STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and resident interviews the facility failed to assess the ability of a resident to self-administer medications that were kept at the bedside for 3 of 3 sampled residents (Resident #250, Resident #251 and Resident #409) reviewed for self-administration of medications. Findings included: 1.Resident #250 was admitted to the facility on 8-18-18 with multiple diagnoses that included malignant neoplasm of the lungs, muscle weakness, perforation of the intestines and atrial fibrillation. The five-day Minimum Data Set (MDS) dated 8-25-18 revealed Resident #250 was cognitively intact. A review of Resident #250's care plan dated 8-27-18 revealed the resident was not care planned to self-administer medication. The physician's orders were reviewed from 8-18-18 to 9-7-18 and there were no orders noted for Resident #250 to self-administer her own medication. An observation was made on 9-4-18 at 2:15pm of 2 prescription medications left in Resident #250's	F 554	Please find attached the POC for Hillcrest Raleigh at Crabtree Valley for the survey ending 9/7/2018. Pursuant to correspondence with the State Director on September 28, 2018 at 12:52 PM, the POC has been prepared in compliance with SOM, Chapter 7, ¿ 7317. The plan of correction: - Addresses how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Addresses how the facility will identify other residents having the potential to be affected by the same deficient practice; - Addresses what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - Indicates how the facility plans to monitor its performance to make sure that solutions are sustained; and -Includes dates when corrective action will be completed. This plan of correction constitutes my	10/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/01/2018

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F 554	Continued From page 1 room on her over the bed table. The 2 medications were; Flonase 50mcg nasal spray-2 sprays each nostril daily at 9:00am, Ipratropium 42mcg nasal spray-2 sprays each nostril three times a day 9:00am, 1:00pm and 9:00pm. During an interview with Resident #250 on 9-4-18 at 2:15pm she stated the nurse left them on her table, so she could take the medication after she ate and that the nurse would come back later in the afternoon to pick them up. The resident also stated that had been the practice since she arrived at the facility. An observation was made on 9-5-18 at 9:52am of Resident #250 having her prescription nasal sprays on her over the bed table. An interview with Nurse #4 occurred on 9-7-18 at 9:45am. The nurse stated that she did watch Resident #250 take her oral medication but that she left the prescribed nasal sprays on the residents table so "she could take them when she was ready." She also stated she had watched Resident #250 use the nasal sprays in the past, so she felt comfortable that the resident could administer her own medication but denied ever seeing an assessment for the resident to ever administer her own medication. During an interview with the Director of Nursing on 9-7-18 at 9:10am she stated she expected the nurses to watch the residents take their medication and not leave the medication in the room. She also stated she expected the nurse to go back later to administer the medication if the resident requested a later time. An interview with the Administrator occurred on	F 554	written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 554] Resident Self-Admin Meds-Clinically Approp Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The stated deficiency regarding Residents #250, #251, and #409, was corrected by: (a) having Nurse #4 and Nurse #5 remove the nasal sprays from the rooms of Residents #250, #251, and #409, on the dates identified; (b) the DON interviewing Residents #250, #251, and #409 on 9/7/2018, and confirming all three residents were cognitively intact; (c) an assessments for self-administration of medications, specifically nasal sprays, being completed by the DON for Residents #250, #251, and #409 on 9/7/2018; and (d) documentation regarding Residents #250, #251, and #409 being able to self-administer nasal sprays, in accordance with their wishes and request, being added to Residents #250□s, #251□s, and #409□s medical records on 9/7/2018. Address how the facility will identify other residents having the potential to be	

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F 554	Continued From page 2 9-7-18 at 2:00pm. The Administrator stated she expected the nurses not to leave medication at the resident's bed side. 2. Resident #251 was admitted on 8-31-18 with multiple diagnoses that included after care joint replacement of the left knee, dysphagia, diabetes and muscle weakness. There was no Minimum Data Set available for Resident #251. A review of the base-line care plan for Resident #251 dated 8-31-18 revealed that there were no goals for the resident to administer her own medication. The physician orders were reviewed from 8-31-18 to the last order written on 9-3-18 and there were no orders noted for Resident #251 to administer her own medication. An observation was made on 9-6-18 at 9:45am of Resident #251's prescribed Flonase 50mcg nasal spray-2 sprays each nostril twice a day at 9:00am and 9:00pm sitting on her over the bed table. During an interview with Resident #251 on 9-6-18 at 9:45am she stated the nurse had left the medication (Flonase) on her table, so she could take it after she ate and that the nurse "usually" came back later to pick it up. The resident also stated the nurse left the Flonase every morning, so she could take it after she ate. During an interview with the Director of Nursing on 9-7-18 at 9:10am she stated she expected the nurses to watch the residents take their medication and not leave the medication in the	F 554	affected by the same deficient practice; On 9/7/2018, the DON observed all Residents on the Carolina Shores Hall, the hall where Nurse #4 and Nurse #5 were assigned, to determine if any other Residents were self-administering any medication without appropriate assessments. Nurse #5 was educated on 9/7/2018 by DON/designee on completing assessments for Self-Administration of Meds-Clinically Appropriate, and on not leaving medication in a resident□s room. On 9/10/2018, the DON audited the charts for all Residents on Carolina Shores Hall, to ensure assessments for self-administration of medications had been completed by the admitting nurse when applicable. All nurses will be re-educated by DON/designee on completing assessments for Self-Administration of Meds-Clinically Appropriate, and not leaving medication unattended if such assessment has not been done; re-education will be completed by 10/5/2018. Nurse #4 is no longer employed by Hillcrest Raleigh. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Two medication pass observations will be performed on random nurses by DON/Designee to ensure facility□s policy	

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F 554	Continued From page 3 room. She also stated she expected the nurse to go back later to administer the medication if the resident requested a later time. An interview with nurse #5 occurred on 9-7-18 at 9:20am. Nurse #5 stated she had left the Flonase in Resident #251's room on 9-6-18 "because my hands were full, and I did not remember to go back and get it." The nurse denied that she would leave any medication in a resident's room for the resident to take later. An interview with the Administrator occurred on 9-7-18 at 2:00pm. The Administrator stated she expected the nurses not to leave medication at the resident's bed side. 3. Resident #409 was admitted to the facility on 8/23/18 with diagnoses which included emphysema and respiratory failure. A review of the resident's current medication list revealed an order was written on 8/23/18 for 50 micrograms (mcg) fluticasone metered spray (a steroidal nasal spray) with instructions to use two sprays in each nostril every day. No physician orders were noted for Resident #409 to self-administer her own medication. A review of Resident #409 ' s admission Minimum Data Set (MDS) assessment dated 8/30/18 revealed the resident had intact cognitive skills for daily decision making. Section G of the MDS assessment indicated she required supervision for eating, limited assistance for walking in her room and personal hygiene, and extensive assistance from staff for bed mobility, transfers, dressing, and toileting. Resident #409 was totally dependent on staff for locomotion on and off the unit.	F 554	and procedures are followed relating to Resident Self-Admin Meds-Clinically Approp. Audits will be performed weekly for 4 weeks, the bi-weekly x2, monthly x 1, if issues are identified immediate education will be provided and documented. 100% audits of active self-administration assessments. Audits will be performed of new admissions, and upon request from existing residents to self administer medications weekly by DON/designee for 4 weeks, then bi-weekly x 2, monthly x 1, if issues are identified, an investigation will be done to determine the cause of the issue and additional education will be completed as necessary. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting, October 24, 2018, and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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F 554	Continued From page 4	F 554		

A review of the resident's care plan dated 8/31/18 was completed. The resident's care plan did not address the self-administration of medications.

