulin pens and a vial of insulin that were available for use on 2 of 2 medication carts observed for medication storage.

1. An observation of medication cart #1 on 11/15/19 at 8:35 AM revealed an opened but undated multi dose Humalog insulin pen and an opened but undated multi use Lantus insulin pen.

F 761

A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice.
It is the policy of Alexandria Place to ensure all insulin is dated upon opening. Appropriate nursing staff were immediately re-trained on the policy of handling insulin pens/vials. The undated Humalog insulin pen, the multi-use lantus insulin pen and the 10ml multi use vial of

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An interview with Nurse #1 on 11/15/19 at 8:37 AM revealed the insulin pens should have been dated at the time they were opened by the person opening them. She stated she did not know when the insulin pens were opened and why they were not dated. Nurse #1 stated because the insulin pens had not been dated when they were opened it could not be determined when the insulin would expire. Nurse #1 immediately removed the insulin pens from medication cart #1. Nurse #1 stated the medications in the medication cart were for residents who resided on the facility's 100 hallway.

An interview with the Director of Nursing (DON) on 11/15/19 at 10:03 AM revealed it was facility policy to date any type of insulin when it was opened because different insulin expired at different times. The DON stated it was the responsibility of the nurse opening the insulin to date the medication.

An interview with the Administrator on 11/15/19 at 10:37 AM revealed she expected the nurse opening the pen or vial of insulin to date the medication when it was opened. The Administrator stated the system in place to check for expired medications or unlabeled medications was to have extra staff come in earlier in the week and check the medication carts but the undated medications were still missed.

2. An observation of medication cart #2 on 11/15/19 at 9:56 AM revealed an opened but undated 10 milliliter (ml) multi use vial of Novolog insulin 100 units/milliliter.

An interview with Nurse #2 on 11/15/19 at 9:57

F 761

novolog insulin were immediately discarded and sent back to the pharmacy.
B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice.
All residents receiving insulin have the potential to be affected by this practice. The Director of Nursing and the Assistant Director of Nursing audited the two medication carts and the medication storage room on 12/5/19 for opened and undated insulin pens and vials. No other open and undated insulin pens/vials were found, no other residents were found to be affected.
C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur.
All licensed nurses will be in-serviced by the Director of Nursing no later than 12/6/19 on the proper labeling, dating, storage and discarding of insulin pens and insulin mulit-use vials. Any licensed nurse not present on 12/6/19 will be in-serviced by the Director of Nursing on proper labeling, dating, storage and discarding of insulin pens and insulin multi-use vials before the start of their shift. All new hires will receive training on the proper labeling, dating, storage and discarding of insulin pens and insulin multi-use vials during the initial classroom orientation that is conducted prior to new staff being assigned to work the floor. The Director of nursing will conduct and audit on the medication storage room and the two medication carts three times a week for

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F 761	Continued From page 5 AM revealed the vial of insulin should have been dated when it was opened by the person opening it. Nurse #2 stated she did not know when the vial of insulin was opened and why it was not dated. She stated because insulin vial had not been dated when it was opened it could not be determined when the insulin would expire. Nurse #2 stated the medications in the medication cart were for residents who resided on the facility's 100 hallway. An interview with the Director of Nursing (DON) on 11/15/19 at 10:03 AM revealed it was facility policy to date any type of insulin when it was opened because different insulin expired at different times. The DON stated it was the responsibility of the nurse opening the insulin to date the medication. An interview with the Administrator on 11/15/19 at 10:37 AM revealed she expected the nurse opening the pen or vial of insulin to date the medication when it was opened. The Administrator stated the system in place to check for expired medications or unlabeled medications was to have extra staff come in earlier in the week and check the medication carts but the undated medications were still missed.	F 761	two weeks, weekly for two weeks, and monthly thereafter. The audits will be presented to and reviewed by the Quality Assurance Committee at the monthly meeting. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The Quality Assurance Committee will be responsible for reviewing the audits completed by the Director of Nursing. The audits will be presented by the Director of Nursing to the Quality Assurance Committee for evaluation monthly for 12 months. The Quality Assurance Committee and the Director of Nursing will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance. The Administrator will be responsible for implementing this plan of correction.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		12/13/19

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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 observations and staff interviews the facility failed to remove expired food from 1 of 1 kitchen walk-in refrigerators and failed to label juice pitchers in 1 of 2 nourishment refrigerators.

