| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| THE LAURELS OF GREENTREE RIDGE | 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation. Event ID# 2RIY11. | F 000 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed | F 636 | | 3/2/18 |

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

Electronically Signed | 02/22/2018

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| F 636 | Continued From page 1<br>on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed underlying causes and contributing factors for the triggered area of cognitive loss/dementia for 1 of 3 sampled residents.<br><br>The findings included:<br><br>Resident #16 was admitted to the facility 4/9/15 with diagnoses that included anemia, anxiety, and unspecified dementia with behavioral | F 636 | The facility will continue to conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.<br><br>Resident #16 will continue to have periodic comprehensive, accurate, standardized, reproducible assessments of functional capacity. No negative outcome was identified relating to this observation. | |

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| F 636 | Continued From page 2<br>disturbance.<br><br>The significant change Minimum Data Set (MDS) dated 3/1/17 coded Resident #16 as having severely impaired cognitive skills, understanding others, and usually being understood.<br><br>The Care Area Assessment dated 3/1/17 for the triggered area of cognition was not completed. There was no analysis of Resident #16's cognition or how her cognition deficit affected her day to day function and ability to make decisions.<br><br>An interview with the MDS Coordinator on 2/2/18 at 12:23 pm revealed the social worker should have completed the analysis for the triggered area of cognition before the MDS was submitted and locked.<br><br>The social worker was unavailable for interview.<br><br>An interview was conducted with the Director of Nursing (DON) on 2/2/18 at 4:30 pm. The DON stated it was her expectation that the analysis for the triggered area of cognition would have been complete before the MDS was submitted and locked. | F 636 | Current residents who have Care Area Assessments that trigger in the area of cognition have the potential to be affected. Current residents with Care Area Assessments that trigger in the area of cognition were reviewed by the Clinical Resource Specialist to ensure that periodic comprehensive, accurate, standardized reproducible assessments of functional capacity have been conducted. NO negative observations were identified.<br><br>The Social Worker will be inserviced by the Clinical Resource Specialist on conducting initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity according to the RAI manual no later than March 2, 2018.<br><br>All Social Workers and MDS Coordinators will be inserviced by the Clinical Resource Specialist on conducting initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity according to the RAI manual no later than March 2, 2018.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the Clinical Resource Specialist. The Clinical Resource Specialist will randomly audit Care Area Assessments for residents that trigger in the area of cognition weekly x 4 weeks, then randomly x 2 months to ensure that periodic, comprehensive, | |

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| F 636 | Continued From page 3 | F 636 | accurate, standardized, reproducible assessments of functional capacity are being conducted. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>Observation results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random audits of Care Area Assessments and through the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |
| F 640 SS=D | Encoding/Transmitting Resident Assessments<br>CFR(s): 483.20(f)(1)-(4)<br><br>§483.20(f) Automated data processing requirement-<br>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there | F 640 | | 3/2/18 |

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| F 640 | Continued From page 4<br>is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.<br><br>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.<br><br>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to complete a quarterly assessment within regulated timeframes for 1 of 5 residents | F 640 | The facility will continue to complete quarterly assessments within regulated timeframes according to the RAI manual. | |

