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	345344	A. BUILDING _____ B. WING _____	C 02/13/2020

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PELICAN HEALTH HENDERSON LLC	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to establish and maintain a comprehensive Emergency Preparedness Program (EP) which described the facility ' s comprehensive approach for meeting the health, safety and security needs of the staff and resident population during an emergency or disaster	E 001	E 001 EPP " The plan for correcting the specific deficiency: The process that led to this deficiency was the facility failed to establish and maintain a comprehensive emergency preparedness (EP) plan which described	2/28/20

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

Electronically Signed | 02/28/2020

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E 001	Continued From page 1 situation. The facility ' s EP Program did not include the following required elements: 1. Policies and Procedures to address the provision of food, water, medical and pharmaceutical supplies for resident ' s, staff and volunteers whether they evacuate or shelter in place. 2. Policies and Procedures to address the use of volunteers in an emergency and other staffing strategies to address surge needs during an emergency. 3. Policies and Procedures for sheltering staff, volunteers and/or family members in the event of an emergency or disaster situation. 4. Method to share information the facility determined to be appropriate with residents and their family or resident representatives. 5. The staffing list with phone numbers in the facility ' s EP Manual was not updated to include the current administrative staff. 6. Policies and Procedures related to accepting residents from other facilities and how they would be able to provide care for these residents. 6. The EP Program did not include information to develop and maintain an EP training/testing program at least annually. 7. The facility was unable to provide documentation of exercises to test the EP Program that included participation in a full-scale exercise with the community or exercises conducted in house to demonstrate staff knowledge of emergency procedures. On 2/13/20 at 3:00 PM the Administrator stated in an interview she had worked at the facility for 4 months and had not had time to review the Emergency Preparedness Program. The Administrator further stated she thought she had updated the list of staff in the EP manual. The Administrator continued and stated the	E 001	the facility□s comprehensive approach for meeting the health, safety and security needs of the staff and resident population during an emergency or disaster situation. On 02/13/2020, the regional director of operations re-educated the administrator and maintenance Director related to development of a comprehensive EP plan which described the facilities comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. The facility□s EP Plan includes addressing: 1. Policies and procedures to address the provision of food, water, medical and pharmaceutical supplies for residents, staff and volunteers whether they evacuate or shelter in place. 2. Policies and Procedures to address the use of volunteers in an emergency and other staffing strategies to address surge needs during and emergency. 3. Policies and Procedures for sheltering staff, volunteers and/or family members in the event of an emergency or disaster situation. 4. Method to share information the facility determined to be appropriate with residents and their family or resident representatives. 5. The staffing list with phone numbers in the facility□s EP Manual. 6. Policies and Procedures related to accepting residents from other facilities and how they would be able to provide care for these residents. 7. The facility will test the EP Program by participating in a full-scale exercise with members of the community or conduct	

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E 001	Continued From page 2 Maintenance Director told her the facility participated in a disaster drill with Vance County this past year. The Maintenance Director joined the interview via telephone and stated the previous administrator had the documentation of the facility ' s participation in the disaster drill with Vance County. The Administrator stated she was unable to locate any documentation of training for the facility during the past year.	E 001	in-house exercises to demonstrate staff knowledge of emergency procedures. " Procedure for implementing the plan: By 02/28/2020, the director of operations will review the facility EP plan to ensure the facility plan included a comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. ¿ The facility Administrator, and the maintenance director have reviewed, and updated our current manual, as of 02/28/2020, to include: A)Current facility risk population identified, including residents needing special care like oxygen and immobility and services the facility is capable of providing to residents during an emergency situation. B)Collaboration with local, federal and state EP officials. C)Process to track staff and residents if displaced D)Shelter in place criteria for residents and/or staff who need to remain in the facility in the event evacuation could not occur E)Maintaining confidentiality of resident medical records during an evacuation or transfer to another facility, during an emergency. F)Process to utilize volunteers G)Transfer arrangements with other facilities H) A defined role under a waiver declared by the secretary I)Communication Plan, including name,	

