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	345286	A. BUILDING _____ B. WING _____	C 11/19/2015

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of November 29, 2015. Event ID # N1H111	F 000		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interview the facility filed to resolve group grievances for resident council. The findings included: Observations of Resident bathrooms on 100, 200, 300, 500 and 600 halls were conducted on 11/19/15 at 8:00am. Observations revealed 5 out of 6 shared bathrooms on the 100 hall, 8 out of 12 bathrooms on 200 hall, 3 out of 6 bathrooms on the 300 hall, 4 out of 6 bathrooms on the 500 hall and 5 out of 6 bathrooms on the 600 hall were observed to not be clean. Resident council minutes were reviewed from May 2015 through November 2015. The minutes revealed a group grievance that Resident bathrooms were not clean. Resident council note dated 5/1/15 revealed bathrooms on 300 hall were dirty and smelled. It further stated some tiles need to be changed. Resident council note dated 7/10/15 indicated bathrooms/rooms were not being cleaned regularly on 300, 500, and 200	F 244	F244 Failed to follow up on resident council concerns with complaints of dirty bathrooms Residents affected: Rooms identified by surveyor environmental rounds will be cleaned by Environmental Services Director or designee by 12-17-15 Residents potentially affected: On 12/7/15 The Administrator ensured that all resident council concerns in the last year had been followed up on and signed by the department head and Administrator Systemic changes: Administrator inseviced all department heads on the procedure for follow up and timeliness of responding to resident council concerns. Department heads were inserviced that when given a concern form they are to address it, with appropriate actions and stated satisfaction within 3 days. Resident council concerns will be given to the	12/17/15

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

Electronically Signed | 12/15/2015

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F 244	Continued From page 1 hall. Resident council note dated 8/14/15 indicated bathrooms were not being cleaned regularly. Resident council note dated 9/4/15 indicated bathrooms/rooms not clean on a regular basis on 200/500 hall bathrooms " still dirty " . Resident council note dated 11/6/15 indicated bathrooms were not being cleaned on the 200 hall. Interview with the Activities Coordinator on 11/19/15 at 3:08 pm revealed she was responsible for the documenting the minutes for the resident council meetings. She stated she ensured the concerns discussed were taken to the appropriate department via a response form. The responsible department was to respond to the response form within 3 days. The group grievance dated 11/6/15 had been given to the Director of Nursing (DON) by the Housekeeping Director. The Activities Coordinator stated she had not gotten the response form back from the DON as of 11/19/15. The Activities Coordinator revealed she was not responsible for ensuring the concerns were addressed. The Administrator would sign off on the department response form when completed. Interview with the resident council president (Resident #112) on 11/19/15 at 3:22 pm revealed the resident council met monthly. The council had communicated issues concerning the cleanliness of the resident bathrooms. The facility ' s response to the grievance indicated the bathrooms would be cleaned. The issue with the cleanliness of the resident bathrooms was an ongoing issue for about 5 months. Interview with the Housekeeping Director on 11/19/15 at 12:43 pm revealed housekeeping duties included sweeping, dusting, and mopping of resident rooms and bathrooms daily. The housekeeping manager revealed she had only	F 244	department head who will address the concern, activities department will track the return of resident council response forms and assure complete. Once complete the Administrator will sign the form as will the department head signifying resident satisfaction achieved. All concern forms will be reviewed by activities in morning meeting each day until resolved. Monitoring and QA: The activities department will track resident council concerns and assure the are given to the department head and returned to them within 3 days, the activities department will take the completed form stating satisfaction by the resident to the administrator for their signature.	

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F 244	Continued From page 2 one occurrence of a family member approaching her about a resident ' s room not being clean enough. Housekeeping staff had responded by cleaning the room to the family ' s satisfaction. The Housekeeping Director explained there was not a method of tracking what housekeeping duties were performed. Interview with the Administrator on 11/19/15 at 3:29 pm revealed his expectation was for the resident council meetings to be documented and that concerns communicated by the council be put on a concern form and forwarded to the appropriate department. The turnaround time for the response form was 3 days. The Administrator indicated he signed off on the response forms to ensure the response to the concerns were appropriate. The Administrator indicated he did not observe the resident bathrooms for cleanliness. The Administrator further indicated he was not aware of the resident council response form dated 11/6/15. He had not signed the form indicating it was reviewed by the administrator.	F 244		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain clean bathrooms for 5 out of 6 shared bathrooms on the 100 hall, 8 out of 12 bathrooms on 200 hall, 3 out of 6	F 253	Ftag 253 failed to maintain clean bathrooms, spider webs were under the heating/air conditioning units, bent blinds, and baseboards not fastened to the walls	12/17/15

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F 253	Continued From page 3 bathrooms on the 300 hall 4 out of 6 bathrooms on the 500 hall and 5 out of 6 bathrooms on the 600 hall. Spider webs were observed underneath heating/air conditioning units in resident rooms #107, #109, #202, #204, #207, #209, #215, #219, #516, and #601. Bent blinds were observed in rooms #105, #211, #512, and #611. Baseboards were observed as not fastened to the wall in Rooms #216, and shared bathrooms #307 and #305, and #307, shared bathrooms #510 and #512 and shared bathrooms #601 and #603. The findings included: An observation was conducted of Resident rooms and bathrooms on 100, 200, 300, 500 and 600 halls on 11/19/15 beginning at 8:00 am and ending at 10:45 am Observations of resident bathrooms and resident rooms on 100 hall revealed the following: Resident room #105 window blinds were observed to be bent. The shared bathroom for rooms #105 and #103 revealed a brown substance around the base of the toilet. The bathroom tile was observed as discolored. The shared bathroom for rooms #104 and #106 had a brown substance around the base of the toilet. The tile was discolored. The shared bathroom for rooms #108 and #110 revealed a brown substance around the base of the toilet. The tile was observed as discolored. Room #110 had paper and food particles located underneath the heater/air conditioner unit. The shared bathroom for rooms #109 and #107 revealed a brown substance around the base of the toilet. The tile was observed as discolored and not clean. Room #109 had spider webs along the bottom of the bedroom vanity. The spider web had a dead black beetle underneath it.	F 253	Resident affected: Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 100 hall were cleaned by the Environmental Services and maintenance staff Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 200 hall were cleaned by the Environmental Services and maintenance staff Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 300 hall were cleaned by the Environmental Services and maintenance staff Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 500 hall were cleaned by the Environmental Services and maintenance staff Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 600 hall were cleaned by the Environmental Services and maintenance staff Residents potentially affected: Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 100 hall were cleaned by the Environmental Services and maintenance staff Environmental services Director and Maintenance Director validated all	

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F 253	Continued From page 4 The shared bathroom for rooms #111 and #115 revealed a brown substance around the base of the toilet. The tile on the bathroom floor was observed to be discolored and not clean. Observations of resident bathrooms and resident rooms on 200 hall revealed the following: The shared bathroom for rooms #204 and #202 revealed heavy brown and black build up around the base of the toilet. A black and brown substance was observed between tiles. Room #204 was observed to have spider webs along the side of the heater/air conditioning unit. Room #202 was observed to have spider webs and an unidentified dead insect behind the residents night stand. The shared bathroom for rooms #221 and #219 revealed a brown substance around the base of the toilet. The shared bathroom for rooms #201 and #203 revealed a brown substance around the base of the toilet. A dried spill containing hair was observed on the floor beside the toilet. Resident room #203 was observed to have dried brown substance on the wall. Dried food and a dried substance was observed to the bedroom floor. The shared bathroom for rooms #217 and #215 revealed a brown substance around the base of the toilet. The tile was observed as discolored. The shared bathroom for rooms #214 and #216 was observed to have a brown substance around the base of the toilet. Room #216 baseboard was observed as detached from the wall. The shared bathroom for rooms #211 and #209 was observed with discolored tile floors and a brown and black substance was around the base of the toilet. Room #209 was observed to have spider webs	F 253	identified areas in the residents rooms and bathrooms on 200 hall were cleaned by the Environmental Services and maintenance staff Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 300 hall were cleaned by the Environmental Services and maintenance staff Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 500 hall were cleaned by the Environmental Services and maintenance staff Environmental services Director and Maintenance Director validated all identified areas in the residents rooms and bathrooms on 600 hall were cleaned by the Environmental Services and maintenance staff systemic changes: All housekeeping staff were trained on the seven step cleaning procedure for resident rooms and bathrooms, Environmental complete quality control room inspections daily Monday through Friday with each housekeeper for 4 weeks and then weekly for 3 months Environmental rounds will be made weekly by the Environmental Director, maintenance director and administrator and or Director of Nursing for 4 weeks then monthly to ensure that baseboards, blinds, floors are intact and clean and to identify any new concerns.	

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F 253	Continued From page 5	F 253		

along the side and underneath the heater/air conditioner unit. Paper could also be observed under the heater/air conditioner unit.
Room #211 was observed to have bent window blinds. The telephone jack cover was observed as not attached to wall.
Room #207 was observed to have spider webs along the side of the heater/air conditioner unit.
Room #206 revealed no door knob cover (the piece that covers the moving mechanisms for the device) exposing screws to the inside of the bathroom. The exterior knob was observed as loose. Baseboard was observed to be coming loose from the wall in the bathroom. A brown substance was observed around the toilet and the tile in the bathroom was observed as discolored and not clean.
Observations of resident bathrooms and resident rooms on 300 hall revealed the following:
The shared bathroom for rooms #307 and #305 had base board coming loose from the wall.
The shared bathroom for rooms #306 and #308 was observed with discolored tile, and a brown substance was observed on the floor that was removed with a wet paper towel.
The shared bathroom for rooms #314 and #316 revealed a brown substance around the base of the toilet. The tile was observed as discolored. A brown substance was observed between the bathroom tiles. The caulking between the tiles was observed to have black and brown build up. The floor was observed as not clean.
Bathroom #320 revealed a brown and black substance around the base of the toilet.
Observations of resident bathrooms and resident rooms on 500 hall revealed the following
The shared bathroom for rooms #505 and #507 was observed to have yellow and brown substance along the caulking at the base of the

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F 253	Continued From page 6	F 253		

toilet.
Resident room #509 floor was observed to be dirty and in need of mopping. The substance was removed with a wet paper towel.
Room #512 window blinds were observed as bent.
The shared bathrooms for rooms #513 and #515 revealed a brown substance around the base of the toilet. A white and green substance was observed around the sink faucet.
Room #516 heater/air conditioning unit was observed to have spider webs underneath and along the sides.
Room #517 was observed to have a dried substance on the wall. The bedroom floor was observed as sticky and unclean.
Room #518 floor was observed as sticky when walked on. Dried spills were observed on the bedroom floor. The tile in the bathroom was observed to be discolored and not clean.
The shared bathroom for rooms #512 and #510 was observed to have baseboard detached from the wall.

