STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345516	A. BUILDING _____ B. WING _____	C 04/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONOVER NURSING AND REHAB CTR	920 4TH STREET SOUTH WEST CONOVER, NC 28613

(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
F 000	INITIAL COMMENTS No deficiencies were cited as result of the complaint investigation. Event ID #VMVJ11. An amended Statement of Deficiencies was provided to the facility because tag F-258, that was cited during the facility's recertification survey, was deleted during Informal Dispute Resolution (IDR). Event ID# VMVJ11.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		5/8/14

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

Electronically Signed | 05/02/2014

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy and staff interviews, facility failed to submit a 24 hour report for 1 of 4 residents (Resident #159) reviewed with allegations of abuse. The findings included: 1. Resident #159 was admitted to the facility on 11/19/13 with diagnosis including peripheral vascular disease, generalized pain, and atrial fibrillation. The most recent Minimum Data Set (MDS) dated 11/26/13 assessed Resident #159 as cognitively intact, able to understand others and able to be understood. Resident #159 was no longer in the facility at the time of the recertification survey. Review of Resident Grievance/Complaint submitted by social worker (SW) on 12/12/13 revealed Resident #159 had reported to SW on morning of 12/12/13 that Nurse Aide (NA) #3 had come in to Resident #159's room around 3:00 AM, had spoken rudely and said to "shut up" to Resident #159. The report also revealed Resident #159 had reported to the SW NA #3 had refused to roll Resident #159's wheelchair over to her, and when NA #3 started to work with Resident #159's roommate, the roommate was screaming more than usual and yelling out "You're hurting	F 225	F225 1. As a precautionary measure, Resident #159 was immediately protected by removing NA#3 from the hall upon notification of the incident. Director of Nursing interviewed Resident #159 same morning to clarify information needed for potential allegation. Resident #159 had no recollection of the incident and stated she was happy with her care. 2. A log was created for allegations of abuse that is separate from the log currently used for grievances. The Director of Nursing or designee will immediately report all allegations of abuse on the 24 hour report to HCPR followed by the 5 Working Day Report. 3. Nursing staff was inserviced on 4/22/14 regarding reporting allegations of abuse and submitting the 24 hr report to HCPR. The system for logging abuse allegations was changed so that all abuse allegations are logged separately from grievances.	

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F 225	Continued From page 2 me!" The Resident Grievance/Complaint revealed Resident #159 had reported to the SW on the morning of 12/12/13 that she was afraid of NA #3 and was so upset she could not eat her breakfast and had thrown it up. Finally, the report revealed Resident #159 had requested to not receive care by NA #3 again. Interview with Social Worker on 04/09/14 at 3:41 PM revealed Resident #159 had told her NA #3 had been very rude to her and Resident #159 had observed NA #3 hurting her roommate. SW reported that even though the roommate of Resident #159 frequently yelled when receiving care, Resident #159 had never before reported her roommate yelling "you're hurting me" or an observation of any NA hurting her roommate. The SW stated she did not submit a 24-hour report because there was no evidence of bodily harm to Resident #159 or her roommate. Interview with Director of Nursing (DON) on 04/09/14 at 5:13 PM revealed the facility process for handling allegations of mistreatment was when a resident reported an allegation to the SW, the SW was to complete a grievance form which she passed on to the nursing supervisor. The DON stated if the allegation involved possible harm to a resident, the DON got directly involved with the investigation. When asked the difference between an allegation that would warrant filing a 24-hour report and an allegation that was handled as a grievance, the DON stated that if the allegation included the potential for resident harm, it was handled as a grievance but if the allegation involved intent to do harm and direct observation of that intent by another staff person, it was handled as an abuse investigation. The DON stated when she heard the report regarding Resident #159 and NA #3 , she had sent NA #3 home and called the night supervisor to instruct	F 225	4. Director of Nursing or designee will monitor abuse and grievance logs monthly for 3 consecutive months to ensure allegations of abuse are appropriately classified and accurately reported if warranted. QA will review results at quarterly QA meeting.	

