STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 06/28/2018

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GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to allow an alert and oriented resident the choice to have more than one cigarette at a time by requiring the resident return to the nurse's station for each additional cigarette for 1 of 2 residents reviewed for smoking. (Resident #12).	F 561	F561 Self-Determination CFR(s): 483.10(f)(1)-(3)(8) Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	7/20/18

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

Electronically Signed | 07/20/2018

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F 561	Continued From page 1 Findings included: Resident #12 was admitted to the facility on 3/31/18. Her active diagnoses included anemia, heart failure, hypertension, peripheral vascular disease, diabetes mellitus, anxiety, asthma, respiratory failure, and acquired absence of the right leg below the knee. Review of Resident #12's minimum data set assessment dated 4/7/18 revealed the resident was assessed as cognitively intact. She was assessed to have no current tobacco use. Review of Resident #12's care plan dated 5/1/18 revealed she was care planned as an independent and safe smoker. The interventions included to evaluate her continued ability to smoke safely on a consistent and regular basis. Another intervention was to observe Resident #12 for potential violations of the smoking policy, document, and report observations to Administrator and Administrative staff. Resident #12 could smoke at times of her own choice in designated smoking areas independently and without supervision. Review of Resident #12's smoking evaluation dated 5/26/18 revealed the resident was assessed to be a safe smoker and could smoke independently at that time. Review of Resident #12's chart revealed no concerns with violations of the facility's smoking policy. During an interview on 6/25/18 at 12:08 PM Resident #12 stated she was an independent	F 561	this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Grantsbrook Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Grantsbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that lead to the deficiency was based on record review and staff and resident interview, that facility failed to allow an alert and oriented resident the choice to have more than one cigarette at a time by requiring the resident return to the nurse□s station for each additional cigarette for 1 of 2 residents reviewed for smoking. (Resident #12). 100% interviews were completed with all residents that smoke per the smoking assessment, to include resident #12 on 07/16/2018 by the Social Workers (SW) regarding preferences related to how many cigarettes they would like to receive at a time. The Minimum Data Set nurse	

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F 561	Continued From page 2 smoker based on the facility's assessment. She stated she could get a cigarette and smoke it without supervision outside the facility in the back. She further stated she was only allowed one cigarette at a time. She had asked to be allowed to take two or three cigarettes with her to smoke since she was independent and liked to smoke two or three cigarettes at a time, but the facility would not allow it. She stated she had to take one cigarette outside at a time, finish the cigarette, return to the nurse's station to get another cigarette and finally go back outside to continue smoking. Resident #12 stated the problem with this was she had a right leg amputation. She stated it was exhausting to self-propel herself back and forth from the smoking area to the nurse's station two or three times to smoke when she knew she would want two or three when she was going out the first time. She stated the situation made her feel frustrated since it wasted so much of her time to simply enjoy her cigarettes. During an interview on 6/27/18 at 9:02 AM the Unit Clerk stated independent smokers had their smoking equipment at the nurse's station. She further stated she was only allowed to give one cigarette to residents at a time. The Unit Clerk stated Resident #12 would regularly ask for two cigarettes but she was only allowed to give her one at a time. She further stated the Director of Nursing informed the Unit Clerks that residents were only allowed one cigarette at a time, so if Resident #12 wanted more than one, she had to come back in and request another cigarette at the nurse's station to smoke two cigarettes. She further stated she had explained this to Resident #12 but she would still ask for two cigarettes most of the time.	F 561	(MDS) updated the resident care plans and the resident care guides on 07/16/2018 to reflect the residents smoking preferences. 100% audit was completed on 07/17/2018 by the Director of Nursing (DON), the Quality Improvement (QI) nurse, and Staff Facilitator for all residents that smoke to ensure each resident is given the choice of how many cigarettes they would like to receive per their preference and those changes were made on the resident care guides. All identified issues were addressed immediately by the DON on 07/17/2018 to ensure each resident that smokes is given the choice of how many cigarettes they would like to receive at a time. 100% in-service of all staff, to include unit clerks, was initiated by the Staff Facilitator on 07/17/2018 regarding the resident right to make choices about his or her life in the facility that are significant to the resident including their smoking preferences. The in-service will be completed by 07/20/2018. All new staff will be in serviced by the Staff Facilitator during orientation regarding the resident□s right to make choices about his or her life in the facility that are significant to the resident including their smoking preference. 100% of all residents that smoke, to include resident #12, will be reviewed by the Quality Improvement (QI) nurses and Staff Facilitator to ensure that each resident is given the choice of receiving more than one (1) to two (2) cigarettes per	

