The center provides the following plan of correction (POC) without admitting or denying the validity or existence of the alleged deficiencies. The POC is prepared and executed solely because it is required by provisions of Federal State law. The facility reserves all rights to contest the survey findings through dispute resolution, final appeal proceedings or any administration or legal proceedings.

Corrective action for those affected:
Shower room was immediately cleaned again without successful removal of discolorations. The metal plate was tightened immediately. Corporate property management was notified on July 27, 2012 to evaluate the opportunity to move the shower renovations from next years capital list to renovate the shower now. The facility quote already received for the shower renovation was pulled forward on 7/27/12.
The decision was made to renovate the shower utilizing this company on August 1, 2012. The estimated renovation cost of $49779.00 is scheduled to begin August 31, 2012 and to be complete no later than the first week in October 2012.

Corrective action for those potentially affected:
Patients utilizing the shower room on the 200 and 600 hall was addressed as stated above.

Systemic changes:
Until renovations begin the shower room will be cleaned daily and will be detail cleaned weekly to include scrubbing the tiles with a deck brush. Environmental staff was inserviced on shower cleaning procedure and schedule. Maintenance staff was inserviced to check the shower rooms weekly and document findings on the audit sheet. Nursing staff was inserviced to notify the...
maintenance staff with any repair. The Environmental Services Director or designee will audit the shower rooms daily to assure cleaning has occurred for 2 weeks, weekly times 2 weeks, monthly times 3 months and quarterly thereafter. Until renovations begin the Maintenance Director or designee will check shower room to assure grip bars are tightly secured to the wall and document findings on the audit sheet weekly. Results of audits will be reviewed in QA monthly times 3 months then quarterly thereafter.

Quality Assurance and Monitoring:
The Environmental Services Director or designee will audit the shower rooms daily to assure cleaning has occurred for 2 weeks, weekly times 2 weeks, monthly times 3 months and quarterly thereafter. Until renovations begin the Maintenance Director or designee will check shower room to assure grip bars are tightly secured to the wall and document findings.

Resident #114 had diagnoses which included dementia with hallucinations. Review of the medical record of Resident #114 revealed she had been on Risperdal (an antipsychotic medication) the past year with the current dose of 0.25 milligrams twice a day since 01/23/2012.

The Care Area Assessment (CAA) for psychotropic medication for Resident #114 dated 04/13/2012 included review triggered due to resident receiving antipsychotic, anti-anxiety, antidepressant medications in the past seven days. A decision was made to “care plan with goal of avoiding complications/adverse effects from medications.”
F 329  Continued from page 3
The current care plan for Resident #114 last updated 07/12/2012 included the problem area.
"Resident exhibits behavior. Resists care or treatment. Resident refuses to get out of bed and refuses care and refuses to have labs drawn."
Approaches to this problem area included.
"Medicate resident as ordered by physician and monitor for side effects."
Review of the medical record of Resident #114 revealed the last time an AIMS test was completed was from readmission June 2010.
On 07/27/2012 at 1:20 PM the Director of Nursing (DON) stated AIMS tests are done for any resident on a psychoactive medication on admission and every six months. The DON stated the AIMS test was completed in the electronic system utilized by the facility and, once completed, subsequent tests would be triggered by the system. The DON reviewed the medical record of Resident #114 and confirmed the last AIMS test completed was 06/19/2010. In a follow-up interview on 07/27/2012 at 3:30 PM the DON stated if a resident is discharged from the facility greater than 24 hours it clears the trigger for the AIMS test and the AIMS assessment has to be completed on readmission within the electronic system. The DON stated when Resident #114 was readmitted 06/27/2010 an AIMS test was not completed which would have triggered the report for an AIMS test every six months. The DON stated it was the responsibility of the unit managers to complete the AIMS test. The DON stated she could not determine why the AIMS test was not completed for Resident #114 on readmission because she was not working at on the audit sheet weekly.
Results of audits will be reviewed in QA monthly times 3 months then quarterly thereafter.

