STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT LEXINGTON	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

(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 584 SS=E	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; §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	F 584		10/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the removable air filters in Packaged Terminal Air Conditioning (PTAC) units free of visible dust and debris in 10 of 10 rooms (rooms 103, 209, 305, 401, 403, 506, 602, 603, 604, and 609). The findings included: An observation on 9/10/18 at 5:36 PM revealed visible dust on the removable air filter for the PTAC unit in room 602. An observation on 9/10/18 at 5:45 PM revealed visible dust on the removable air filter for the PTAC unit in room 604. An observation on 9/11/18 at 8:57 AM revealed visible dust on the removable air filter for the PTAC unit in room 609. An observation on 9/11/18 at 9:31 AM revealed visible dust on the removable air filter for the PTAC unit in room 603. An observation on 9/11/18 at 10:23 AM revealed visible dust on the removable air filter for the PTAC unit in room 506. An observation on 9/11/18 at 2:07 PM revealed visible dust on the removable air filter for the PTAC unit in room 209. An observation on 9/12/18 at 2:46 PM revealed visible dust on the removable air filter for the	F 584	The plan for correcting the specific deficiency: The facility was found to have visible dust in the packaged terminal air units in the following rooms: 103,209,305,401,403,506,602,603,604,609. The facility failed to remove the dust from the packaged terminal air units. All resident's room packaged terminal air units will be free from visible dust. The packaged terminal air units cited in the deficiency were cleaned immediately by the Maintenance Director. Procedure for implementing the plan: 1.The Administrator will provide education to the maintenance director on keeping the packaged terminal air units free of visible dust on 9-17-18. 2.The packaged terminal air units in the following rooms 103,209,305,401,403,506,602,603,604,609 were cleaned of visible dust on 9-13-18 by the maintenance director. 3.All other rooms that contain packaged terminal air units were cleaned on 9-13-18 by the maintenance director. 4.Packaged terminal air conditioning units are placed on a monthly cleaning schedule whereby the units will be free of dust. Monitoring process:	

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F 584	Continued From page 2 PTAC unit in room 103. An observation on 9/12/18 at 2:50 PM revealed visible dust on the air removable filter for the PTAC unit in room 305. When the filter was removed, dust and lint dropped off of the filter some dust and debris floated up into the air from the removable air filter. An observation on 9/12/18 at 2:56 PM revealed visible dust on the removable air filter for the PTAC unit in room 401. An observation on 9/12/18 at 2:57 PM revealed visible dust on the removable air filter for the PTAC unit in room 403. An observation on 9/12/18 at 3:02 PM revealed visible dust on the removable air filter for the PTAC unit in room 506. An observation on 9/12/18 at 3:10 PM revealed visible dust on the removable air filter for the PTAC unit in room 604. An observation on 9/12/18 at 3:11 PM revealed visible dust on the removable air filter for the PTAC unit in room 603. An observation on 9/12/18 at 3:12 PM revealed visible dust on the removable air filter for the PTAC unit in room 602. An observation on 9/12/18 at 3:04 PM revealed visible dust on the removable air filter for the PTAC unit in room 305. An interview with the Maintenance Director (MD) on 9/13/18 at 10:14 AM revealed that the routine	F 584	A facility audit will be completed weekly for 4 weeks by the Administrator of 4 resident rooms to ensure resident room packaged terminal air units are free of visible dust, then bi-monthly for 2 months. The Administrator will present the results of the audits to the Quality assurance performance committee on a monthly basis for 3 months. Title of the person responsible for implementing the plan: The Administrator.	

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F 584	Continued From page 3 cleaning of the air filters on the PTAC units was his responsibility. A round of the facility in conjunction of an interview was conducted with the MD on 9/13/18 at 10:15 AM. The round revealed observations of visible dust on the removable air filter of the PTAC units in rooms: 103, 209, 305, 506, and 604. An observation of the removable air filter of the PTAC unit in room 401 revealed no buildup of visible dust. The MD stated he had started cleaning the removable air filters from the PTAC units that morning and had started on the 400 Hall. The MD stated he cleaned the removable air filters from the PTAC units monthly and he had last cleaned the removable air filters from the PTAC units on 8/1/18. The MD explained he cleaned the removable air filters for the PTAC units by vacuuming the dust off with a portable vacuum cleaner. The MD stated to avoid such a buildup of dust on the removable air filters from the PTAC units he was going to have to have to clean them more often. An interview conducted with the Administrator on 9/13/18 at 4:53 PM revealed that it was the Administrator's expectation that the removable air filters on the PTAC units should not have a buildup of dust. The Administrator further stated it was his expectation for the filters to be cleaned frequently enough to remain clean.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,	F 607		10/10/18

