STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345495	A. BUILDING _____ B. WING _____	01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STEWART HEALTH CENTER	6920 MARCHING DUCK DRIVE CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation of the dinner meal, staff interviews, and record review, the facility failed to follow the pureed diet menu for 9 of 9 residents in the facility who received a pureed diet (Residents #4, #7, #14, #15, #21, #33, # #39, #44 and #51). The findings included: Review of the therapeutic diet spreadsheet for the dinner meal on 01/18/17 revealed residents on a pureed diet were to receive pureed southwest white bean stew, pureed ham, pureed mashed sweet potatoes, pureed black eyed peas, and pureed stewed tomatoes. Observation on 01/18/17 at 3:40 PM revealed pureed ham and mashed sweet potatoes available on the steam table. Observation on 01/18/17 at 3:54 PM revealed dietary assistant specialist (DAS) #1 pureed the black eyed peas and the stewed tomatoes. Observation on 01/18/17 at 4:02 PM revealed DAS #1 plated pureed ham, pureed black eyed peas and pureed stewed tomatoes onto a divided plate with three compartments. DAS #1 did not	F 363	1.) . Corrective action to be accomplished for each resident affected by the deficient practice: All identified residents immediately received their pureed meal in accordance with the planned menu. 2.) Corrective action to be accomplished for those residents having the potential to be affected by deficient practice: RD or designee completed daily audits beginning 1/23/17 to ensure all residents on a puree diet received meals in accordance with planned menu. 3.) Measures put in place or systemic changes made to ensure that the deficient practice will not occur: In-Service training conducted by Registered Dietician 2/8/17 and 2/9/17 for all dietary assistant specialists regarding menu development, importance of adhering to the menu provided, and new processes to ensure puree menu is followed in compliance with regulatory requirement. Registered Dietician or designee to complete audit of all puree meals served daily x 2 weeks, weekly x 10	2/9/17

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

Electronically Signed | 02/12/2017

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F 363	Continued From page 1 plate the mashed sweet potatoes. There was no pureed southwest white bean stew available. DAS #1 prepared 9 pureed meals for delivery. Interview with the assistant dietary manager (DM) on 01/18/17 at 4:40 PM revealed residents on a pureed diet did not receive the soup/stew course. The assistant DM explained the practice of pureeing a soup menu item stopped after a resident who liked soup left the facility several months ago. Interview with DAS #1 on 01/18/17 at 5:15 PM revealed she omitted the sweet potatoes because the divided plate could not contain more than 3 food items. DAS #1 explained she plated the lunch and dinner meals on a full time basis and always plated one protein, one starch and one vegetable. DAS #1 reported she chose which food item to omit. Interview with the Registered Dietician (RD) on 01/18/17 at 5:16 PM revealed she was not aware of the regular omission of food items from the pureed menu. The RD explained residents should receive the pureed stew and the choice between the black eyed peas and stew did not adversely affect the nutritional content of the meal. The RD reported staff should follow the menu to ensure receipt of a nutritionally balanced meal.	F 363	weeks, and bi-weekly thereafter. 4.) Monitoring Process: Results of all above audits to be presented by RD at monthly QAPI meeting until compliance is maintained.	
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	F 431		2/16/17

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F 431	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to remove 2 expired medications that were ready for use from 1 or 4 medication carts (Riverbirch medication cart). Findings included: An observation on 01/017/2017 at 4:15 PM of the Riverbirch medication cart revealed Lantanoprost	F 431	1.) Corrective action to be accomplished for each resident affected by the deficient practice: All expired medications were immediately disposed of by Director of Nursing in compliance with regulatory requirements 2.) Corrective action to be accomplished	