F 329 Corrective action for those affected:
Resident number 114 was immediately assessed using the AIMS test.
Corrective action for those potentially affected:
A review of 100% of patients receiving antipsychotic medications was complete.
Every resident was assured to have an AIMS test performed and in the medical record.
Systemic changes:
When a resident is discharged and returns to the facility receiving antipsychotic medication an AIMS test will be performed within 24-72 hours and entered into the computer to set the computer tickler file schedule.
The DON or designee will also keep a log of all patients receiving antipsychotic medications. When an antipsychotic...
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<td>F 329</td>
<td>Continued from page 4</td>
<td>medication is ordered the DON or designee will record the medication and date of the AIMS test on the antipsychotic log. The DON or designee will review the log monthly to assure an AIMS test has been completed on admission and every 6 months while a patient is receiving an antipsychotic medication. DON or designee will audit all telephone orders in facility's morning meeting and assure any orders for a patient's antipsychotic medications has an AIMS test performed, is in the medical record, and logged on the antipsychotic tracking tool. Staff will be inserviced to complete an AIMS test with any antipsychotic medication and every 6 months as long as a patient continues to receive the medication. Inservices were provided on the process of tracking antipsychotic medications and AIMS testing. Quality Assurance and Monitoring:</td>
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<td>F 371</td>
<td>SS=F</td>
<td>463.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</td>
<td>This REQUIREMENT is not met as evidenced by: Based on staff interviews and observations of the kitchen and pantry refrigerators the facility failed</td>
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DON or designee will audit all telephone orders in facility’s morning meeting and assure any orders for a patient’s antipsychotic medications has an AIMS test performed, is in the medical record, and logged on the antipsychotic tracking tool. Results of audit, review of log and telephone order for antipsychotic meds will be reported in QA meeting monthly times three months then quarterly thereafter.

F 371 Corrective action for those affected:
1) As stated in the deficiency statement the Maintenance Director was notified immediately and pushed the button to reset the booster heater. The rinse temperature returned to 180 degrees F and has continued at least 180 degrees F.
2) Food items without labels were immediately discarded, food thawing in dietary refrigerator was placed in a non-perforated pan immediately, sprinkler head in refrigerator was checked immediately and insulation added in the attic at the sprinkler head. 3) The fan in the dish room was immediately cleaned and the
Continued From page 6

Final rinse temperature of the dish machine was reviewed and the last recorded final rinse temperature was 180 degrees F, at lunch on 07/23/2012. The log book was designed for temperatures to be monitored and recorded after every meal. At approximately 11:15 AM the FSD asked the dietary aide (that was working in the position responsible for checking and recording the final rinse temperature) if the final rinse temperature of the dish machine had been checked while dishes were washed that morning. The aide reported she had not checked the final rinse temperature that morning and had not planned on checking the final rinse temperature until all dishware had been washed. The aide stated she only had a few racks of dishes left to wash from the morning meal service and was not aware the final rinse temperature was less than 180 degrees F. The FSD stated her expectation was for staff to check the final rinse temperature of the dish machine at every meal and at the start of washing dishes in the event there were problems with the final rinse temperature. The FSD stated the aide (that was in the position to check the final rinse temperature that morning) did not typically work with dishwashing but should have known to check the final rinse temperature at the beginning of doing dishes as it was part of their training. The AFSD contacted the maintenance director to resume use of the dish machine. At approximately 11:30 AM the maintenance director reported the booster heater had to be raised as he thought an element had blown.

1.b. A wall mount fan positioned at ceiling level was observed in the room where clean dishes were washed by staff utilizing the three stainless steel enclosed boxes for pest control was immediately cleaned.

Corrective action for those potentially affected:
1) Staff will check dish machine temperature prior to beginning use of the dish machine and record temperature on log.
If the temperature is noted to be less than 180 Degrees F staff will push the reset button for the booster heater. If the temperature does not increase to at least 180 degrees F on the last rinse cycle dietary staff will notify the maintenance department using the maintenance request form. Maintenance will respond to the work order and address the situation to assure the dish machine is working properly.
2) Nourishment refrigerators will have a florescent colored sign indicating all food must be dated, labeled with patient name or it will be thrown away.
The Environmental Services staff or designee will check the refrigerator daily and document compliance and
disposable and dish machine. The fan was on high speed with air blowing throughout the room. The front grill of the fan was noted to have long strands of dust-like matter blowing from the fan. The AFSD was present at the time of the observation and the fan was turned off. When turned off both the front and back grills were observed with dust-like strands and there was a significant amount of black matter on the outer surface of each fan blade. The AFSD stated maintenance staff was responsible for cleaning the fan and did this about twice a month. The AFSD stated usually dietary staff would inform maintenance staff about the need to clean the fan and the AFSD agreed the fan needed to be cleaned.

1c. A pan of raw chicken was observed stored on the bottom shelf of open three-tiered shelving in the walk-in refrigerator. The pan of chicken was covered with plastic wrap that was loosely secured to the pan. In the center of the plastic wrap was an approximately half cup of pooled clear liquid. Directly above the pan of raw chicken (on open shelving) was a perforated pan housing two hams and a bag of chopped turkey. The AFSD notified the staff about the observation and stated the chicken and turkey had been placed in the walk-in refrigerator to store prior to use for an upcoming meal. The AFSD suspected the liquid pooled on the plastic wrap covering the chicken had come from the bag of thawed turkey stored on the perforated pan directly above the chicken. The AFSD stated the staff should be informed on placing thawing meat in a non-perforated pan when placed in the walk-in refrigerator.