The findings included:

On 11/12/19 at 9:45 AM during the initial tour of the kitchen with the Food Service Director (FSD) observations were made of the facility's walk-in refrigerator. Contents of the refrigerator were observed to contain a half pound container of chicken salad with a use by date of 11/6/19, six half gallon jugs of cultured buttermilk with an expiration date of 10/23/19 and a plastic container labeled "PB&J" (peanut butter and jelly) with a use by date of 11/10/19.

On 11/12/19 at 9:45 AM an observation was made of the facility's nourishment refrigerators. In the refrigerator on the facility's 200 hallway a pitcher of liquid was observed without a label to specify when it was prepared. The FSD, who was present at the time of the observation, identified the liquid as apple juice.

F 812

A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice.
It is the policy of Alexandria Place to ensure that all expired and outdated foods are removed from the kitchen and are not available for use. It is also the policy of Alexandria Place to ensure all juice pitchers are labeled and dated. The expired half pound container of chicken salad, six half gallon jugs of cultured buttermilk and the plastic container labeled PB&J were immediately discarded. The apple juice and orange juice liquids that were not labeled were immediately discarded and new pitchers with labels and dates were put into place immediately.
B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice.
All residents have the potential to be affected by this deficient practice. All items in the walk-in cooler were audited

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An additional observation of the nourishment refrigerator, located on the facility's 200 hallway, was made on 11/13/19 at 11:15 AM. This observation revealed a pitcher of what appeared to be orange juice in the refrigerator without a label to specify when it was prepared.

An interview was conducted with the FSD on 11/14/19 at 1:30 PM who reported that all food was to be labeled when opened with an opened date and a use by date. The FSD stated that everyone was responsible for checking dates in the walk-in refrigerator and that it was done daily. If something was expired, it should have been thrown out. She further reported that the chicken salad, PB&J and Cultured Buttermilk that were beyond the use by date should have been thrown out and not have remained in the cooler. The FSD further reported that the food service department would take a tray of snacks to the halls each day, they place a label on the tray. The juice pitchers found in the nourishment refrigerators had arrived on these snack trays. The FSD stated that moving forward the food service department would be labeling the juice pitchers directly.

The Administrator was interviewed at 3:12 PM on 11/14/19 who explained that food items that have expired should have been thrown out and should not remain in the refrigerators. She further reported that juice pitchers placed in nourishment refrigerators should be labeled individually-- as other food items are-- before being placed in the refrigerator.

F 812

on 12/5/19 to ensure all items were labeled, dated and not expired. An audit was also completed on 12/5/19 for the 100 hall and 200 hall nourishment refrigerators to ensure all juice pitchers were labeled and dated. On 12/5/19 the kitchen aides and cooks were observed and re-educated with return back demonstration on labeling and dating all liquid pitchers that were prepared in the kitchen. No other residents were found to be affected.

C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur.

The Administrator will educate and train the food service manager on proper labeling, dating and storage of foods and liquids on 12/6/19. The Food service manager will in-service all dietary staff, with return back demonstration by 12/9/19 on proper food labeling, dating and storage of foods and liquids. Any dietary staff member not present on 12/9/19 will receive an in-service from the food service manager on proper labeling, dating and storage of foods and liquids before the start of their shift. All new hires will receive training on proper food labeling, dating and removing expired foods from use during the initial classroom orientation that is conducted prior to new staff being assigned to work. The Administrator will ensure that when there is a change in food service managers, the new food service manager will receive the proper education and training on proper labeling, dating and