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F 225	Continued From page 3 her to not allow NA #3 to work around Resident #159 during the duration of her investigation. The DON stated anytime an allegation sounded suspicious, she took action to protect the resident's safety, but did not submit a 24-hour report until she had time to investigate the allegation more thoroughly. The DON stated no 24-hour report had been submitted regarding this incident. Interview with the Administrator on 04/10/14 at 10:04 AM revealed his expectation that any allegation by a resident is investigated and if anytime during the initial 24 hours abuse or neglect was suspected, a 24-hour report was to be submitted to the North Carolina Healthcare Registry.	F 225		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to provide residents with the amount of baths/showers that they wanted each week for 2 of 3 residents sampled for choices (#32 and #36) and the time to go to bed at night for 1 of 3 residents sampled for choices (#32). The findings included:	F 242	F242 1. Resident #32 and Resident #36 were immediately offered the choice of how many times each week they would like to receive a shower/bath. Resident #32 was interviewed to determine what time she would like to go to bed.	5/8/14

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F 242	Continued From page 4 1. Resident #32 was admitted to the facility on 06/25/13 with diagnosis including joint pain, chronic kidney disease, and atrial fibrillation. The most recent Minimum Data Set (MDS) assessment dated 03/18/14 assessed resident #32 as cognitively intact, able to understand others and able to be understood. The MDS assessment revealed Resident #32 required physical help with at least one part of bathing. Interview with Resident #32 on 04/07/14 at 3:20 PM revealed Resident #32 would choose to shower every other evening if given a choice about shower frequency. Resident #32 stated when living at home, she took a shower every other night, and liked that schedule very much. Resident #32 stated she hadn't asked to change her shower schedule of two showers weekly because she felt the staff would get mad if she asked for more. Resident #32 stated she had never been asked how often she would like to shower, and instead was told which two days weekly she would be offered a shower. Resident #32 also stated each evening the Nurse Aides came in between 7:00 PM and 8:00 PM and told her it was time to go to bed. Resident #32 stated she had never gone to bed before 9:00 PM in her life. When asked if she had told staff she preferred to stay up later, Resident #32 stated when she had told staff, they left her up but then had been rude to her and made her wait an hour or more to go to bed once she called them and told them she was ready and needed help to get into bed. Resident #32 stated she had decided it was better to allow them to put her to bed each night between 7:00 PM and 8:00 PM even though she wasn't tired, rather than have them treat her disrespectfully when she spoke up about her preferences. Interview with Nurse Aide (NA) #5 on 04/10/14 at	F 242	2. Each Resident in the facility was interviewed on 4/11/14 to ensure choices were offered for frequency of bath/shower and choice of bedtime. 3. Activity Director or designee will interview residents upon admission and annually thereafter to determine resident choice for how many times/wk Residents receive shower/bath and what time residents prefer to go to bed. Staff were inserviced on 4/22/14 regarding resident choices. 4. Activity Director or designee will interview 20% of residents once monthly to ensure that shower/bath frequency and bedtime preferences are honored for 3 consecutive months. QA will review results at quarterly meeting.	

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1:32 PM revealed residents are offered two showers weekly based on the location of their room. NA #5 stated residents were reminded of their set shower schedule if they asked for showers.
Interview with MDS Coordinator on 04/10/14 at 2:30 PM revealed preferences were assessed through the MDS process. The MDS Coordinator stated she was not aware of any assessment that was done specifically to discover resident preferences of shower frequency or time to go to bed.
Interview with Nurse #4 on 04/10/14 at 3:52 PM revealed each hall had a shower schedule stating which residents were scheduled for showers each day. Nurse #4 stated each resident was offered two showers weekly and the schedule was set up by room number. When asked about residents who request extra showers, Nurse #4 stated the Nurse Aides struggle with having enough time to provide the two showers per week each resident is given.
Interview with NA #6 on 04/10/14 at 4:48 PM revealed the shower schedule was set for residents based on their room numbers and each resident was given two showers each week. NA #6 stated when residents asked for an extra shower she told them when their next shower day was. NA #6 stated Resident #32 had asked before to stay up later at night, but because Resident #32 got tired at night, the nurse aides all encouraged her to go to bed early. NA #6 stated the wait time for care at night could be longer than during the day, and it was easier to get residents to bed at an earlier time.
Interview with NA #7 on 04/10/14 at 4:55 PM revealed all nurse aides started their routine of getting residents ready for and in bed just after supper. NA #7 stated the hall was very quiet by