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F 561	Continued From page 3 During an interview on 6/27/18 at 9:06 AM the Director of Nursing stated nurses performed the safe smoking evaluations on residents. She stated they assessed if the resident could light the cigarette safely and smoke it safely. the Director of nursing continued to state that Resident #12 was a very safe smoker and was alert and oriented. She further stated Resident #12's cigarettes and lighters were kept at the nurse's station and Resident #12 would request to smoke and could get a cigarette and go to the smoking area and smoke independently. The Director of Nursing stated residents who could smoke independently get one cigarette at a time and the reasoning for the one cigarette at a time rule was to help residents not be pressured by other residents to give them another cigarette in case the other resident was not a safe smoker and was outside on a nice day. She further stated if Resident #12 requested more than one cigarette the facility could not deny them two, however it was her expectation the unit clerk give the resident one cigarette and then take the second cigarette out to the resident about five minutes after the resident had taken the first cigarette outside so the resident did not have to go back and forth from the smoking area to the nurse's station.	F 561	their preference is on the resident care guide 3 times per week for 4 weeks, then weekly for 4 weeks then monthly for 1 month using the Resident Smoking Audit Tool. The Director of Nursing will review and initial the Resident Smoking Audit Tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all identified areas of concern were addressed. The Executive QI committee will meet to review the smoking assessments and Resident Smoking Audit Tool monthly X□s 3 months to determine issues and trend to include continued monitoring frequency. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		7/20/18

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F 677	Continued From page 4 Based on observations, record review and staff interviews the facility failed to keep the area under the finger nails free of debris for 1 of 1 dependent resident (Resident #35) reviewed for activities of daily living (ADLs). The findings included: Resident #35 was admitted to the facility on 1/31/17. His diagnoses included Parkinson's disease and dementia. A review of the most recent Minimum Data Set, a quarterly assessment, dated 4/20/18 revealed Resident #35 was severely cognitively impaired and required extensive assistance with personal hygiene and was totally dependent on staff for bathing. He had no range of motion impairments. During an observation on 6/25/18 at 3:17 PM Resident #35 was observed to have black debris under the fingernails of his right hand. During an observation on 6/26/18 at 1:02 PM Resident #35 was observed to continue to have black debris under his fingernails of his right hand. On 6/26/18 at 1:45 PM Resident #35 was observed being transported by staff to the activity room. On 6/26/18 at 2:05 PM Resident #35 was observed in the dining room with the activity assistant present in the room. The activity assistant was performing nail care and nail painting for the residents present for the activity. Resident #35 was seated in the room with the other residents.	F 677	F677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Grantsbrook Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Grantsbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that lead to the deficiency was based on observations, record review and staff interviews the facility failed to keep the area under the finger nails free of debris for 1 of 1 dependent resident (Resident #35) reviewed for activities of daily living (ADLs). 100% observation of all licensed nurses,	