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F 812	Continued From page 8	F 812	storage of foods and liquids as well as education on the proper audits that need to be carried out during their initial classroom orientation that is conducted prior to working in the kitchen. The food service manager will complete and audit of the walk-in cooler for expired food products and the nourishment refrigerators for labeled pitchers daily for 6 weeks and then weekly thereafter. The food service manager will document the audits and report them monthly to the Quality Assurance Committee. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The quality Assurance Committee will be responsible for reviewing the audits completed by the food service manager. The audits will be presented to the Quality Assurance committee for evaluation monthly for 24 months. The Quality Assurance Committee and the Administrator will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance. The Administrator will be responsible for implementing this plan of correction.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of	F 867		12/13/19

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F 867	Continued From page 9 action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification survey of 11/16/18. This was for one recited deficiency that was originally cited in November 2018 and subsequently recited on the current recertification and complaint investigation of 11/15/19. The recited deficiency was in the area of food procurement and storage. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F-812: Food Procurement and Storage: Based on observations and staff interviews the facility failed to remove expired food from 1 of 1 kitchen walk-in refrigerators and failed to label juice pitchers in 1 of 2 nourishment refrigerators. During the annual recertification survey of 11/16/18 the facility was cited for failure to date potentially hazardous food after opening, remove expired food, discard tuna salad after being opened in accordance with manufacturers guidelines and discard thawed bacon per manufacturer's guidelines. On 11/15/19 at 09:43 AM an interview was conducted with the Administrator who indicated	F 867	A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice. It is the policy of Alexandria Place for the Quality Assurance Committee to meet at least quarterly to include the Administrator, Director of Nursing, Pharmacist, Medical Director and at least three other staff members. The quality assurance forms, audits and plans initiated for the prior year citation of F812 has been reviewed and revised on 12/6/19 by the Quality Assurance Committee to ensure the food labeling, dating and storage process is effective and maintains substantial compliance. B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice. Any resident has the potential to be affected by this practice. All current dietary staff will be in-serviced on 12/9/19 by the food service manger on proper labeling, dating and storage of foods in the walk in cooler and liquids that are prepared for use. All future new hires will be observed demonstrating proper labeling, dating and storage of foods in the walk-in cooler and prepared liquids in pitchers during their week of floor orientation to ensure that they are aware and are proficient in labeling, dating and storage of foods in the walk-in cooler and prepared liquids in pitchers. The food service manger will conduct daily audits of	

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F 867	Continued From page 10 there was a dietary process in place to monitor for outdated, undated, and expired food and juice for a period of time and due to improvement the process was stopped. The Administrator shared there had been a change of Dietary Manager and the process for thoroughly monitoring for outdated, undated, and expired food and juice was not carried out.	F 867	observations of proper labeling, dating and storage of foods in the walk-in cooler and proper labeling, dating and storage of prepared liquid pitchers daily for 6 weeks and weekly thereafter. These observations will be recorded on a Quality Assurance form. C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The food service manager will conduct daily audits and observations with the forms and plans the Quality Assurance Committee revised on 12/6/19 on proper labeling, dating and storage of foods in the walk-in cooler and proper labeling, dating and storage of prepared liquids in pitchers daily for 6 weeks and weekly thereafter. The Quality Assurance form will be submitted to the monthly Quality Assurance Committee meeting for review and the QAPI Committee quarterly for review. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The Quality Assurance form with observations and plans revised on 12/6/19 on proper labeling, dating and storage of foods in the walk-in cooler and proper labeling, dating and storage of prepared liquids in pitchers, completed by the food service manager daily for 6 weeks and weekly thereafter will be submitted to the monthly Quality Assurance Committee meeting for review and quarterly to the QAPI Committee. If no issues are identified by the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 11	F 867	Committee and the QAPI Committee after 24 months, the food service manager will report the observations and quality assurance form on a quarterly basis to the Quality Assurance Committee and QAPI Committee. The Quality Assurance Committee and the Administrator will be charged with the responsibility to ensure that the correction is achieved and sustained. The Administrator will be responsible for implementing this plan of correction.	