

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2020
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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 000	Initial Comments An unannounced Recertification survey was conducted on 02/04/20 through 02/07/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # I58B11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 02/04/20 through 02/07/20. Event ID # I58B11.	F 000		
F 561 SS=D	[1] of 12 complaint allegations were substantiated but did not result in a deficiency. Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561		2/21/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/24/2020
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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 561	<p>Continued From page 1 facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interview the facility failed to provide showers as scheduled for 1 of 1 resident sampled for choices. (Resident #85).</p> <p>The findings included:</p> <p>Resident #85 was admitted 05/16/2017 with diagnoses including Atrial Fibrillation, Heart Failure and Depression. The admission Minimum Data Set (MDS) dated 01/14/2020 had Resident #85 coded as cognitively intact and able to make needs known and was coded as having little interest or pleasure in doing things, feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much and feeling tired or having little energy. She was also coded as it being very important to her to choose between a tub bath, shower, bed bath, or sponge bath. She was coded as needing extensive assistance with her activities of daily living (ADL).</p> <p>The care plan dated 01/27/2020 had the focus of her having a self-care deficit related to (r/t) impaired mobility, and weakness. There were no references to manipulative behaviors in the care plan.</p> <p>Reviewed the shower schedule for Resident #85 and her shower days were Monday and</p>	F 561	<p>How Corrective action was accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #85 received a shower per her choice on 2/8/2020, and this was confirmed by the facility's RN Supervisor. Residents #8's shower schedule and the shower sheets will be monitored by the RN Supervisor for 90 days to ensure showers are provided based on the Resident's schedule. Any refusals of showers will be verified with Resident #85 to ensure ongoing compliance with intervention to ensure choice is honored regarding Resident #85 receiving showers.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>An audit of all interviewable residents was completed on 2/21/2020 by the facility's Social Worker and Activities Director in which Residents were asked about their choices being honored regarding showers. Auditors were instructed to report any findings indicating noncompliance with honoring resident</p>		

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F 561	<p>Continued From page 2 Thursday.</p> <p>Reviewed shower form dated 01/09/2020 resident refused, 01/14/2020 resident had shower, 01/20/2020 resident had a shower, 01/28/2020 resident had a shower and shampoo, 01/30/2020 resident had a shower, 02/03/2020 resident had bed bath but did not have refusal for shower checked.</p> <p>During an interview with Resident #85 on 02/04/20 at 03:21 PM, Resident #85 stated her shower days were Monday and Thursday and she did not receive a shower or bed bath on 02/03/2020 and she told NA#1 that it was her shower day and she still didn't get one. Resident #85 also stated she has not refused a shower but has asked the staff to come back at a later time for one because she always wants her showers on her shower days.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 02/05/20 at 04:03 PM, the ADON stated she signed the shower form on 02/03/2020 when NA#1 told her Resident #85 refused her shower for the day and had a bed bath. The ADON also stated she was new and was still learning how to fill out the paperwork and did not check the refusal box for Resident #85.</p> <p>During an interview with the Director of Nursing (DON) on 02/05/2020 at 4:44 PM, the DON stated the nursing assistants are supposed to check the shower log and follow the residents schedule for showers and document if they refused on the shower form and report it to the nurse on the hall.</p> <p>During a telephone interview with NA#1 on</p>	F 561	<p>choice immediately to the Director of Nursing and RN Supervisor. No negative findings were identified from audit. Measures put into place to ensure that the same deficient practice does not recur:</p> <p>Education will be provided to all licensed nurses and certified nursing assistants by 2/21/2020 which includes Resident's Rights, Person-Centered Approach to Care and Adhering to each Resident Choices. Any newly hired nursing staff will receive education regarding Resident Choice in orientation.</p> <p>Audits of interviewable residents will continue by the Social Worker and /or the Activities Director five times a week to include a minimum of five Residents per day for 30 days and, then three times a week for 60 days to ensure ongoing compliance with the adherence to each resident's choice related to showers. The shower sheets of all interviewable residents will be reviewed by the DON or designee for 90 days and any shower refusals identified will be validated with resident in question to ensure ongoing compliance with facility's' adherence to Resident Choice.</p> <p>Any negative findings from the audits will result in a concern form being completed by the auditor, and immediate action taken to resolve the issue.</p> <p>Facility's plan to monitor its performance to make sure that solutions are sustained includes:</p> <p>Audits will be reviewed in the facility's</p>		