During a 100 Hall Medication Cart check conducted on 9/6/18 at 8:44 AM, an empty vial labeled for Resident #409 ' s fluticasone nasal spray was observed to be stored on the med cart. Nurse #4 was assigned to the medication cart. Upon inquiry as to why fluticasone nasal spray was not stored in the container, Nurse #4 stated, "I have to get that back from her." When asked if the resident administered the nasal spray to herself, the nurse reported she did.

An observation was made on 9/6/18 at 8:50 AM as the resident was lying on the bed in her room. A bottle of fluticasone nasal spray was sitting on the resident ' s tray table next to the bed. After the observation was made, Nurse #4 entered the room, took the bottle of fluticasone off of the tray table, and asked the resident, "Are you done?" The resident stated, "Yes." The nurse took the fluticasone and exited the room.

An observation and interview was conducted on 9/7/18 at 8:10 AM with Resident #409. During the interview, the resident was asked about the medication observed sitting on her tray table the previous morning. The resident stated the nurse usually left the nasal spray in her room so she could take her time to use it.

An interview was conducted on 9/7/18 at 9:10 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she expected nurses to watch the residents take their medication and not leave the medication in the

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F 554	Continued From page 5	F 554		

room. She also stated she expected the nurse to go back later to administer the medication if the resident requested a later time.

A telephone interview was conducted on 9/7/18 at 9:45 AM with Nurse #4. During the interview, the nurse was asked how she knew whether or not it was okay for Resident #409 to self-administer the fluticasone nasal spray. Nurse #4 stated the resident was alert and oriented times three (oriented to person, place and time). The nurse also reported having watched the resident use the nasal spray correctly in the past.

An interview was conducted on 9/7/18 at 10:32 AM with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator was asked what the facility ' s process was to assess a resident ' s ability to self-administer medications. The MDS Coordinator reported the nursing staff would do an assessment in the electronic medical record, talk with the resident ' s physician, obtain an order, and care plan the resident for the self-administration of medications. Upon review of Resident #409 ' s electronic medical record, the MDS Coordinator reported there was not a Nursing Assessment for Resident #409 ' s self-administration of medication.

A follow-up interview was conducted 9/7/18 at 3:45 PM with the DON. During the interview, the DON was asked what process would be implemented if a resident wished to self-administer medications. The DON responded by stating a self-administration of medication assessment would be completed and the request would be put to the interdisciplinary team for consideration. After that, the resident ' s physician approval for the self-administration of

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F 554	Continued From page 6 medication would need to be obtained and an order received. And finally, the self-administration of medication would need to be care planned for the resident.	F 554		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		10/5/18

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F 584	Continued From page 7 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews the facility failed to (1) maintain clean resident care equipment in 1 of 7 residents rooms (219), (2) maintain a functional bed or provide a shower head in 2 of 7 resident rooms (107 and 204) and (3) maintain clean air vents and grout in resident bathrooms in 3 of 7 resident rooms (104, 115, and 204). Findings included: 1. An observation of room 219 conducted on 9/4/2018 at 11:13am revealed the tube feeding pump had a tan colored dried splatter on the tube feeding pump and an oxygen (O2) concentrator had a substance splattered on it that resembled tube feeding formula. A second observation of room 219 was conducted on 9/4/2018 at 1:00 pm. The dried splatters remained on the tube feeding pump and oxygen concentrator. A third observation of room 219 was conducted on 9/5/2018 at 11:11am. The dried splatter remained on the tube feeding pump and oxygen concentrator. A fourth observation of room 219 on 09/06/2018	F 584	Please find attached the POC for Hillcrest Raleigh at Crabtree Valley for the survey ending 9/7/2018. Pursuant to correspondence with the State Director on September 28, 2018 at 12:52 PM, the POC has been prepared in compliance with SOM, Chapter 7, ¿ 7317. The plan of correction: - Addresses how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Addresses how the facility will identify other residents having the potential to be affected by the same deficient practice; - Addresses what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - Indicates how the facility plans to monitor its performance to make sure that solutions are sustained; and -Includes dates when corrective action will be completed.	

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F 584	Continued From page 8 at 12:27 pm revealed the outside of the enteral feeding pump and the oxygen concentrator remained soiled with a dried tan colored splatter. The enteral feeding pump was opened by Nurse #7 where a dried tan and brown colored substance was noted inside of the corners of the pump. Nurse #7 completed the feeding set up and closed the pump door without removal of the dried substance. Interviews were attempted on 9/7/2018 at 1:00 pm with Nurse #7 were unsuccessful. An observation was made of room 219 with the Housekeeping Manager and the Maintenance Director on 9/7/2018 at 12:01 pm and the dried splatter remained on the feeding pump. During an interview with the Housekeeping Manager (HM) on 9/7/2018 at 12:15pm revealed housekeeping personnel were responsible for cleaning equipment from the tube feeding spillage. The HM stated his expectation was for the housekeepers to check for spills every day and that he expected his employees to be more diligent when cleaning a resident's room. During an interview with the Administrator on 9/7/2018 at 2:00 pm she stated her expectation was for the facility to continuously work on changing and upgrading things in the building. 2a. Room 107 was observed on 9/5/2018 at 8:33 am. The head of the bed was in a 45 degree angle. The resident revealed that head of the bed did not work. The bed would not raise higher or lower. A second observation of room 107 was done on	F 584	This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 584] Safe/Clean/Comfortable/Homelike Environment Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; (a) Outside of Room 219 tube feeding pump/concentrator equipment was cleaned by housekeeping manager immediately on 9/7/2018, when spatter was brought to housekeeping manager□s attention, spatter was removed from the pump and concentrator. (b) Nurse #7 was called into Room 219 on 9/7/2018 and directed to open pump and instructions were given by the housekeeping manager on cleaning the inside of pump to clear spatter in corners of pump in accordance with facility□s policies. (c) On 9/7/2018, while walking rounds with the surveyor, the maintenance director independently and without any questions from the surveyor about the bed in Room 107 observed that the bed was not level in Room 107. The Maintenance Director	

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F 584	Continued From page 9 9/7/2018 at 12:01 pm with the Housekeeping Manager and Maintenance Director and the head of the bed remained in a 45-degree angle. The bed would not raise higher or lower. The Head of the bed would not change positions. b. Room 204 was observed on 9/5/2018 at 8:00 am and the shower head was missing. A second observation was done on 9/7/2018 at 12:02 pm with the Housekeeping Manager and Maintenance Director and the shower head was still missing. During an interview with the Maintenance Director (MD) on 9/7/2018 at 12:20 pm he stated he had been trying to remodel the rooms as they need remodeling but that other things had interrupted the remodeling. He stated his expectation was that corrections would be made within 2 months. The MD indicated that room 107 would get a new shower head as soon as possible. During an interview with the Administrator on 9/7/2018 at 2:00 pm she stated her expectation was for the facility to continuously work on changing and upgrading things in the building. 3 a. Room 104 was observed on 9/5/2018 at 9:58 am, with cob webs covering the bathroom ceiling vent. There were white raised spots in the room vent. A Mold like substance was also observed in the bathroom by the sink. A second observation of room 104 was done on 9/7/2018 at 12:05 pm with the Housekeeping Manager and the Maintenance Director and the cob webs were still present on the bathroom ceiling vent.	F 584	immediately corrected the issue by lowering the bed to the floor, allowing the bed to rise and lower as designed, no mechanical issues were noted. (d) The Room 204 shower head had been removed by maintenance on 9/5/2018 as a result of a work order request. The Residents of Room 204 had not been using the Room 204 shower because of a preference for showering in the spa bathroom on that hall. The replacement showerhead was ordered on 9/5/2018 by maintenance. On 9/6/2018 the showerhead was replaced by maintenance. (e) The referenced Room 204 black colored substance on the floor grout near toilet was determined to be caulking and it was removed immediately by the maintenance director on 9/7/2018 and replaced on that same day. (f) The Room 104 cobwebs on the bathroom ceiling vent were removed on 9/7/2018 by housekeeping director. The substance by the bathroom sink was caulking that was stripped out and replaced immediately on 9/7/2018. (g) The Room 115 dust on the bathroom ceiling vent was removed on 9/7/2018 by housekeeping director. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The housekeeping/maintenance directors inspected all resident bathrooms and beds on 9/10/2018 to ensure bathrooms ceiling vents were free of dust/cobwebs,	