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F 607	Continued From page 4 neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, observations, family and staff interviews, the facility failed to report an allegation of staff to resident abuse to the administrator and the state agency within two hours of the allegation being made and conduct a thorough investigation of the abuse allegation for 1 of 1 residents reviewed for abuse (Resident #92). Findings included: The facility policy "Abuse Prevention Program" with a revision date of December 2016 was reviewed and it stated, in part, "Investigate and report any allegations of abuse within timeframes as required by federal requirements." The facility policy "Abuse and Neglect Prohibition" with a revision date of August 2017 was reviewed and it read, in part, "Investigation: the facility will timely conduct an investigation of any alleged abuse/neglect ... in accordance with state law; any employee alleged to be involved in an instance of abuse and/or neglect will be interviewed and suspended immediately and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated." And, "Reporting and Response: the facility will report all allegations	F 607	The Plan for correcting the specific deficiency: The alleged deficiency occurred when the facility failed to follow the abuse policy with the requirement to report an allegation of abuse within 2 hours. The Director of Nursing was notified of the allegation and immediately investigated the allegation and found it to be a misunderstanding and therefore did not report. The 24 hour and 5 day report were completed and submitted on 10-5-18 by the Director of Nursing to the required state agency. Procedure for implementing the plan: 1. There have been no other allegations of abuse reported during the review period. 2. Education was provided to the leadership team (Administrator, Director of nursing, dietary manager, rehabilitation manager, activities manager, housekeeping supervisor and the maintenance director) on 9-21-18 by the Regional Clinical Consultant regarding the importance of immediate notification to	

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F 607	Continued From page 5 and substantiated occurrences of abuse ... to the administrator, State Survey Agency and law enforcement officials ... in accordance with Federal and State law through established procedures ... a report is made not later than 2 hours after the management staff becomes aware of the allegation ..." Resident #92 was admitted to the facility on 11/3/2017 and readmitted on 8/3/20018 with diagnoses to include fractured right femur, diabetes and communication deficit. The most recent significant change Minimum Data Set (MDS) assessment dated 8/23/2018 assessed Resident #92 to be severely cognitively impaired without behaviors or rejection of care and she required extensive one-person assistance with bed mobility, transfers, locomotion, dressing, eating, toileting, hygiene and bathing. Resident #92 was unstable and non-ambulatory and had an indwelling urinary catheter and frequent bowel incontinence. There were no 24 hours/5-day Health Care Personnel Registry (HCPR) reports from the facility reporting allegations of abuse in 2018. Resident #92 was observed on 9/10/2018 at 4:41 PM and she was not interviewable. An interview was conducted with Resident #92 ' s family member (FM) #1 on 9/10/2018 at 4:41 PM. The family member reported an allegation of abuse when Resident #92 told FM #2 she was slapped by a staff member. FM #1went on to explain that FM #2 was told by the facility that the facility had investigated the incident and the incident had not happened. FM #1 was not certain of the date of the allegation, but she thought it occurred in late June 2018 or early July	F 607	the administrator or the director of nursing of any alleged abuse, neglect, exploitation or mistreatment, injury of unknown source or misappropriation of property. Education included the requirement to complete notification via initial allegation report to the state survey agency immediately but not later than 2 hours after the allegation is made. 3. On 10/3/18, the Director of nursing trained current licensed and non-licensed staff on the facility's abuse and neglect policy. 4.A log will be maintained by the Administrator that documents all notifications of alleged abuse/neglect to the State Survey Agency, including Resident name, fax cover sheet, confirmation page, allegation, date, time of discovery and time of notification. The log will be placed in a binder maintained by Administrator. Monitoring Process. The Administrator will review the log daily (Monday through Friday) for four weeks then weekly for 4 weeks and monthly for 1 month to validate that all notifications to the State Survey Agency are timely. Findings will be reported by the Administrator to the Quality Assurance Performance Improvement Committee monthly for three months. Any recommendations or modifications will be made by the committee until compliance is maintained.	

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F 607	Continued From page 6	F 607		

2018.