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E 001	Continued From page 3	E 001	contact information for all staff working in the facility, contact information of resident□s attending physician, and contact information of facilities available to provide care and services to residents in an emergency. J)To include emergency officials contact information k) Communication plan to include how resident information and medical documents will be shared with other facilities and health care providers to ensure continuity of care. L) To include communication of available beds M) Communication plan to include how emergency plan information that is shared with facilities residents, family members and resident□s representative. N) A process for testing and training requirements of this plan. O) To include integrated health system polices P) Identified emergency power system that is in place in case of a power failure during an emergency situation. The Safety Committee members, including the Maintenance Director, Director of Nursing, and the Administrator will educate the facility staff and residents, on the updated information related to the Emergency Program 03/12/2020. " Monitoring procedure: ¿A review of the Emergency Preparedness manual will be conducted by the director of operations for compliance of Emergency prep testing and conduct any staff exercise to test their	

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E 001	Continued From page 4	E 001	EP plan; Policies and procedures for sheltered residents and staff who remained in the facility; Policies and procedures to track resident and staff who were moved to other facilities; Contact information of staff, pharmacy, resident physicians, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman; Procedures of sharing information and medical documentation of a resident with other health care providers that would be providing continuity of care; Method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency; Establishing a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives by completion 03/12/2020 and Biannually X 2. The emergency plan will be evaluated annually by the Safety Committee to ensure the contents are current. " Title of the person responsible for implementing the plan: ¿ Administrator " Date the written plan will be completed ¿ 02/28/2020	
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted on 2/10/20 through	F 000		

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F 000	Continued From page 5 2/13/20. Event ID: E5G911. 2 of 21 complaint allegations were substantiated resulting in deficiencies. The scope and severity for EP 0001-F was added to the 2567 on 3/4/2020 and the deficiency was reposted.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff, family and physician interviews the facility failed to have two staff members present during a transfer with a Hoyer lift which resulted in a fall with no injury for 1 of 3 residents reviewed for accidents. (Resident #5) Findings included: Resident #5 was admitted to the facility on 5/24/19. Her active diagnoses included paralytic ileus, anemia, depression, and Alzheimer ' s disease. Resident #5 ' s most recent minimum data set assessment dated 10/30/19 revealed she was assessed as severely cognitively impaired. She had no moods or behaviors. Resident #5 required	F 689	F 689 The facility failed to have two staff members present during a transfer with a Hoyer lift which resulted in a fall with no injury for 1 of 3 residents reviewed for accidents. Corrective action for the resident On February 06, 2020, the interdisciplinary team investigated the potential contributing factors that may have caused resident #5 to sustain a fall during a transfer with the Hoyer lift from the wheelchair to bed. The nursing assistant was identified as performing a Hoyer lift transfer alone and was counseled and educated on using a 2-person assist when performing a Hoyer	2/28/20

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F 689	Continued From page 6 assistance with transfers by two people. She was frequently incontinent of urine and bowel. Resident #5 had sustained no falls since the prior assessment. A nursing note dated 2/6/2020 at 3:15 PM, written by Nurse #1, revealed Resident #5 ' s nurse aide came to nurses' station stating Resident #5 fell out of the Hoyer lift while being transferred from her wheelchair to her bed. The nurse aide stated Resident #5 hit her head. Upon the nurse entering the room, Resident #5 was noted lying on her right side. No changes were noted in Resident #5's mental status. Resident #5 denied pain and did not show any signs or symptoms of any pain. She was assisted back into bed via Hoyer lift with four-person assist. Resident #5 was able to move her extremities as she was able to prior to her fall. No changes were noted in Resident #5 ' s mental status. Physician #1 was contacted and made aware and Resident #5 ' s family member was made aware as well. A post fall review dated 2/6/2020 revealed Resident #5 sustained a witnessed fall with possible head injury. Upon assessment there was no injury as a result of the fall. The nurse aide was present with Resident #5 and stated the resident fell out of the Hoyer lift upon being transferred, via Hoyer lift, from her wheelchair, to her bed. The fall occurred in the resident ' s room and the physician and family were notified of the incident. Physician #1 ' s progress note dated 2/6/2020 revealed the physician assessed Resident #5 following her fall. He had been scheduled to assess her due to reports by staff that her abdomen was increasing in size and she had	F 689	lift transfer and a return demonstration competency was completed on 02/06/2020 by the Director of Nursing. Resident #5 was assessed by nursing staff and no changes were noted in her mental status and no apparent injuries. Neuro checks were started. The primary physician was contacted and on 02/06/2020 after the incident, resident #5 was assessed by the primary physician and he noted no injuries from the fall. Resident #5 was sent to the Emergency room on 02/06/2020 for evaluation due to her history of paralytic ileus. The hospital was notified of a fall occurring earlier in the day. A CT scan of her head was obtained on 02/10/2020 with no acute injuries were noted from the fall. Maintenance inspected all mechanical lifts on 02/06/2020 with no defects noted. Corrective action taken for those residents having the potential to be affected All nursing staff including Licensed nurses and CNAs were in-serviced by the Director of Nursing and/or Unit Manager using 2-person assist while doing Hoyer lift transfers between 02/06/2020 and 02/20/2020. Newly hired nursing staff will be educated on Hoyer lift transfers during orientation by the Director of Nursing or a Unit Manager. Audits will be conducted by the Director of Nursing or Unit Managers to ensure each resident□s care plan is being followed for those residents requiring a mechanical lift for transfers.	