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| F 640 | Continued From page 5<br>(Resident #47) reviewed for resident assessments.<br><br>The findings included:<br><br>Resident #47 was admitted to the facility 07/27/16. The quarterly Minimum Data Set (MDS) dated 12/28/17 indicated Resident #47 had a diagnosis of Alzheimer's disease among other diagnoses.<br><br>Record review for Resident #47 indicated the most recent quarterly MDS dated 12/28/17 was initially set with an Assessment Reference Date (ARD) of 12/11/17. Upon further record review, Section K of the quarterly MDS was not completed until 12/26/17 and Section Z was signed off on 12/28/17.<br><br>During an interview with MDS Coordinator (MDSC) #1 on 02/01/18 at 9:50 AM, the MDSC reviewed the quarterly MDS dated 12/28/17 and acknowledged Section K had been completed late and Section Z was signed off 2 days later for Resident #47.<br><br>During an interview with the Dietary Manager (DM) on 02/02/18 at 4:58 PM, the DM stated the MDSC lets him know when assessments are due and he had never had a late assessment that he had been made aware of. The DM stated he completed Section K for this quarterly MDS assessment for Resident #47 and is unsure why it was completed late unless it had to do with the timing around the holidays.<br><br>During an interview with the Director of Nursing (DON) on 02/02/18 at 5:32 PM, the DON stated her expectation were for the MDS to be | F 640 | Resident #47 will continue to have quarterly assessments completed within regulated timeframes according to the RAI manual. No negative outcome was identified relating to this observation.<br><br>Current residents have the potential to be affected. Current residents were reviewed to ensure that quarterly assessments had been completed within regulated timeframes according to the RAI manual. No negative outcomes were identified.<br><br>The Dietary Manager will be inserviced by the Clinical Resource Specialist on completing quarterly assessments within regulated timeframes according to the RAI manual no later than March 2, 2018.<br><br>The MDS Coordinators will be inserviced by the Clinical Resource Specialist on completing quarterly assessments within regulated timeframes according to the RAI manual no later than March 2, 2018.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the Clinical Resource Specialist. The Clinical Resource Specialist will randomly audit quarterly assessments weekly x 4 weeks then randomly x 2 months to ensure that quarterly assessments are being completed within regulated timeframes according to the RAI manual. Variances will be corrected at the time of observation and additional education provided when indicated. | |

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| F 640 | Continued From page 6<br>completed in a timely manner. | F 640 | Observation results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random audits of quarterly assessments and through the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect a fall with injury (Resident #71), broken and obvious cavities (Resident #447), receiving insulin injections for 7 days (Resident #2), and for receiving dialysis treatment (Resident #53) for 4 of 26 residents reviewed for MDS assessment.<br><br>Findings included:<br><br>1. Resident #71 was admitted to the facility 10/03/17 with diagnoses including Parkinson disease and insomnia. | F 641 | The facility will continue to complete assessments that accurately reflect the resident's status. The facility's process of accurately coding the Minimum Data Set to reflect a fall with injury, broken and obvious cavities, receiving insulin injections for 7 days, and for receiving dialysis treatment, lead to this deficient practice.<br><br>Resident #71, #447, and #53 had MDS corrections completed at the time of discovery. No negative outcomes were identified relating to this observation. | 3/2/18 |

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| F 641 | Continued From page 7<br><br>A review of most recent quarterly MDS dated 01/02/18 revealed in section J1800, Resident #71 had no falls since previous assessment done 10/10/17.<br><br>A review of the nursing note dated 12/02/17 at 9:30 PM revealed the direct care staff reported Resident #71 had fallen and was bleeding from the left leg. The nurse assessed the injury and found a gash with exposed tissue and called the Medical Doctor and received an order to send to the Emergency Department (ED). The wound was cleaned and stapled at the ED.<br><br>During an interview on 02/02/18 at 12:10 PM, the MDS Coordinator #1 reviewed the quarterly MDS dated 01/02/18 section J1800 and confirmed she was the person who documented no prior falls since last assessment. She explained the nursing documentation supported there had been a fall between the assessment periods reviewed to answer the question in section J1800. She explained a modification would be submitted to reflect a fall with injury occurred during the look back period and it was an oversight that was coded incorrectly.<br><br>During an interview conducted on 02/02/18 at 7:37 PM, the Director of Nursing revealed her expectations was for the MDS to reflect the resident and for the MDS Coordinator #1 to correctly code section J1800 to reflect Resident #71 had a fall with injury.<br><br>2. Resident #447 was admitted to the facility 01/18/18.<br><br>A review of the admission MDS dated 01/25/18 | F 641 | Current residents with falls, obvious cavities and broken teeth, injections, and dialysis have the potential to be affected. Current residents with these conditions were reviewed to ensure that assessments had been completed that accurately reflect each resident's status. No negative observations were identified.<br><br>The MDS Coordinator will be inserviced by the Clinical Resource Specialist on completing assessments that accurately reflect the resident's status no later than March 2, 2018.<br><br>All MDS Coordinators will be inserviced by the Clinical Resource Specialist on completing assessments that accurately reflect the resident's status no later than March 2, 2018.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the DON. The DON will randomly audit assessments weekly x 4 weeks then randomly x 2 months to ensure that assessments are being completed that accurately reflect the resident's status. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. | |

