STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345462	A. BUILDING _____ B. WING _____	C 01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted 01/06/20 through 01/10/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# XMCS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 01/06/10 through 01/10/20. At total of 39 allegations were investigated and none were substantiated. Event ID# XMCS11.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		2/7/20

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

Electronically Signed | 02/06/2020

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F 565	Continued From page 1 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to resolve and communicate the facility's efforts to address resident concerns voiced during 7 of 8 Resident Council meetings. Findings included: During a Resident Council group interview conducted on 01/08/20 at 11:00 AM, residents present voiced an ongoing issue with the resolution of concerns voiced during Resident Council meetings. The Resident Council minutes for the period May 2019 through December 2019 were reviewed and revealed the following: Resident Council minutes dated 05/24/19 indicated residents voiced concerns related to showers not being provided as scheduled due to low staffing and waiting to long for supper to be served. Resident Council minutes dated 06/28/19 included no documentation of the facility's	F 565	This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this Allegation of Compliance does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Resident Council Response form will be distributed to each applicable discipline following Resident Council meeting. "Each documented concern will be followed up by the department manager within 72 hours.	

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F 565	Continued From page 2 response to the concerns voiced during the previous meeting. There were no new concerns noted. Resident Council minutes dated 07/26/19 indicated residents voiced concerns related to staffing, dirty dishes and silverware and waiting too long for supper to be served. Resident Council minutes dated 08/22/19 indicated residents voiced new concerns related to the blinds in a resident's room needed repaired, the resident dining room was too cold and dirty glasses were received from dietary. It was noted last month's issues were reviewed and staffing was being worked on. There was no facility response documented regarding the dietary concerns. Resident Council minutes dated 09/24/19 indicated residents voiced repeated concerns related to the blinds not being repaired and dirty glasses received from dietary. It was noted residents voiced new concerns regarding missing laundry and wanted to know who to contact with maintenance issues on the weekend. Resident Council minutes dated 10/25/19 indicated residents voiced repeated concerns related to missing laundry. It was noted residents voiced the temperature in the dining room was too cold. Resident Council minutes dated 11/22/19 indicated residents voiced ongoing concerns related to missing laundry. Resident Council minutes dated 12/27/19 indicated residents voiced repeated concerns	F 565	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "Activity Director will be educated by Clinical Competency Coordinator on utilizing Resident Council Department Response forms to document concerns voiced by residents during monthly Resident Council meetings. These forms are to be completed for each discipline for which a concern is voiced during the council meetings, and the applicable Department Manager is to follow up on the documented concern within 72 hours and then return the form to the Activity Director to be placed in the Resident Council meeting logbook. "This education was completed on 1/24/2020. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "The Administrator and applicable Department Manager will review and sign Resident Council logbook monthly effective 1/24/2020 to ensure each item has been addressed. "Activity Director and all Managers will be educated by CCC on proper Resident Council Reporting measures and forms to be utilized by 1/24/2020.	

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F 565	Continued From page 3 related to showers not being provided and meals not being served on time. A notation under 'Review of Past Months Issues' read, "yes but issues unaddressed." There was no evidence the facility's response to the concerns voiced during the meetings was provided or discussed during the subsequent meetings. An interview was conducted on 01/10/20 at 11:11 AM with the Administrator who confirmed he was Grievance Officer for the facility. He explained when concerns were voiced during the Resident Council meetings, they were supposed to be documented on a concern form, investigated, sent to him for review, and follow-up provided to the Resident Council by the next scheduled meeting. He was unaware the Resident Council members had not received a response to their concerns voiced during the Resident Council meetings for the period of May 2019 to December 2019. An interview was conducted on 01/10/20 at 2:28 PM with the Activity Director (AD) who confirmed she attended and recorded the minutes for the Resident Council meeting held on 12/27/19. The AD stated she had not notified anyone of the concerns voiced by the members during the meeting and explained she had intended to email the minutes to the other facility Directors but did not get around to it. A follow-up interview was conducted with the Administrator on 01/10/20 at 3:40 PM. The Administrator shared the AD had only been in the position for approximately one month and had not yet learned the reporting process. He confirmed	F 565	How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "The Administrator will be responsible for compliance of the monitoring of this plan of correction. In addition, the Administrator will monitor the compliance of this POC in Monthly QAPI meetings for 3 months to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and/or immediate corrective action. Date of Compliance: 2/7/2020	