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F 689	Continued From page 7 been lethargic the past few days. He documented staff reported the resident had a fall earlier that day while being transported via a Hoyer lift. No injuries were reported from the fall. His assessment revealed Resident #5 was in no distress with no rashes or prominent lesions on exposed areas. Her head was normal with no abrasions or lacerations noted. She also had an extended abdomen and the physician sent Resident #5 to the emergency room due to her history of a paralytic ileus. A head computed tomography scan dated 2/10/2020 revealed Resident #5 had no acute injuries as a result of the fall. During an interview on 2/10/2020 at 2:04 PM Nurse Aide #1 stated he was weighing Resident #5 on 2/6/2020. He stated Resident #5 ' s weight was always taken by Hoyer lift. He further stated she was in her wheelchair and the Hoyer lift pad was already in place under her from first shift. He began to raise her from the wheelchair and noticed the pad was shifted to her left side and she was leaning to her left over the pad. Nurse Aide #1 stated he was lifting Resident #5 with the Hoyer lift by himself. He had Resident #5 approximately two feet elevated from the wheelchair seat. When he noticed this, he began to lower Resident #5 back down to fix the pad. As he did this, Resident #5 slid over of the left side of the pad and hit the floor. He stated he saw she hit her head when she fell because she landed headfirst. Nurse Aide #1 stated he went and got the nurse and the nursing station. The Director of Nursing and Nurse #1 reentered the resident ' s room with him, and the Director of Nursing assessed the resident. Resident #5 stated she was okay and not in any pain. She was then	F 689	Residents that require a mechanical lift for transfers were visually audited by the Director of nursing on 02/06/2020, 02/08/2020, 02/11/2020, 02/12/2020, 02/15/2020, 02/19/2020, 02/20/20/2020, and 02/21/2020 to ensure their care plan was being followed. No issues were noted during observations. Measures put into place or systemic changes A Hoyer Lift Transfer Audit Tool will be utilized and used by the Director of Nursing or Unit Manager 5 days per week X 4 weeks, then 3 days per week X 3 weeks, then 2 days per week X 2 weeks, then the Director of Nursing or Unit Manager will visually audit 5 residents a week for 4 weeks transfers of residents requiring the use of a mechanical lift to ensure the care plan is being followed. Monitoring: The Director of Nursing or Unit Manager will report audit findings to the QA Committee monthly X 4 months. The committee will review and discuss the findings to ensure compliance and will determine whether there is a need for further auditing or staff education. DON Will be responsible for implementing this plan 2/28/19 is date of implementation of this plan	

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assisted to the bed. He further stated he should have had another staff member with him any time a resident was moved in a Hoyer lift even for just weights. He further stated he was planning on getting Resident #5 ' s weight and was going to transfer Resident #5 to her bed. He had planned on another nurse aide on the hall helping with the transfer after the weight was recorded and he was trying to get the work done as fast as possible which was why he did not wait for the other nurse aide just to get the weight. He added he was not aware at that time the pad had shifted over so far on Resident #5 prior to getting her weight.