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F 677	Continued From page 5 On 6/27/18 at 2:34 PM Resident #35 was observed in his room. His fingernails were observed and the right hand fingernails continued to contain black debris on his right hand. During an interview with Nursing Assistant (NA) #1 on 6/27/18 at 2:40 PM she stated bathing a resident included washing between the fingers and observing the finger nails to see if they needed cleaning. She said if a resident needed nail care she would return later to complete the nail care after she obtained a nail care kit. She added the facility also had a manicure activity where the activity staff cleaned and painted residents' nails. She stated she had not cleaned the nails for Resident #35 today but was planning to. She added she had not worked with Resident #35 until today. During an observation on 6/27/18 at 2:55 PM the Director of Nursing (DON) observed Resident #35's fingernails and stated his nails needed to be cleaned and trimmed. She also stated she had observed Resident #35 in the manicure activity yesterday so his nails should have been cleaned there. She added resident's fingernails should be cleaned with the daily bath or as needed. On 6/27/18 at 3:05 PM the Activity Director stated she saw Resident #35 go to the manicure activity but it was the Activity Assistant who was performing the activity. On 6/27/18 at 3:08 PM the Activity Assistant stated Resident #35 was present during the manicure activity but she was not aware that he was there for active participation in the activity because he was frequently taken to activities for	F 677	nursing assistants (NA), to include NA #1, Activity Director and Activity Assistant was completed by the Quality Improvement (QI) nurse, the Director of Nursing (DON), and the Staff Facilitator on ADL care provided to dependent residents, to include resident #35, to ensure correct procedure is being followed including nail care and keeping the area under the finger nails free of debris. This will be completed by 07/20/208 utilizing the Resident Nail Care Audit Tool for ADL nail care. An inservice for 100% of all licensed nurses, NA□s, to include NA #1, the Activity Director, and Activity Assistant was initiated by the Staff Facilitator on 07/16/2018, regarding the correct procedure for providing nail care including keeping the area under the finger nails free of debris and will be completed by 07/18/2018. Nail care to a resident, to include resident #35, will be observed weekly for 8 weeks and then monthly for one month utilizing a Resident Nail Care Audit Tool for ADL nail care observations by the QI nurse and Staff Facilitator. The Director of Nursing (DON) will review and initial the Resident Nail Care Audit Tool for ADL nail care observations weekly for 8 weeks and then monthly for one month to ensure all areas of concern were addressed. The Administrator will review and present the findings of the Resident Nail Care Audit Tool to the Executive QI committee	

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F 677	Continued From page 6 closer monitoring for safety. She stated she did not clean or trim Resident #35's fingernails.	F 677	monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to assess a resident's reaction during a dressing change for 1 of 2 residents observed for wound care. (Resident #21) Findings included: Resident #21 was admitted to the facility on 1/3/18. Her active diagnoses included unstageable pressure ulcer of the sacral region and low back pain. Review of the resident's most recent minimum data set assessment dated 4/12/18 revealed the resident was assessed as severely cognitively	F 697	F697 Pain Management CFR(s): 483.25(k) Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Grantsbrook Nursing and Rehabilitation	7/20/18

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F 697	Continued From page 7 impaired. She required extensive assistance with bed mobility. Resident #21 was documented to have denied pain presence during the assessment. Resident #21 had one stage III pressure ulcer at the time of the assessment. Review of the resident's care plan dated 6/11/18 revealed she was care planned for having interference with the structural integrity of her skin caused by prolonged pressure. The interventions included therapy to be provided as ordered. diet as ordered by physician, and ensure special mattress was in place. Review of the physician orders revealed Resident #21 was ordered to have the pressure ulcer cleansed with normal saline and medi-honey gel applied to site and covered with dressing every other day or as needed. Resident #21 was also ordered Tylenol 650 milligrams as needed for pain and had ultrasound therapy during wound care. Review of Resident #21's medication administration record for 6/27/18 revealed the resident had not received any pain medication prior to the wound care for the afternoon of 6/27/18. During observation on 6/27/18 at 2:39 PM the Wound Care Specialist was observed providing wound care to Resident #21. Resident #21 was turned to her right side and held on to the side rail as the old dressings were removed. The resident stated the treatment would take longer than the Wound Care Specialist said and stated she would like for the treatment to already be over. She had not indicated she was in pain at that time, however she remarked it was uncomfortable to	F 697	Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Grantsbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that lead to the deficiency was based on observations, staff interviews, and record review the facility failed to assess a resident's reaction during a dressing change for 1 of 2 residents observed for wound care. (Resident #21) 100% of all residents, to include Resident #21, were assessed for pain to include residents that received wound care treatments by the Quality Improvement (QI) nurse, hall nurses, and Treatment Nurse on 07/18/2018. 100% of all residents, to include resident #21, progress notes and flow sheets for all residents receiving dressing changes for the last 2 weeks, starting 07/04/2018 to 07/18/2018 were reviewed by the Quality Improvement (QI) nurse and Staff Facilitator for documentation of signs and symptoms of pain. All residents identified with having signs and symptoms of pain will have their Medication Administration Records (MARs) reviewed to ensure	