2. On 07/28/2012 at 10:00 AM observations were dispose of any unlabeled undated foods. Families will be notified and staff will be instructed that all foods are to be labeled with the patients' name and the date food is placed in the refrigerators.

3) The dietary refrigerator sprinkler head will be added to the weekly cleaning schedule. Dietary employees will check for water drops and notify maintenance if water drops are noted when they complete their weekly cleaning schedules. The Maintenance Director or designee will follow up to assure the situation is corrected. 4) Food items will be stored in non-perforated pans while food is thawed. Staff will be instructed regarding thawing food in perforated pans. 5) The fan in the dietary dish room and the pest control box will be added to the weekly cleaning schedule.

Systemic Changes:
1) Staff will check dish machine and take corrective action if needed as specified above. Maintenance will conduct weekly audits of the dish machine to assure it continues to reach at least 180 degrees F during the last rinse cycle and document these weekly checks. Working
F 371. Continued From page 8

made of the walk in refrigerator. A sprinkler was observed in the ceiling and an open cart with trays of individual servings of covered food was stored below the sprinkler. Water was observed slowly dripping from the sprinkler onto covered food items on the open cart. The AFSD was present at the time of the observation and stated he was unaware of the dripping water from the sprinkler. The AFSD called the maintenance director to assess the sprinkler in the walk in refrigerator. The maintenance director stated since the sprinkler had been installed in the walk in refrigerator there had been problems with it dripping water when outside temperatures got too high.

3. On 07/26/2012 at 10:15 AM a significant amount of dust was observed coating the top of a wall mounted stainless steel box used to electronically eradicate flying insects. The electrodes on the front of the unit were coated with a significant amount of dust. This unit was above a work table where beverages were prepared. The AFSD was present at the time of the observation and stated that no cleaning had been done on the unit.

4. Observation on 07/26/2012 at 10:15 AM of the 100000 Nourishment Refrigerator revealed two (2) bowls of a yellow pudding-type substance that were not labeled or dated and two (2) 1/2 sandwiches that appeared to be egg salad which were not labeled or dated. A bag with a restaurant comment containing a sandwich, which was not dated or labeled, was on a shelf of the refrigerator. A cake labeled with a resident's name and room number was not dated as to when it was placed in the refrigerator. The top shelves in the refrigerator door were coated with condition of the dish machine will be reported in QA meetings monthly times 3 months and quarterly thereafter by the maintenance department.

2) Nourishment refrigerators will have a florescent colored sign indicating all food must be dated, labeled with patient name or it will be thrown away. The Environmental Services staff or designee will check the refrigerator daily and document compliance and dispose of any unlabeled undated foods. Families will be notified by this unit. The Food Service Director or designee will audit the cleaning schedules weekly times 3 weeks, monthly times 3 months then
Continued from page 9:

A yellow sticky residue and the bottom drawer had spots of yellow and brown sticky residue. The bottom of the refrigerator in front of the drawer also had spots of a yellow sticky residue. The inside of the freezer compartment was covered with a build-up of ice approximately 1/4 inch thick and there was also a thin layer of ice accumulated on the upper, back wall of the refrigerator.

Observation on 07/26/2012 at 2:45 PM of the 209/500 nourishment refrigerator revealed a bag of food labeled with a resident's name which was not dated. A cooler labeled with a resident's name which contained a plastic storage container of an unidentified substance with no date, and an opened container of skim milk with no date.

An interview on 07/26/2012 at 3:40 PM with LN #1 revealed any items put in the refrigerator are supposed to be dated with the date they are placed in the refrigerator. LN #1 stated she wasn't aware of who put food items in the refrigerator for the residents but that one of the residents had private slitter who could have put food in the refrigerator for them. LN #1 stated dietary staff check the refrigerator for expired food items and that nursing staff is responsible for dating any food items placed in the refrigerator.

An interview on 07/26/2012 at 5:28 PM with the Assistant Food Service Director revealed dietary staff check nourishment refrigerators about 10:00 AM every day. He stated all food items should be labeled with resident's name, contents and date. He stated all items brought from the kitchen should be labeled with contents and date. He stated the date on an item is the date it was put in non-perforated pans while food is thawed. Staff will be instructors regarding thawing food in perforated pans. The Food Service Director or designee will complete audits to assure foods are being thawed in non-perforated pans weekly times 4 weeks, monthly times 2 months and quarterly thereafter. 5) The fan in the dietary dish room and the pest control box will be added to the weekly cleaning schedule. Food Service Director or designee will conduct audits of the cleaning schedules weekly times 4 weeks, monthly times 3 months then quarterly thereafter.