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F 584	Continued From page 10 b. An observation of room 115 was conducted on 9/5/2018 at 9:44 am. The bathroom vent cover was observed with an accumulation of dust. A second observation was done in room 115 with the Housekeeping Manager and the Maintenance Director on 9/7/2018 at 12:06 pm and the vent in the bathroom still had an accumulation of dust. c. Room 204 was observed on 9/5/2018 at 8:00 am revealed a black colored substance on the floor grout near toilet. A second observation was done in room 204 with the Housekeeping Manager and the Maintenance Director on 9/7/2018 at 12:07 pm and the black colored substance was still on the floor. During an interview with the Housekeeping Manager (HM) on 9/7/2018 at 12:15 pm he stated housekeeping personnel were responsible for cleaning the vents in the bathroom. He stated checking the airs vents in the bathrooms were part of the housekeeper's everyday duties as well as checking for spills. He stated he expected his employees to be more diligent when cleaning a resident's room. During an interview with the Administrator on 9/7/2018 at 2:00 pm she stated her expectation was for the facility to continuously work on changing and upgrading things in the building.	F 584	free of black substance in grout, shower heads were in all appropriate showers, beds were operating as designed, and areas around resident room sinks were free of black substances. All tube feeding pumps and oxygen concentrators were inspected by housekeeping and DON for spatter on 9/10/2018. In-services for housekeeping aides regarding being observant for cobwebs, dust, discolored grout/tube feeding spatter began on 9/10/2018. All housekeeping aides will be in-serviced by 10/5/2018. In-services were led by the housekeeping supervisor. In-service for nurses regarding checking oxygen concentrators and cleaning when necessary began on 9/10/2018. All nurses will be in-serviced by 10/5/2018. In-services were led by DON/housekeeping supervisor. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Audits of resident rooms will be performed by housekeeping and maintenance to ensure: (a) proper bed function, (b) bathrooms are free of dust/cobwebs in ceiling vents, clean grout and free of black substances in floor grout and sink areas; and (c) functioning shower heads. Audits will be made by housekeeping director/designee of all tube feeding pumps and oxygen concentrators to ensure no spatters on machines. Audits will occur weekly x 4 weeks, then	

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F 584	Continued From page 11	F 584	bi-weekly x2, monthly x 1. If issues are identified they will be corrected and additional education will be completed as necessary. Housekeeping/Maintenance Director/Designee will be responsible for implementing this plan of correction. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting, October 24, 2018 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the active diagnoses and medications received for 1 of 7 residents reviewed for unnecessary medications (Resident #18). The findings included: Resident #18 was admitted on 2/28/17 with re-entry to the facility from the hospital on	F 641	Please find attached the POC for Hillcrest Raleigh at Crabtree Valley for the survey ending 9/7/2018. Pursuant to correspondence with the State Director on September 28, 2018 at 12:52 PM, the POC has been prepared in compliance with SOM, Chapter 7, ¿ 7317. The plan of correction: - Addresses how corrective action will be accomplished for those residents found to	10/5/18

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F 641	Continued From page 12 8/21/17. The resident's cumulative diagnoses included hypothyroidism. A review of Resident #18 ' s current medications (initiated on 8/21/17) included the following: 25 micrograms (mcg) levothyroxine (a thyroid replacement hormone used to treat hypothyroidism) given as one tablet by mouth one time a day; and, 100 milligrams (mg) trimethoprim (an antibiotic) given as one tablet by mouth once daily. A review of Resident #18 ' s quarterly Minimum Data Set (MDS) assessment dated 6/15/18 was completed. Section I of the MDS assessment did not include a diagnosis of "Thyroid Disorder (hypothyroidism)." Section N of the MDS did not indicate the resident received an antibiotic during the 7-day look back period. A review of the resident ' s June 2018 Medication Administration Record (MAR) revealed the resident received both levothyroxine and trimethoprim on a daily basis during the 7-day look back period of 6/9/18-6/15/18. A review of Resident #18 ' s annual Minimum Data Set (MDS) assessment dated 8/27/18 was completed. Section I of the MDS assessment did not include a diagnosis of "Thyroid Disorder (hypothyroidism)." Section N of the MDS did not indicate the resident received an antibiotic during the 7-day look back period. A review of the resident ' s August 2018 MAR revealed the resident received both levothyroxine and trimethoprim on a daily basis during the 7-day look back period of 8/20/18-8/27/18. An interview was conducted on 9/7/18 at 10:20 AM with the facility ' s MDS Coordinator. During	F 641	have been affected by the deficient practice; - Addresses how the facility will identify other residents having the potential to be affected by the same deficient practice; - Addresses what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - Indicates how the facility plans to monitor its performance to make sure that solutions are sustained; and -Includes dates when corrective action will be completed. This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 641] Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #18□s diagnoses code and antibiotic coding was corrected immediately on 9/10/2018 by the MDS Nurse to reflect the Resident□s existing	

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F 641	Continued From page 13 the interview, the MDS Coordinator reviewed both the 6/15/18 quarterly and 8/27/18 annual MDS assessments for Resident #18. When the MDS Coordinator was asked if Section I should have been coded to reflect a diagnosis of "Thyroid Disorder," she indicated it should have been. The MDS Coordinator reported if there was an active diagnosis with an active medication order to treat it, the diagnosis should have been checked. If the resident ' s diagnosis of hypothyroidism had not been listed in the resident ' s medical record as an active diagnosis, the facility should have obtained a physician ' s order to add it because there was a medication currently prescribed to treat the condition. When the MDS Coordinator was asked if the 6/15/18 and 8/27/18 MDS assessments should have reflected the resident ' s receipt of trimethoprim as an antibiotic, she stated, "Absolutely, it's an antibiotic." An interview was conducted on 9/7/18 at 11:00 AM with the facility ' s Director of Nursing (DON). During the interview, concerns regarding the accuracy of coding Resident #18 ' s MDS assessments were discussed. The DON stated she was aware Resident #18 had hypothyroidism and was on a prophylactic (preventative) antibiotic. Upon further inquiry, the DON stated her expectation was, "For it (the MDS assessment) to be coded correctly."	F 641	Thyroid Disorder and administration of the trimethoprim. The information was then submitted by MDS Nurse. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 9/11/2018 the DON□s/designee audited 10 quarterly/annual assessments to ensure diagnoses codes and medication codes were consistent with Resident□s actual diagnoses and medications and that the documentation has been submitted as appropriate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Up to 10 assessments will be audited of MDS document by DON/designee will be performed weekly for 4 weeks, then bi-weekly x 2 months and monthly x 1 month to ensure coding is consistent with Residents□ actual condition and treatment. If issues are identified they will be corrected and additional education will be completed as necessary. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;	

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F 641	Continued From page 14	F 641	This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 24, 2018 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		10/5/18

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F 655	Continued From page 15 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan within 48 hours of admission for 2 of 5 new resident admissions. (Resident #347 and #249). Findings included: 1. Resident #249 was admitted to the facility on 8-31-18 with multiple diagnoses that included dislocation of the right hip, dementia, diabetes and an open wound to his left foot. There was no Minimum Data Set available for Resident #249 A review of the base- line care plan dated 8-31-18 for Resident #249 revealed there were no goals or interventions listed to address Resident #249's wound that was acquired prior to entering the facility. A review of the physician orders dated 8-31-18 revealed there was no diagnoses or intervention/treatment to a wound on Resident #249's upper right thigh.	F 655	Please find attached the POC for Hillcrest Raleigh at Crabtree Valley for the survey ending 9/7/2018. Pursuant to correspondence with State Director on September 28, 2018 at 12:52 PM, the POC has been prepared in compliance with SOM, Chapter 7, ¿ 7317. The plan of correction: - Addresses how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Addresses how the facility will identify other residents having the potential to be affected by the same deficient practice; - Addresses what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - Indicates how the facility plans to	