Observations of resident bathrooms and resident rooms on 600 hall revealed the following:
The shared bathroom for rooms #601 and #603 was observed to have baseboard to be detached from the wall behind the toilet.
Resident room #601 was observed to have a brown substance on walls and a brown substance on the window blinds. The window blinds were observed as bent. Spider webs were along the side and underneath the heater/air conditioning unit.
The shared bathroom for rooms #606 and #608 was observed to have discolored tile and the floor was not clean.
The shared bathroom for rooms #604 and #602

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F 253	Continued From page 7	F 253		

was observed has having discolored tile and a brown build up around caulking between tiles on floor.
Bathroom for room #613 was observed to have areas of rust on the tile. The bathroom tile was observed as discolored and not cleaned.
The shared bathroom for rooms #610 and #612 revealed a brown dried substance smeared on the walls.
Room #611 window blinds were observed as bent. A paper clip was observed to be fastening the blinds.
Interview with the Maintenance Director on 11/19/15 at 12:43 pm indicated he became aware of maintenance needs by maintenance request forms submitted by staff. The work orders were reviewed every 2 hours. Maintenance indicated bariatric beds were digging holes into the walls. Maintenance department checked resident rooms every week.
Review of facility maintenance request from June 2015 to November 2015 revealed there were no maintenance requests in regards to the identified areas observed on 11/19/15.
Interview with the housekeeping manager on 11/19/15 at 12:43 pm revealed housekeeping duties included sweeping, dusting, and mopping of resident rooms and bathrooms daily. Resident bedrooms should be mopped daily. The housekeeping manager revealed she had only one occurrence of a family member approaching her about a resident ' s room not being clean enough and was concerned about dust. The housekeeper revealed housekeeping staff had responded by cleaning the room to the family ' s satisfaction. Housekeeping revealed there was no method of tracking what housekeeping duties were performed.
Interview with the administrator on 11/19/15 at

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F 253	Continued From page 8 3:29 pm revealed his expectation was for the residents living environment to be clean. The administrator revealed he was unaware of the conditions of the bathrooms and the uncleanliness of the resident rooms during observations on 11/19/15 at 1:15pm.	F 253		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 24 residents sampled for timeliness of quarterly assessments (Resident #46). The findings included: Resident #46 was admitted to the facility on 6/13/2000. A review of the resident's MDS assessments revealed her last annual MDS assessment was completed with an Assessment Reference Date (ARD) of 1/1/2015. Subsequent quarterly assessments were completed with (ARD) dates of 1/17/2015 and 4/14/2015. The resident's last quarterly MDS assessment was dated 7/14/15. A review of Resident #46's electronic medical record on 11/17/15 revealed no quarterly MDS	F 276	F276 failed to complete a quarterly MDS assessment within the required time frame Resident affected: A quarterly assessment was completed on 11/18/15 for resident number 46 Residents potentially affected: An audit of all residents was completed on 12/16/2015 by Administrator and Clinical Review Coordinator(CRC)Nurse to assure MDS assessments were complete as required. Systemic change: Facility social work director or designee will run a report weekly and bring to AM meeting so IDT team can review that all assessments are scheduled as required. Social Work and MDS staff were in serviced on 12/14/15	12/17/15

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F 276	Continued From page 9 assessments had been completed since 7/14/15. An interview was conducted on 11/18/15 at 10:20 AM with MDS Nurse #2. The nurse reported she shared responsibility with the MDS Coordinator for ensuring all MDS assessments were completed on time. The responsibilities were divided between the two nurses based on the resident ' s payment source. Upon inquiry, MDS Nurse #2 indicated she had just noticed this morning that Resident #46's quarterly MDS assessment was overdue. The nurse reported it must have been an oversight from when the resident transitioned from one payment source to another back in August and September of 2015. MDS Nurse #2 stated, "It was just missed." An interview was conducted on 11/19/15 at 8:50 AM with the facility's Director of Nursing (DON). Upon inquiry, the DON stated her expectation for the completion of MDS assessments would be, "That they be done on a timely basis."	F 276	on this new system by Administrator. Monitoring and QA: Facility Social worker director or designee will bring a MDS Audit 1x weekly x 4 weeks then 1x monthly thereafter to morning meeting and IDT to assure patient MDS assessments are completed as required. Results of audits will be reviewed in monthly QA meeting	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		12/17/15

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F 279	Continued From page 10 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop a care plan for contracture management for one of two sampled residents with contractures (Resident #125). The findings included: Resident #125 was admitted to the facility on 9/13/13 with diagnosis including osteoarthritis, contractures and dementia. A Physical Therapy (PT) note dated 4/29/15 for Resident #125 included the use of an abductor wedge between her knees when in a wheelchair and a Posey pillow between her knees when in bed in side lying position. When Resident #125 was in a supine (on her back), she was to have the Posey pillow under her left knee to decrease flexion contracture risk. The PT discharge summary dated 5/13/15 indicated the recommendations upon discharge included FMP/RNP (functional maintenance program/restorative nursing program). " Equipment recommended: equipment in room. " The discharge plan included a Restorative Program for application of positioning devices	F 279	F 279 failed to develop a plan of care for contracture management with one resident with contractures Residents affected: Resident number 125 was referred to physical therapy to screen for positioning devices indicated at this time. Care plan will be updated to indicate the positioning devices indicated. Potential for residents affected: Medical records, DON and or designee will audit communication forms for residents with restorative programs requested. Residents identified as needing a restorative program will have rehab screen them to assure needed services at this time, the physician orders will be obtained, inservice staff, kardex updated and care plan updated to reflect patient restorative needs. Systemic changes: When a communication form is given to the DON or designee they will review the form, inservice the staff, obtain the order from the physician, update the kardex and update the careplan as indicated. Monitoring and QA: DON or designee will audit communication forms for all steps as described above weekly times 2 weeks,	

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F 279	Continued From page 11 and bilateral lower extremities stretching to decrease further contracture risk and pressure areas on skin. The Minimum Data Set (MDS) dated 7/7/15, an annual, indicated Resident #125 had moderate impairment with short and long term memory, required total assistance of two staff for bed mobility and transfers. Resident #125 was assessed as having limitation in functional movement of both sides of upper and lower extremities. The Care Area Assessments (CAAs) dated 7/7/15 indicated Resident #125 had limited range of motion to bilateral upper and lower extremities. Review of the CAAs revealed there were no therapies noted at that time. Limitation in movement was due to osteoarthritis. Review of the Resident #125 ' s care plan dated 7/7/15 did not include contracture management or interventions for treatment. The contractures were included for a problem of being dependent on staff for activities of daily living. Observations and interview with nurse aide #1 on 11/18/15 at 3:10 PM revealed the resident had a positioning pillow to be used when in bed. She would know what to use by the information posted inside the closet on the door. The information posted included the use of a Posey pillow for contracture management. Aide #1 explained the Posey pillow " was green" and she did not see it in the room. Observations on 11/19/2015 7:58 AM of Resident #125 revealed the resident was side lying with no positioning device between her legs.	F 279	monthly times 2 months, quarterly times 2 quarters and report findings in monthly QA meeting.	

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F 279	Continued From page 12 Interview with MDS nurse coordinator #1 on 11/19/2015 at 11:05AM revealed care plans would be updated by reviewing the physician orders. She explained " normally there would be an order for restorative/maintenance program. " MDS nurse coordinator #1 explained she did not receive the communication forms when residents were referred to restorative. The process for care planning included assessment for contractures, referral to therapy and then proceed with a care plan. Further interview revealed a care plan had not included the contractures and a maintenance program. The MDS nurse coordinator was not aware Resident #125 had been referred to restorative.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		12/17/15

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F 280	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a care plan for behaviors and use of an antipsychotic medication for one of two sampled residents receiving antipsychotic medications. (Resident #41) The findings included: Resident #49 was admitted to the facility on 6/4/13 with current diagnosis of dementia, psychosis and hypertension. Review of a consult progress note dated 7/715 indicated Resident #41 had been seen by the psychiatrist due to hallucinations. The progress note included a diagnosis of premorbid dementia with new development of psychosis. The psych assessment included " expect it (behavior) is from advancing dementia. Due to level of distress caused by symptoms and possible safety risks (Pt talks about killing people when talking to herself) I would still recommend a medication trial. " A low dose of Risperdal was initiated. Review of Resident #49 ' s behavior sheet revealed target behavior was "screaming/disruptive sounds." The resident had no documented behaviors for the month of August 2015. Review of the Minimum Data Set (MDS) dated 8/4/2015, a quarterly, indicated no behaviors were exhibited during the assessment timeframe. The MDS indicated use of an antipsychotic for	F 280	F280 failed to update a care plan for behaviors and use of an antipsychotic medication for one resident Resident affected: Resident number 49 had care plan updated to reflect behaviors and the use of antipsychotic medications Residents potentially affected: 100% of residents orders were reviewed for antipsychotic medication use and care plans updated as indicated by the social work department. Systemic changes: Social worker will assure all patients who have antipsychotic medications ordered have the care plan updated with the behavior being monitored and the use of antipsychotic medications. Monitoring and QA: Social workers were inserviced by the Administrator on patients with antipsychotic medications having a care plan with the identified behavior listed on the care plan. Nursing staff will be inserviced by the DON or designee on behaviors documentation for patients on antipsychotic meds. Audits for patients with antipsychotic medications care plans will be completed by the social worker weekly times 2 weeks, monthly times 2 months and quarterly times 2 quarters, results of audits will be brought to monthly QA meetings.	