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F 561	Continued From page 3 02/05/2020 at 5:03 PM, NA#1 stated she was not familiar with that hall and did not look to check if she was supposed to have a shower and gave her a bed bath instead. NA#1 also stated she did not recall being told by Resident #85 that it was her shower day.	F 561	QAPI meeting monthly for three months. The facility's decision to extend the audits will be based on the findings of the audits.		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer residents for re-evaluation of the Preadmission Screening and Resident Review (PASARR) level II for 3 of 6 residents reviewed for PASARR. (Resident #22, #24, and #36). Findings included:	F 644	How Corrective action was accomplished for those residents found to have been affected by the deficient practice: A new Change of Condition PASARR Level II Screening Request to NC Must was completed for Residents #22, #24 and #36 on 2/6/2020 and Determination	2/12/20	

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F 644	<p>Continued From page 4</p> <p>1. Resident #22 was admitted 11/25/2015 with the last reentry dated 5/21/19 from an acute care hospital. The diagnoses were noted to include dementia, hypertension, schizophrenia, congestive heart failure, end stage renal disease and insomnia.</p> <p>The PASARR Level I determination notification dated 11/24/2015 was for a Level I PASARR. There was no PASARR Level II screening found for this resident in the medical records.</p> <p>The annual comprehensive Minimum Data Set dated 9/02/19 assessed Resident #22 as cognitively intact and needing extensive assistance for activities of daily living. He was not coded as having had a level II PASARR processed for having a serious mental illness.</p> <p>The care plan dated 2/14/17 with last revision on 1/30/19 had focus areas to include at risk for adverse effects related to psychoactive medication use secondary to anxiety, insomnia and schizophrenia. An additional focus area included impaired cognitive function/impaired thought processes related to impaired decision making, dementia, difficulty making decisions and schizophrenia.</p> <p>Diagnosis report for Resident #22 dated 2/04/20 revealed schizophrenia onset dated 1/10/18 and anxiety disorder dated onset 5/21/19.</p> <p>An interview with the Social Worker (SW) on 2/05/20 at 4:35 PM revealed Resident #22 was not reevaluated for a Level II PASARR when the diagnosis of schizophrenia and/or anxiety disorder was added. She explained the resident</p>	F 644	<p>Letters were received from NC Must for all three residents by 2/10/2020.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>An audit for all current residents was conducted to determine if a Level II Screening was indicated based on newly evident or possible serious mental disorder, intellectual disability or related condition. For any resident identified as meeting this criteria, a new Change of Condition PASARR Level II Screening Request to NC Must was completed by 2/11/2020.</p> <p>Measures put into place to ensure that the same deficient practice does not recur:</p> <p>Education will be provided by 2/12/2020 by the Administrator to the Interdisciplinary Clinical Team, which consists of ,at minimum, Director of Nursing, Assistant Director of Nursing, Social Worker, Medical Records Manager, MDS Nurse and RN Supervisor, on the requirements of ensuring that any new onset or knowledge related to any resident's mental, intellectual or related condition is to be communicated to the facility's Social Worker immediately, in which a new Change of Condition PASARR Level II Screening Request to NC Must will be completed at once. Any newly evident or possible serious mental disorder, intellectual disability or other related condition will be reviewed daily,</p>		

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F 644	<p>Continued From page 5</p> <p>should have been submitted for Level II PASARR evaluation.</p> <p>On 2/05/20 at 4:55 PM the Director of Nursing revealed the facility will be completing an audit of residents to assess who needs to be referred for Level II PASARR evaluation that may have been missed.</p> <p>An interview with the Administrator on 2/05/20 at 5:10 PM, he revealed the staff missed the submission for the Level II PASARR and the facility would be addressing the missed evaluation immediately.</p> <p>2. Resident #24 was admitted 04/07/17 with diagnoses including Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Major Depressive Disorder, Anxiety Disorder, and Dementia with Behavioral Disturbance. The annual Minimum Data Set (MDS) dated 01/31/2020 had Resident #24 coded as severely cognitively impaired needing extensive assistance with personal hygiene, limited assistance with transfers, and dressing and supervision with eating, toilet use and bed mobility. The Annual MDS dated 03/13/19 was not coded as having had a level II PASRR processed for having a serious mental illness.</p> <p>The care plan dated 01/31/20 had focuses of at risk for adverse effects R/T psychoactive medication use: Dementia with behaviors. Resident shows signs and symptoms of physical behavior towards others. Resists when staff attempts activities of daily care. Resident has behaviors of yelling at staff 05/19 struck CNA and attempted to eat food from other residents; trays.</p>	F 644	<p>Monday-Friday, during the facility's Clinical Meeting.</p> <p>Medical record audits will continue to be conducted by the Administrator or designee five times a week to include a minimum of five residents per day for 30 days and, then three times a week for 60 days to ensure ongoing compliance for referring to level II PASARR review for all new evidence of possible serious mental disorder, intellectual disability or related condition.</p> <p>Facility's plan to monitor its performance to make sure that solutions are sustained includes:</p> <p>Audits will be reviewed in the facility's QAPI meeting monthly for three months. The facility's decision to extend the audits will be based on the findings of the audits.</p>		