Quality Assurance and Monitoring:
Maintenance will conduct weekly audits of the dish machine to assure it continues to reach at least 180 degrees F during the last rinse cycle and document these weekly checks. Working condition of the dish machine will be reported in QA meetings monthly times 3 months and quarterly thereafter by the maintenance department.

2) The Environmental Services
<table>
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<tr>
<th>REQUIREMENT</th>
<th>FINDINGS</th>
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<tr>
<td>F 371</td>
<td>Continued from page 10 the refrigerator. He further stated if dietary finds an item that is undated, the item should be discarded. He stated housekeeping is responsible for cleaning &amp; defrosting the refrigerator.</td>
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<tr>
<td>F 428</td>
<td>&quot;&quot;&quot;&quot;&quot;&quot;</td>
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<td>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on interviews with staff the consultant pharmacist and medical record review, the consultant pharmacist failed to identify and report the need for AIMS (Abnormal Involuntary Movement) testing for one (1) of two (2) sampled residents on an antipsychotic medication (Resident #114) . The findings are: Resident #114 had diagnoses which included dementia with hallucinations. Review of the medical record of Resident #114 revealed she had been on Risperdal (an antipsychotic medication) the past year with the current dose of 25 milligrams twice a day since 01/23/2012.</td>
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<td>F 428</td>
<td>Corrective action for those affected: Resident number 114 had an AIMS test done immediately.</td>
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<td>Staff or designee will check the refrigerator daily and document compliance and dispose of any unlabeled undated foods. Audits will be conducted weekly times 3 months and reported in monthly QA meetings and quarterly thereafter.</td>
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<td>3) The Food Service Director or designee will audit the cleaning schedules weekly times 3 weeks, monthly times 3 months then quarterly thereafter. 4) The Food Service Director or designee will complete audits to assure foods are being thawed in non-perforated pans weekly times 4 weeks, monthly times 2 months and quarterly thereafter 5) Food Service Director or designee will conduct audits of the cleaning schedules weekly times 4 weeks, monthly times 3 months then quarterly thereafter.</td>
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<td>FF 428 Corrective action for those affected: Resident number 114 had an AIMS test done immediately.</td>
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Corrective action for those potentially affected
A 100% audit was conducted for all residents receiving antipsychotic medications.
AIMS tests are in place for all patients receiving antipsychotics. The Pharmacist will obtain a list of all patients who are receiving antipsychotic medications and conduct a review of the meds during his monthly visits. These reviews will assure AIMS testing is in place. If the Pharmacist does not see an AIMS test in the medical record he will notify the DON or designee and one will be completed. The Pharmacist will conduct these reviews in addition to the computer system to assure an AIMS test is not missed. Pharmacist was educated that even though he may feel the computer is tracking the AIMS testing the above stated plan will be followed as a back up to assure AIMS testing is occurring. The DON or designee will log all antipsychotic medications when ordered
Resident #114 was readmitted on 08/27/2010 an AIMs test was not completed which would have triggered the need for an AIMs test every six months. The DON stated it was the responsibility of the unit managers to complete the AIMs test. The DON stated she could not determine why the AIMs test was not completed for Resident #114 on readmission because she was not working at the facility at that time and the unit manager in place 08/27/2010 was no longer employed by the facility. The DON stated she would have expected the MDS coordinator or consultant pharmacist to identify the need for AIMs tests when doing their assessments of residents.

Review of monthly consultant pharmacy reviews for Resident #114 revealed the need for an AIMs test had not been identified as a concern. On 07/27/2012 at 2:40 P.M. the consultant pharmacist stated he used to look for AIMs tests but since the facility began using the electronic system for AIMs tests two to three years ago he quit looking for AIMs tests. The consultant pharmacist stated staff had informed him the electronic system triggered when AIMs tests were due and he trusted the electronic system was ensuring AIMs tests were done as needed for residents on antipsychotic medication.