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F 655	Continued From page 16 An observation was made for Resident #249 on 9-5-18 at 9:34am. The resident was noted to be laying on his bed with no covers or pants on and was noted to have a large open area on his upper right thigh that was red and draining a yellow liquid. During an interview with Resident #249 on 9-5-18 at 9:34am he stated he did not know why the wound on his upper right thigh was not covered but stated it was hurting. Resident #249 was unable to state when he received the wound or if he had any treatment since his admission for the wound. An interview with Nurse #4 occurred on 9-5-18 at 9:37am who stated she was aware of the wound and that she would inform the wound nurse of the drainage and change in the wound condition. The nurse was noted to cover the wound to Resident #249's upper right thigh with a dry gauze bandage. Nurse #4 stated Resident #249's wound was not part of his base-line care plan but that she remembered the wound had a dry gauze dressing earlier and that the resident must have removed it. During an interview with Nurse #6 on 9-6-18 at 9:35am she stated Resident #249 came to the facility with the wound to his upper right thigh and that she was not aware of any orders, treatment/ interventions or goals for the residents wound on the base-line care plan. An interview with the Director of Nursing (DON) occurred on 9-7-18 at 1:20pm. The DON stated the process for the base line care plan was the nurse admitting would write down the discharge orders from the hospital on the "Admission orders	F 655	monitor its performance to make sure that solutions are sustained; and -Includes dates when corrective action will be completed. This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 655] Baseline Care Plans Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 9/10/2018 Resident #249□s care plan was updated by the DON to include goals and interventions related to Resident #249□s wounds, which information had already been included in Resident #249□s medical record. The care plan was then reviewed with Resident #249 by the DON on 9/10/2018. Resident #347□s was discharged on 8/15/2018 prior to completion of care plan. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 9/11/2018, the DON□s designee	

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F 655	Continued From page 17	F 655		

and Plan of Care" form and the physician would sign the form. She also stated she was unaware the care plan needed to have goals and interventions to care for the resident's immediate healthcare concerns but then stated the facility's process on base-line care plans used to include the goals and interventions but felt the one-page order sheet "was sufficient." The DON stated her expectation was that base-line care plans were correct and complete.

During an interview with the Administrator on 9-7-18 at 2:00pm she stated she expected base-line care plans would include goals and interventions for the resident's immediate health care needs.

2. Resident #347 was admitted to the facility on 8/11/2018 with diagnoses that included cellulitis of the left upper limb, atrial fibrillation, osteoarthritis, osteoporosis, and muscle weakness.

Review of the admission physician orders dated 8/11/18 included:

" Fluid restriction of 1.5 liters a day (qd).
" Eliquis 2.5 milligrams (mg) by mouth (po) twice a day. Eliquis is a blood thinner.
" Aldactone 25 mg po qd used to treat hypertension.
" Norvasc 10 mg po qd. Norvasc is long-acting calcium channel blocker to treat chest pain or hypertension.
" Lisinopril 40 mg po qd. Lisinopril is an angiotensin converting enzyme (ACE) inhibitor used for treating high blood pressure and heart failure.
" Tramadol 50 mg po every 8 hours when necessary for severe pain.

Record review of the electronic and paper

audited all active resident charts to ensure baseline care plans that addressed goals and intervention had been completed within 48 hours of admission. Any charts found to not have a baseline care plan in place or which had baseline care plans that did not include goals and intervention were corrected and resident/family notified by DON/designee. All Nurses will be educated by DON/designee as to proper procedure and implementation of baseline care plan reviews, and to ensure that goals and interventions for treatment of Residents are included in baseline care plan. The in-service will be completed by 10/5/2018.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

50% of audits of baseline care plans of new admissions will be performed by DON/designee weekly x 4 weeks, then 25% bi-weekly x 2, and monthly x 1 to ensure policy and procedures are followed relating to the implementation of baseline care plans, including the inclusion of goals and interventions within 48 hours of admission, reviewing a copy of the plan with resident/family, and documenting information appropriately. If issues are identified they will be corrected and additional education will be completed as necessary. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction

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F 655	Continued From page 18 medical record revealed no baseline care nor a comprehensive care plan. An interview with the Director of Nursing (DON) occurred on 9-7-18 at 1:20pm. The DON stated the process for the base line care plan was the nurse admitting would write down the discharge orders from the hospital on the "Admission orders and Plan of Care" form and the physician would sign the form. She also stated she was unaware the care plan needed to have goals and interventions to care for the resident's immediate healthcare concerns but then stated the facility's process on base-line care plans used to include the goals and interventions but felt the one-page order sheet "was sufficient." The DON stated her expectation was that base-line care plans were correct and complete. During an interview with the Administrator on 9-7-18 at 2:00pm she stated she expected base-line care plans would include goals and interventions for the resident's immediate health care needs	F 655	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 24, 2018 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		10/5/18

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F 684	Continued From page 19 Based on observations, record review, staff interview and resident interviews the facility failed to provide treatment to a leg wound, which showed signs of infection, for 1 of 1 residents reviewed for wound treatment and care (Resident #249). Findings included: Resident #249 was admitted to the facility on 8-31-18 with multiple diagnoses that included dislocation of the right hip, dementia, diabetes and an open wound to his left foot. There was no Minimum Data Set available for Resident #249 A review of the base- line care plan dated 8-31-18 for Resident #249 revealed there were no orders, goals or interventions listed for Resident #249's wound to his upper right thigh that was acquired prior to entering the facility. A review of the physician orders dated 8-31-18 revealed there was no intervention/treatment for a wound on Resident #249's upper right thigh. The skin condition report completed by the wound care nurse (#6) dated 9-1-18 was reviewed and revealed an order for skin prep daily for 7 days to Resident #249's upper thigh wound. The wound measured 6.2x6.0 centimeters with no drainage or discoloration. The report also revealed the wound was a boil. There was no further documentation noted for treatment till 9-5-18. An observation was made for Resident #249 on 9-5-18 at 9:34am. The resident was noted to be	F 684	Please find attached the POC for Hillcrest Raleigh at Crabtree Valley for the survey ending 9/7/2018. Pursuant to correspondence with the State Director on September 28, 2018 at 12:52 PM, the POC has been prepared in compliance with SOM, Chapter 7, ¿ 7317. The plan of correction: - Addresses how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Addresses how the facility will identify other residents having the potential to be affected by the same deficient practice; - Addresses what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - Indicates how the facility plans to monitor its performance to make sure that solutions are sustained; and -Includes dates when corrective action will be completed. This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 684	Continued From page 20 laying on his bed and was observed to have a large open area on his upper right thigh that was red and draining a yellow liquid. During an interview with Resident #249 on 9-5-18 at 9:34am he was unable to state how he received the wound to his upper right thigh or state whether he had received treatment for the wound. The resident did state the area was hurting and wanted "someone" to help him. An interview with Nurse #4 occurred on 9-5-18 at 9:37am who stated she was aware of the wound and that she would inform the wound nurse of the drainage and change in the wound condition. The nurse was noted to cover the wound to Resident #249's upper right thigh with a dry gauze bandage. The skin condition report completed by the wound care nurse (#6) dated 9-5-18 revealed there was no wound care completed to Resident #249's upper thigh because the resident refused and was "agitated." The documentation also revealed there were no further attempts made. During an interview with Nurse #6 (wound care nurse) on 9-6-18 at 9:35am she stated Resident #249 came to the facility with the wound to his upper right thigh and that she was to provide treatment consisting of skin prep to the wound daily but that she had not been able to provide the care since 9-1-18 due to the resident refusing care. Nurse #6 stated the last time she saw the wound on 9-1-18 the wound was intact with no redness or drainage. She also stated she made one attempt to see the wound yesterday (9-5-18) but the resident refused even after she explained the importance of caring for the wound, and she	F 684	[F 684] Quality of Care This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Address how corrective action will be accomplished for the residents found to have been affected by the deficient practice. On 9/5/2018, Resident #249 received additional care and appropriate interventions relating to care of the wound which was a boil. Resident #249□s treatment records and wound care protocol were updated to indicate the progression of the boil. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice On 9/11-12/2018, skin assessments were performed and treatment records were reviewed for all Residents by the nurse supervisor to ensure all Residents were receiving appropriate wound treatment, any Resident found to have a wound that was not documented had wound documented and treatment initiated	