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F 280	Continued From page 14	F 280		

seven days of the assessment.

Review of the social service note dated 8/4/2015 indicated Resident # 49 had long term memory intact and mild impairment of short term memory. Resident #49 was assessed as alert, oriented to person, place and time. This note had no mention of psychotropic medication use. This note had no mention of behavior disturbances or target behaviors.

The resident ' s care plan dated 8/12/15 did not include a problem of dementia with behaviors, hallucinations or the use of an antipsychotic medication.

Review of the November 2015 monthly physician orders indicated Risperdal (antipsychotic medication) .25 milligram (mg) one tablet every night. The initial order date was 7/21/2015.

Interview with the MDS nurse coordinator #2 on 11/19/2015 at 9:57 AM revealed Resident #41 did not have a care plan for the use of antipsychotic medication and/or behaviors. This process for updating or initiating a new care plan included review of new orders. The yellow copy from telephone orders would be reviewed at the morning meeting. The nursing management initiated those care plans or completed the update. This nurse explained as an LPN, she could not initiate a new care plan. The system that had been in place included the unit managers did the new care plans or updates. Currently there were no unit managers.

Interview with the Director of Nursing on 11/19/2015 at 2:01PM revealed staff would be expected to update care plans as needed. The

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F 280	Continued From page 15 Director of Nursing confirmed staff failed to update Resident #41 ' s care plan to address the use of an antipsychotic medication and behaviors.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow the care plan for fall interventions for one of two sampled residents with falls (Resident #81) The findings included: Resident #81 was readmitted to the facility on 10/1/15 with diagnosis that included COPD, Diabetes, and muscle weakness. The initial care plan dated 10/2/15 included a problem of being at risk for falls. The approaches included low bed with mats on the floor, bed and chair alarms. The Minimum Data Set (MDS) dated 10/8/15, an admission, indicated Resident #81 had short and long term memory intact, required extensive assistance with bed mobility, transfers, toileting and dressing . Resident #81 required total assistance of one staff for personal hygiene. This MDS indicated he was non-ambulatory and one fall with minor injury had occurred.	F 282	F 282 Failed to follow the care plan for fall interventions for one resident with falls Resident affected: Resident discharged from the facility on Friday, December 4, 2015 Residents potentially affected: 100% of residents were reviewed for presence of kardex in patients closets and nursing assistant assignment sheets are updated. Systemic changes: DON or designee will obtain a list of fall assistive devices indicated for residents. Kardex and nursing assistant assignment sheets will be updated to indicate assistive devices for falls. Staff will be inserviced to follow their assignment sheets and kardexes. Each morning in morning meeting the telephone orders will be usd to update the nursing assistant assignment sheets and the kardexes. Monitoring and QA: The DON or designee will audit the nursing assistant assignment sheets and kardexes for	12/17/15

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F 282	Continued From page 16 Review of the November 2015 monthly orders revealed physician orders for use of bed and wheelchair alarms for safety and low bed with mats. The updated care plan of 11/5/15 for a problem of at risk for falls included the approach for dycem to the wheelchair cushion. Review of the nurse ' s note dated 11/6/15 indicated dycem was added to the wheelchair cushion. Observations on 11/18/2015 at 3:12 PM revealed the resident was assisted to bed. Observations of the wheelchair revealed the dycem was on top of the wheelchair cushion and underneath the sensor pad alarm. Aide #1 assisted the resident to bed, placed the alarm on the resident in the bed. The mat was not placed beside the bed. The bed was not lowered to its lowest position after he was transferred into the bed. Observations of Resident #81 ' s closet revealed no kardex was posted for the aides ' information on his care. Interview on 11/18/15 at 3:30 PM with the MDS nurse coordinator #2 revealed she would expect the dycem to be placed under the wheelchair cushion to prevent sliding. Observations on 11/19/2015 8:10:51 AM Resident #81 was sitting on the side of the bed taking a pan bath independently. A mat was not in place beside the bed. Interview with aide #1 on 11/19/2015 at 11:26 AM revealed she was assigned to Resident #81 for that day. Aide #1 explained the interventions for	F 282	being current and updated. Audits will be completed weekly times 2 weeks, monthly times 2 months, quarterly times 2 quarters, audits will be reviewed in monthly QA meetings.	

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F 282	Continued From page 17 falls included alarms on the chair and bed. Further interview revealed she had not seen a fall mat at bedside. She was not aware dycem was to be used in the wheelchair and a fall mat was to be placed beside the bed. Further interview with aide #1 revealed the nurse would inform her of fall interventions and she had a sheet with information about the residents. Review of her assignment sheet revealed no fall interventions were on the sheet. Interview with charge nurse #1 on 11/19/2015 at 11:29 AM revealed she did not update the assignment sheets for the aides. Charge nurse #1 was not aware who updated the assignment sheets. Interview on 11/19/2015 at 11:31 AM with the Director of Nursing revealed the staffing person updated the assignment sheets for the aides. The DON explained the aides also had a kardex with instructions for care of residents. The kardex was kept inside the door of the residents ' closets. . Interview with the DON on 11/19/2015 at 2:01PM revealed staff would be expected to follow the care plan and provide the interventions for falls.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		12/17/15

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F 318	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide therapy recommended restorative nursing for contracture management for one of two sampled residents. (Resident #125) The findings included: Resident #125 was admitted to the facility on 9/13/13 with diagnosis including osteoarthritis, contractures and dementia. A Physical Therapy (PT) note dated 4/29/15 included the use of an abductor wedge between her knees when in a wheelchair and a Posey pillow between her knees when in bed in side lying position. When Resident #125 was in a supine (on her back), she was to have the Posey pillow under her left knee to decrease flexion contracture risk. The PT discharge summary dated 5/13/15 indicated the recommendations upon discharge included FMP/RNP (functional maintenance program/restorative nursing program). " Equipment recommended: equipment in room. " The discharge plan included a Restorative Program for application of positioning devices and bilateral lower extremities stretching to decrease further contracture risk and pressure areas on skin. The Minimum Data Set (MDS) dated 7/7/15, an annual, indicated Resident #125 had moderate impairment with short and long term memory, required total assistance of two staff for bed mobility and transfers. Resident #125 was	F 318	F 318 failed to provide restorative nursing for contracture management with one resident with contractures Residents affected: Resident number 125 was referred to physical therapy to screen for positioning devices indicated at this time. Care plan will be updated to indicate the positioning devices indicated. Potential for residents affected: Medical records, DON and or designee will audit communication forms for residents with restorative programs requested. Residents identified as needing a restorative program will have rehab screen them to assure needed services at this time, the physician orders will be obtained, inservice staff, kardex updated and care plan updated to reflect patient restorative needs. Systemic changes: When a communication form is given to the DON or designee they will review the form, inservice the staff, obtain the order from the physician, update the kardex and update the careplan as indicated. Monitoring and QA: DON or designee will audit communication forms for all steps as described above weekly times 2 weeks, monthly times 2 months, quarterly times 2 quarters and report findings in monthly QA meeting.	

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assessed as having limitation in functional movement of both sides of upper and lower extremities.

The Care Area Assessments (CAAs) dated 7/7/15 indicated Resident #125 had limited range of motion to bilateral upper and lower extremities. Review of the CAAs revealed there were no therapies noted at that time. Limitation in movement was due to osteoarthritis.

Review of the care plan dated 7/7/15 did not include contracture management or interventions for treatment. The contractures were included for a problem of being dependent on staff for activities of daily living.

Review of the monthly re-cap orders for November 2015 revealed no orders for restorative nursing.

Interview with the restorative nursing assistant (RNA) on 11/18/15 at 3:00 PM revealed this resident was not on restorative. Further interview revealed Resident #125 had not been on restorative this year.

Observations and interview with aide #1 on 11/18/15 at 3:10 PM revealed the resident had a positioning pillow to be used when in bed. She would know what to use by the information posted inside the closet on the door. The information posted included the use of a Posey pillow for contracture management. Aide #1 explained the Posey pillow " was green" and she did not see it in the room.