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7:30 or 8:00 PM and all the residents were in bed. NA #7 stated she did not ask residents what time they wanted to go to bed because they were all tired and needed their rest. NA#7 stated the showers are set for each resident to get two showers weekly, and Nurse Aides didn ' t have time to give more showers than that, unless there was an emergency.
Interview with the Admissions Coordinator on 04/11/14 at 8:50 AM revealed during the admissions process, residents were not specifically asked about their shower frequency preference or their choice on time to go to bed.
Interview with Social Worker on 04/11/14 at 9:27 AM revealed that preference assessment was completed by activities staff for the MDS, but the residents were not specifically asked about their choices in shower frequency or time to go to bed unless they came forward to complain about the set schedule.
Interview with the Director of Nursing on 04/11/14 at 10:21 AM revealed the shower schedule was set for each resident to be offered two showers each week, based on the location of the resident's bedroom. The DON stated if a resident wanted an extra shower, they needed to request it, and her expectation was that staff would accommodate that need. The DON stated unless the resident requested, the staff would not be aware of a choice for more showers or a different bedtime.
2. Resident #36 was admitted to the facility on 01/05/11 with diagnosis including failure to thrive, joint pain, and neuropathy in Diabetes. The most recent Minimum Data Set (MDS) assessment dated 03/18/14 assessed resident #36 as cognitively intact, able to understand others and able to be understood. The MDS assessment revealed Resident #36 required extensive

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assistance to shower.
Interview with Resident #36 on 04/08/14 at 8:27 AM revealed Resident #36 would prefer to have at least 3 showers weekly instead of the two weekly showers he was offered. Resident #36 stated he has told staff he'd prefer more showers, and has been told they don't have enough staff to offer more than two showers weekly. Resident #36 stated at home he had taken a shower daily, and although he could live without daily showers, he didn't like to feel dirty and unsanitary, which is how he felt with only two showers weekly. Resident #36 stated no staff had ever asked him about his preference for frequency of showers and he had been told each resident was offered two showers each week.
Interview with Nurse Aide (NA) #5 on 04/10/14 at 1:32 PM revealed residents are offered two showers weekly based on the location of their room. NA #5 stated residents were reminded of their set shower schedule if they asked for showers.
Interview with MDS Coordinator on 04/10/14 at 2:30 PM revealed preferences were assessed through the MDS process. The MDS Coordinator stated she was not aware of any assessment that was done specifically to discover preferences of residents' choices of shower frequency.
Interview with Nurse #4 on 04/10/14 at 3:52 PM revealed each hall had a shower schedule stating which residents were scheduled for showers each day. Nurse #4 stated each resident was offered two showers weekly and the schedule was set up by room number. When asked about residents who request extra showers, Nurse #4 stated the Nurse Aides struggle with having enough time to provide the two showers per week each resident is given.
Interview with NA #6 on 04/10/14 at 4:48 PM

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F 242	Continued From page 8 revealed the shower schedule was set for residents based on their room numbers and each resident was given two showers each week. NA #6 stated when residents asked for an extra shower she told them when their next shower day was. Interview with NA #7 on 04/10/14 at 4:55 PM revealed the showers are set for each resident to get two showers weekly, and Nurse Aides didn't have time to give more showers than that, unless there was an emergency. Interview with the Admissions Coordinator on 04/11/14 at 8:50 AM revealed during the admissions process, residents were not specifically asked about their shower frequency preference. Interview with Social Worker on 04/11/14 at 9:27 AM revealed that preference assessment was completed by activities staff for the MDS, but the residents were not specifically asked about their choices in shower frequency unless they came forward to complain about the set schedule. Interview with the Director of Nursing on 04/11/14 at 10:21 AM revealed the shower schedule was set for each resident to be offered two showers each week, based on the location of the resident's bedroom. The DON stated if a resident wanted an extra shower, they needed to request it, and her expectation was that staff would accommodate that need. The DON stated unless the resident requested, the staff would not be aware of a choice for more showers.	F 242		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		5/8/14