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| F 641 | Continued From page 8<br>revealed section L for dental was coded as none of the above.<br><br>During an observation on 02/01/18 at 11:22 AM, Nurse #2 observed Resident #447's teeth and confirmed the resident had obvious cavities and broken teeth.<br><br>During an interview on 02/01/18 at 2:32 PM, the MDS Coordinator #2 explained she was the person who documented the dental information for the admission MDS and interviewed the resident and ask if there were any problems with pain or chewing and observed the residents mouth and tongue and looked for obvious cavities and broken teeth.<br><br>During an interview on 02/01/18 at 5:14 PM, the MDS Coordinator #2 observed Resident #447 mouth and revealed there were cavities and broken teeth. The MDS Coordinator #2 explained she did examine the resident's mouth and should have coded section L to show obvious cavities and broken teeth. She confirmed a modification would be done and correctly coded to show obvious cavities and broken teeth.<br><br>During an interview conducted on 02/02/18 at 7:39 PM, the Director of Nursing revealed her expectations was for the MDS to reflect the resident and for the MDS Coordinator #2 to correctly code section L to reflect Resident #447 had broken teeth and obvious cavities.<br><br>3. Resident #2 was admitted to the facility on 10/12/17 with diagnoses including heart failure, fibromyalgia, diabetes mellitus, and hypertension (high blood pressure). | F 641 | Continued compliance will be monitored through random audits of assessments and through the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.<br><br>A | |

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| F 641 | Continued From page 9 | F 641 | | |

An admission Minimum Data Set (MDS) dated 10/19/17 indicated Resident #2 was coded under Section N Medications as receiving injections 7 out of 7 days and receiving insulin injections 7 out of 7 days.

A review of physician orders revealed both Lantus (a long acting insulin) and Novolog (a short acting insulin) insulin were ordered for Resident #2.

A review of Resident #2's Medication Administration Record (MAR) from January 2018 revealed Resident #2 had received both Lantus and Novolog insulin as ordered.

A record review of the quarterly MDS dated 1/9/18 indicated Resident #2 was not coded under Section N Medications as receiving injections of any type during the last 7 days.

The MDS Coordinator was interviewed on 2/1/18 at 9:58 am, regarding the accuracy of Resident #2's quarterly MDS. The MDS did not reflect that Resident #2 received insulin injections 7 out of 7 days. The MDS Coordinator stated the MDS should have been coded to reflect Resident #2 was receiving insulin injections for 7 out of 7 days and was missed for coding. The MDS Coordinator stated the quarterly MDS would require a correction to reflect Resident #2 was receiving insulin injections.
On 2/1/18 at 3:30 pm an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the quarterly MDS would have been coded accurately to reflect Resident #2 was receiving insulin injections.

