The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

How the corrective action will be accomplished for the resident(s) affected. A Therapy Screen/Evaluation was completed on March 29, 2012. Results presented to surveyors. An Restorative Care Plan initiated and computer system updated to add Restorative Documentation to CNA section

How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Staff Development Coordinator will complete in-servicing of Nurses and CNA's on Restorative Referrals implementing referrals and scheduling Restorative for CNA documentation by April 13, 2012. Current residents in facility
Review of Resident #116's medical record revealed an initial physical therapy evaluation dated 10/10/11. The evaluation form noted late effect acute polio of right extremities with deformities and chronic lower extremity length discrepancy status post hip fracture. The Prior Level of Function section of the form indicated the resident used a crutch to ambulate "functional distances" at home until he was bed-bound three weeks prior to the June 2011 hospital admission. Additionally, a check mark was noted in the box next to the word "good" in the Rehabilitation Potential section of the form.

Review of therapy notes revealed the resident received therapy until November 2011. Review of a physical therapy note dated 11/3/11 revealed the resident was referred to daily restorative therapy by a Physical Therapist to maintain gains and to help prevent new contractures. The referral noted for restorative nursing services noted Resident #116 was to have active ROM in both arms at the shoulders and both legs at the hip, knee, and ankle areas. An additional comment was added that noted the resident needed to do push-ups from [wheelchair] seat to relieve buttocks pressure due to hip decubitus.

An interview about Resident #116 was conducted with Nursing Assistant (NA) #1 on 3/29/12 at 9:15 a.m. When asked about the care she provided to the resident to help him maintain range of motion, NA #1 stated she turned and repositioned him at least every two hours and stretched his right leg as much as she would allow. The NA demonstrated how she performed one ROM exercise to the resident's right leg and explained how she placed a pillow under his leg to help
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keep it straight. The NA said she did ROM
exercises on his leg at least every two hours
NA#1 stated she did not document when she
provided the ROM exercises and when asked
how she knew what ROM exercises to do for the
resident, NA #1 was unable to provide a clear
answer.

During an interview on 3/29/12 at 10:00 a.m., the
Unit Manager indicated the referral was missed
due to several staffing changes that occurred in
November 2011.

During an interview on 3/29/12 at 10:52 a.m., the
Rehabilitation Manager explained there was no
system in place for therapy to follow-up after a
referral was made.

F 431  483.60(b), (d), (e) DRUG RECORDS,
LABEL/STORE DRUGS & BIOLOGICALS
The facility must employ or obtain the services of
a licensed pharmacist who establishes a system
of records of receipt and disposition of all
controlled drugs in sufficient detail to enable an
accurate reconciliation, and determines that drug
records are in order and that an account of all
controlled drugs is maintained and periodically
reconciled.

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.

In accordance with State and Federal laws, the
facility must store all drugs and biologicals in

How the corrective action will be accomplished for the resident(s)
affected. Two treatment carts were
immediately locked and Nurses that
were present on duty were in-
serviced on locking medication carts
and treatment carts and the rationale
behind this practice. Rounds were
immediately started to ensure that
practice did not recur. The expired
medications were sent back to
pharmacy for disposal. The
medication rooms and
medication/treatment carts were
checked for expired medications, no
medications other than the meds in
the medication room were found to
be present.

4/27/12
How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Nurses were inserviced on locking treatment and medication carts as well as checking medication rooms and medication/treatment carts for expired medications, to include rationale behind this practice. Completed on April 13, 2012.

Measures in place to ensure practices will not occur. Unit Managers/Supervisor will monitor, utilizing Medication/Treatment Cart Security, Check of Medication Storage and Unit Manager Daily Checklist, daily X 14 days, weekly x4, monthly x 3, and then Quarterly x 3.

How the facility plans to monitor and ensure correction is achieved and sustained. DON will report results of monitoring to QA&A committee Monthly x 3 then Quarterly x 3 for continued compliance/revision to plan if needed.
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An interview was conducted on 03/26/12 at 8:00 PM with Licensed Nurse #1. He stated the cart was supposed to be locked when unattended. He reported he usually locked the cart before he walked away from it. He could not explain why the cart was not locked as he had not started his treatments and had not noticed the cart was unlocked.

An interview was conducted on 03/29/12 at 3:44 PM with the Director of Nursing. She stated the treatment cart should always be locked whenever it is not in the licensed nurse's sight.

2. An inspection of the west side medication storage room was conducted on 3/26/12 at 7:00 PM with Licensed Nurse (LN) #2 present. Observation of the room revealed 2 boxes of Ipratropium bromide/Albuterol sulfate inhalation solution [a bronchodilator medication] with an expiration date of November 2011. Inside each box were six pouches, and each pouch contained five vials of the expired medication for a total of 60 vials.

During an interview on 3/26/12 at 7:15 PM, LN #2 confirmed the bronchodilator medication was expired. The nurse indicated someone from pharmacy services checked the storage room for expired medications every two to three months. The nurse also said she straightened the room the previous night but did not check medications for expiration dates. LN #2 stated she was unaware if any particular staff member was assigned to check for expiration dates and said "It's up to all of us to check the dates before we use it."
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An interview was conducted with the Director of Nursing (DON) on 3/29/12 at 1:44 p.m. The DON stated she expected nurses to check expiration dates prior to using any medications. She indicated someone from pharmacy came to check medications on a monthly basis. The DON said pharmacy was in the facility for four full days the week before and had reported expired medications were pulled from use. During the interview, the DON produced the pharmacy report dated 3/20/12, which noted expired medications were discarded. Additionally, the DON said a nurse had checked the medication room the week before pharmacy came and she too missed the expired medication.

3. On 03/26/12 at 6:20 PM an observation was made of an unlocked and unattended treatment cart. The cart was located near the nurses’ station on the 200 half. The treatment cart contained numerous creams and topical ointments labeled with residents’ names. Some of the creams and topical ointments found were Hydrocortisone cream, Bacitracin, Zinc Dimethacone packets, and Voltaren.

An interview was conducted on 03/26/12 at 8:00 PM with Licensed Nurse #1. He stated the cart was supposed to be locked when unattended. He reported he usually locked the cart before he walked away from it. He could not explain why the cart was not locked as he had not started his treatments and had not noticed the cart was unlocked.

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