Resident #92 ' s FM #2 was interviewed on 9/12/2018 at 5:45 PM. FM #2 reported that Resident #92 was confused. FM #2 reported Resident #53 was the roommate of Resident #92 and she had told him that a nursing assistant (NA) had slapped Resident #92. FM#2 went on to explain he had reported the allegation to the Unit Manager (UM). FM #2 was not certain of the date, but felt it was happened in early July.

The facility Administrator was interviewed on 9/12/2018 at 6:05 PM. The Administrator shared no allegations of abuse had been reported to him by facility staff or management and no 24 hours/5-day HCPR reports had been submitted by the facility in 2018.
The UM was interviewed on 9/12/2018 at 6:21 PM. The UM reported Resident #53 alleged NA #1 had slapped Resident #92 and she reported the incident to the Director of Nursing (DON). The UM was not certain of the date of the allegation.

The DON was interviewed on 9/12/2018 at 6:27 PM. The DON explained the allegation of abuse was reported to her by the UM and FM #2. The DON went on to explain she had investigated the allegation by interviewing NA #1, Resident #92, #53 and FM #2.

The DON was interviewed again on 9/13/2018 at 8:56 AM. The DON reported she had not completed or submitted a 24 hour or 5-day investigation HCPR report of the abuse allegation because both she and FM #2 were convinced the allegation had not happened. The DON reported she had interviewed NA #1 and had suspended her during the investigation. The DON concluded

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F 607	Continued From page 7	F 607		

she had not reported the allegation to the Administrator or had called law enforcement because she had decided the incident had not happened and was a fabricated story of Resident #53. The DON stated she did not have any written documentation or statements from the abuse investigation to show how extensive the facility ' s investigation was and the information obtained to make the decision to not substantiate the allegation of staff to resident abuse.

NA #1 was interviewed on 9/13/2018 at 10:56 AM via a phone call. NA #1 reported she had been assigned to Resident #92 and had provided care for Resident #92 multiple times during the day of the allegation, but NA #1 did not remember the exact date of the incident, but believes it was a Thursday. NA #1 went on to explain she had been asked to leave the facility before lunch on the day of the allegation and she interviewed with the DON prior to leaving the facility. NA #1 concluded by reporting when she returned to work on the following Monday she was told the allegation of abuse was not substantiated and she could return to work.

The Administrator was interviewed on 9/13/2018 at 2:05 PM. He reported it was his expectation that allegations of abuse were reported immediately and the guidelines for reporting and investigating abuse allegations were followed according to the regulations. In relation to the allegation of staff slapping Resident #92 he would have expected to of been notified immediately of this allegation. The administrator further stated he would have expected the DON to have written documentation of the facility ' s investigation to show how extensive the investigation was and how it was determined the allegation was

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F 607	Continued From page 8 unsubstantiated by the facility.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, observations, family and staff interviews, the facility failed to report to the administrator and the state agency within two hours of an allegation of abuse for 1 of 1	F 609	The Plan for correcting the specific deficiency: The alleged deficiency occurred when the	10/10/18

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F 609	Continued From page 9 residents reviewed for abuse (Resident #92). Findings included: Resident #92 was admitted to the facility on 11/3/2017 and readmitted on 8/3/20018 with diagnoses to include fractured right femur, diabetes and communication deficit. The most recent significant change Minimum Data Set (MDS) assessment dated 8/23/2018 assessed Resident #92 to be severely cognitively impaired without behaviors or rejection of care and she required extensive one-person assistance with bed mobility, transfers, locomotion, dressing, eating, toileting, hygiene and bathing. Resident #92 was unstable and non-ambulatory and had an indwelling urinary catheter and frequent bowel incontinence. There were no 24 hours/5-day Health Care Personnel Registry (HCPR) reports from the facility reporting allegations of abuse in 2018. Resident #92 was observed on 9/10/2018 at 4:41 PM and she was not interviewable. An interview was conducted with Resident #92 ' s family member (FM) #1 on 9/10/2018 at 4:41 PM. The family member reported an allegation of abuse when Resident #92 told FM #2 she was slapped by a staff member. FM #1went on to explain that FM #2 was told by the facility that the facility had investigated the incident and the incident had not happened. FM #1 was not certain of the date of the allegation, but she thought it occurred in late June 2018 or early July 2018. Resident #92 ' s FM #2 was interviewed on	F 609	facility failed to follow the abuse policy with the requirement to report an allegation of abuse within 2 hours. The Director of Nursing was notified of the allegation and immediately investigated the allegation and found it to be a misunderstanding and therefore did not report. The 24 hour and 5 day report were completed and submitted on 10-5-18 by the Director of Nursing to the required state agency. Procedure for implementing the plan: 1. There have been no other allegations of abuse reported during the review period. 2. Education was provided to the leadership team (Administrator, Director of nursing, dietary manager, rehabilitation manager, activities manager, housekeeping supervisor and the maintenance director) on 9-21-18 by the Regional Clinical Consultant regarding the importance of immediate notification to the administrator or the director of nursing of any alleged abuse, neglect, exploitation or mistreatment, injury of unknown source or misappropriation of property. Education included the requirement to complete notification via initial allegation report to the state survey agency immediately but not later than 2 hours after the allegation is made. 3. On 10/3/18, the Director of nursing trained current licensed and non-licensed staff on the facility's abuse and neglect policy. 4.A log will be maintained by the	