4. Resident #53 was admitted to the facility 7/7/17 with diagnoses including anemia,

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| F 641 | Continued From page 10<br>pneumonia, and end stage renal disease.<br><br>A quarterly MDS dated 10/6/17 indicated Resident #53 was coded under Section O Special Treatments, Procedures, and Programs as receiving dialysis.<br><br>A care plan for end stage renal disease was in place for Resident #53 and was last updated 12/19/17.<br><br>A record review of the quarterly MDS dated 12/26/17 indicated Resident #53 was not coded under Section O Special Treatments, Procedures, and Programs as receiving dialysis.<br><br>The MDS Coordinator was interviewed 2/1/18 at 3:00 pm, regarding the accuracy of Resident #53's quarterly MDS. The MDS did not reflect dialysis care for Resident #53. The MDS Coordinator stated the MDS should have been coded to reflect Resident #53 was receiving dialysis and was missed for coding. The MDS Coordinator stated the quarterly MDS would require a correction to reflect Resident #53 was receiving dialysis.<br><br>On 2/1/18 at 3:30 pm an interview was conducted with the DON. The DON stated it was her expectation that the quarterly MDS would have been coded accurately to reflect Resident #53 was receiving dialysis. | F 641 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and | F 692 | | 3/2/18 |

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| F 692 | Continued From page 11<br>percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident and staff interviews the facility failed to follow a physician prescribed diet for 1 of 5 residents being reviewed for nutritional services (Resident #10).<br><br>The findings include:<br><br>Resident #10 was admitted to the facility 01/26/16. The annual Minimum Data Set (MDS) dated 11/03/17 indicated Resident #10 was alert and oriented with diagnoses including heart failure and renal insufficiency among others. The MDS also indicated Resident #10 required supervision with eating and was on a therapeutic diet.<br><br>Record review of physician's orders indicated on 10/10/17 Resident #10 was to be on a no added | F 692 | The facility will continue to offer a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br><br>Resident #10 will continue to receive a No Added Salt diet. No negative outcome was identified relating to this observation.<br><br>Current residents with orders for No Added Salt diets have the potential to be affected. Current residents with No Added Salt diets were reviewed to ensure that they are being offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. No negative observations were identified. | |

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| THE LAURELS OF GREENTREE RIDGE | 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 |

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| F 692 | Continued From page 12<br>salt (NAS) diet with regular texture and consistency. Physician's orders also indicated on 10/13/17 Resident #10 was started on a diuretic (increases the removal of urine from the body) medication daily due to heart failure.<br><br>Observation of Resident #10 at dinner in his room on 01/30/18 at 5:30 PM revealed a tray card that indicated a NAS diet. One salt packet was observed unopened on his dinner meal tray. Resident #10 stated he used the salt they send him on his tray sometimes because the food was bland.<br><br>Observation of Resident #10 at lunch in his room on 01/31/18 at 12:50 PM revealed a tray card that stated NAS diet. One salt packed was observed unopened on his lunch meal tray. Resident #10 stated he did not ask for the salt and further stated "it's just on there when I get the tray."<br><br>During an interview with the Dietary Manager (DM) on 01/31/18 at 1:01 PM, the DM was in the room with Resident #10 and observed the salt packet on his meal tray for lunch. The DM stated the dietary staff was supposed to check the tray card to make sure it is being followed correctly. The DM also stated his dietary aide working today was new and that might be why this was accidentally overlooked. The DM further stated he was unsure what happened the previous night with Resident #10 receiving salt on his dinner tray.<br><br>During an interview with the Nurse Aide (NA #1) on 01/31/18 at 1:23 PM who delivered the lunch tray to Resident #10, NA #1 stated she set his meal tray up for lunch. NA #1 further stated she had not looked at the tray card for Resident #10 | F 692 | NA #1 and DA #1 will be in-serviced by the ADON on offering a therapeutic diet when there is a nutritional problem and the health care provider order a therapeutic diet no later than March 2, 2018<br><br>All NAs and DAs will be in-serviced by the ADON on offering a therapeutic diet when there is a nutritional problem and the health care provider order a therapeutic diet no later than March 2, 2018.<br><br>A QA monitoring toll will be utilized to ensure ongoing compliance by the ADON and/or Dietary Manager. The ADON and/or Dietary Manager will randomly observe meal trays for those guests with orders for No Added Salt diets 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 2 months to ensure that therapeutic diets are being offered when there is a nutritional problem and the health care provider orders a therapeutic diet. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>Observation results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meeting.<br><br>Continued compliance will be monitored through random observations of meal trays and through the facility's Quality Assurance program.<br><br>Compliance will be monitored by the QA | |