Interview on 11/18/2015 at 3:56 PM with the DON revealed the process for therapy referrals to

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F 318	Continued From page 20 restorative included nurse management would include the resident on the caseload and complete the restorative plan of care for the type of program. The nurse educator for the facility had been the restorative nurse supervisor. Since her departure, the DON had assumed supervision of the program. Interview with the DON on 11/18/15 at 4:35 PM revealed Resident #125 had not been provided restorative nursing services this year Observations on 11/19/2015 at 7:58 AM of Resident #125 revealed the resident was side lying with no positioning device between her legs. Interview with MDS nurse coordinator #1 on 11/19/2015 at 11:05AM revealed " Normally there would be an order for restorative/maintenance program. " MDS nurse coordinator #1 explained she did not receive the communication forms when residents were referred to restorative. The MDS nurse coordinator was not aware Resident #125 had been referred to restorative. Interview with aide #2 on 11/19/15 at 11:25 AM revealed she usually worked on the 600 hall and was responsible for Resident #125 ' s care on that date. Further interview revealed the positioning device she used for Resident #125 was a regular pillow. During the interview aide #2 explained the resident did not have a special pillow or Posey pillow for her.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		12/17/15

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F 323	Continued From page 21 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide interventions for falls for one of two sampled residents with falls. Resident #81. The findings included: Resident #81 was readmitted to the facility on10/1/15 with diagnosis that included COPD, Diabetes, and muscle weakness. The initial care plan dated 10/2/15 included a problem of being at risk for falls. The approaches included low bed with mats on the floor, bed and chair alarms. Review of the incident report dated 10/7/15 indicated Resident #81 had fallen at 7:30 PM. He was found on his knees on the floor in front of the wheelchair. The incident report documented the resident explained his foot got caught under wheelchair and he slid onto knees. Injuries included he bumped his nose and head on the nightstand and sustained a small laceration to the bridge of his nose from his glasses, two bruises were noted on top of his head, skin tears to both elbows and bruises to both knees. The resident was able to stand with staff assistance. Staff assisted Resident #81 back into bed.	F 323	F 323 Failed to provide fall interventions for one resident with falls Resident affected: Resident discharged from the facility on Friday, December 4, 2015 Residents potentially affected: 100% of residents were reviewed for presence of kardex in patients closets and nursing assistant assignment sheets updated with resident fall prevention devices. Systemic changes: DON or designee will obtain a list of fall assistive devices indicated for residents. Kardex and nursing assistant assignment sheets will be updated to indicate assistive devices for falls. Staff will be inserviced to follow their assignment sheets and kardexes. Each morning in morning meeting the telephone orders will be usd to update the nursing assistant assignment sheets and the kardexes. Monitoring and QA: The DON or designee will audit the nursing assistant assignment sheets and kardexes for being current and updated. Audits will be completed weekly times 2 weeks, monthly times 2 months, quarterly times 2 quarters, audits will be reviewed in monthly QA meetings.	

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The Minimum Data Set (MDS) dated 10/8/15, an admission, indicated Resident #81 had short and long term memory intact, required extensive assistance with bed mobility, transfers, toileting and dressing . Resident #81 required total assistance of one staff for personal hygiene. This MDS indicated he was non-ambulatory and one fall with minor injury had occurred.

Review of the incident report dated 11/5/15 indicated Resident #81 had fallen at 5:00 PM. The resident explained to staff he slid out of wheelchair onto the floor. Staff observed him sitting on the floor next to the bed and in front of the wheelchair. The incident report indicated no injuries were sustained from this fall.

Review of the November 2015 monthly orders revealed physician orders for use of bed and wheelchair alarms for safety, low bed with mats.

The updated care plan of 11/5/15 for a problem of at risk for falls included the approach for dycem to wheelchair cushion.

Review of the nurse ' s note dated 11/6/15 indicated dycem was added to the wheelchair cushion.

Observations on 11/18/2015 at 3:12 PM revealed the resident was assisted to bed. Observations of the wheelchair revealed the dycem was on top of the wheelchair cushion and underneath the sensor pad alarm. Aide #1 assisted the resident to bed, placed the alarm on the resident in the bed. The mat was not placed beside the bed. The bed was not lowered to its lowest position after he was transferred into the bed.

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Observations of Resident #81 ' s closet revealed no kardex was posted for the aides ' information on his care.

Interview on 11/18/15 at 3:30 PM with the MDS nurse coordinator #2 revealed she would expect the dycem to be placed under the wheelchair cushion to prevent sliding.

Observations on 11/19/2015 8:10:51 AM Resident #81 was sitting on the side of the bed taking a pan bath independently. A mat was not in place beside the bed.

Interview with aide #1 on 11/19/2015 at 11:26 AM revealed she was assigned to Resident #81 for that day. Aide #1 explained the interventions for falls included alarms on the chair and bed. Further interview revealed she had not seen a fall mat at bedside. She was not aware dycem was to be used in the wheelchair and a fall mat was to be placed beside the bed. Further interview with aide #1 revealed the nurse would inform her of fall interventions and she had a sheet with information about the residents. Review of her assignment sheet revealed no fall interventions were on the sheet.

Interview with charge nurse #1 on 11/19/2015 at 11:29 AM revealed she did not update the assignment sheets for the aides. Charge nurse #1 was not aware who updated the assignment sheets.

Interview on 11/19/2015 at 11:31 AM with the Director of Nursing (DON) revealed the staffing person updated the assignment sheets for the aides. The DON explained the aides also had a kardex with instructions for care of residents.

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F 323	Continued From page 24 The kardex was kept inside the door of the residents ' closets. . Interview with the DON on 11/19/2015 at 2:01PM revealed staff would be expected to follow the care plan and provide the interventions for falls.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 3 medication errors out of 27 opportunities for 2 of 5 residents (Resident #119 and Resident #197) observed during medication pass, resulting in a medication error rate of 11%. The findings included: 1) Resident #119 was admitted to the facility on 9/3/15 with a cumulative diagnoses which included Type 2 diabetes. On 11/17/15 at 5:00 PM, Nurse #3 was observed as she checked Resident #119's blood glucose level and noted the reading to be 205 milligrams per deciliter (mg/dl). On 11/17/15 at 5:05 PM, Nurse #3 was observed as she prepared and subsequently administered 4 units of NovoLog insulin to Resident #119.	F 332	F332 failed to be free of a medication error rate of greater than 5% Resident affected: Resident number 119 order was clarified for sliding scale dosage ordered for blood sugar of 201-250 mg/dl. The physician was notified and the correct dosage was administered after clarification of the order. Resident # 197 mouth was washed out immediately when brought to the attention of nurse after Symbicort was given. Resident # 197 Metformin was given immediately when brought to the attention of nurse. Residents potentially affected: Audit of all residents on SS Insulin was completed on 11/17/15 by Director of Nursing (DON)and compared to the physician's orders to assure accuracy. All Nurses were observed during Medication Pass from	12/17/15

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F 332	Continued From page 25 A review of Resident #119's signed Physician's Orders for November 2015 included an order for Sliding Scale Insulin (SSI) using NovoLog insulin before meals. SSI means that the dose of insulin administered would be dependent on the resident's blood glucose result. Resident #119's current SSI orders indicated 6 units of NovoLog insulin were to be administered for a blood glucose level of 201 - 250 mg/dl. An interview was conducted on 11/17/15 at 5:22 PM with Nurse #3. Nurse #3 was joined by the facility's Director of Nursing during the interview. A review of Resident #119's November 2015 Medication Administration Record (MAR) revealed the number "4" had been hand-written over the typed SSI dose required for a blood glucose of 201 - 250 mg/dl. During the interview, Nurse #3 and the DON acknowledged there was a discrepancy between the signed November Physician Orders and the SSI dose written on the November 2015 MAR. The DON indicated the facility would need to call the resident's physician for a clarification order to ensure the correct SSI dose was ordered and administered to Resident #119. A follow-up interview was conducted on 11/18/15 at 10:00 AM with the DON. During the interview, the DON stated she would have expected the SSI order to have been clarified for Resident #119. She reported a medication variance report was being completed due to the error and the facility had reviewed all of their SSI orders to be sure these had been transcribed correctly. 2) Symbicort is a combination aerosol medication used for the management of asthma and chronic obstructive pulmonary disease (COPD). A review	F 332	12/2/2015-12/16/2015 by DON, Nurse Practice Educator(NPE)and Pharmacy Nurse to ensure proper instructions were followed when administering medications such as Symbiocrt and that prescribed medications were given timely such as Metformin. All Nurses were in-serviced on 12/2/2015-12/16/2015 by DON and NPE using Month end turnover and accuracy of orders on Medication Allocation Report(MAR)and Treatment Allocation Report(TAR) ensuring resident on inhalers have their mouths rinsed out after use and medications were being given in a timely manner. Systemic affects: Sliding scale insulin orders will be written on the MAR as stated in the physician orders. All sliding scale insulin orders will have the yellow copy of the orders compared to the MAR and yellow order sheet the next morning in morning meeting. Medication Pass Audits were completed on all nurses from 12/2/15-12/16/2015 by DON, NPE and Pharmacy Nurse using the Medication Pass worksheet and compliance noted. Monitoring and QA: DON or designee will audit new SS insulin orders each morning Monday-Friday in morning meeting to ensure accuracy of Physician Order Sheet(POS)and MAR x 3 months. Medication Pass Audits on various shifts will be completed by DON or NPE or Pharmacy Nurse or Nurse Unit Managers on 3 nurses monthly x 3 months including weekends and holidays then random Medication Pass Audits on various shifts	

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F 332	Continued From page 26 of the package insert from the manufacturer of Symbicort (Revised 10/2015) included the following statement, in part: "In clinical studies, the development of localized infections of the mouth and pharynx with Candida albicans has occurred in patients treated with Symbicort ...Patients should rinse the mouth after inhalation of Symbicort." Additionally, the Medication Guide (Revised 5/2012) approved by the Food and Drug Administration (FDA) for Symbicort specified the following administration guidelines: "Rinse your mouth with water and spit the water out after each dose (2 puffs) of Symbicort. Do not swallow the water. This will help to lessen the chance of getting a fungus infection (thrush) in the mouth and throat." Resident #197 was admitted to the facility on 11/13/15 with a cumulative diagnoses which included diabetes and COPD. A review of Resident #197's admission medication orders included 160 microgram (mcg) / 4.5 mcg Symbicort to be given as two puffs twice daily. On 11/18/15 at 7:45 AM, Nurse #4 was observed as she prepared and administered medications to Resident #197. The medications pulled for administration included 160 microgram (mcg) / 4.5 mcg Symbicort. The resident was observed as she inhaled two puffs of the aerosol medication. The nurse did not prompt the resident to rinse her mouth out with water; no water was offered to the resident after the Symbicort inhaler was used. An interview was conducted on 11/18/15 at 8:05 AM with Nurse #4. When asked if she had prompted the resident to rinse her mouth out with water after the Symbicort inhaler was used, the	F 332	will be completed on 1 nurse monthly thereafter. Audits will be reviewed in monthly QA meeting.	

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F 332	Continued From page 27	F 332		

nurse indicated she did not. Nurse #4 stated, "I usually do but I was nervous."