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F 431	Continued From page 3 ophthalmic Solution 0.005% had been opened 12/04/2016. The medication box stated it was good for 6 weeks after opening. It was expired on 01/05/2017. A bottle of Tizanide 4 milligrams labeled by the pharmacy was outdated on 01/07/2017. An interview on 01/17/2017 at 4:15 PM with Nurse #1 revealed the night shift went through the carts and removed expired medications, medications for resident who were discharged or medications that had been discontinued. An interview 01/19/2017 at 08:45 AM with Nurse #2 revealed the night shift nurses go through the carts and the pharmacy goes through the carts once a month. She stated every nurse should be checking the medications and expired medications or medications left from discharged residents should be sent back to the pharmacy. An interview on 01/19/2017 at 11:05 AM with the Pharmacist revealed she did monthly audits of the medication carts and removed expired medications. The results of the audit were shared with the facility. An interview on 01/19/2017 at 1:34 PM with the Director of Nursing (DON) revealed the night shift was responsible for removing expired medication or medication no longer in use by a resident. She stated the pharmacy had done a full review of the carts and medication storage rooms quarterly to remove expired medication or discontinued medications. She stated her expectation was that all medications administered were in date and that all expired medication or medication no longer being administered to a resident were removed from the medications carts.	F 431	for those residents having the potential to be affected by deficient practice: An audit of all medication storage was completed 1/20/2017 by Director of Nursing to confirm that no expired medications were present in the facility. 3.) Measures put in place or systemic changes made to ensure that the deficient practice will not occur: All active RN and LPN staff in-serviced regarding medication storage by RN DON or designee by 2/16/17 and upon hire. Third Shift Nurses to complete audits nightly to ensure expired medications are disposed of in compliance with regulatory requirements. RN MDS Coordinator and LPN Clinical Coordinator will each be assigned medication storage areas to monitor on a weekly basis and verify the accuracy of nursing audits. These assignments will encompass all medication storage areas. Director of Nursing will conduct a monthly follow up audit to ensure adherence to this plan of correction. Consultant Pharmacist will conduct additional independent monthly audits. 4.) Monitoring Process: DON and consultant pharmacist to present results of all above audits at the monthly QAPI meeting until compliance is maintained.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		2/16/17

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F 520	Continued From page 4 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in December 2015. This was for one recited deficiency which was originally cited in December 2015 on a recertification survey and again on the current recertification survey. The deficiency was in the area of medication storage. The facility's continued failure to implement and	F 520	1.) . Corrective action to be accomplished for each resident affected by the deficient practice: No residents were affected by this deficient practice. 2.) Corrective action to be accomplished for those residents having the potential to be affected by deficient practice: An audit of all medication storage was completed 1/20/2017 by Director of	

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F 520	Continued From page 5 maintain procedures from a QAA Committee, during two federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 431: Drug Labeling and Storage: Based on observations and interviews the facility failed to remove 2 expired medications that were ready for use from 1 or 4 medication carts (Riverbirch medication cart). During the December 2015 recertification survey, the facility was cited for failure to remove expired insulin, blood thinner, cough suppressant and a protein supplement from medication storage. The facility was recited during the current recertification survey for failure to remove expired eye drops and a muslce relaxant from medication storage. During an interview on 01/19/2017 at 3:15 PM the administrator stated that facility's QAA Committee met monthly to discuss monthly tracking of measurable goals and monitoring for agenda items brought before the committee on a rotational basis. He stated that any identified deficiencies from a state survey were kept on the QAA calendar throughout the year. The administrator also stated that since the December 2015 annual state survey, the pharmacy consultant and director of nursing were both monitoring medication storage and conducting internal audits. He attributed a repeat deficiency with medication storage to a potential need for individual staff re-education, competency training	F 520	Nursing to confirm that no expired medications were present in the facility. 3.) Measures put in place or systemic changes made to ensure that the deficient practice will not occur: Administrator or Designee In-Service training for all staff regarding the QA process. Additionally, All active RN and LPN staff in-serviced regarding medication storage by RN DON or designee by 2/16/17 and upon hire. Third Shift Nurses to complete audits nightly to ensure expired medications are disposed of in compliance with regulatory requirements. RN MDS Coordinator and LPN Clinical Coordinator will each be assigned medication storage areas to monitor on a weekly basis and verify the accuracy of nursing audits. These assignments will encompass all medication storage areas. Director of Nursing will conduct a monthly follow up audit to ensure adherence to this plan of correction. Consultant Pharmacist will conduct additional independent monthly audits. 4.) Monitoring Process: Results of all above audits will be presented at monthly QAPI meetings until compliance is maintained.	

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F 520	Continued From page 6 and the need for continued oversight and medication cart audits.	F 520		