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| F 692 | Continued From page 13<br>when she set his meal tray up for lunch. NA #1 also stated she doesn't normally look at the tray cards that often except for when new residents come in.<br><br>During an interview with the Dietary Aide (DA #1) on 01/31/18 at 1:44 PM, DA #1 stated he set up the tray and put the utensils, adaptive equipment, beverages, condiments and other items on the trays for all the residents. DA #1 also stated he thought he was going too fast this morning in preparing the lunch trays and put the salt packet on the tray of Resident #10 by accident. DA #1 further stated he recognized how important it was to make sure the tray card was being followed and would be more cautious in the future.<br><br>During an interview with the Director of Nursing (DON) on 01/31/18 at 2:35 PM, the DON stated her expectations were for whoever passed the tray to make sure the tray card matched what the resident was being served. The DON also stated if a resident was on a NAS diet and still wanted salt, the resident would be educated why they were on a NAS diet, but would still be given the right to choose whether to have the salt, otherwise she expected the NAS diet to be followed per the physician order. | F 692 | Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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. | F 761 | | 3/2/18 |

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| F 761 | Continued From page 14<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) 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.<br><br>§483.45(h)(2) 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, resident and staff interviews the facility failed to ensure medications were under direct observation by the administering nurse who left medications unattended at the bedside for 1 of 1 resident (Resident #76).<br><br>Findings included:<br><br>Resident #76 was admitted to the facility 07/16/17 with diagnoses including diabetes mellitus, cerebrovascular accident, and depression.<br><br>The quarterly Minimum Data Set (MDS) dated 01/05/18 indicated Resident #76 was cognitively intact. The MDS also indicated Resident #76 received antidepressant and opioid medications for 7 days during the look back period of the assessment. | F 761 | The facility will continue to ensure that medications are under direct supervision of the administering nurse.<br><br>Resident #76 will continue to receive medications under direct supervision of the administering nurse. No negative outcome was identified relating to this observation.<br><br>Current residents who receive medications have the potential to be affected. No negative observations were identified.<br><br>Nurse #1 will be in-serviced by the ADON on ensuring that medications are under direct supervision of the administering nurse no later than March 2, 2018. | |

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| F 761 | Continued From page 15<br><br>During an observation on 01/29/18 at 8:56 AM, Resident #76 had a small, clear cup with loose medications sitting on a tray table at the bedside in a room shared by 2 residents. There were approximately 9 medications left unattended by the administering nurse.<br><br>During an interview on 01/29/18 at 8:56 AM, Resident #76 explained at times the nurses left medications unattended to self-administer. Resident #76 revealed taking medications one at a time was time consuming and at times the nurses would leave the medications at the bedside to self-administer. Resident #76 confirmed pain medication was included in the cup left at the bedside.<br><br>During an interview on 01/31/18 at 12:54 PM, Nurse #1 confirmed she was the administering nurse the morning the medications were left unattended and had left them at the bedside. Nurse #1 also confirmed Resident #76 did not have a physician's order to self-administer medications and medication should not be left unattended by the administering nurse.<br><br>During an interview on 01/31/18 at 1:12 PM, the Unit Manager (UM) revealed her expectation was for the nurses to watch the residents take and swallow medications. The UM revealed it was her expectation nurses would not leave medication unattended in the resident room at any time.<br><br>During an interview on 02/02/18 at 6:47 PM, Resident #76 explained another resident would at times enter the room and take items that belong to Resident #76. | F 761 | All nurses will be in-serviced by the ADON on ensuring that medications are under direct supervision of the administering nurse no later than March 2, 2018.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON. The ADON will randomly observe residents rooms during medication administration 5x/week x 2 weeks then weekly x 2 weeks then bi-weekly x 2 months to ensure that medications are under direct supervision of the administering nurse. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>Observation results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random observations of resident rooms during medication administration and through the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |