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F 565	Continued From page 4 he received the minutes for the Resident Council meetings held May 2019 to December 2019 but had not reviewed them. He acknowledged the concerns voiced by the Resident Council were not addressed or followed up on. The Administrator stated he felt the breakdown in communication with the members of the Resident Council occurred due to him focusing on more emergent issues such as staffing.	F 565		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed within 14 days of a resident being admitted into Hospice care for 1 of 1 resident reviewed for Hospice (Resident #49). Findings included: Resident #49 was admitted to the facility on 07/13/15 with multiple diagnoses that included	F 637	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "A significant change MDS assessment was completed on resident #49 on 11/1/19. How will you identify other residents having the potential to be affected by the	2/7/20

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F 637	Continued From page 5 Alzheimer's disease. Review of the Hospice Certification Statement, with an effective date of 09/06/19, indicated Resident #49 was certified to receive Hospice services for end of life care. Review of the significant change MDS assessment dated 09/16/19 indicated Resident #49 received Hospice care while a resident at the facility. Further review revealed the assessment was marked as complete on 11/01/19. During an interview on 01/08/20 at 3:15 PM the MDS Coordinator shared she had only been employed at the facility for 2 months and was not sure who was responsible for completing the MDS assessments prior to her starting on 11/04/19. The MDS Coordinator confirmed Resident #49 was admitted to Hospice services on 09/06/19. She reviewed the significant change MDS assessment dated 09/16/19 for Resident #49 and confirmed it was completed on 11/01/19 which was past the regulatory timeframe. The MDS Coordinator stated the MDS assessment should have been completed within 14 days of the assessment reference date (end date of the look back period for completing the assessment) of 09/16/19. During an interview on 01/08/20 at 3:45 PM, the Administrator shared the previous MDS Coordinator resigned, without notice, around the end of September 2019 which left the facility with only a part-time MDS Coordinator for approxmiately 45 days. He added he felt this contributed to MDS assessments not being completed in time. The Administrator stated he would expect for MDS assessments to be	F 637	same deficient practice and what corrective action will be taken? "MDS Coordinator will complete a 100% audit of residents placed on hospice services since September 2019 to ensure a significant change MDS assessment was completed within 14 days per RAI guidelines. This audit will be completed by 1/9/2020. "MDS Coordinator will audit all residents placed on hospice weekly on an on-going basis beginning the week of 2/3/2020 to ensure significant change MDS assessment is completed within 14 days per RAI guidelines. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "MDS Coordinator and all partners completing MDS assessments will be educated on RAI guidelines by regional Clinical Reimbursement Consultant on completing significant change assessments within 14 days of a resident being placed on hospice services. This education will be completed by 2/7/2020. "An audit tool was created to monitor residents placed on hospice services to ensure assessments are completed within 14 days per RAI guidelines. How will the corrective action be monitored to assure that the deficient	

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F 637	Continued From page 6 completed and transmitted within the regulatory timeframes.	F 637	practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "The audit tool will be reviewed weekly x 4 weeks and then monthly x 3 months by The administrator "The Administrator will be responsible for compliance of the monitoring of this plan of correction. In addition, the Administrator will monitor the compliance of this POC in monthly QAPI meeting for 3 months to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and/or immediate corrective action. Date of Compliance: 2/7/2020	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		2/7/20

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F 640	Continued From page 7 (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and transmit a	F 640	What Corrective action will be accomplished for the residents found to	