During an interview on 2/10/2020 at 2:27 PM the family member of Resident #5 stated on 2/6/2020 Nurse #1 called her and informed her about the fall. She told her Nurse Aide #1 was in the room by himself and did not want to wait for the nurse and Resident #5 fell and hit the floor. The family member then stated Resident #5 went to the emergency room due to a preexisting medical issue and she took that opportunity to request a scan. The scan was completed today and was negative for any trauma related injury.

During an interview 2/10/2020 at 3:10 PM the Director of Nursing stated she was one of the nurses who first responded to Nurse Aide #1 requesting assistance in Resident #5 ' s room. She stated she and Nurse #1 got to the room and Resident #5 was in the floor on her side, but she could not remember which side. She asked Resident #5 if she was hurt and checked her head for any signs of trauma. Resident #5 shook her head no and there were no signs of trauma to her head. Neuro checks were initiated and once she was assessed to have no injuries, they

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F 689	Continued From page 9	F 689		

repositioned the Hoyer pad under Resident #5 and placed her in the bed. She stated she ensured Nurse #1 was going to notify the family and physician as well as initiate neuro checks on the e-chart. She stated then Physician #1 arrived at the facility to assess Resident #5 as she had been on his list to assess due to a history of paralytic ileus and a distended abdomen. She stated she then counseled Nurse Aide #1 on the Hoyer lift that there should be two staff members always present utilizing the lift including when taking weights. She further stated if the resident was being lifted out of the chair for any reason with a Hoyer lift, two staff members were to be present. She further stated he had been educated about this prior to this incident and he was aware of this. The Director of Nursing stated Nurse Aide #1 had attempted to lift Resident #5 alone with the Hoyer lift without other staff assistance and he did not give her a reason why he chose to operate the lift without another staff assistance. She stated a facility wide Inservice was initiated on the use of Hoyer lifts needing two staff members present and maintenance checked all Hoyer lifts in the facility. The Director of Nursing stated the facility had not audited all alert and oriented residents who required Hoyer transfers to see if any other residents had been in a Hoyer lift while only one staff member was present. The in-services were started 2/6/2020 and they are still on going and had not been completed as of this date. She stated she was unaware of a compliance date but knew the action plan stated it would be revaluated every three weeks.

During an interview on 2/10/2020 at 3:32 PM Nurse #1 stated she was at the nursing station and Nurse Aide #1 came to her and said Resident #5 fell and hit her head. She went to the room

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F 689	Continued From page 10	F 689		

and the Director of Nursing was in the room. Resident #5 was lying on her right side and the Director of Nursing was assessing Resident #5. She stated Resident #5 did not sustain any injuries but due to Nurse Aide #1 saying she hit her head during the fall, neuro checks were initiated. She further stated Nurse Aide #1 had used the Hoyer lift to raise Resident #5 out of her chair without assistance from other staff. She further stated two staff members must be present when using the Hoyer lift to lift a resident even if it was just to get a weight. She stated this was included in all education with staff and Nurse Aide #1 had been educated on this prior to the incident. She stated she then notified Physician #1 and the family member of the incident. She further stated Nurse Aide #1 informed her the Hoyer lift pad was not under her correctly from first shift. She concluded when Physician #1 assessed Resident #5, he did not identify any injuries as a result of the fall.

During an interview on 2/11/2020 at 1:40 PM the Administrator stated she was in the facility at the time Resident #5 sustained her fall. She stated someone came and informed her that there was an incident with Resident #5 and Nurse Aide #1. She stated she had been told he did not have a second person with him to use the Hoyer lift. She stated all staff were trained and knew to have two people present when using the Hoyer lift. She stated she knew Physician #1 was coming in to look at her extending abdomen and that Resident #5 had a paralytic ileus. She stated she spoke to Physician #1 when he came in and requested, he check her status post fall. After assessing Resident #5, the physician informed her he was sending her out due to the paralytic ileus and he assessed no injuries from the fall. The hospital