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F 312	Continued From page 9 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, family interviews, staff interviews, and medical record review, the facility failed to provide oral care for 3 of 4 residents (Resident #50, #36, and #94) requiring extensive assistance for activities of daily living. The findings included: 1. Resident #50 was admitted to the facility on 06/27/13 with diagnosis including Alzheimer's Disease, paralysis, and psychosis. The most recent Minimum Data Set (MDS) assessment dated 02/06/14 assessed resident #50 as severely cognitively impaired, rarely understood and rarely able to understand others. The MDS assessed Resident #50 as requiring extensive assistance of at least two persons for personal hygiene. Interview with family member of Resident #50 on 04/08/14 at 10:39 AM revealed family was concerned because food and tartar were visible in mouth and on teeth of Resident #50 each day when they visited. The family member stated that she had provided care for Resident #50 for three years before moving her into the facility, and she had worked hard to keep Resident #50's teeth clean each day. The family member also stated earlier in Resident #50's life, Resident #50 had been extremely particular about keeping her teeth clean and her breath fresh. The family member stated Resident #50's dirty teeth had been the most difficult thing to adjust to since her	F 312	F312 1. Oral care was immediately provided to Residents #50, #36, and #94 upon notification. Nurse aides were counseled on reporting to nurse when a resident refused care. 2. Each resident in the facility received pm oral care on 4/10/14 unless refused and then twice daily thereafter unless refused or requested otherwise. 3. The policy for tooth brushing was revised 4/11/14 to indicate the frequency for providing oral care at least twice daily. Staff were inserviced on 4/22/14 regarding the policy change and frequency for offering oral care twice daily. The system for documenting oral care was improved on 4/15/14 to include an option for nurse aides to select □No □ refused □ nurse notified□ should a resident refuse oral care. 4. Director of Nursing or designee will monitor frequency of oral care provided for 50% of residents once weekly for 1 month, then twice monthly for 2 months. QA will review results during quarterly QA meeting.	

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admission to the facility. The family member stated she had reported Resident #50's need for oral care to the Nurse Aids who work with Resident #50, and she had been told because Resident #50's teeth were difficult to get to with a traditional toothbrush, they would look into having someone supply Resident #50 with mouth swabs to keep her mouth clean. The family member stated since that report, no swabs had been provided and Resident #50's mouth and teeth continued to be dirty and filled with tartar at each visit.

Resident #50 was observed on 04/08/14 at 11:30 AM in the dining room, waiting for lunch. White debris and food particles were observed around the top of Resident #50's upper teeth. Also observed was a cloudy film across Resident #50's tongue and debris between her bottom teeth. Resident #50 had white matter at the top of each tooth, where it met the gum line.

Observation of Resident #50 on 04/09/14 at 2:49 PM revealed dried food on corners of resident's mouth, on teeth, and on tongue, as well as foul odor detected around Resident #50's mouth.

Interview with Nurse Aid (NA) #5 on 04/10/14 at 1:32 PM revealed all nurse aides assigned to hall worked on oral care with all residents. NA #5 stated Resident #50's teeth were very difficult to get to because Resident #50 did not like to open her mouth for staff. NA #5 stated that their system of documentation showed when an attempt at oral care had been made and did not show when the resident had refused or the staff was unable to complete the oral care. NA #5 stated as a result, staff marked off oral care for Resident #50 daily even though they were not

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usually able to get into her mouth to clean her teeth.

Interview with Director of Nursing (DON) on 04/10/14 at 3:22 PM revealed her expectation was that nurse aides would provide oral care for residents who were non-verbal whenever it was needed by the resident.

Interview with NA #6 and NA #7 on 04/10/14 at 3:55 PM revealed they attempted to brush the teeth of Resident #50 daily but Resident #50 frequently refused to open her mouth. NA #6 and NA #7 stated they had been asked by the DON ten minutes earlier to provide oral care for Resident #50 and had just done so. NA #6 and NA #7 demonstrated Resident #50's teeth and gums, which were observed clean with bleeding and swollen gums, especially just above each tooth. NA #6 stated she had not seen Resident #50's mouth bleed like that before but usually they were not able to get that far into her mouth.

Interview with Nurse #4 on 04/10/14 at 3:52 PM revealed her expectation that nurse aides would assist all residents with tooth brushing and oral care after each meal, at bedtime, and as needed. Nurse #4 stated if a resident's teeth were difficult to clean or the resident refused care, the NA was to report to the nurse to make alternate arrangements for the oral care to be completed.

Interview with Administrator on 04/11/14 at 9:40 AM revealed his expectation was that all residents would receive oral care at least twice daily and as needed.