An interview was conducted on 11/18/15 at 10:00 AM with the facility's Director of Nursing (DON). During the interview, the DON stated she would have expected the nurse to ask the resident to rinse her mouth out with water after using the Symbicort inhaler because of the risk of developing a yeast infection. The DON indicated they would need to re-educate the nursing staff on this issue.

3) Resident #197 was admitted to the facility on 11/13/15 with a cumulative diagnoses which included diabetes and chronic obstructive pulmonary disease (COPD). A review of Resident #197's admission medication orders included 500 milligrams (mg) metformin (an antidiabetic oral agent) to be given as one tablet by mouth twice daily. The metformin was scheduled to be given at 8:00 AM and 5:00 PM every day.

On 11/18/15 at 7:45 AM, Nurse #4 was observed as she prepared and administered medications to Resident #197. The administered medications did not include metformin.

An interview was conducted on 11/18/15 at 8:05 AM with Nurse #4. Upon request, Nurse #4 reviewed Resident #197's Medication Administration Record (MAR) and list of medications scheduled for 8:00 AM. When asked about the metformin also scheduled for 8:00 AM, the nurse acknowledged she had missed administering this medication stating, "I owe her that."

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F 332	Continued From page 28 An interview was conducted on 11/18/15 at 10:00 AM with the facility's Director of Nursing (DON). During the interview, the DON stated she would need to do a medication variance report and provide re-education to the nursing staff due to missing a scheduled dose of medication (metformin) for Resident #197.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff: 1. The facility failed to date opened food items of frozen hamburger, frozen french fries, and frozen julienne chicken. 2. The facility failed to have the food delivery carts on the units free from damage on the door, dried food on the tray rails and a missing door closure. 3. The facility failed to have splash guard and the top of stove free from buildup of dirt and food debris. This was evident in 2 of 2 days of dietary observations. The findings included: 1. Observations on 11/16/15 at10:30 AM revealed opened and undated 3 lbs. (pounds) of	F 371	F 371 failed to date opened food items, failed to have the food delivery carts on the units free from damage on the door, dried food on the tray rails and a missing door closure, failed to have a splash guard and the top of the stove free from buildup of dirt and food debris. Resident affected: The undated opened foods were immediately discarded, the cart rails were washed immediately, the splash guard and the top of the stove were clean, the door was repaired and a door closure added. Residents potentially affected: The undated opened foods were immediately	12/17/15

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F 371	Continued From page 29 frozen hamburger wrapped in plastic wrap, 3 lbs. of julienne chicken pieces wrapped in plastic wrap, and a bag of frozen french fries that were in a bag undated. The Dietary Manager took the items and discarded them in the trash can. Interview with the Dietary Manager on 11/19/15 at 9:14 AM revealed that his expectation was that the dry foods and refrigerated foods were labeled per the weekly schedule and dated according to the policy and procedure. They should label and date the opened food products at the time they put the food where it belongs, in the refrigerator or on the shelf in the dry storage room. 2. Observations on 11/18/15 at 9:45 AM revealed that the delivery cart that delivered the breakfast to the 500 hall, had dried food and liquid along the rails inside of the delivery cart that the trays set on and on the outside of the cart. The delivery cart that delivered breakfast meal trays to the residents on the 600 hall had a missing latch at the top of the cart that kept the door to the cart closed and the right door was bent. Review of the job responsibilities for the Dietary Aide 1 Position Dinner 1:45 PM to 7:45 PM indicated that on Friday the assignment was to " Hose out your cart. " Review of the job responsibilities for the Dietary Aide 2 Position 1:45 PM to 7:45 PM indicated that on Monday the assignment was to " Hose out your carts. " . Review of the job responsibilities for the Dietary Aide 3 Position 12 PM to 8 PM indicated that on	F 371	discarded, the cart rails were washed immediately, the splash guard and the top of the stove were clean and the door was repaired with a door closure added. Systemic changes: On 11/29/15 an audit was conducted by the dietary director of the dry storage area and freezer to ensure that the food was properly dated. Any food found not dated was immediately discarded On 12/8/15 the dietary director validated all carts had been checked and are in proper working order, on 12/4/15 the dietary director validated all carts had been cleaned. All dietary staff were inserviced on proper food , how to use "use by label", reviewed state regulations on use by dates and cleaning food carts after each meal Monitoring and QA: The dietary director and or assistant dietary director and or cook will check dry storage and freezer for outdated food, using the "use by date" audit tool, and the cleaning schedule audit tools will be completed daily for 4 weeks then weekly thereafter. The dietary director and or assistant dietary director and or cook will check Stove and Splashguards using the Food Safety and Sanitation Audit Tool 1x weekly for 4 weeks then weekly thereafter. The Administrator will check food carts 3 times weekly for 4 weeks then weekly times 3 months to ensure they are free of dried food and liquid. The Administrator will check the Stove and Splashguards using the food Safety and Sanitation Audit 3 times weekly for 4 weeks then weekly times 3 months to ensure they are free of	

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F 371	Continued From page 30 Saturday the assignment was to " Hose out both carts including middle. " Interview on 11/19/15 at 9:30 AM with the dietary manager revealed that he was the person that checked if the task was complete. The task for this position was scheduled on Saturday and he did not work on Saturday so there was no one to check on the sheet that the task was completed. However, there was no sign off for the Friday and Monday cart cleaning task. He did not know the last time the carts were cleaned. 3. Observations on 11/16/15 at 11:00 AM and 11/18/15 at 7:30 AM revealed discoloration ranging from black to brown to yellow on the back of the stove splash guard. There was also discoloration of black from between the burners to where the oven door opened on top of the stove. Interview with the dietary manager on 11/18/15 at 7:30 AM revealed he could not get it off. (Referring to the discoloration on the back splash and the discolored area between the burners and the oven door). Interview on 11/19/15 at 10:01 AM with the Dietician revealed that she performed monthly audits for food safety and sanitation. What she had experienced was that the equipment will get clean or there will be a process where it will be replaced. The Dietician continued that if she saw something on her survey, it would get corrected. If she saw meat that was not dated or labeled, it would be thrown away. Her expectation was that when she had given them her findings on the audit tool, she expected them to be fixed.	F 371	dried food and liquid. The Dietary director will report results of audits to the QA monthly meeting.	

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F 371	Continued From page 31 Interview with the Administrator on 11/19/15 at 3:30 PM revealed that his expectation was that the kitchen would be safe and sanitary and the staff would follow the policy and procedures.	F 371		
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		12/17/15

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F 431	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to label medications with an expiration date to ensure expired medications were identified/removed from 1 of 5 medication carts (500 Hall Medication Cart). The findings included: 1) An observation of the 500 Hall medication cart on 11/19/15 at 10:45 AM revealed two boxes of 0.5 milligrams (mg) / 2 milliliters (ml) budesonide solution (a nebulizer solution used for asthma and chronic obstructive pulmonary disease) labeled for use by Resident #157 were stored in the medication cart. Box 1 of 2 (dispensed from the pharmacy on 10/27/15) contained 3 unopened envelopes of single dose ampules and one opened foil envelope containing two ampules of solution. The opened foil envelope was dated as having been opened on 11/16/15. Box 2 of 2 (dispensed from the pharmacy on 10/27/15) contained two unopened foil envelopes of single dose ampules and one opened envelope containing two ampules of nebulizer solution. The opened envelope containing two ampules of solution was not dated to indicate when the envelope was opened. The manufacturer's labeling on the box of budesonide solution for inhalation read, in part: "Once the foil envelope is opened, use the ampules within two weeks." A review of Resident #157's Physician Orders revealed there was a current order for 0.5 mg / 2 ml budesonide solution to be given as one	F 431	F421 failed to label medications with an expiration date and/or date opened Resident affected: Unlabeled medications for resident #157 were immediately discarded. Undated Medications for Resident # 30 was immediately discarded and reordered. Residents potentially affected: Each resident requiring budesonide solution was audited on 12/16/2015 by Director of Nursing(DON) and residents with nebulizer solution meds that were not labeled were discarded. Systemic affects: All nurses were educated by DON,and Nurse Practice Educator(NPE) on 12/13/2015 to label all medications when opened and or with an expiration date. Facility Pharmacy Nurse will check all Medication Carts 1x weekly to ensure no expired medications. Any unlabeled medications will be discarded. Monitoring and QA: DON or designee will audit medications carts to ensure medications are being labeled and expired medications are discarded if expired weekly times 2 weeks, monthly times 2 months, quarterly times 2 quarters, results of audits will be reviewed in QA meeting monthly	

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F 431	Continued From page 33	F 431		

ampule inhaled via a nebulizer twice daily.

An interview was conducted on 11/19/15 at 10:55 AM with Nurse #2. Nurse #2 was the hall nurse assigned to the 500 hall and 500 hall medication cart. Upon inquiry, Nurse #2 indicated he would not have any way of knowing when the undated foil envelope had been opened or whether the budesonide ampules in the opened, undated envelope were expired.

A follow up interview was conducted on 11/19/15 at 2:10 PM with Nurse #2. At that time, the nurse stated the budesonide ampules found in the opened, undated envelope had been removed from the medication cart.

An interview was conducted on 11/19/15 at 3:15 PM with the facility's Director of Nursing (DON). During the interview, the storage of budesonide nebulizer solution was discussed. The DON reported the nursing staff had made her aware of the medication storage concern and failure to date the foil envelopes of nebulizer solution as to when they were opened. She stated her expectation was for the budesonide foil envelope to be dated when opened due to the fact that the ampules were only good for two weeks after opening.