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F 684	Continued From page 21 was going to try today (9-6-18). Nurse #6 had not informed the resident's physician of the resident's refusals of the daily treatment to his leg wound. An interview with Nurse #6 occurred on 9-6-18 at 1:20pm who stated the wound to Resident #249's upper thigh had deteriorated, and she had contacted the physician and received orders for an antibiotic and Santyl ointment to be applied to the wound daily. During an interview with the Director of Nursing (DON) on 9-7-18 at 1:20pm she stated when a resident was admitted to the facility, the facility uses the hospital discharge orders to render care to the resident till the resident would be seen by the physician and acknowledged Resident #249 did not have orders to care for his wound to his upper thigh for 24 hours when he was assessed by the wound care nurse. The DON stated she expected residents to have complete orders and care rendered as needed when they are admitted to the facility.	F 684	immediately. Nurses will be educated by DON/designee by 10/5/2018 on the use of standing orders as they relate to wound care and procedures to implement regarding wound care and documentation of those interventions. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. On 9/11/2018, the DON/treatment nurse audited treatment orders for any resident found to have wounds to ensure orders were in place and were being followed, any resident found to need interventions were addressed immediately. Audits of treatment sheets and skin care checks will be conducted by DON/designee to ensure wounds are being cared for, described appropriately, documentation regarding treatment is accurate, and residents are receiving appropriate interventions for wound care. Audits of 50% of residents with wounds will be done weekly x 4 weeks, bi-weekly x 2 and monthly x 1. If issues are identified they will be corrected and additional education will be completed as necessary. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in	

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F 684	Continued From page 22	F 684	the next regularly scheduled Quality Assurance meeting October 24, 2018 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		10/5/18

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F 690	Continued From page 23 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews, staff interviews, resident interviews and Physician's Assistant (PA) interview the facility failed to properly insert an indwelling urinary catheter for Resident #408 which resulted in excruciating pain, bleeding and trauma to the urethra and failed to keep the urinary drainage bag tubing from touching and dragging on the floor. This was evident in 2 of 3 residents reviewed for urinary catheters (Residents #408 and, Resident #4). Findings included: 1. Resident #408 was admitted to the facility on 8/23/18 with cumulative diagnoses which included diabetes, post-operation urinary retention, benign prostatic hyperplasia (BPH) and a past pulmonary embolism. Review of the admission Minimum Data Set assessment dated 8/30/18 revealed Resident #408 was alert, oriented and cognitively intact with no behaviors present. The resident was noted to have an indwelling urinary catheter and required extensive assistance from staff for bed mobility and toileting. Review of the care area assessment (CAA) dated 8/30/18 for urinary incontinence/indwelling urinary catheter revealed the resident had bladder cancer, and benign prostatic hypertrophy. The CAA stated the resident was admitted to the	F 690	Please find attached the POC for Hillcrest Raleigh at Crabtree Valley for the survey ending 9/7/2018. Pursuant to correspondence with State Director on September 28, 2018 at 12:52 PM, the POC has been prepared in compliance with SOM, Chapter 7, ¿ 7317. The plan of correction: - Addresses how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Addresses how the facility will identify other residents having the potential to be affected by the same deficient practice; - Addresses what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - Indicates how the facility plans to monitor its performance to make sure that solutions are sustained; and -Includes dates when corrective action will be completed. [F 690] Bowel/Bladder Incontinence, Cather, UTI	

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F 690	Continued From page 24 facility with a urinary catheter and had urinary retention, which would be care planned. Review of the written care plan dated 8/29/18 included in part the use of a urinary catheter. The interventions included to change the urinary catheter and bag per the policy. Physician's orders dated 8/23/28 revealed initially the resident had a 16 French/10 milliliter urinary catheter ordered, which was to be changed monthly and as needed. Laboratory work dated 8/28/18 revealed the resident INR was 2.7 and PT was 32.0 (The INR and PT values show how long it takes for blood to clot while taking coumadin (an anticoagulant medication. Recommended therapeutic range for the INR after a pulmonary embolus is 2 to 3. A usual PT level is 12 to 13 seconds)). A urology note dated 9/4/18 revealed Resident #408 was seen for urinary catheter removal and a voiding trial. Instructions were provided to have Resident #408 drink plenty of fluids and try to void. If Resident #408 was unable to void, the facility could insert another urinary catheter or have the resident return to the urologist office for a urinary catheter placement. As a follow up to urology's recommendation, a physician's order dated 9/4/18 revealed the resident's urinary catheter was removed at the urology appointment and if the resident is unable to void after 8 hours to place a 16 French urinary catheter. Review of the laboratory results dated 9/4/18 revealed an elevated INR over 8.0 and PT value	F 690	Address how corrective action will be accomplished for the residents found to have been affected by the deficient practice; Immediately upon observing blood and urine in Resident #408□s foley tubing and bag on the morning of 9/5/2018, Nurse #1 called the urologist for an appointment for Resident #408. The situation was explained to the urologist and a 1:00 PM appointment was made with the urologist. There was a follow-up call to the urologist at 10:50 am to ensure that urologist was aware of the situation, and the 1:00 PM appointment was confirmed. Resident #408 was monitored and observed ambulating in the hall by Nurse Supervisor on day shift while awaiting his 9/5/2018 appointment, Resident #408 was not expressing any complaints of pain, or acting as if he was in pain at this time. Resident #408 was taken to the urologist on 9/5/2018 who replaced the catheter and sent Resident #408 back to Hillcrest Raleigh on that same day. Resident #4□s tubing was immediately adjusted on 9/6/2018, by nurse supervisor, so it was not on the floor. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice; On 9/10/2018, the DON audited orders for any resident found to have a foley	