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F 644	<p>Continued From page 6</p> <p>The PASARR level I determination notification dated 04/5/17 read: this level I screening and PASRR number remains valid for the individuals stay. No further PASARR screening is required unless a significant change occurs with the individual's status which suggest a diagnosis of mental illness or mental retardation or, if present, suggest a change in treatment needs for those conditions.</p> <p>Diagnosis report read: Major Depressive Disorder 5/12/2017, Anxiety Disorder 5/12/17, Schizophrenia 5/23/2017.</p> <p>There was no PASARR level II screening found for this resident in her medical records.</p> <p>During an interview with the social worker (SW) on 02/05/2020 at 4:32 PM, the SW stated she did not put in for a PASARR level II screening because she did not know she had to apply for a PASARR level II.</p> <p>During an interview with the Director of Nursing (DON) on 02/05/2020 at 4:44 PM, the DON stated there should have been a screening for Resident #24 for a PASARR level II.</p> <p>During an interview with the Administrator on 02/05/2020 at 5:17 PM, the Administrator stated a PASRR level II should be completed for Resident #24.</p> <p>3. Resident #36 was admitted 05/14/18 with diagnosis including Coronary artery disease (CAD), Heart Disease, Depression, and Schizophrenia. The quarterly Minimum Data Set (MDS) dated 12/13/19 had Resident #36 coded as moderately cognitively intact needing</p>	F 644			

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F 644	<p>Continued From page 7</p> <p>extensive assistance with bed mobility, personal hygiene, transfer, dressing, independent with eating, and total dependence for toilet use. Medication received: Days: Antipsychotic Medication received: Days: Antidepressant during the last 7 day look back period.</p> <p>The care plan dated 12/13/19 had the focus of at risk for adverse effects R/T psychoactive medication use secondary to Depression, Schizophrenia.</p> <p>The PASARR level I determination notification dated 04/5/17 read: this level I screening and PASARR number remains valid for the individuals stay. No further PASARR screening is required unless a significant change occurs with the individual's status which suggest a diagnosis of mental illness or mental retardation or, if present, suggest a change in treatment needs for those conditions.</p> <p>Diagnosis report read: Major Depressive Disorder 5/14/2018 and Schizophrenia 5/16/2019.</p> <p>There was no PASARR level II screening found for this resident in her medical records.</p> <p>During an interview with the social worker (SW) on 02/05/2020 at 4:32 PM, the SW stated she did not put in for a PASARR level II screening because she did not know she had to apply for a PASARR level II. The SW also stated she would review all residents' records that have a diagnoses that would require them to have an screen for PASRR level II and submit them for consideration.</p> <p>During an interview with the Director of Nursing</p>	F 644			

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F 644	Continued From page 8 (DON) on 02/05/2020 at 4:44 PM, the DON stated there should have been a screening for Resident #36 for a PASRR level II. During an interview with the Administrator on 02/05/2020 at 5:17 PM, the Administrator stated a PASARR level II should be completed for Resident #36.	F 644			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		2/19/20	

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F 758	<p>Continued From page 9</p> <p>psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews, the facility failed to address a gradual dose reduction of an antipsychotic medication as required for 1 of 5 residents reviewed for unnecessary medication. (Resident #10).</p> <p>The findings included:</p> <p>Resident # 10 was admitted to the facility on 10/18/2018 and had a diagnosis of dementia, anxiety and depression.</p> <p>Review of Resident # 10's physician order revealed antipsychotic medication of Buspar 10 mg three times a day was ordered on 11/23/2018 to treat Resident # 10's anxiety.</p> <p>Review of the medical record revealed gradual</p>	F 758	<p>How Corrective action was accomplished for those residents found to have been affected by the deficient practice :</p> <p>The most recent pharmacy recommendation for resident #10 was presented to the attending physician on 2/19/2020 for review which resulted in no new orders to reduce medication.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>All other residents receiving psychotropic medications have been reviewed by the Director of Nursing on 2/19/2020 to ensure that the most recent</p>		