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F 689	Continued From page 11 was informed that Resident #5 had sustained a fall. Resident #5 had a computed tomography scan on 2/10/2020 which indicated bruising with no indication of internal injuries or a brain bleed. Resident #5 returned to the facility on 2/10/2020. She concluded there had been education in the facility regarding Hoyer lifts however she was not sure where they were in their plan of correction at that time. During an interview on 2/11/2020 at 2:26 PM Physician #1 stated on 02/06/20 he was already en route to the facility to assess Resident #5 ' s abdomen due to extension related to her history of a paralytic ileus. He stated he was informed upon arrival she sustained a fall and he assessed her at that time and found no injuries related to the fall. He stated due to her history of paralytic ileus and her abdominal distention he had her sent to the emergency room for evaluation. He stated on 2/10/2020 he requested a computed tomography scan of the head as a precaution from the fall which was negative for any trauma as a result of the fall. He concluded she did not sustain any injuries as a result of the fall on 2/6/2020.	F 689		
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	F 758		2/28/20

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	345344	A. BUILDING _____ B. WING _____	C 02/13/2020

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F 758	Continued From page 12 (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 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 §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. §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:	F 758		

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F 758	Continued From page 13 Based on record review and staff, pharmacist, and physician interviews the facility failed to provide a duration for an as needed psychotropic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #66) Findings included: Resident #66 was admitted to the facility on 10/17/18. Her active diagnosis included major depressive disorder, anxiety disorder, and hypertension. Resident #66's minimum data set assessment dated 1/6/2020 revealed she was assessed as cognitively intact. She had no moods and no behaviors. She received an antianxiety medication 7 days of the previous 7 days. Resident #66's care plan dated 12/30/19 revealed she was care planed for psychotropic drug use. The interventions included to administer medications as ordered by the physician. A discharge summary from the hospital dated 1/24/2020 revealed Resident #66 was discharged from the hospital with an order for alprazolam 0.25 milligrams orally 3 times per day as needed. Resident #66's orders revealed on 1/24/2020 the resident was ordered alprazolam tablet 0.25 milligrams give 1 tablet orally every 8 hours as needed for anxiety. The order was documented to be indefinite. The monthly signed orders for Resident #66 signed 2/7/2020 by the physician, the order was for alprazolam 0.25 milligrams enterally every 8 hours as needed for anxiety. There was no end	F 758	Free from Unnecessary Psychotropic Meds/PRN Use Based on record review and staff, pharmacist, and physician interviews the facility failed to provide a duration for an as needed psychotropic medication for 1 of 5 residents reviewed for unnecessary medications. The plan for correcting the specific deficiency: On 02/12/2020 Resident #66 was evaluated by the Primary Care Physician and alprazolam 0.25 milligrams PRN was discontinued. On 02/25/2020 the NP and Medical Director met to discuss the guidelines for PRN use of psychotropic medications. On 02/19/2020 the licensed nurses were re-educated by the Director of Nursing regarding the guidelines for PRN use of psychotropic medications and if an order is obtained it must be time limited not to exceed 14 days or have a physician□s rationale to extend the order and still have a specific duration. Procedure for implementing the plan: On 02/19/2020 the licensed nurses were re-educated by the Director of Nursing regarding the guidelines for PRN use of psychotropic medications and if an order is obtained it must be time limited not to exceed 14 days or have a physician□s rationale to extend the order and still have a specific duration. No current licensed nurse will be allowed to work until re-education is complete and this education has been added to the new hire orientation. The Director of Nursing and Unit Manager	