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F 640	Continued From page 8 discharge tracking Minimum Data Set (MDS) to the Centers for Medicare and Medicaid Services (CMS) system within the required time frame for 1 of 1 resident (Resident #1) reviewed for resident assessments. Findings included: Resident #1 was admitted to the facility 07/25/18 with diagnoses including Alzheimer's disease, osteoporosis, and muscle weakness. A review of Resident #1's last MDS dated 09/19/19 was coded as a discharge return not anticipated assessment. The MDS was noted to be "in process" and had not been transmitted to CMS. An interview with the MDS Coordinator on 01/08/20 at 8:56 AM revealed she was not employed at the facility in September 2019 and did not know why the resident's discharge tracking MDS was not completed or transmitted. An interview with the interim Director of Nursing (DON) on 01/08/20 at 9:04 AM revealed the facility had been without a MDS Coordinator for a couple of months around October 2019 and she was not sure who was responsible for completing and transmitting MDS during the time frame when the facility had no MDS Coordinator. The DON further stated MDS assessments should be completed and transmitted within the allotted time frame. An interview with the Administrator on 01/08/20 at 9:59 AM revealed toward the end of September 2019 the facility's MDS Coordinator resigned without giving any notice. He explained after the	F 640	have been affected by the deficient practice? "Resident #1 had incomplete assessment with date 09/19/2019. Assessment was completed by MDS on 1/8/2020 and transmitted to the QIES system and accepted. "Resident MDS 3.0 Status report was pulled with beginning date of 5/1/2019 thru 1/8/2020. (start date determined by start of Matrix system usage and end date was determined by noted date of late assessment.) All assessments that were not completed and delinquent were completed and transmitted to the QIES system for acceptance. This affected a total of 4 assessments. All assessments were completed and transmitted with acceptance from QIES system by MDS on 1/8/2020. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "MDS nurse will pull Resident MDS 3.0 status report weekly to ensure timely completion of MDS assessments beginning on 1/28/2020 and utilize this report as an audit to ensure all assessments were completed and transmitted with acceptance from QIES system. What measures will be put in place or what systemic changes will be made to	

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F 640	Continued From page 9 MDS Coordinator resigned he had a licensed practical nurse (LPN) who worked part time, that filled in as the MDS Coordinator, but he was without a full time MDS Coordinator for around 45 days. The Administrator stated MDS staff from other facilities came to the facility to help out with completing MDS assessments for around 3 days when the facility was without an MDS Coordinator. The Administrator stated not having a full time MDS Coordinator was why Resident #1's 09/19/19 discharge tracking MDS was not completed or transmitted. He stated he expected MDS assessments to be completed and transmitted within the allotted time frame.	F 640	ensure that the deficient practice will not reoccur? "MDS Coordinator received education on how to pull the Resident MDS 3.0 Status report on 1/7/2020 by Regional Clinical Reimbursement Consultant. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "MDS 3.0 status report will be reviewed and signed weekly x 4 by Administrator and then monthly x 3 thereafter. "The Administrator will be responsible for compliance of the monitoring of this plan of correction. In addition, the Administrator will monitor the compliance of this POC in monthly QAPI meeting for 3 months to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and/or immediate corrective action. Date of Compliance: 2/7/2020	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		2/7/20

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F 641	Continued From page 10 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) in the areas of prognosis (Residents #49 and #20) and weight loss (Resident #26) for 3 of 12 residents reviewed for activities of daily living, hospice and nutrition. Findings included: 1. Resident #49 was admitted to the facility on 07/13/15 with multiple diagnoses that included Alzheimer's disease. Review of the Hospice Certification Statement, with an effective date of 09/06/19, indicated Resident #49 was certified to receive Hospice services for end of life care. Review of the significant change MDS assessment dated 09/16/19 indicated Resident #49 received Hospice care; however, under section J 1400 for Prognosis, Resident #49 was not coded as having a chronic condition that might result in a life expectancy of less than six months. During an interview on 01/08/20 at 3:15 PM the MDS Coordinator shared she had only been employed at the facility for 2 months and was not sure who was responsible for completing the MDS assessments prior to her starting on 11/04/19. The MDS Coordinator confirmed Resident #49 was admitted to Hospice services on 09/06/19. She reviewed the MDS assessment dated 09/16/19 for Resident #49 and confirmed there was no prognosis marked for a life	F 641	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Resident #26 was determined to have incorrect coding of section K significant weight loss item number #K0300. Modification of the assessment was completed and assessment was transmitted to the QIES system and accepted. Effective date 1/9/2020 by MDS nurse. "A complete active census was printed effective date 1/21/2020 and all active resident□s last quarterly, Admission or Annual assessments were audited for correct coding of Section K. Any assessments with incorrect coding were modified and transmitted to the QIES system for acceptance. This will be completed by 1/31/2020 by MDS. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "MDS nurse will audit all assessments with sections K and J 1400 for correct coding weekly times 4 weeks, monthly times 2 months with audit form. This will begin the week on 1/27/2020 and be complete 4/30/2020.	