2. Resident #36 was admitted to the facility on 01/05/11 with diagnosis including failure to thrive,

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joint pain, and diabetic neuropathy. The most recent Minimum Data Set (MDS) assessment dated 03/18/14 assessed resident #36 as cognitively intact, able to understand others and able to be understood. The MDS assessed Resident #36 as requiring extensive assistance of one person for personal hygiene. The MDS also specified the resident did not refuse care.

Resident #36's care plan included a goal for Nurse Aides to assist Resident #36 with oral care daily, and that Resident #36 would be well groomed and odor free.

Interview with Resident #36 on 04/08/14 at 12:04 PM revealed staff assisted him with oral care once weekly or less often. Resident #36 stated he couldn't brush his teeth or tongue without help from staff and they did not include tooth brushing in his care routine most of the time. Resident #36 stated at times a nurse aide would ask him about brushing his teeth when he was doing something and he would ask them to come back when he was finished but they never came back.

Observation of Resident #36's mouth and teeth on 04/08/14 at 12:10 PM revealed food debris between teeth at front and back of mouth, a white film across tongue, and a line of dried debris across the top of teeth at gum line. Also observed was a foul odor around Resident #36's mouth.

Observation of Resident #36 on 04/10/14 at 11:28 AM revealed a line of tartar above lip line on top of font teeth, foul odor from moth, and food debris on top back teeth on both sides. When asked when he had last received assistance with oral care, Resident #36 stated it had been several

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days.

Interview with Nurse Aid (NA) #5 on 04/10/14 at 1:32 PM revealed all nurse aides assigned to hall worked on oral care with all residents. NA #5 stated Resident #36 did not always allow staff to brush his teeth, even when they needed brushing. NA #5 stated that their system of documentation showed when an attempt at oral care had been made and did not show when the resident had refused or the staff was unable to complete the oral care. NA #5 stated as a result, staff marked off oral care for Resident #36 daily even though they were often not able to clean his teeth.

Interview with Director of Nursing (DON) on 04/10/14 at 3:22 PM revealed her expectation was that nurse aides would provide oral care for residents who were able to speak when the residents requested the oral care. The DON stated she did not expect residents who were able to verbalize their needs to receive oral care unless they requested the care.

Interview with Nurse #4 on 04/10/14 at 3:52 PM revealed her expectation that nurse aides would assist all residents with tooth brushing and oral care after each meal, at bedtime, and as needed. Nurse #4 stated if a resident's teeth were difficult to clean or the resident refused care, the NA was to report to the nurse to make alternate arrangements for the oral care to be completed.

Interview with Resident #36 on 04/11/14 at 8:45 AM revealed a nurse had met with him that morning, checked his teeth, and told him from now on he would receive oral care each day instead of every week or every month. Resident #36 stated he was very happy with the change

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and looked forward to having clean teeth every day.

Interview with Administrator on 04/11/14 at 9:40 AM revealed his expectation was that all residents would receive oral care at least twice daily and as needed.

3. Resident #94 was admitted to the facility on 12/27/13 with diagnosis including paralysis, generalized pain, and difficulty walking. The most recent Minimum Data Set (MDS) assessment dated 01/06/14 assessed Resident #94 as cognitively intact, able to understand others and able to be understood. The MDS assessed Resident #94 as requiring extensive assistance of one person for personal hygiene. The MDS also specified the resident did not refuse care.

Resident #94's care plan revealed a goal for nurse aide staff to assist Resident #94 with oral care daily.

Interview with Resident #94 on 04/07/14 at 3:03 PM revealed Resident #94 had not received assistance with oral care since early January of 2014. Resident #94 stated she had been told by staff that it took too long for staff to assist her to brush her teeth. Resident #94 stated her daughter had been coming in nightly for a month to brush her teeth at night, but she didn't receive oral care any other time of day from any facility staff. Resident #94 stated she had always brushed her teeth at least twice daily before living in the facility.

Observation of Resident #94 on 04/09/14 at 2:55 PM revealed particles of food between front teeth and on back teeth as well as white film on tongue.

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Resident #94 stated her mouth felt stale and she was very uncomfortable after meals when her teeth were not brushed.