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F 697	Continued From page 8 be on her side. The Wound Care Specialist then began ultrasound therapy which was to last five minutes as a timer was turned on the ultrasound machine. Ultrasound therapy was used to deliver a high frequency mechanical vibration to facilitate wound healing at a cellular level. A Gel is placed on the wound and the ultrasound wand is then run across the wound bed for the duration of the therapy. As the ultrasound and gel was placed on the resident's wound, the resident stated that the Wound Care Specialist was hurting her and why she was hurting like an itch. The Wound Care Specialist asked the resident if it still hurt as she ran the ultrasound around the edges of the wound. The Resident asked if the Wound Care Specialist was finished. The Wound Care Specialist then apologized for the discomfort and informed the resident of the time remaining on the ultrasound therapy. When the ultrasound again made contact with her wound, Resident #21 clinched the side rail and again informed the staff she was in pain. The Wound Care Specialist asked Resident #21 if she was itching or if she was in pain and Resident #21 replied she was in pain. The Wound Care Specialist apologized again and informed the resident of the time remaining on the ultrasound therapy and then attempted to speak with the resident about a family member to attempt to distract Resident #21. Resident #21 asked if the three minutes were up yet and the Wound Care Specialist informed her forty-five seconds were left. Resident #21 then stated her wound had never had so much pain. The Wound Care Specialist then finished with no more verbal statements of pain from the resident. After the treatment was finished the resident was then turned back on the bed and placed comfortably. The Wound Care Specialist asked Resident #21 if she was still in	F 697	prescribed pain medications were being administered per physician's order by the Director of Nursing (DON) on 07/18/2018. The physician was immediately notified of all residents having breakthrough pain and ineffective pain management by the Director of Nursing on 07/18/2018 and any new orders were implemented and the resident Care plan updated as needed. An in-service was initiated on 07/16/2018 by the Staff Facilitator, with 100% of all licensed nurses and Wound Care Specialist from the therapy department regarding pain assessment documentation in the resident chart in Point Click Care (PCC) and pain management to include when residents are having signs and symptoms of pain such as grimacing, verbalization, flinching and other bodily movements that would indicate pain to include during dressing changes. This education will include assessing the resident for pain prior to and during dressing changes, immediately stopping the dressing change if the resident appears to be in pain, providing pain meds as ordered and notifying the MD with new or ineffective pain management by the hall nurses and will be completed by 07/18/2018. All newly hired licensed nurses and Wound Care Specialist from therapy will be inserviced regarding pain assessment documentation in the resident chart in Point Click Care (PCC) and pain management to include when residents are having signs and symptoms of pain	

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F 697	Continued From page 9 any pain and the resident stated she was not in any pain at that time. During an interview on 6/27/18 at 3:07 PM the Wound Care Specialist stated that Resident #21 did not normally have pain when she performed wound care. She further stated that Resident #21 normally did not complain about pain that much and today was unusual. She further stated usually she could get the resident's mind off the pain if she mentioned it by talking about family as she had done this time, but she could not get her mind off the pain today. She further stated that she did not check to see if Resident #21 had received pain medication prior to performing her procedure. She further stated the reason she did not stop the treatment and see if the resident needed or had received pain medication during the treatment was due to the attention of the surveyor being in the room. She further stated normally she would stop and get the nurse to administer pain medication if a resident reported pain during treatment, however she felt in this case because the resident had attention of more staff in the room, that was why she was indicating she was in pain and complaining of pain more than normal. During an interview on 6/27/18 at 3:16 PM the Director of Nursing stated that it was her expectation when a resident expressed pain, the staff providing care would stop and ask if the resident needed pain medication prior to continuing treatment. She stated this was because pain was subjective and staff had to listen to what the resident was reporting. She further stated the Wound Care Specialist should have stopped the procedure and asked Resident #21 if she needed pain medication as it was	F 697	such as grimacing, verbalization, flinching and other bodily movements that would indicate pain to include during dressing changes during orientation by the Staff Facilitator. This education will include assessing the resident for pain prior to and during dressing changes, immediately stopping the dressing change if the resident appears to be in pain, providing pain meds as ordered and notifying the MD with new or ineffective pain management by the hall nurse. The Quality Improvement Nurse (QI) will observe dressing changes 3 time a week for 4 weeks, then weekly for 4 weeks then monthly for 1 month to ensure If any resident is identified as having signs and symptoms of pain prior to the dressing change, the treatment nurse and/or the Wound Care Specialist from therapy will notify the hall nurse immediately and pain medications will be administered as ordered. If a resident is identified as having pain during a dressing change the treatment nurse and/or the Wound Care Specialist from therapy will immediately stop the dressing change, assess the resident will notify the hall nurse immediately and pain medications will be administered as ordered and if no pain medication is prescribed or is ineffective the treatment nurse will notify the physician utilizing a Dressing Change QI Tool. The Executive QI committee will meet to review the Dressing Change QI tool monthly for 3 months to determine issues	