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F 758	Continued From page 14 dated and the order start dated was 1/24/2020. Resident #66's medication administration record for February 2020 revealed on 2/9/2020 Resident #66 was administered alprazolam 0.25 milligrams. During an interview on 2/12/2020 at 8:28 AM Nurse #1 stated the alprazolam 0.25 milligrams was ordered as needed and did not have a stop date. She stated it was started on 1/24/2020. She stated the medication was on the cart and there was no end duration to the medication. During an interview on 2/12/2020 at 8:34 AM the Treatment Nurse stated she was aware as needed psychoactive medication should have an end date of 14 days or a physician's rational to extend the order and still have a specific duration. Upon review of Resident #66's orders she stated she did enter the as needed alprazolam order from the hospital as an indefinite order and did not notify the physician for clarification. During an interview on 2/12/2020 at 9:23 AM the Director of Nursing stated she was unaware that as needed psychotropic medication required a duration. She further stated she would get clarification. During an interview on 2/12/20 at 9:26 AM Physician #1 stated Resident #66 had been on as needed alprazolam 0.25 milligrams for a very long time. He further stated she returned from the hospital on 1/24/2020 and the medication did not have an end duration. He stated he was aware all psychotropic medications were to have a specific duration, but he did not feel Resident #66 needed this because they had tried to discontinue it	F 758	completed an audit on current residents receiving PRN psychotropic medications to ensure all were limited to 14 days and rational was documented. The consultant pharmacist will review PRN psychotropic orders for residents and notify both the medical doctor and the Director of Nursing if no end date is present and if rational of use is not included in the medical record. Director of Nursing or Unit Manager will bring a copy of the previous day□s orders to the morning clinical review to ensure any orders for PRN psychotropics include stop dates. Monitoring the plan The Director of Nursing will review 5 charts weekly for 4 weeks of residents receiving prn psychotropic medications to ensure a stop date is included and the rational is documented in the medical record. Effective 02/28/2020, the Director of Nursing will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Title of Person Responsible for implementing plan: Director of Nursing Date the written plan will be completed: 2/28/20	

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F 758	Continued From page 15 before and she had indicated she needed the medication. During an interview on 2/12/2020 at 10:05 AM the Consultant Pharmacist stated for psychotropic medications that are as needed there needed to be a reevaluation after 14 days to see if the resident needed to have the medication extended. If the medication was to be extended past the 14 days and was not an antipsychotic such as alprazolam, the physician would document a rational and provide a specific duration such as one year but did not require a stop date. He stated the medication could not be ordered as indefinite.	F 758		
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	F 761		2/28/20

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F 761	Continued From page 16 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 secure 1 of 3 medication carts (cart #2) and 1 of 2 medication storage rooms (Nurses' Station #1 medication room). Findings included: 1. On 2/10/20 at 12:27 PM medication cart #2 was observed parked against the wall outside of room 107. The lock mechanism was extended and the red dot on the side of the lock was visible, indicating the lock was not engaged. No staff were observed in the hall. On 2/10/20 at 12:31 PM an interview with Nurse #1 was conducted. She verified the cart was unlocked by engaging the lock and stated it should be locked when unattended. She explained she thought she had locked it when she had walked away. An interview with the Director of Nursing (DON) was conducted on 2/13/20 at 12:23 PM. The DON stated it would be her expectation for the medication carts to be secured when the nurse leaves the cart. 2. On 2/11/20 at 8:52 AM the Nursing Station 1 medication storage room door was observed ajar; no staff were in the nurses' station or medication room. On 2/11/20 at 8:55 AM the Social Worker (SW)	F 761	1. Residents Affected: There were no residents determined to be affected by the alleged deficient practice. 2. Resident with the potential to be Affected: Current residents have the potential to be affected. The Licensed Nurse identified as leaving the medication cart unlocked and unattended was in-serviced by the Director of Nursing on locking medication cart when cart not in sight on 2/17/2020. All nursing staff were in-service by the Director of Nursing or Unit Manager on locking the medication cart when not in sight on 02/17/2020. Newly hired nursing staff will be educated on locking the medication cart during orientation by Director of Nursing or Unit Manager. Medication storage rooms were equipped with self-shutting mechanism on 2/18/2020 by the Maintenance Department. All nursing staff were in-serviced on 02/17/2020 on keeping medication storage rooms closed and locked. No current licensed nurse will be allowed to work until re-education is complete and this education has been added to the new hire orientation. 3. Systematic Change:	