2) An observation of the 500 Hall medication cart on 11/19/15 at 10:45 AM revealed one box of 0.25 milligrams (mg) / 2 milliliters (ml) Pulmicort Respules (brand name of a budesonide nebulizer solution in single dose ampules; used for asthma and chronic obstructive pulmonary disease) labeled for use by Resident #30 was stored in the medication cart. The box of Pulmicort Respules (dispensed from the pharmacy on 9/3/15)

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F 431	Continued From page 34	F 431		

contained 3 unopened envelopes of single dose ampules and one opened foil envelope containing 3 ampules of solution. The opened envelope containing 3 ampules of solution was not dated to indicate when the envelope was opened. The manufacturer's labeling on the box of Pulmicort Respules solution for inhalation read, in part: "Once the foil envelope is opened, use the Respules within two weeks."

A review of Resident #30's Physician Orders revealed there was a current order for 0.25 mg / 2 ml Pulmicort Respules solution to be given as one ampule inhaled via a nebulizer twice daily.

An interview was conducted on 11/19/15 at 10:55 AM with Nurse #2. Nurse #2 was the hall nurse assigned to the 500 hall and 500 hall medication cart. Upon inquiry, Nurse #2 indicated he would not have any way of knowing when the undated foil envelope of Pulmicort Respules had been opened or whether the Respules in the opened, undated envelope were expired.

A follow up interview was conducted on 11/19/15 at 2:10 PM with Nurse #2. At that time, the nurse stated the Pulmicort Respules found in the opened, undated envelope had been removed from the medication cart.

An interview was conducted on 11/19/15 at 3:15 PM with the facility's Director of Nursing (DON). During the interview, the storage of Pulmocort Respules (budesonide nebulizer solution) was discussed. The DON reported the nursing staff had made her aware of the medication storage concern and failure to date the foil envelopes of nebulizer solution as to when they were opened. She indicated her expectation was for the foil

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F 431	Continued From page 35 envelope of Pulmocort Respules (budesonide) to be dated when opened due to the fact that the Respules (ampules) were only good for two weeks after opening.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		12/17/15

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F 441	Continued From page 36 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow contact precautions for one of one sampled residents. (Resident #34) The findings included: Review of the facility policy for contact precautions with a review date of 9/1/15 read in part " Policy Contact Precautions will be used in addition to Standard Precautions when caring for a patient who is colonized or infected with epidemiologically important microorganisms that can be transmitted by direct contact (hand or skin to skin) or indirect contact with environmental surfaces in patient care environment... 4. Staff must use barrier precautions when entering the room. 4.1 Wear gown and gloves ....4.5 Remove and bag gown and gloves and wash hands upon exiting room. 4.5.1 Remove bagged PPE (personal protective equipment) from room and discard in soiled utility. 4.5.2 Wash hands .... " Resident #34 was admitted to the facility on 5/18/12. Recent diagnosis included Methicillin Resistant Staph Aureus (MRSA) in the blood. Review of a blood culture obtained on 9/30/15 indicated the results were MRSA. A telephone order dated 10/7/15 indicated Resident #34 was to be on contact isolation. A telephone order dated 10/21/15 included Resident #34 was to be sent to the emergency	F 441	F441 failed to follow contact precautions for one resident Resident affected: Physicians orders for Resident #34 were clarified and is no longer on isolation. Residents potentially affected: All residents charts were audited on 12/16/2015 by Director of Nursing(DON) and Nurse Practice Educator(NPE)for need for isolation and orders were obtained as indicated and isolation implemented if needed. All staff were in-serviced on 12/3/15 to 12/16/15 on Isolation Precautions and Infection Control including hand washing and the use of Personal Protective Equipment(PPE). Systemic changes: When residents are admitted or readmitted the chart will be reviewed in the next morning meeting by DON and or Administrator using the Morning Meeting Audit Sheet. Isolation orders will be obtained as indicated and implemented. Monitoring and QA: DON or NPE will conduct audits using the Infection Control Process Surveillance Monitoring Tool to	

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F 441	Continued From page 37 room for evaluation. Review of the hospital discharge summary dated 11/9/15 included diagnosis of bacteremia due to Staphylococcus Aureus and acute cystitis, complete heart block and bradycardia. The hospital discharge summary indicated Resident #34 had a blood culture which again grew MRSA. Intravenous (IV) antibiotic (Vancomycin) had been administered in the hospital. The discharge orders included three IV antibiotics were to be administered upon return to the facility. The antibiotics were Vancomycin 1gram IV to end on 12/8/15, Rifampin 600milligram (mg) every 8 hours until 12/8/15 and Daptomycin 500 mg IV every other day until 11/29/15. Resident #34 was to have blood work obtained and followed by an infectious disease physician. Review of the medical record revealed contact precautions were not reordered on 11/09/15 upon the resident ' s readmission to the facility. Observations on 11/19/15 at 1:00 PM revealed Resident #34 had a contact precaution " stop " sign on his door and a container with PPE located outside his door. Observations of Nurse Aide (NA) #4 revealed she was in Resident #34 ' s room without a gown or gloves. NA #4 was observed touching the resident ' s tray table and fed the resident his lunch. Resident #34 was observed touching the tray table, utensils and food tray. NA #4 removed the tray from tray table and returned it to the food cart. After placing the tray on the food cart, NA #4 stopped by another resident's doorway to answer a question. Aide #4 had not washed her hands prior to leaving the room or after leaving the room.	F 441	ensure staff are following proper infection control practices when giving care to residents on isolation 3x weekly x 4 weeks then 1x weekly for 3 months. Audits will be reviewed in monthly QA meeting.	

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F 441	Continued From page 38 Interview with NA #4 on 11/19/15 at 1:08 PM revealed she had not washed her hands, was aware there was a contact precaution sign on the door and gave no explanation as to why she had not followed the contact precautions. Aide #4 explained she had gone into Resident #34 ' s room to encourage him to eat and attempted to feed him lunch. Further interview revealed she was not aware why Resident #34 was on contact precautions. Interview with NA #5 on 11/19/2015 at 1:10 PM, who was providing care to Resident #34 ' s roommate, revealed she had informed aide #4 Resident #34 was on contact precautions. NA #5 did not know why NA #4 did not use the PPE per the signage on the door. Interview with the charge nurse #3 on 11/19/2015 at 1:15 PM revealed he was not aware NA #4 was feeding the resident without PPE in place. Nurse #3 explained he would expect staff to wash their hands when leaving the room. Nurse #3 was asked what the policy would be for contact precautions and he replied he was not sure what the policy stated. He further explained the resident had MRSA in the urine and the aide would not need a gown to feed the resident. Interview with the Director of Nursing on 11/19/2015 at 2:14 PM revealed she would expect staff to wear a gown and gloves to care for the resident. Further interview revealed an order for contact precautions should have been obtained on when Resident #34 was readmitted to the facility.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		12/17/15

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F 514	Continued From page 39 LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to follow established procedures for the consistent and accurate documentation of the administration of controlled medications on the Medication Administration Records and Controlled Drug Records for 2 of 8 residents (Resident #194 and #163) receiving controlled substance medications on an as needed basis. The findings included: 1a) A review of the facility's policy, "Controlled Drugs: Management of - State of North Carolina" (Revised 5/15/14) included the following, in part: "4. Administration of Controlled Drugs: 4.1 After pouring the medication for administration, log out the drug on the controlled drug Inventory Page. Include date, time, number/amount of drug, and signature."	F 514	Ftag 514 failed to follow established procedures for the documentation of the administration of controlled medications on the Medication Allocation Record(MAR) and the Controlled Drug records Resident affected: Resident number 194 and resident number 163 were alert and oriented residents who verified they received the pain medication as documented. Residents potentially affected: MAR and Controlled drug records for all residents were audited by the Director of Nursing(DON) and Nurse Practice Educator(NPE) on 12/7/2015 to ensue the MAR and Controlled drug record was complete. All nurses were in-serviced on 12/7/2015 by DON and NPE using the	

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F 514	Continued From page 40 A review of the facility's policy, "NSG305 Medication: Administration: General" (Revised 7/1/15) included a section outlining "Practice Standards" which read, in part: "8. Document: 8.1 Administration of medication on Medication Administration Record (MAR); 8.2 Patient's response to medication; 8.2.1 Notification of physician/mid-level provider, if applicable; 8.3 For medication refused by patient, circle your initials in the date and time space where that medication is ordered, and document patient's refusal of medication on the back of the MAR; 8.3.1 For Electronic Order management (EOM) Centers, document refusal by entering the refusal code on the MAR. 8.4 Effectiveness of PRN (as needed) medication." Resident #194 was admitted to the facility on 10/30/15. She was discharged to the hospital on 11/3/15 and then re-entered the facility on 11/5/15. Resident #194's medication orders included 15 mg oxycodone (an opioid or narcotic analgesic) given as one tablet by mouth every 4 hours as needed for pain (initiated 10/30/15 and re-ordered 11/5/15). Oxycodone is a controlled substance medication. On 11/17/15, a review and comparison of the Controlled Drug Record (a declining inventory record) with Resident #194's Medication Administration Record (MAR) from 11/1/15 to 11/16/15 was completed. This comparison identified the following documentation discrepancies for the 15 mg oxycodone tablets dispensed for Resident #194:	F 514	MAR/Signed Controlled Medication Sheet Audit Tool. Systemic changes: Residents MAR and Controlled drug records are audited by the oncoming nurse and the off going nurse by looking at the MAR and Controlled drug record simultaneously. Nurses will not accept the keys to any med cart unless the medication record and the controlled drug records are complete. All nurses were inserviced on this system on 12/7/2015 by the DON and NPE. Monitoring and QA: The DON and or designee will audit 5% of the MARs and controlled drug records for completeness using the MAR/Signed Control Medication Sheet Audit Tool weekly times 2 weeks, monthly times 2 months, quarterly times 2 quarters and quarterly thereafter. Results of these audits will be reviewed in monthly QA meeting.	

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11/2/15 Controlled Drug Record: 1 tablet removed at 8:30 (no notation of AM or PM);
11/2/15 MAR: No documentation of a tablet given.