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F 697	Continued From page 10 unusual for Resident #21 to have discomfort she could not be redirected from during treatment.	F 697	and trend to include continued monitoring frequency. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §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. This REQUIREMENT is not met as evidenced by:	F 761		7/20/18

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F 761	Continued From page 11 Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 3 medication carts observed. (100 Hall Medication Cart). Findings included: During observation on 6/26/18 at 8:51 AM Nurse #1 was observed to exit a resident's room with an Advair inhaler and Dorzolamide/Timolol eye drops and placed them on top of the 100 hall medication cart. At 8:52 AM she left the medication cart unattended and entered a resident's room with the medications still on top of her medication cart. A family member was observed in the hallway approximately ten feet from the unattended medication cart with the medications on top. At 8:54 AM the nurse returned to her medication cart. During an interview on 6/26/18 at 8:54 AM Nurse #1 stated medications were to be locked in the medication cart and not left out and unattended. She further stated the Advair inhaler and Dorzolamide/Timolol should have been locked in the medication cart when she left her medication cart and entered the resident's room. During an interview on 6/26/18 at 8:57 AM the Director of Nursing stated it was her expectation all medications be locked in the medication cart and not left out and unattended by staff. She further stated the Advair inhaler and Dorzolamide/Timolol should have been locked in the 100 hall medication cart prior to the nurse leaving the medication cart unattended.	F 761	F761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Grantsbrook Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Grantsbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that lead to the deficiency was based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 3 medication carts observed. (100 hall Medication Cart). 100% audit was completed on all 3 medication carts to include 100 hall medication cart, to ensure all medication	

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F 761	Continued From page 12	F 761	were stored in medication carts by the licensed nurse by the Quality Improvement (QI) nurse on 07/16/2018. Any areas of concern s were addressed at that time. 100% inservice to all licensed nurses regarding keeping medications stored in a locked medication cart when left unattended was initiated on 07/16/2018 by the Staff Facilitator and will be completed on 07/18/2018. All newly hired licensed nurses will be inserviced nurses regarding keeping medications stored in a locked medication cart when left unattended by the Staff Facilitator. Medication Carts will be observed, to include 100 hall medication cart, using a Medication cart observation QI Tool to ensure all medication were stored in the medication carts by the QI nurse 3 times a week for 4 weeks, then weekly for 4 weeks then monthly for 1 month. The licensed nurses will be immediately re-trained for any identified areas of concern. The DON will review and initial the Medication cart observation QI Tool for completion and to ensure all areas of concerns were addressed weekly for 8 weeks and monthly for 1 month. The Executive QI committee will meet to review the Medication cart observation QI tool monthly for 3 months to determine issues and trend to include continued monitoring frequency.	