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F 761	Continued From page 17 was observed walking through the nurses' station and closed the medication room door. An interview with the SW was conducted on 2/11/20 at 8:55 AM. She stated the medication room door should be closed but was unsure if it should be locked. An interview with Nurse #1 was conducted on 2/11/20 at 8:57 AM. She stated the medication room door should be locked when staff were not in attendance. An interview with the Administrator was conducted on 2/11/2020 at 9:12 AM. The Administrator stated the medication room door should remain locked.	F 761	Drug Storage Audit Tool will be reviewed by IDT team at clinical morning meeting for completion and locking of medication cart and rooms. The Drug Storage Audit tool will be completed by the Director of Nursing or a Unit Manager five (5) days per week x 4 weeks; then (3) days per week x 4 weeks; then (2) days per week x 4 weeks.. After these audits, the DON and/or the Unit Manager will randomly audit medication carts and medication storage rooms on a quarterly basis to determine if we are continuing to lock medication carts and storage rooms. The results of the audits will be presented to the QAPI committee at the monthly meeting. Newly hired nursing staff will be educated on locking of medication carts and storage rooms during orientation by the Director of Nursing or Unit Manager. 4. Monitoring of the change to sustain system compliance ongoing: The Director of Nursing or Unit Manager will report audit findings to the QAPI committee monthly x 3 months. The committee will review and discuss the findings. The administrator will be responsible for monitoring to ensure all audits are completed timely and that the results are reported to the QAPI committee for discussion, review and any action that may be needed. Title of person responsible for implementing plan: Director of Nursing	

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F 761	Continued From page 18	F 761	Date the written plan will be completed: 2/28/19	
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 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to label and date a package of French toast, a package of tater tots, and a package of biscuits stored in 1 of 1 freezer observed and failed to discard a package of hot dog buns which had an expired "best by date" stored in 1 of 1 food storage rooms observed. Findings included: 1. During observation of the facility's freezer on 2/10/2020 at 10:05 AM with the Dietary Manager,	F 812	F 812 Food Procurement store/Preparation/serve sanitary The facility failed to label and date a package of French toast, a package of tater tots, and a package of biscuit stored in the freezer and failed to discard a package of hot dog buns which had expired “best by date” stored in the food storage room. The plan of correcting the specific	2/28/20

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F 812	Continued From page 19 a package of French toast, a package of tater tots, and a package of biscuits were observed in the freezer. The packages were on the freezer shelf and not in any storage box. There were no labels or dates on the packages. During an interview on 2/10/20 at 10:05 AM the Dietary Manager stated when items were removed from their packaging, they should be dated prior to being placed in the freezer. He further stated the packages of tater tots, biscuits, and French toast were available for residents and did not have any dates on them and they should have been dated. During an interview on 2/11/2020 at 1:40 PM the Administrator stated foods stored in the freezer were to be labeled and dated. 2. During observation of the kitchen storage on 2/10/2020 at 10:02 AM with the Dietary Manager, a package of hot dog buns was observed to be in storage and have an expired "best by date" of 2/6/2020. During an interview on 2/10/2020 at 10:03 AM the Dietary Manager stated he performed walk throughs of the storage room and checked the dates every weekday. The Dietary Manager also stated the hot dog buns were in storage and available for use with resident meals. He concluded the hot dog buns dated 2/6/2020 should have been removed from storage. During an interview 2/11/2020 at 1:40 PM the Administrator stated food stored in the storage room were to be discarded by their best by date.	F 812	deficiency: All items that were found to not have a use by date and the item found to be “out of date” were discarded by the Certified Dietary Manager. All dietary employees were in-serviced by the Certified Dietary Manager on 02-10-2020 on the policy for Food Receiving and Storage which included education on removing items from the original packaging, labeling and dating foods with the “use by” date, and rotating items using a “first in – first out” system. Education was also provided on discarding any food items that have expired past their “use by date”. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The dietary manager or the scheduled cook for the day will check all food items in the freezer, cooler and stockroom for the “use by” dates on all food products and the opened bags/containers daily and discard any items that have expired past the ”use by” date noted on the product. This will be done daily during food service compliance rounds. The monitoring processes and systemic changes to ensure plan of correction is effective: Food service compliance rounds will be completed daily and kept in the Certified Dietary Managers office in a notebook. All concerns will be addressed immediately per policy. Any concern will be noted on	

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F 812	Continued From page 20	F 812	the daily compliance round audit sheet. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator will review all daily round sheet audit forms weekly times 4 weeks, then monthly times 2 months and report the findings monthly to the QA Committee members (Administrator, Director of Nursing MDS nurses, Nurse Managers, Staff Development Coordinator, Social Worker, Activities Director, Certified Dietary Manager, Medical Director and Pharmacy Representative). The committee will review the audit sheets to ensure compliance is ongoing and determine the need for further audits/re-education beyond the period of three months. Title of person responsible for Implementing Plan: Facility Administrtor Date the written Plan will be completed: 2/28/20	