11/6/15 Controlled Drug Record: 1 tablet removed one time only at 8:00 PM;
11/6/15 MAR: 2 tablets were documented as given on this date.

11/8/15 Controlled Drug Record: 1 tablet removed at 4:30AM and 1 tablet removed at 12:00PM;
11/8/15 MAR: Only 1 tablet was documented as given at 12:00 PM.

11/11/15 Controlled Drug Record: 1 tablet removed at 3:45PM and 1 tablet removed at 10:00PM;
11/11/15 MAR: No documentation of a tablet given.

11/12/15 Controlled Drug Record: 1 tablet removed at 8:00 PM;
11/12/15 MAR: No documentation of a tablet given.

11/16/15 Controlled Drug Record: 1 tablet removed at 1:00 PM;
11/16/15 MAR: No documentation of a tablet given.

An interview was conducted on 11/18/2015 at 2:10 PM with Nurse #5. Upon request, the nurse discussed the process employed for the administration / documentation of a PRN (as needed) controlled substance medication to a resident. Nurse #5 stated a resident would be assessed, the physician orders and dates/times

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of prior receipt of the medication(s) would be reviewed. The nurse indicated if deemed appropriate, the medication would be pulled from the medication cart, given to the resident, and then documentation would be completed. Nurse #5 reported she would document the medication administration on both the front and back of the resident's MAR, and in the declining inventory book for controlled substances.

An interview was conducted on 11/19/2015 at 8:50 AM with the facility's Director of Nursing (DON) in regards to the documentation discrepancies identified between the resident's Controlled Drug Record and the MAR. Upon inquiry, the DON outlined the facility's procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident's MAR. The DON stated a nurse should sign out a controlled drug on the Controlled Drug Record when the medication was removed from the cart and document on the front of the MAR that the medication was given. The DON added that for pain and anxiety medications, additional documentation should be recorded on the back of the resident's MAR, including the reason why that medication was given and the effectiveness of it. When asked, the DON acknowledged she would expect documentation on the Controlled Drug Records and MARs to be consistent with one another. The DON identified the nurses (by his/her signature on the Controlled Drug Record and/or MAR) who pulled / administered the residents' medication on the dates/times discrepancies in documentation were noted.

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A telephone interview was conducted on 11/19/15 at 12:43 PM with Nurse #10. Nurse #10 was identified to have pulled Resident #194's oxycodone from the medication cart without documenting its administration to the resident on the MAR on 11/8/15 at 4:30 AM. Upon inquiry, Nurse #10 discussed the process involved for the documentation/administration of controlled substance medications. He reported the documentation included initialing on the front of the MAR, and writing on the back of the MAR the medication, dose, date/time and effectiveness of the medication. He also stated the medication taken from the med cart needed to be written in the blue narcotic book (referring to the Controlled Drug Record) with the time/date and number of tablets given. When asked about the specific date/time in question, Nurse #10 stated he was, "not sure what was going on at that time."

A telephone interview was conducted on 11/19/15 at 1:02 PM with Nurse #6. Nurse #6 was identified to have been assigned to the medication cart and cared for Resident #194 at the time when documentation discrepancies were noted on each of the following dates: 11/2/15; 11/6/15; and 11/12/15. Upon inquiry regarding the process followed for the administration/documentation of controlled substance medication, Nurse #6 stated nurses were supposed to initial on the front of the MAR, document on the back of the MAR, and sign out the medication on the narcotic log each time a controlled substance medication was given. In regards to when this documentation was completed, the nurse stated she would typically document on both the MAR and narcotic log after the medication was given to the resident. When asked if she could provide insight as to why the

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MAR and narcotic log may not be consistent when compared to one another, Nurse #6 stated, "Sometimes you get busy."

Nurse #8 was not available to be interviewed by telephone. Nurse #8 was identified to have been assigned to the medication cart and cared for Resident #194 at the time when documentation discrepancies were noted on 11/11/15.

A follow-up interview was conducted on 11/19/15 at 1:40 PM with Nurse #5. Based on the Controlled Drug Record review, Nurse #5 was identified to have pulled Resident #194's oxycodone from the medication cart without documenting its administration to the resident on the MAR on 11/16/15 at 1:00 PM. During the interview, Nurse #5 reiterated the process she typically employed for documenting and administering controlled substance medications to a resident. She indicated documentation would be expected on the Controlled Drug Record and both the front and back of the resident's MAR.

1b) A review of the facility's policy, "Controlled Drugs: Management of - State of North Carolina" (Revised 5/15/14) included the following, in part:
"4. Administration of Controlled Drugs:
4.1 After pouring the medication for administration, log out the drug on the controlled drug Inventory Page. Include date, time, number/amount of drug, and signature."

A review of the facility's policy, "NSG305 Medication: Administration: General" (Revised 7/1/15) included a section outlining "Practice Standards" which read, in part:
"8. Document:

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8.1 Administration of medication on Medication Administration Record (MAR);
8.2 Patient's response to medication;
8.2.1 Notification of physician/mid-level provider, if applicable;
8.3 For medication refused by patient, circle your initials in the date and time space where that medication is ordered, and document patient's refusal of medication on the back of the MAR;
8.3.1 For Electronic Order management (EOM) Centers, document refusal by entering the refusal code on the MAR.
8.4 Effectiveness of PRN (as needed) medication."

Resident #194 was admitted to the facility on 10/30/15. She was discharged to the hospital on 11/3/15 and then re-entered the facility on 11/5/15. Resident #194's medication orders included 5 milligrams (mg) diazepam (an antianxiety medication) to be given as one tablet by mouth four times daily as needed for anxiety (initiated 10/30/15); on 11/5/15 an order was received for 5 mg diazepam to be given as one tablet by mouth every 6 hours as needed for anxiety. Diazepam is a controlled substance medication.

On 11/17/15, a review and comparison of the Controlled Drug Record (a declining inventory record) with Resident #194's Medication Administration Record (MAR) from 11/1/15 to 11/16/15 was completed. This comparison identified the following documentation discrepancies for the 5 mg tablets of diazepam dispensed for Resident #194:
11/2/15 Controlled Drug Record: 1 tablet removed at 12:00 PM and 1 tablet removed at

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8:30 (no notation of AM or PM);
11/2/15 MAR: Only 1 tablet was documented as given at 12:30 PM on this date.

11/12/15 Controlled Drug Record: 1 tablet removed at 8:00 PM;
11/12/15 MAR: No documentation of a tablet given.

An interview was conducted on 11/19/2015 at 8:50 AM with the facility's Director of Nursing (DON) in regards to the documentation discrepancies identified between the resident's Controlled Drug Record and the MAR. Upon inquiry, the DON outlined the facility's procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident's MAR. The DON stated a nurse should sign out a controlled drug on the Controlled Drug Record when the medication was removed from the cart and document on the front of the MAR that the medication was given. The DON added that for pain and anxiety medications, additional documentation should be recorded on the back of the resident's MAR, including the reason why that medication was given and the effectiveness of it. When asked, the DON acknowledged she would expect documentation on the Controlled Drug Records and MARs to be consistent with one another. The DON identified the nurses (by his/her signature on the Controlled Drug Record and/or MAR) who pulled / administered the residents' medication on the dates/times discrepancies in documentation were noted.

A telephone interview was conducted on 11/19/15

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at 1:02 PM with Nurse #6. Nurse #6 was identified to have been assigned to the medication cart and cared for Resident #194 at the time when documentation discrepancies were noted on each of the following dates: 11/2/15 and 11/12/15. Upon inquiry regarding the process followed for the administration/documentation of controlled substance medication, Nurse #6 stated nurses were supposed to initial on the front of the MAR, document on the back of the MAR, and sign out the medication on the narcotic log each time a controlled substance medication was given. In regards to when this documentation was completed, the nurse stated she would typically document on both the MAR and narcotic log after the medication was given to the resident. When asked if she could provide insight as to why the MAR and narcotic log may not be consistent when compared to one another, Nurse #6 stated, "Sometimes you get busy."

2a) A review of the facility's policy, "Controlled Drugs: Management of - State of North Carolina" (Revised 5/15/14) included the following, in part:
"4. Administration of Controlled Drugs:
4.1 After pouring the medication for administration, log out the drug on the controlled drug Inventory Page. Include date, time, number/amount of drug, and signature."

A review of the facility's policy, "NSG305 Medication: Administration: General" (Revised 7/1/15) included a section outlining "Practice Standards" which read, in part:
"8. Document:
8.1 Administration of medication on Medication Administration Record (MAR);
8.2 Patient's response to medication;
8.2.1 Notification of

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physician/mid-level provider, if applicable;
8.3 For medication refused by patient, circle your initials in the date and time space where that medication is ordered, and document patient's refusal of medication on the back of the MAR;
8.3.1 For Electronic Order management (EOM) Centers, document refusal by entering the refusal code on the MAR.
8.4 Effectiveness of PRN (as needed) medication."

Resident #163 re-entered the facility on 9/24/15. The resident's medication orders included: 5 milligrams (mg) / 325 mg Norco (a combination opioid analgesic containing hydrocodone and acetaminophen) given as one tablet by mouth every 6 hours as needed for pain (ordered 10/9/15). Norco is a controlled substance medication.

On 11/17/15, a review and comparison of the Controlled Drug Record (a declining inventory record) with Resident #163's Medication Administration Record (MAR) from 11/1/15 to 11/16/15 was completed. This comparison identified the following documentation discrepancies for the 5/325 mg Norco tablets dispensed for Resident #163:
11/2/15 Controlled Drug Record: 1 tablet removed at 2:00 PM;
11/2/15 MAR: No documentation of a tablet given.

11/3/15 Controlled Drug Record: 1 tablet removed at 6:00 PM;
11/3/15 MAR: No documentation of a tablet given.

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11/6/15 Controlled Drug Record: 1 tablet removed at 9:00 PM;
11/6/15 MAR: No documentation of a tablet given.