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F 641	Continued From page 11 expectancy of less than 6 months. The MDS Coordinator stated the MDS assessment dated 09/16/19 should have been coded to reflect Resident #49 had a life expectancy of less than six months and verified a modification would be submitted to accurately reflect Resident #49's prognosis. She explained that while she had not completed the MDS assessment for Resident #49, she felt the coding error was likely due to a misinterpretation of the Resident Assessment Instrument (RAI) guidelines as she had also been confused with the interpretation on how to code prognosis under Section J for MDS assessments. During an interview on 01/08/20 at 3:45 PM, the Administrator stated he would expect for MDS assessments to be accurately coded and completed within the regulatory timeframe. 2. Resident #20 was admitted to the facility on 1/15/19 with diagnoses to include Chronic Respiratory failure, Cerebral Vascular Accident (CVA) and end-stage renal disease. A Hospice Certification Statement with an effective date of 10/25/19 through 1/22/20 signed by the physician on 10/28/19 indicated the Resident #20 had a life expectancy of six months or less for a diagnosis of Chronic Respiratory Failure. The resident's significant change of status Minimum Data Set (MDS) dated 10/31/19, section J1400 did not specify the resident had a chronic condition that might result in a life expectancy of six months or less. On 1/8/20 at 3:15 PM an interview conducted with MDS Coordinator indicated that her	F 641	"MDS Coordinator will audit all hospice resident□s charts to ensure accurate coding of section J 1400 related to life expectancy. This will be completed by 1/14/2020. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "MDS nurses and CMD will complete Pruitt University MDS 3.0 sections K and L training, and section J, and pass posttest to ensure they know how to accurately code these sections. This training will be completed by 1/14/2020. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "The Administrator will be responsible for compliance of the monitoring of this plan of correction. In addition, the Administrator will monitor the compliance of this POC in monthly QAPI meeting for 3 months to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and/or immediate corrective action. Date of Compliance: 2/7/2020	

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	345462	A. BUILDING _____ B. WING _____	C 01/10/2020

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understanding of the coding for Resident #20's MDS assessment was incorrect and the resident's 10/31/19 MDS should have been coded with a life expectancy of six months or less for J1400 section. She confirmed that based on the Hospice Certification in the Resident's Electronic Medical Record (EMR) the 10/31/19 MDS was not coded correctly.

An interview was conducted with the Administrator on 1/8/20 at 3:45 which revealed this was a system failure due to the facility being without a MDS Coordinator for approximately 45 days prior. Regardless, he stated Resident #20's 10/31/19 MDS should have been completed correctly.

3. Resident #26 was admitted to the facility 12/11/13 with diagnoses including fibromyalgia, insomnia, and non-Alzheimer's dementia.

A quarterly Minimum Data Set (MDS) dated 11/16/19 indicated Resident #26 was coded under Section K Swallowing/Nutritional Status as having weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a physician-prescribed weight loss regimen.

A review of Resident #26's weights were as follows: 08/06/19 142.6 pounds, 09/12/19 135 pounds, 10/07/19 136.4 pounds, and 11/05/19 139.2 pounds.

An interview with the MDS Coordinator on 01/09/20 at 9:09 AM revealed Resident #25 did not have significant weight loss and the quarterly MDS dated 11/16/19 was coded incorrectly. The MDS Coordinator stated it was human error and

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F 641	Continued From page 13 she would do a modification. An interview with the interim Director of Nursing (DON) on 01/09/20 at 1:36 PM revealed she expected the MDS to be coded correctly and if not for a modification to be submitted. An interview with the Administrator on 01/09/20 at 5:50 PM revealed he expected the MDS to be coded correctly and if not for a modification to be done.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for 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	F 761		2/7/20