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F 690	Continued From page 25 of 96 seconds. The physician was contacted on 9/4/18 and ordered the (3mg) Coumadin medication to be held, 5 mg of Vitamin K to be given (to help the blood to clot and prevent excessive bleeding), and to recheck INR and PT on 9/5/18. The INR and PT were completed on 9/5/18 and the results indicated a high INR 4.1 and PT 48. The physician was notified on 9/5/18 of the results and ordered to continue to hold Coumadin (3mg) medication. Per the Medication Administration Record for 9/5/2018 (no time), a 16 French urinary catheter was inserted by Nurse #2. On review of the resident's chart, there was no nursing notes regarding the insertion of the urinary catheter dated 9/5/18. Observation and interview with Resident # 408 was conducted on 9/05/18 at 9:40 AM. Resident #408 had bright red colored liquid that resembled blood in the urinary catheter's tubing. The urinary drainage bag was empty. Resident #408 stated they (referring to the nurse) put his urinary catheter back in this morning (referring to 9/5/18) and they didn't know how to do it properly. He stated it was painful and had never had blood in his urinary catheter tube before the nurse reinserted today (referring 9/5/18). Continued interview with Resident #408 who stated he was going to see the urologist today about it and was worried about the catheter. Nurse #1 was interviewed on 9/5/18 at 10:15 AM. She stated the resident went to the urologist on 9/4/18 and removed the urinary catheter. Nurse	F 690	catheter in place to ensure proper insertion had occurred, and confirm there was no blood in any tubing. No other situations of improper insertion were found. Nurse #2 was re-educated on 9/10/2018 by DON to ensure knowledge of proper techniques on insertion of foley catheters. All Nurses will be re-educated by DON/designee on the proper insertion of foley catheters and to ensure tubing is not on the floor by October 5, 2018. Nurses will be re-educated by DON/designee on placement of foley catheters by October 5, 2018. Residents with order for voiding trial will have bladder scan completed prior to catheter placement per standing order to determine urine retention amount and need for catheter. While a foley insertion is taking place it will be witnessed by another nurse prior to balloon inflation and documentation will reflect procedure being witnessed. In-service of CNA□s to re-educate on securing tubing so that it does not touch the floor will be conducted by nurse supervisors no later than October 5, 2018. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur; 100% Audits of active foley catheter orders and usage will be conducted by DON/designee to ensure nurses are following proper procedures for both evaluation for the need of insertion of catheters, monitoring of placement, and	

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F 690	Continued From page 26 #1 stated the urologist recommended if the resident did not void the urinary catheter could be reinserted. Continued interview with Nurse #1 who indicated Resident #408 requested the catheter be reinserted. Nurse #1 stated Nurse #2 reinserted the urinary catheter around 7:00 AM on 9/5/18. Nurse #1 stated she thought the urinary catheter was bleeding from trauma. She added that the resident had been up and down a lot today to the bathroom. She stated she called urology around 9:00 AM about the status of the catheter after she noticed blood in the tube of the urinary catheter drainage bag. She stated now the resident wanted his catheter to be taken out. Nurse #1 stated Nurse #2 only told her that Resident #408 had not voided, which was why the catheter had to be replaced. Nurse #2 (who inserted the urinary catheter) was interviewed via phone on 9/5/18 at 11:47 AM. She stated the urologist stated (per note) to put the urinary catheter back in. She stated Resident #408 reported to her that he voided around 1:00 AM on 9/5/18. Continued interview with Nurse #2 revealed around 3:00 AM, the resident stated he had the urge to void but could not void. She stated between 7:00 AM and 7:30 AM on 9/5/18, she inserted the urinary catheter (during shift change) with no concerns noted. She stated the urine she got back after inserting the urinary catheter was dark yellow in color. She stated there was no resistance noted on insertion of the catheter. She also stated that she didn't see any blood or anything like that after insertion. She stated she lubricated the urinary catheter, inserted the catheter and inflated the balloon. She stated she also secured the catheter to the resident's leg.	F 690	proper placement of tubing to prevent it from being on the floor. 100% Audits of active foley catheter orders will be done weekly x 4 weeks, bi-weekly x 2 and monthly x 1. If issues are identified they will be corrected and additional education will be completed as necessary. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 24, 2018 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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Another interview with Nurse #1 stated on 9/5/18 at 10:50 AM, the urologist was called again and was aware of the bleeding. Nurse #1 indicated the urology physician stated to her the bleeding was from trauma and not to remove the catheter as the urologist would look at it during the appointment today.

Record review of the consultation note dated 9/5/18 from the PA at the urology office revealed the resident's "catheter was incorrectly placed, balloon was inflated inside the urethra causing bleeding and urinary retention." The urinary "catheter was removed and replaced correctly." "Traumatic Foley will cause bleeding from the penis, this is expected." The note continued to say that the resident did not require a visit to the Emergency Room and to leave the urinary catheter in place and return to the clinic in 1 month.

The Director of Nursing (DON) was interviewed on 9/5/18 at 3:17 PM. She stated the resident went to a urology today and the Physician's Assistant (PA) had written a note. She stated she called the PA and asked if the resident could have pulled the catheter out. She stated the PA stated it was a possibility but that she would not change her note to reflect that. She also added that nurse #2 knew how to insert in urinary catheter.

Further interview with Nurse #1 on 9/5/18 at 3:52 PM stated that resident had a new urinary catheter inserted during the urology visit but the facility was not to remove it. She stated she did not go into Resident #408's room when the urinary catheter was reinserted by Nurse #2.

The DON stated on 9/5/18 at 4:34 PM that

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urology took out the urinary catheter out yesterday and the resident was not able to void so they replaced the urinary catheter at the facility. She stated that was all she knew.

The resident was interviewed again on 9/5/18 at 4:47 PM stated this morning he wanted the urinary catheter in. He stated Nurse #2 and himself were the only 2 people in the room when the catheter was inserted. Resident #408 stated he kept telling the nurse that it hurt too much and that it was being done incorrectly, bleeding started right away. Resident #408 stated the nurse saw it and told him that it was just from the trauma but didn't know if any urine came out after the urinary catheter was inserted.

On 9/7/18 at 1:43 PM a telephone interview with the PA at the urology office stated the resident had urinary retention and the resident was unable to void after removal of the catheter so the catheter was replaced at the facility. Continued interview with the PA indicated Resident #408 was in excruciating pain and bleeding when he arrived for his appointment. The PA stated there was about 1 inch to 1.5 inches of catheter in the urethra and there was no way the catheter had been in the bladder. During this continued interview the PA stated facility called her about the note she had written, and the facility suggested that maybe the resident had pulled on the urinary catheter causing it to come out of the bladder. The PA stated Resident #408 was alert, and oriented and able to recall previous lab values. She stated it was very unlikely that the resident pulled the catheter out of the bladder as he would have had to pull very hard to get the catheter down that far into the urethra. She added that when the facility inserted urinary catheter

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was removed, a 10 milliliter (ml) catheter balloon was deflated, and 450 ml of urine was drained from the bladder. She stated the resident bled about 10 ml of blood and bright red urine was noted after a new catheter was inserted. This PA stated the resident could expect bleeding for 7 to 10 days, and would require the urinary catheter for a month to let the urethra heal from the trauma and was concerned because Resident #408 was on a blood thinner.

The Administrator was interviewed on 9/5/18 at 4:49 PM. She stated she would expect for the nurses to stay current on their practices regarding urinary catheter care (The administrator did not clarify what she meant regarding practices.)
2. Resident #4 was readmitted to the facility on 2/28/18 with cumulative diagnoses which included multiple sclerosis and a supra pubic catheter (a surgically created connection directly into the urinary bladder to drain urine) due to a neurogenic bladder. A neurogenic bladder is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve conditions.

Review of the Annual Minimum Data Set (MDS) assessment dated 8/27/18 indicated a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. The MDS coded Resident #4 as requiring extensive assistance from staff for toilet use and had a urinary appliance. There were with no behavioral issues coded.

The Care Area Assessment (CAA) associated with the 8/27/18 MDS triggered a problem area of urinary incontinence and indwelling catheter. The notes stated resident had urinary retention due to a neurogenic bladder with issues in the past of

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urinary tract infections. A decision was made to develop a care plan to address the above issues.

Review of the written care plan dated 8/21/18 with a target date of 11/21/18 (unclear if 11/27/18) indicated in part an approach to keep drainage bag below the bladder level and off the floor.

Observation on 09/05/18 at 10:05 AM revealed the urinary catheter drainage tube was positioned directly on the floor while Resident #4 was sitting in a wheelchair at nurses' station. When the resident moved to his room the urinary tubing dragged on the floor.

Observation on 09/05/18 at 10:44 AM revealed the urinary catheter drainage tube was positioned directly on the floor while sitting in a wheelchair.

An attempt to interview Resident #4 was unsuccessful regarding the catheter.