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| F 761 | Continued From page 16<br>During an interview on 02/02/18 at 7:34 PM, the Director of Nursing (DON) revealed it was her expectation the administering nurse would stay with the resident and watch them take medication. The DON revealed it was her expectation the administering nurse would not leave medication unattended in a resident's room. | F 761 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to label and date potentially hazardous food after opening for 2 of 2 walk in coolers, label and date potentially hazardous food after opening for 1 of 1 kitchen storage rooms, and store potentially hazardous food after opening in sealed containers for 1 of 1 kitchen | F 812 | The facility will continue to ensure that food is stored, prepared, distributed, and served under sanitary conditions.The facility process of dating food /beverage, and ensuring proper storage of food and beverage lead to this deficient practice. | 3/2/18 |

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| F 812 | Continued From page 17<br>storage rooms.<br><br>The findings included:<br><br>1. a. Initial observation of walk in cooler 1a on 1/29/18 at 8:06 AM revealed the following foods were unlabeled and undated:<br>2 bowls of salad<br>2 cups of salad dressing<br>8 cups of thickened juice<br><br>b. Initial observation of walk in cooler 1b on 1/29/18 at 8:09 AM revealed the following foods were unlabeled and undated:<br>1 package of hot dogs<br>1 package of shredded cheese<br>1 jar of pickles<br>1 package of cheese slices<br>3 half gallon containers of soy milk<br>1 metal pan of hot dogs covered in plastic wrap<br>1 container of pimiento cheese<br>1 bottle of lemon juice<br>1 a metal pan filled with 6 cake slices<br>1 tray of 6 slices of apple pie<br><br>c. Initial observation of the kitchen storage room on 1/29/18 at 8:12 AM revealed the following foods were unlabeled and undated:<br>1 bag of grits<br>1 package of dry gravy mix<br>1 bag of chocolate cake mix<br>1 bag of brownie mix<br>1 bag of brown sugar<br>3 packages of dry pasta<br>1 bin of rice<br>1 bin of cornmeal<br>1 bin of powered thickener for liquids<br>4 bins of cereal | F 812 | The items in walk-in cooler 1a, walk-in cooler 1b and the kitchen storage room that were not labeled, dated, and sealed were discarded immediately. No negative outcome was identified relating to this observation.<br><br>Current residents have the potential to be affected. All remaining food items in the kitchen were inspected for labels, date, and seals. No negative observations were identified.<br><br>The Food Service Director will be in-serviced by the Administrator on the facility's policy for labeling, dating, and sealing food items no later than March 2, 2018.<br><br>A QA monitoring tool will be utilized to ensure ongoing compliance by the Food Service Director. The Food Service Director will randomly observe the walk-in coolers (1a and 1b) and the kitchen storage room in the kitchen 5x/week x 4 weeks then weekly x 2 months to ensure that all items are properly stored. Variances will be corrected at the time of observation and additional education provided when indicated.<br><br>Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.<br><br>Continued compliance will be monitored through random observations and through | |

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| F 812 | Continued From page 18<br>d. Observation of the kitchen storage room on 1/29/18 at 8:15 AM revealed the following food was not in a sealed container:<br>1 package of dry pasta<br><br>An interview with the Dietary Manager (DM) on 1/29/18 at 8:20 AM revealed that all opened food in both walk in coolers and the kitchen storage room should be labeled and dated at the time it was opened. The DM further stated that all opened food should be in a sealed container and labeled and dated at the time it was opened. He also stated that any unlabeled and undated food or food that was opened but not sealed should be discarded.<br><br>An interview with the Administrator on 2/2/18 at 3:30 PM revealed it was her expectation that kitchen staff make sure all opened food was labeled and dated and stored in sealed containers. She also stated if food was not labeled and dated and in a sealed container it should be discarded. | F 812 | the facility's Quality Assurance Program.<br><br>Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. | |