Interview with family member of Resident #94 on 04/09/14 at 3:15 PM revealed family member had coming in to the facility each night after dinner to brush Resident #94's teeth for about a month. Family member stated she and her brother had been called in to the facility a month ago and told by facility social worker that brushing Resident #94's teeth was taking too much time for the nurse aide staff and they didn't know what to do. Family member stated she felt they were not going to complete oral care for Resident #94 and so she started to come in each night to brush her teeth. Resident #94's family member stated her extensive need for assistance with oral care had been the main reason she had moved from assisted living to skilled nursing. The family member also stated it had been extremely difficult for her to come into the facility each night to brush Resident #94's teeth and she didn't understand why the facility staff were not able to provide that care for her family member.

Observation of Resident #94 on 04/10/14 at 11:34 AM revealed Resident with food debris in her teeth, above her teeth, and a film across her tongue. Resident #94 stated her teeth had not been brushed since her family member brushed them the night before. Resident #94 stated again that facility staff had not assisted her with brushing her teeth in several months, and did not brush her teeth in the mornings, even though she had asked them for help repeatedly.

Interview with Nurse Aid (NA) #5 on 04/10/14 at 1:32 PM revealed all nurse aides assigned to hall

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worked on oral care with all residents. NA #5 stated Resident #94's teeth were very difficult to keep clean because Resident #94 had Parkinson's disease, which caused Resident #94 to shake while she worked on her teeth and made the process take a very long time. NA #5 stated staff would make attempts to assist Resident #94 but she frequently took so long they were forced to leave and assist other residents. NA #5 stated that their system of documentation showed when an attempt at oral care had been made and did not show when the care had been initiated but not completed. NA #5 stated as a result, staff marked off oral care for Resident #50 daily even though they were not sure the care was completed. NA #5 stated she could not remember the last time she had assisted Resident #94 with oral care because Resident #94's family member had been providing that care.

Interview with Director of Nursing (DON) on 04/10/14 at 3:22 PM revealed her expectation was that nurse aides would provide oral care for residents who were able to speak when the residents requested the oral care. The DON stated she did not expect residents who were able to verbalize their needs to receive oral care unless they requested the care.

Interview with Nurse #4 on 04/10/14 at 3:52 PM revealed her expectation that nurse aides would assist all residents with tooth brushing and oral care after each meal, at bedtime, and as needed. Nurse #4 stated if a resident's teeth were difficult to clean or the resident refused care, the NA was to report to the nurse to make alternate arrangements for the oral care to be completed.

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F 312	Continued From page 17 Interview with Administrator on 04/11/14 at 9:40 AM revealed his expectation was that all residents would receive oral care at least twice daily and as needed.	F 312		
F 431 SS=D	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 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 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.	F 431		5/8/14

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F 431	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to discard an opened insulin medication vial that was expired for 4 days and was available for use in 1 of 4 medication carts. Findings included: A review of prescribing information for the use of Novolog insulin indicated after opening may be used for up to 28 days and then discarded. Resident #19 was admitted to the facility on 05/16/13 with diagnoses of diabetes mellitus. Record review of a significant change Minimum Data Set (MDS) dated 03/06/14 revealed Resident #19 was severely cognitively impaired. Record review revealed an order dated 01/17/14 for Novolog 100 Unit/milliliter (ml) vial sliding scale for Resident #19 to be administered 4 times a day and a new order dated 03/20/14 for Novolog 100 units/ML vial for Resident #19 to be administered in the morning and evening. Review of the April Medication Administration Record (MAR) revealed Resident #19 received outdated Novolog insulin for 4 days after the 28 days expiration date of 04/09/14. On 04/10/14 at 11:42 AM, an open Novolog 100 unit/ML vial sliding scale insulin dated 03/09/14 was observed in the 300 hall medication cart.	F 431	F431 1. The expired insulin was immediately discarded upon discovery. Resident #19 was immediately assessed to ensure no ill effects were caused by receiving the expired insulin. A medication error report was completed and MD notified of error. 2. All other medication storage areas were immediately assessed on 4/10/14 and no other expired medications were found. 3. All nurses who administered expired insulin were counseled. The system for monitoring medication carts for expired insulin was revised. The previous label system did not include expiration date, only the open date. This was determined to be the contributing factor to the error. A new method of labeling insulin when opened and noting expiration date of insulin based on open date was implemented. The new labels will be completed and affixed upon newly opened insulin. The QA representative responsible for monitoring for expired insulin received education on personally verifying expiration dates of insulin. Nursing staff were inserviced on verifying expiration dates of insulin prior to administration on 4/22/14. Nursing staff were also inserviced on the new labeling system. QA representative will verify accuracy of labeling system and	