Observation on 09/06/18 at 12:40 PM revealed Resident #4 was sitting in a wheelchair by the nurses' desk with his urinary catheter drainage tube positioned directly on the floor.

Observation on 09/06/18 at 4:00 PM revealed the urinary catheter drainage tube continued to be positioned on the floor and looped in the manner to cause the dark colored urine with a red clot to stagnate in the middle of the loop. At this time Nursing Shift Supervisor (SS) #1 observed the positioning of the tubing.

Interview on 09/06/18 at 4:20 PM with Nursing Assistant (NA) #2 stated the tubing should be off the floor and the facility used a band to stabilize the catheter.

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F 690	Continued From page 31 Interview on 09/07/18 at 9:29 AM with the Director of Nurses stated her expectations were the urinary catheter tubing not drag or touch the floor and position the tubing, so urine would be free flowing.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		10/5/18

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	345555	A. BUILDING _____ B. WING _____	C 09/07/2018

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F 758	Continued From page 32 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, pharmacist, Nurse Practitioner (NP), and physician interviews, the facility failed to obtain documentation of the rationale and duration to extend as needed (PRN) orders for a psychotropic medication beyond 14 days for 1 of 7 residents reviewed for unnecessary medications (Resident #41). The findings included: Resident #41 was admitted to the facility on 4/14/18 with a cumulative diagnoses which included depression, dysthymic disorder (a chronic type of depression), and anxiety/agitation. A review of Resident #41 ' s medical record revealed the resident was seen on 5/10/18 by a psychiatry service for initiation of a treatment plan and ongoing management at the facility. The resident was seen by psychiatry for multiple	F 758	Please find attached the POC for Hillcrest Raleigh at Crabtree Valley for the survey ending 9/7/2018. Pursuant to correspondence with the State Director on September 28, 2018 at 12:52 PM, the POC has been prepared in compliance with SOM, Chapter 7, ¿ 7317. The plan of correction: - Addresses how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Addresses how the facility will identify other residents having the potential to be affected by the same deficient practice; - Addresses what measures will be put into place or systemic changes made to	

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F 758	Continued From page 33 follow-up visits, including those made on 5/17/18, 5/24/18, 6/7/18, 6/21/18, 6/28/18, 7/19/18, 8/9/18, and 8/23/18. A review of the resident ' s medications included the following orders written by the psychiatry Nurse Practitioner (NP) and dated 7/5/18: 1) 0.25 milligrams (mg) lorazepam (an antianxiety medication) to be given as one tablet by mouth three times daily for anxiety. 2) 0.5 mg lorazepam to be given as one tablet by mouth every 6 hours as needed (PRN). A quantity of 15 tablets was authorized to be dispensed with no refills allowed. A further review of Resident #41 ' s medications included an order written on 7/10/18 by his physician at the facility. This order changed the resident ' s lorazepam to 0.25 mg given as one tablet by mouth every 8 hours as needed. The order did not include a stop date for this medication or a rationale for extending the duration of the PRN medication past 14 days. On 7/14/18, another order was written by the resident ' s physician for 0.25 mg lorazepam to be given 3 times daily due to a diagnosis of anxiety; and, an order was also written for 0.5 mg lorazepam to be given as one tablet by mouth every 6 hours as needed for agitation. The order did not include a stop date for this medication or a rationale for extending the duration of the PRN medication past 14 days. A significant change Minimum Data Set (MDS) assessment dated 7/16/18 was completed for Resident #41. The assessment indicated he had moderately impaired cognitive skills for daily decision making. Section N of the MDS indicated	F 758	ensure that the deficient practice will not recur; - Indicates how the facility plans to monitor its performance to make sure that solutions are sustained; and -Includes dates when corrective action will be completed. This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 758] Free from Unnec Psychotropic Meds/PRN Use Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 9/7/2018 Resident #41□s medications were reviewed and evaluated by physician to ensure Resident #41 was receiving appropriate medication and necessary documentation was included. An order was entered by physician that specified the rationale for extending the previously prescribed psychotropic drug prn administration past 14 days. Resident #41, with a diagnosis of depression, dysthymic disorder and anxiety/agitation,	

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F 758	Continued From page 34 the resident received an antianxiety medication on 3 of 7 days during the look back period. Further review of Resident #41 ' s medication orders revealed an order was written by the resident ' s physician on 7/17/18 to discontinue his scheduled lorazepam. An order was also received on 7/17/18 to continue 0.5 mg lorazepam to be given as one tablet every 6 hours as needed. The order did not include a stop date for this medication or a rationale for extending the duration of the PRN medication past 14 days. On 7/31/18, an order was written by the resident ' s physician to give 0.5 mg lorazepam by mouth one time now; and, to give 0.5 mg lorazepam as one tablet by mouth if Resident #41 did not sleep between the hours of 10:00 PM and 2:00 AM. Additionally, an order was written on 7/31/18 to continue 0.5 mg lorazepam to be given as one tablet by mouth every 6 hours as needed. The order did not include a stop date for this medication or a rationale for extending the duration of the PRN medication past 14 days. A review of Resident #41 ' s medical record included a pharmacist ' s Consultation Report dated 8/16/18 which read, in part: "Comment: [Name of resident] has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam 0.5 mg every 6 hours PRN. Recommendation: Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time	F 758	had been seen repeatedly in the past by physicians and psychiatry services for evaluation of behaviors relating to diagnosis. Medication adjustments were made per family request while physician continued to monitor by frequent visits on 5/17/2018, 5/24/2018, 6/7/2018, 6/21/2018, 6/28/2018, 7/19/2018, and 8/9/2018. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The pharmacist audited 100% of orders on 9/13 -18/2018 for any resident found to be on PRN psychotropic medications to ensure documentation of rationale and duration to extend as needed orders for a psychotropic medication beyond 14 days were in place when appropriate. Residents with order for psychotropic meds will have orders evaluated by physician/NP to ensure a stop date or rationale for extending the duration of the PRN medication past 14 days is documented in the record, by the nurse/physician. The DON/designee will communicate and document her communication with physician(s) to ensure compliance. The DON/designee will round with physician weekly to ensure physician reviews of communication and that psychotropic PRN medications have a stop date or rationale for extending the duration of the PRN medication past 14 days. Address what measures will be put into	

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F 758	Continued From page 35 period." The resident ' s physician signed at the bottom of the report with a hand-written response, "Psych" (dated 8/29/18). On 8/27/18, an order was written by Resident #41 ' s physician to give 0.5 mg lorazepam as one tablet by mouth every 6 hours as needed. The order did not include a stop date for this medication or a rationale for extending the duration of the PRN medication past 14 days. An interview was conducted on 9/7/18 at 2:00 PM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked about the pharmacist ' s recommendation regarding Resident #41 ' s PRN lorazepam. Upon further inquiry, the DON stated the pharmacist emailed her recommendations to her after each visit and she would then pass these on to the physician for review. After the physician signed the consultation report, a Nurse Supervisor or nurse would typically review the consultation report and note any new orders. The DON reported that apparently the pharmacist's consultation report was signed by the physician and placed in the medical record prior to being passed on to the psych service for further review. A telephone interview was conducted on 9/7/18 at 2:10 PM with the facility ' s consultant pharmacist. Upon inquiry, the pharmacist reported her understanding was that after the physician wrote "psych" on her consultation report, the report should have been forwarded onto the appropriate person (which would have been the Nurse Practitioner working with the psychiatry service). A telephone interview was conducted on 9/7/18 at	F 758	place or systemic changes made to ensure that the deficient practice will not recur; Audits of 50% of orders for PRN psychotropic med use will be conducted weekly x 4 weeks, then biweekly x 2 and monthly x 1 by DON/designee to ensure compliance with regulation. Facility DON /designee will monitor 50% physician communication weekly x four weeks, bi-weekly x 2, and monthly x 1 to ensure pharmacists and physician communication are being delivered and responded to as appropriate. If issues are identified they will be corrected and additional education will be completed as necessary. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 24, 2018 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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F 758	Continued From page 36 2:30 PM with the Nurse Practitioner (NP) who worked with the psychiatry service caring for Resident #41. The NP stated she had seen this resident frequently. When asked about the pharmacist ' s consultation report dated 8/16/18, the NP stated, "I did not see it." The NP reported she signed every pharmacist recommendation that she saw. Upon further inquiry, the NP stated she routinely wrote an end date for all psychotropic PRN medications. When the notation ("psych") written by the physician on the consultation report was described to the NP, she stated that if he wrote psych on there, she would assume he was handing it over to her to handle. When asked how often she came to the facility, the NP reported she came once a week. A telephone interview was conducted on 9/7/18 at 3:00 PM with the resident's physician. Upon inquiry, the physician reported by writing "psych" on the pharmacist's consultation report for Resident #41, he was referring the consult report to the resident ' s psych providers for consideration. A follow-up interview was conducted on 9/7/18 at 3:15 PM with the DON. Upon inquiry, the DON reported her expectation for PRN psychotropic medications was for these medications to be appropriately managed by the facility ' s pharmacist, physicians, and the facility itself.	F 758		
F 761 SS=E	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	F 761		10/5/18