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F 758	Continued From page 10 dose reduction (GDR) had been requested by the pharmacist on 10/30/2019 but the physician had not addressed the pharmacist request for the drug reduction. The facility's Consulting Pharmacist stated in an interview on 2/6/2020 at 2:10 PM that he had requested a GDR on 10/30/2019 on antipsychotic medication Buspar but he did not recall getting the response back from the physician. On 2/6/18 at 4:25 PM the Director of Nursing(DON) stated in an interview she expected the physician to had addressed a GDR of an antipsychotic medication from the pharmacist in October of 2019. DON reported she will start reviewing all the pharmacist recommendations before filing in the residents medical records to make sure they had been addressed by the physician.	F 758	recommendations have been addressed and noted by the attending physician. Measures put into place to ensure that the same deficient practice does not recur: Education will be provided by 2/19/2020 by the DON to the Assistant Director of Nursing, RN Supervisor and attending physician on the requirements of ensuring that medical provider is addressing all recent pharmacy recommendations as related to gradual dose reduction of psychotropic medications. Each month pharmacy recommendations will be reviewed by the DON to ensure that all recent recommendations as related to gradual dose reductions are acknowledged and addressed by the physician. Any issues or missing recommendations will be discussed by the DON and the provider and addressed at once. This audit will be conducted monthly for 90 days. Facility's plan t o monitor its performance t make sure that solutions are sustained includes: Audits will be reviewed in the facility's QAPI meeting monthly for three months. The facility's decision to extend the audits will be based on the findings of the audits.		
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	F 761		2/19/20	

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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
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F 761	<p>Continued From page 11</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to secure 1 of 5 medication carts observed.</p> <p>The findings included:</p> <p>During an observation on 2/04/20 at 10:00 AM, the 100/200/500 hall medication cart was observed to be unlocked with the push in lock observed to be in the out position and the nurse was not in view of the cart. The nurse was observed to return to the cart within 90 seconds coming out of the resident 's room where the cart was parked in front of. There were no residents</p>	F 761	<p>How Corrective action was accomplished for those residents found to have been affected by the deficient practice:</p> <p>200 Hall medication cart was secured immediately and education was provided to the medication aide on 2/4/2020 that was assigned to the cart on the requirements of storing drugs and biologicals in locked compartments.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p>		

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F 761	Continued From page 12 observed in the hallway near the cart at the time. There was no other facility staff in the hallway at the time of the observation. During an interview on 2/04/20 at 10:03 AM, Medication Aide #1 stated she should not have left the cart unlocked. She stated it was a new cart and she was getting used to the cart. An interview with the Director of Nursing on 2/04/20 at 11:25 AM revealed she had just reminded staff to lock and secure the carts. She explained all medication carts should be locked when it is out of view of the assigned nurse or medication aide. An interview with the Administrator on 2/05/20 at 11:00 AM revealed the staff should lock all medication carts when they leave the cart.	F 761	All medication carts were assessed to ensure that each one was locked and secured, and that no medications were on top of the cart while the cart was unsupervised. Measures put into place to ensure that the same deficient practice does not recur: Education will be provided by 2/19/2020 by the Director of Nursing or designee to all licensed nurses and medication aides on the requirements of ensuring that medication carts are locked and secured at all times when not directly supervised. Medication cart audits will be conducted on all medication carts by the DON or designee for a frequency of five times a week and will be conducted at varied times to ensure that each shift is represented. Facility's plan to monitor its performance to make sure that solutions are sustained includes: Audits will be reviewed in the facility's QAPI meeting monthly for one year. The facility's decision to extend the audits will be based on the findings of the audits.		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		2/21/20	

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F 867	<p>Continued From page 13</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and staff interviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place. This failure was related to non-compliance at the regulatory grouping of 483.45 on two consecutive annual recertification surveys. A deficiency in the area of medication storage at the regulatory grouping of 483.45 was cited during the facility's 1/26/19 annual recertification survey and was recited again on the current 2/07/20 annual recertification survey. The facility's continued failure during the recertification surveys showed a pattern of the facility's inability to sustain an effective QAA program.</p> <p>Findings included:</p> <p>This tag is cross referenced to:</p> <p>483.45 - Labeling of Drugs and Biologicals: Based on medical record review, observation, and staff interviews the facility failed to secure 1 of 5 medication carts observed for medication storage.</p> <p>483.45 was originally cited during the January 2019 recertification survey for failing to secure 3 of 7 mobile medication carts observed during medication pass for 100, 200 and 500 halls.</p> <p>During an interview on 2/07/20 at 3:30 PM the Administrator acknowledged understanding of the reciting of the repeated deficiency F761 from the</p>	F 867	<p>The Administrator has been reeducated by the Regional Vice President of Operations concerning the policy Quality Assurance and Performance Improvement (QAPI) Program.</p> <p>The facility will hold monthly meetings to review plans for areas identified in state surveys, mock surveys, facility audits, regional team visits, concern form reviews and any other feedback given to the facility. The committee will evaluate the effectiveness of each plan based on the monitoring feedback and decide if there needs to be a continuation, change or resolution of the plans.</p> <p>The meeting minutes will be reviewed by the Regional Vice President of Operations or Regional Director of Clinical Services each month for one year. random audits of identified issues will be done by the Regional Director of Clinical services during visits.</p> <p>The Administrator is responsible for this plan of correction.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 867	Continued From page 14 recertification survey of January 2019. The Administrator stated he was aware of medication storage concerns and the facility will be addressing the concerns on an ongoing basis.	F 867			