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F 431	Continued From page 19 On 04/10/14 at 11:42 AM Nurse #1, who administered medications on the 300 hall, was interviewed and stated she had noted on the prescription label Novolog insulin and who was to receive the insulin but had not noted the expired date. On 04/10/14 at 12:04 PM Nurse #2 was interviewed and revealed the medication carts and medication room was checked every Monday for expired medications. She stated the insulin should have been checked also on Monday 04/07/14. On 04/10/14 at 5:18 PM, the Director of Nursing (DON) was interviewed. The DON stated the pharmacy consultant reviewed the medication carts and medication refrigerator monthly and the staff development nurse checked the medication carts and medication refrigerator every Monday. She revealed her expectation of nurses should be that they check the vials of insulin, noting the date of the 28th day, and if outdated they needed to discard the insulin before they administered it and should get a new insulin vial from the medication room refrigerator.	F 431	expiration dates on all insulin weekly on an ongoing basis. 4. Director of Nursing or designee will monitor labeling system on all insulins for accuracy and ensure that all insulin is within 28 days of being opened once weekly for 1 month, then twice monthly for 2 months. QA will review results and effectiveness of this system at quarterly QA meeting.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		5/8/14

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F 520	Continued From page 20 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure there were no expired medications in 1 of 4 medication carts as part of the monitoring process for quality assurance. The findings included: The facility on the previous recertification survey dated 02/20/13 was cited for failure to discard expired medications in 2 of 4 medication carts at F 431. Cross reference to F 431 - the facility failed to discard an opened insulin medication vial that was expired for 4 days and was available for use in 1 of 4 medication carts. During an observation on 04/10/14 at 11:42 AM, an open Novolog 100 unit/milliliter (ml) sliding scale insulin vial dated 03/09/14 was observed in	F 520	F520 1. The expired insulin was immediately discarded upon discovery. Resident #19 was immediately assessed to ensure no ill effects were caused by receiving the expired insulin. A medication error report was completed and MD notified of error. A root cause analysis was completed on the current PDSA system for checking medication carts for expired insulin. 2. All other medication storage areas were immediately assessed on 4/10/14 and no other expired medications were found. Root cause analysis revealed the issue to be confined to the labeling of insulin to ensure insulin is discarded when it expires after 28 days.	

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F 520	Continued From page 21 the 300 hall medication cart. During an interview on 04/10/14 at 11:42 AM Nurse #1, who administered medication on the 300 hall stated she had not noted the expired date on the Novolog 100 unit/ml vial and confirmed insulin from the expired vial had been given to Resident #19 for 4 days after the expiration date. During an interview on 04/11/14 at 11:35 AM the Administrator explained nursing staff was supposed to check for expired medications as part of the quality assurance monitoring of medications. He explained the regularly scheduled 300 hall nurse was on vacation and the nurse who was on duty was a nurse who was scheduled as needed (PRN) and missed seeing the expired insulin in the 300 hall medication cart. He stated he expected that the monitoring of medications for quality assurance should have caught the expired medication but since it didn't it would have to be fixed. During an interview on 04/11/14 at 11:55 AM the Director of Nursing (DON) explained quality assurance monitoring for medications included a pharmacy consultant checked medications on a monthly basis and the staff development nurse checked the medication carts and medication refrigerator weekly on Monday. She stated the monitoring process should have caught the expired medication in the 300 hall medication cart but she also expected for nurses to check medications for expiration dates before they gave the medication and if a nurse found an expired medication they were supposed to discard it right then.	F 520	3. The system for labeling the insulin was improved so that the open date and expiration date are noted on each insulin. Nursing staff were inserviced on the new labeling system. Assigned QA representative will verify accuracy of labeling system and expiration dates on all insulin weekly on an ongoing basis. 4. The Director of Nursing or designee will monitor outcomes of this PDSA project to ensure labeling and QA verification systems work properly to discard insulin when expired once weekly for 1 month, then twice monthly for 2 months. Outcomes will be reviewed at quarterly QA meeting.	