The facility must ensure that a system of records of receipt and disposition of all controlled drugs is maintained and periodically reviewed to ensure that all controlled drugs are maintained and periodically reviewed.
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(1) PROVIDER/SUPPLIER/CLINIC IDENTIFICATION NUMBER
345263

(2) MULTIPLE CONSTRUCTION
F. BUILDING
G. ROOM

DATE SURVEY COMPLETED
07/27/2012

NAME OF PROVIDER OR SUPPLIER
MOORESVILLE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
650 GLENWOOD DRIVE
MOORESVILLE, NC 28115

ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(Each deficiency must be preceded by full regulatory or identifying information)

ID PREFIX TAG

PROVIDER’S PLAN OF CORRECTION
(Each corrective action should be cross-referenced to the appropriate deficiency)

ON COMPLETION DATE

F 431 Continued From page 13
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 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently fixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on inspection of medication room refrigerators, the facility failed to ensure an unaltered, non-regulated alcoholic beverage was available for resident consumption in one (1) of two (2) medication room refrigerators and failed to ensure an expired narcotic was not available for resident use in the emergency narcotic kit.

stated plan will be followed as a back up to assure AIMS testing is occurring.
The DON or designee will log all antipsychotic medications when ordered utilizing the telephone order review process in morning meetings. This process will assure all antipsychotic meds are logged. Staff was inserviced on process for logging antipsychotic medications.

Monitoring and Quality Assurance
A 100% audit was conducted for all residents receiving antipsychotic medications. The Pharmacist will obtain a list of all patients who are receiving antipsychotic medications and conduct a review of the meds during his monthly visits. If the Pharmacist does not see an AIMS test in the medical record he will notify the DON or designee and one will be completed. The DON or designee will audit all new...
F 431 Continued From page 14

Inspection of the 100/300 milliliter medication room refrigerator on 07/27/2012 at 10:00 AM revealed one (1) full quart size Mason jar of clear liquid labeled with Resident #38’s name but without the contents identified.

Inspection of the facility's emergency narcotic kit on 07/27/2012 at 1:45 PM revealed one (1) tablet hydrocodone/acetaminophen 7.5/500mg with an expiration date of 06/15/2012.

A review of the facility’s policy on storage of alcoholic beverages revealed the policy allowed for resident consumption of alcoholic beverages and did not provide guidance on the use of non-regulated alcoholic beverages.

The facility’s policy on the storage and expiration dating of drugs specified: “Drugs and biologics that have an expired date on the label or are after manufacturer/supplier guidelines/recommendations are stored separately away from use, until destroyed or returned to the provider.”

An interview on 07/27/2012 at 1:45 PM with Licensed Nurse (LN) #2 about the monitoring of medications in the emergency narcotic kit revealed the medications are counted every shift and the nurse administering any medication taken from the kit should check the expiration date before giving it.

In an interview with Resident #38 on 07/27/2012 at 2:08 PM, he stated the quart jar contained "moonshine" and his daughter gave it to him last Thanksgiving. He stated he had not drank any of the moonshine.

medication orders by utilizing the telephone order review process in morning meetings. DON or designee will report findings in QA meeting monthly times 3 months and quarterly thereafter.

F 431 Corrective action for those affected: The alcoholic beverage was immediately sent home with the daughter and the expired narcotic was immediately destroyed. Corrective action for those potentially affected: The medication rooms were immediately checked to assure no unlabeled alcoholic beverages or expired medications were present.

Systemic changes: Medication refrigerators will be audited weekly for unlabeled substances or expired medications. These audits will be conducted weekly and logged. Staff was inserviced on the audit tool.
F 431
Continued From page 15

An interview on 07/27/2012 at 3:15 PM with LN #3 about the facility policy regarding alcoholic beverages revealed residents are allowed to have alcoholic beverages with a physician's order. LN #3 stated it must be labeled with the resident's name & stored in the medication room refrigerator. LN #3 stated she didn't know what the facility's policy was for receiving alcoholic beverages that weren't in a container with a manufacturer label.

An interview with the Director of Nursing (DON) on 07/27/2012 at 3:23 PM about the facility policy for residents consuming alcoholic beverages revealed the policy allowed residents to have alcoholic beverages with a physician's order.

An interview on 07/27/2012 with the Administrator revealed she was not aware of the quart jar of an unidentified alcoholic beverage for Resident #38 in the medication room refrigerator. She stated she would think if the resident wanted to drink moonshine and his family brought it in, the family should inform staff of what was in it and staff should get a physician's order for the resident to have it. She stated she knew Resident #38 had a doctor's order to have alcoholic beverages.

F 431
and to check medication expiration dates, destroy medications prior to expiration date and not to accept alcohol or any substances that are not labeled as to the content in the container.

Monitoring and Quality Assurance:
Medication refrigerators will be audited weekly for unlabeled or expired medications and documented on the audit tool. Findings of audits will be reviewed in QA meeting monthly times 3 months then quarterly thereafter. Staff was inserviced on the audit tool and to check medication expiration dates, destroy medications prior to expiration date and not to accept alcohol or any substances that are not labeled as to the content in the container.