An interview was conducted on 11/18/2015 at 2:10 PM with Nurse #5. Upon request, the nurse discussed the process employed for the administration / documentation of a PRN (as needed) controlled substance medication to a resident. Nurse #5 stated a resident would be assessed, the physician orders and dates/times of prior receipt of the medication(s) would be reviewed. The nurse indicated if deemed appropriate, the medication would be pulled from the medication cart, given to the resident, and then documentation would be completed. Nurse #5 reported she would document the medication administration on both the front and back of the resident's MAR, and in the declining inventory book for controlled substances.

An interview was conducted on 11/19/2015 at 8:50 AM with the facility's Director of Nursing (DON) in regards to the documentation discrepancies identified between the resident's Controlled Drug Record and the MAR. Upon inquiry, the DON outlined the facility's procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident's MAR. The DON stated a nurse should sign out a controlled drug on the Controlled Drug Record when the medication was removed from the cart and document on the front of the MAR that the medication was given. The DON added that for pain and anxiety medications, additional documentation should be

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recorded on the back of the resident's MAR, including the reason why that medication was given and the effectiveness of it. When asked, the DON acknowledged she would expect documentation on the Controlled Drug Records and MARs to be consistent with one another. The DON identified the nurses (by his/her signature on the Controlled Drug Record and/or MAR) who pulled / administered the residents' medication on the dates/times discrepancies in documentation were noted.

A telephone interview was conducted on 11/19/15 at 1:02 PM with Nurse #6. Nurse #6 was identified to have been assigned to the medication cart and cared for Resident #163 at the time when documentation discrepancies were noted on 11/6/15. Upon inquiry regarding the process followed for the administration/documentation of controlled substance medication, Nurse #6 stated nurses were supposed to initial on the front of the MAR, document on the back of the MAR, and sign out the medication on the narcotic log each time a controlled substance medication was given. In regards to when this documentation was completed, the nurse stated she would typically document on both the MAR and narcotic log after the medication was given to the resident. When asked if she could provide insight as to why the MAR and narcotic log may not be consistent when compared to one another, Nurse #6 stated, "Sometimes you get busy."

A follow-up interview was conducted on 11/19/15 at 1:40 PM with Nurse #5. Based on the Controlled Drug Record review, Nurse #5 was identified to have pulled Resident #163 ' s Norco from the medication cart without documenting its

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administration to the resident on the MAR on 11/2/15 and 11/3/15. During the interview, Nurse #5 reiterated the process she typically employed for documenting and administering controlled substance medications to a resident. She indicated documentation would be expected on the Controlled Drug Record and both the front and back of the resident's MAR.

2b) A review of the facility's policy, "Controlled Drugs: Management of - State of North Carolina" (Revised 5/15/14) included the following, in part:

"4. Administration of Controlled Drugs:

4.1 After pouring the medication for administration, log out the drug on the controlled drug Inventory Page. Include date, time, number/amount of drug, and signature."

A review of the facility's policy, "NSG305 Medication: Administration: General" (Revised 7/1/15) included a section outlining "Practice Standards" which read, in part:

"8. Document:

8.1 Administration of medication on Medication Administration Record (MAR);

8.2 Patient's response to medication;

8.2.1 Notification of physician/mid-level provider, if applicable;

8.3 For medication refused by patient, circle your initials in the date and time space where that medication is ordered, and document patient's refusal of medication on the back of the MAR;

8.3.1 For Electronic Order management (EOM) Centers, document refusal by entering the refusal code on the MAR.

8.4 Effectiveness of PRN (as needed) medication."

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Resident #163 re-entered the facility on 9/24/15. The resident ' s medication orders included: 0.5 milligrams (mg) alprazolam (an antianxiety medication) given as one tablet by mouth three times daily as needed for anxiety (ordered 9/24/15). Alprazolam is a controlled substance medication.

On 11/17/15, a review and comparison of the Controlled Drug Record (a declining inventory record) with Resident #163's Medication Administration Record (MAR) from 11/1/15 to 11/16/15 was completed. This comparison identified the following documentation discrepancies for the 0.5 mg alprazolam tablets dispensed for Resident #163:
11/6/15 Controlled Drug Record: 1 tablet removed at 9:00 PM;
11/6/15 MAR: No documentation of a tablet given.

An interview was conducted on 11/19/2015 at 8:50 AM with the facility's Director of Nursing (DON) in regards to the documentation discrepancies identified between the resident's Controlled Drug Record and the MAR. Upon inquiry, the DON outlined the facility's procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident's MAR. The DON stated a nurse should sign out a controlled drug on the Controlled Drug Record when the medication was removed from the cart and document on the front of the MAR that the medication was given. The DON added that for pain and anxiety medications, additional documentation should be recorded on the back of the resident's MAR,

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F 514	Continued From page 53 including the reason why that medication was given and the effectiveness of it. When asked, the DON acknowledged she would expect documentation on the Controlled Drug Records and MARs to be consistent with one another. The DON identified the nurses (by his/her signature on the Controlled Drug Record and/or MAR) who pulled / administered the residents' medication on the dates/times discrepancies in documentation were noted. A telephone interview was conducted on 11/19/15 at 1:02 PM with Nurse #6. Nurse #6 was identified to have been assigned to the medication cart and cared for Resident #163 at the time when documentation discrepancies were noted on 11/6/15. Upon inquiry regarding the process followed for the administration/documentation of controlled substance medication, Nurse #6 stated nurses were supposed to initial on the front of the MAR, document on the back of the MAR, and sign out the medication on the narcotic log each time a controlled substance medication was given. In regards to when this documentation was completed, the nurse stated she would typically document on both the MAR and narcotic log after the medication was given to the resident. When asked if she could provide insight as to why the MAR and narcotic log may not be consistent when compared to one another, Nurse #6 stated, "Sometimes you get busy."	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		12/17/15

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F 520	Continued From page 54 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. 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 record reviews, observations and staff interviews the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place 1/15/15. This was for four recited deficiencies that was originally cited 1/15/15 on a recertification survey and subsequently recited in November 2015 on the current recertification survey. The deficiencies were in the areas of housekeeping and maintenance (F253), supervision to prevent accidents (F323), kitchen sanitation and food storage (F371) and storage of drugs and biologicals (F421).	F 520	F520 Failed to maintain implemented procedures and monitor these interviews that the committee put into place Residents affected: Dietary Director, Assistant Dietary Director, Environmental Services Director, and the Director of Nursing were educated by the Administrator on the QA and process improvement to include implementation of action plans, monitoring tools, and the evaluation of the process and modifications with corrections as indicated Resident potentially affected: Dietary Director, Assistant Dietary	

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F 520	Continued From page 55 The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. The findings included: This tag is crossed referenced to F253: Based on observation and staff interview the facility failed to maintain clean bathrooms for 5 out of 6 shared bathrooms on the 100 hall, 8 out of 12 bathrooms on 200 hall, 3 out of 6 bathrooms on the 300 hall 4 out of 6 bathrooms on the 500 hall and 5 out of 6 bathrooms on the 600 hall. Spider webs were observed underneath heating/air conditioning units in resident rooms #107, #109, #202, #204, #207, #209, #215, #219, #516, and #601. Bent blinds were observed in rooms #105, #211, #512, and #611. Baseboards were observed as not fastened to the wall in Rooms #216, and shared bathrooms #307 and #305, and #307, shared bathrooms #510 and #512 and shared bathrooms #601 and #603. During the recertification survey of 1/15/15 the facility was cited at F253 due to failure to keep rooms clean and air condition/heating units clean. This tag is crossed referenced to F323: Based on observations, staff interviews and record review the facility failed to provide interventions for falls for one of two sampled residents with falls. Resident #81. During the recertification survey of 1/15/15 the facility was cited at F323 due to failure to provide a two person assist for transfers to prevent accidents. This tag is crossed reference to F371: Based on observations, record review and interviews with facility staff: 1.The facility failed to date opened food items of frozen hamburger, frozen french fries, and frozen julienne chicken. 2. The facility failed to have the food delivery carts on the units	F 520	Director, Environmental Services Director, and he Director of Nursing were educated by the Administrator on the QA and process improvement to include implementation of action plans, monitoring tools, and the evaluation of the process and modifications with corrections and indicated Systemic changes: Administrator and Director of nursing were educated by the Executive Administrator on the process of identification of systems to bring before the QA team, development of action plans for areas identified, establishing systems to monitor the corrections implemented and reviewing the monitoring QA tools through monthly QA meetings. Administrator will meet weekly with the department heads where failure to sustain systems to correct areas identified to assure consistent compliance Monitoring and QA Monthly monitoring of the QA process and implementation of action plans will be documented by the Administrator using the QA process monitoring tool during monthly QA meetings for 6 months to assure consistent compliance	

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free from damage on the door, dried food on the tray rails and a missing door closure. 3. The facility failed to have splash guard and the top of stove free from buildup of dirt and food debris. This was evident in 2 of 2 days of dietary observations.
During the recertification survey of 1/15/15 the facility was cited at F371 due to failure to maintain food temperatures on the serving line at the acceptable temperature.
This tag is crossed referenced to F431: Based on observations, record review and staff interviews, the facility failed to label medications with an expiration date to ensure expired medications were identified/removed from 1 of 5 medication carts (500 Hall Medication Cart).
During the recertification survey of 1/15/15 the facility was cited at F431 due to failure to date opened medications and remove expired medications from the medication cart.

Interview on 11/19/15 at 3:30 PM with the Administrator and Director of Nursing revealed the housekeeping director had held her position for two weeks. Any housekeeping issues were reviewed in their QA A meetings. The housekeeping director had not identified all of the problem areas found during the current survey. The dietary department had a recent audit by corporate. The audit did not include inspection for problems identified during the current survey. Interview with the Director of Nursing revealed nursing did not have a QA in place for review of the medication carts.