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F 761	Continued From page 13	F 761	The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed properly store food items by not discarding an expired food item stored in walk in refrigerator and failed to refrigerate an opened bottle of Bar-B-Que sauce during 2 of 2 kitchen observations and failed to place a barrier between ready to eat food and bare hands when serving resident meals during 1 of 2 dining	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	7/20/18

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F 812	Continued From page 14 observations. The findings included: 1. On 6/25/18 at 10:30 AM during the initial tour of the kitchen an opened container of pimento cheese spread was observed on the top shelf of the kitchen's walk-in refrigerator. The open date written on the container was 4/2/18. The use by date stamped from the manufacturer was 6/17/18. During an interview with Cook #1 on 6/25/18 at 10:30 AM she stated the container of pimento cheese was out of date and should be discarded. During an interview with the Dietary Manager on 6/27/18 11:20 AM he stated the container of pimento cheese should have been discarded prior to the expiration date. He stated the kitchen staff were responsible for monitoring the refrigerators and storage areas for expired foods and he provided additional oversight. He was unable to explain how the container of pimento cheese spread was overlooked. 2. During an additional observation of the kitchen storage room on 6/27/18 at 11:25 AM an opened container of Bar-B-Que sauce was observed on the upper shelf in front of an unopened container of Bar-B-Que sauce. The label of the bottle stated "refrigerate after opening". The Dietary Manager was present during the observation on 6/27/18 at 11:25 AM and stated he did not know why the bottle was not refrigerated and he would discard the bottle. He added a staff member must have put it on the storage rack by mistake since the sauce was used on Monday	F 812	this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Grantsbrook Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Grantsbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that lead to the deficiency was based on observations and staff interviews the facility failed to properly store food items by not discarding an expired food item stored in walk in refrigerator and failed to refrigerate an opened bottle of Bar-B-Que sauce during 2 of 2 kitchen observations and failed to place a barrier between ready to eat food and bare hands when serving resident meals during 1 of 2 dining observations. 100% audit was completed by the Certified Dietary Manager on 07/16/2018 for all stored food located in the kitchen, to include the walk in refrigerator, to ensure that all food was properly labeled	

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F 812	Continued From page 15 (6/25/18). 3. During a dining observation on 6/27/18 at 12:24 PM Geriatric Care Aid (GCA) #1 was observed in the Assisted Dining Room where she was assisting a resident with eating his lunch which included mechanically altered beef and 2 slices of bread. GCA #1 picked up a slice of bread with her bare hands and placed the beef on the bread then folded the bread in half and placed it in the resident's hand. During an interview with the Director of Nursing on 6/27/18 at 12:32 PM she stated the GCA was trained in proper food handling and assisting residents with eating and should not have touched the bread without using a piece of paper or to wear gloves when making the sandwich so she did not touch the bread with her bare hands.	F 812	and stored correctly. Any areas of concern with expired food or the storage of opened food were addressed at that time. 100% in-service for all dietary employees, to include Cook #1, regarding the proper way to label and store food items including discarding any expired food items and refrigerating any open food items was initiated on 07/16/2018 by the Staff Facilitator and will be completed on 07/18/2018. All newly hired dietary employees will be in-serviced regarding the proper way to label and store food items including discarding any expired food items and refrigerating any open food items by the Staff Facilitator. Food labeling and storage will be audited by the Administrator 3 times a week for 4 weeks, then weekly for 4 weeks then monthly for 1 month. The Administrator will be immediately re-train dietary staff for any identified areas of concern. The Certified Dietary Manager will review and initial the Food Label and Storage QI Tool for completion and to ensure all areas of concerns were addressed weekly for 8 weeks and monthly for 1 month. 100% in-service for all employees to include Geriatric Care Aid (GCA) #1 for proper food handling and assisting residents with eating was initiated on 07/16/2018 and will be completed on 07/18/2018 by the Staff Facilitator and/or Quality Improvement Nurse (QI). Proper food handling and assisting residents with	

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F 812	Continued From page 16	F 812	eating audits will be conducted 3 times a week for 4 weeks, then weekly for 4 weeks then monthly for 1 month by the Staff Facilitator and QI Nurse and will be immediately re-train staff for any identified areas of concern. The Director of Nursing will review and initial the Proper Food Handling QI Tool for completion and to ensure all areas of concerns were addressed weekly for 8 weeks and monthly for 1 month. The Executive QI committee will meet to review the Food Label and Storage QI tool monthly for 3 months to determine issues and trend to include continued monitoring frequency. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	