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F 761	Continued From page 14 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to maintain proper temperatures in 1 of 3 refrigerators reviewed for medication storage (East wing medication refrigerator). Findings included: A review of an undated "Medication Storage in Healthcare Centers" policy was conducted. The policy statement under Procedure section, paragraph #9 stated, Medications requiring 'refrigeration' are stored at temperatures between 2 degrees Celsius (C) or 36 degrees Fahrenheit (F) and 8 degrees C or 46 degrees F and are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage 'in a cool place' are refrigerated unless otherwise directed on the label. (Insulin vials/pens currently in use MAY be kept in the medication cart). On 1/7/20 at 09:45 AM an observation was made with Nurse #1 of the medication refrigerator on East wing revealed a temperature of 20 degrees F upon opening the door. The temperature log on the refrigerator door indicated that the acceptable temperatures were to be between 2 degrees and 8 degrees Celsius, or 36 degrees and 46 degrees Fahrenheit. Nurse #1 stated that the refrigerator was not in the correct temperature range and she would discuss this with the Director of Nursing. The following temperatures were recorded on the log sheet found on the East wing refrigerator: 1/1/2020 - 24 degrees	F 761	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "All medications and vaccines in refrigerator on East Wing were discarded per pharmacy protocol on 1/7/2020. "The medication refrigerator and thermometer on the East Wing were replaced on 1/28/2020. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "Medication refrigerator temperatures will be audited twice daily on an on-going basis beginning on 1/28/2020 to ensure recommended temperature range is being maintained. "Audits will be completed by the Director of Health Services weekly for 4 weeks, and then monthly for 2 months beginning on 2/7/2020 to ensure that both the maintenance department and the pharmacy are notified if medication refrigerator temperatures are found to be out of recommended range. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not	

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F 761	Continued From page 15 1/2/2020 - 38 degrees 1/3/2020 - 24 degrees 1/4/2020 - 24 degrees 1/5/2020 - 24 degrees 1/6/2020 - no recorded temp An interview with Pharmacist on 1/7/2020 at 1:44 PM indicated that the staff should contact the Pharmacist when refrigerator temperatures were found to be out of the recommended range. He stated that some medications had variances that allow for temperatures outside of the recommended range. He said that temperatures that were too cold may cause some vaccination medications to be crystallized and become ineffective. The interview further revealed the vaccination medications would need to be discarded. An interview was conducted on 1/7/20 at 10:05 with Director on Nursing (DON). She reviewed the temperature log for East wing refrigerator and stated the temperatures recorded were not in the correct range for medication storage. She stated she would let maintenance know so they could evaluate the refrigerator and adjust or repair as necessary. The DON indicated she would also need to conduct education with staff regarding the correct temperatures of the medication refrigerators and what to do when they are out of range. On 1/8/20 at 4:35 PM an interview with the Maintenance Director was conducted. He stated that if the refrigerator temperatures were out of range, he would expect staff to let him know so he could evaluate the refrigerator in question. He stated that he doesn't always get work orders for needed work. Sometimes, staff just see him on	F 761	reoccur? "Education will be provided to all licensed nurses by the DHS on the correct temperature range for the medication refrigerators (36-46 degrees), and on the process of notifying the maintenance department and the pharmacist as soon as a temperature is found to be out of acceptable range in a medication refrigerator. The notification will be documented on a form signed by the nurse at the time notification is complete and will include the maintenance partner□s name and the pharmacy partner□s name. This education will be completed by 2/7/2020. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance "The Administrator will be responsible for compliance of the monitoring of this plan of correction. In addition, the Administrator will monitor the compliance of this POC in monthly QAPI meeting for 3 months to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and/or immediate corrective action. Date of Compliance: 2/7/2020	

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the hall and let him know when there is a problem and he would go and fix it then. When he did get a work order, he destroyed it once the repair had been completed. The interview further revealed the Maintenance Director had not been made aware of any refrigerators in the medication storage areas with temperatures being out of range.

An interview with the Administrator was conducted on 1/8/20 at 3:45 PM. He stated the staff should contact maintenance when the refrigerator was found to be out of the correct temperature range. The Administrator explained the staff may have checked the temperature after the door was open for a while and adjusted the temperature down when they were high, making the refrigerator colder than it should have been when the door was closed for a length of time. He felt staff needed to have further education on what to do when the refrigerator temperatures were found out of the correct range.