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F 761	Continued From page 37 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: Based on observations and staff interviews, the facility failed to store medications at the refrigeration temperature specified by the manufacturer in 1 of 2 Medication Storage Rooms observed (Triangle Medication Room). The findings included: Accompanied by Nurse #3, an observation was made of the Triangle Medication Room (Med Room) on 9/6/18 at 4:50 PM. A digital thermometer placed in the Med Room refrigerator indicated the temperature was 6.3 degrees Fahrenheit (o F). The temperature of the refrigerator was confirmed by Nurse #3. At the time of the observation, multiple droplets of ice	F 761	Please find attached the POC for Hillcrest Raleigh at Crabtree Valley for the survey ending 9/7/2018. Pursuant to correspondence with the State Director on September 28, 2018 at 12:52 PM, the POC has been prepared in compliance with SOM, Chapter 7, ¿ 7317. The plan of correction: - Addresses how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Addresses how the facility will identify other residents having the potential to be	

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F 761	Continued From page 38 were observed on the back wall inside the refrigerator. The medication contents of the refrigerator at the time of the observation included the following: --1 unopened vial of Humulin R insulin; --5 unopened Novolog Flexpen insulin pens; --1 unopened vial of Novolog insulin; --1 unopened vial of Lantus insulin; --1 unopened syringe of 40 micrograms per milliliter (mcg/ml) Aranesp (an injectable medication that stimulates the production of blood cell components in the treatment of the anemia due to chronic kidney disease or chemotherapy in cancer patients); --8 unopened 40 milligrams per milliliter (mg/ml) syringes of Copaxone (an injectable medication used for the treatment of multiple sclerosis). A pharmacy auxiliary sticker was placed on the manufacturer ' s box which read, "Do not freeze". --17 vials of 20 mcg/2 ml Perforomist nebulization solution (an inhalation medication used in the treatment of asthma or chronic obstructive pulmonary disease). A pharmacy auxiliary sticker was placed on the manufacturer ' s box which read, "Keep in refrigerator; Do not freeze." --Approximately 20 vials of 15 mcg/2 ml Brovana nebulization solution (an inhalation medication used in the treatment chronic obstructive pulmonary disease) labeled and dispensed in a brown plastic bag by the pharmacy. --Approximately 30 vials of 15 mcg/2 ml Brovana nebulization solution (an inhalation medication used in the treatment chronic obstructive pulmonary disease) labeled and dispensed in a brown plastic bag by the pharmacy. --1 unopened vial of 10,000 units/ml Procrit (an injectable medication used to stimulate red blood cell production).	F 761	affected by the same deficient practice; - Addresses what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - Indicates how the facility plans to monitor its performance to make sure that solutions are sustained; and -Includes dates when corrective action will be completed. This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 761] Label/Store Drugs and Biologicals Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 9/6/2018 the Triangle med room refrigerator identified was immediately replaced by maintenance with a new refrigerator and the medications in the refrigerator were discarded and replaced with new medications by nurse supervisor. It was also confirmed that no Resident had received medication from the Triangle med room refrigerator between the time	

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F 761	Continued From page 39 A refrigerator temperature log was posted on the front of the refrigerator for September 2018. Temperatures were recorded once daily from 9/1/18 to 9/6/18 and ranged between 38.1o F to 40.1o F. A note at the bottom of the temperature log read, "Temperature should be below 41 degrees." On 9/6/18 at 5:00 PM, Shift Supervisor #1 accompanied Nurse #3 back into the Triangle Med Room as the inventory of the medications stored in the refrigerator was being conducted. After the inventory was completed, the Shift Supervisor placed the medications back into the same Med Room refrigerator. Upon inquiry, the Shift Supervisor reported the pharmacy would be contacted for advice on what should be done with the refrigerated medications. A review of the manufacturers' product information for the individual medications stored in the Triangle Medication Room refrigerator included the following storage requirements: -- Unopened vials of Humulin R insulin should be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened Novolog Flexpen insulin pens may be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Novolog insulin may be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Lantus insulin should be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Aranesp should be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Copaxone should be stored in a refrigerator (36o - 46o F); Do not freeze.	F 761	when a temperature in acceptable range was logged by third shift on 9/5/2018 and the refrigerator was inspected by the surveyor on 9/6/2018. This corrective action was taken without verifying whether the temperature in the refrigerator was in fact 6.3 degrees Fahrenheit. The refrigerator had been checked during the third shift on 9/5/2018 and a temperature of 40.1 degrees Fahrenheit recorded. If there was an issue with the temperature, utilizing the facility□s processes it would have been identified when the refrigerator was opened to remove drugs or when the temperature was checked by third shift on 9/6/2018. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 9/7/2018, the temperature in the other medication refrigerators was also checked by the nurse supervisor on third shift. Temperatures for the Triangle Gardens med room refrigerator is checked by nursing staff on third shift (11 p.m. □ 7 a.m.) daily. Temperatures are documented on a log sheet, if temperatures are found to be out of acceptable ranges medications are removed and maintenance is notified to verify thermometer operation and refrigerator operation is correct. Temperatures are also checked by visually viewing the thermometer when medication is removed from the refrigerator to be administered to ensure temperature is in appropriate range.	

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F 761	Continued From page 40 -- Perforomist vials may be stored in a refrigerator (36o - 46o F); -- Brovana solution for nebulization may be stored in a refrigerator (36o - 46o F); -- Unopened vials of Procrit should be stored in a refrigerator (36o - 46o F); Do not freeze. An interview was conducted on 9/7/18 at 7:10 AM with the facility's Director of Nursing (DON). During the interview, the temperature of the Triangle Medication Room refrigerator was discussed. The DON reported she had been informed of the refrigerator temperature on 9/6/18 and all medications stored in that refrigerator were re-ordered and replaced the evening of 9/6/18. The DON also stated the Triangle Medication Room refrigerator was replaced. Upon inquiry, the DON reported the recommended temperature range for the medication room refrigerator was 36o - 46o F. A follow-up interview was conducted 9/7/18 at 3:45 PM with the DON. During the interview, the DON stated she would expect, "All medications to be stored appropriately within the guidelines."	F 761	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Audits of all med room refrigerators temperatures are checked nightly. In addition to routine checks of the nightly monitoring and logging of the med room refrigerators; a second check will be conducted for a period of weekly x 4 weeks, bi-weekly x 2 months, monthly x 1, to ensure proper temperatures are accurate. The DON/designee will be responsible for implementing the acceptable plan of correction. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 24, 2018 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	