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F 609	Continued From page 10 9/12/2018 at 5:45 PM. FM #2 reported that Resident #92 was confused. FM #2 reported Resident #53 was the roommate of Resident #92 and she had told him that a nursing assistant (NA) had slapped Resident #92. FM#2 went on to explain he had reported the allegation to the Unit Manager (UM). FM #2 concluded by reporting that the allegation had not happened, and that Resident #92 was confused when FM #2 had asked about the incident. FM #2 was not certain of the date, but felt it was happened in early July. The facility Administrator was interviewed on 9/12/2018 at 6:05 PM. The Administrator shared no allegations of abuse had been reported to him by facility staff or management and no 24 hours/5-day HCPR reports had been submitted by the facility in 2018. The UM was interviewed on 9/12/2018 at 6:21 PM. The UM reported Resident #53 alleged NA #1 had slapped Resident #92 and she reported the incident to the Director of Nursing (DON). The UM was not certain of the date of the allegation. The DON was interviewed on 9/12/2018 at 6:27 PM. The DON explained the allegation of abuse was reported to her by the UM and FM #2. The DON went on to explain she had investigated the allegation by interviewing NA #1, Resident #92, #53 and FM #2. The DON was interviewed again on 9/13/2018 at 8:56 AM. The DON reported she had not completed or submitted a 24 hour or 5-day investigation HCPR report of the abuse allegation because both she and FM #2 were convinced the allegation had not happened. The DON reported she had interviewed NA #1 and had suspended	F 609	Administrator that documents all notifications of alleged abuse/neglect to the State Survey Agency, including Resident name, fax cover sheet, confirmation page, allegation, date, time of discovery and time of notification. The log will be placed in a binder maintained by Administrator. Monitoring Process. The Administrator will review the log daily (Monday through Friday) for four weeks then weekly for 4 weeks and monthly for 1 month to validate that all notifications to the State Survey Agency are timely. Findings will be reported by the Administrator to the Quality Assurance Performance Improvement Committee monthly for three months. Any recommendations or modifications will be made by the committee until compliance is maintained.	

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F 609	Continued From page 11 her during the investigation. The DON concluded she had not reported the allegation to the Administrator or had called law enforcement because she had decided the incident had not happened and was a fabricated story of Resident #53. NA #1 was interviewed on 9/13/2018 at 10:56 AM via a phone call. NA #1 reported she had been assigned to Resident #92 and had provided care for Resident #92 multiple times during the day of the allegation, but NA #1 did not remember the exact date of the incident, but believes it was a Thursday. NA #1 went on to explain she had been asked to leave the facility before lunch on the day of the allegation and she interviewed with the DON prior to leaving the facility. NA #1 concluded by reporting when she returned to work on the following Monday she was told the allegation of abuse was not substantiated and she could return to work. The Administrator was interviewed on 9/13/2018 at 2:05 PM. He reported it was his expectation that allegations of abuse were reported immediately and the guidelines for reporting and investigating abuse allegations were followed according to the regulations. In relation to the allegation of staff slapping Resident #92 he would have expected to of been notified immediately of this allegation. The administrator further stated he would have expected the DON to have written documentation of the facility ' s investigation to show how extensive the investigation was and how it was determined the allegation was unsubstantiated by the facility.	F 609		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F 640		10/10/18

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F 640	Continued From page 12	F 640		

§483.20(f) Automated data processing requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer,

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F 640	Continued From page 13 reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transmit a discharge assessment for 1 of 1 residents reviewed for discharge (Resident # 1). The findings included: Resident # 1 was admitted to the facility on 07/10/2018 and discharged on 07/13/2018. The facility records were reviewed for the assessments transmitted to the national database regarding Resident #1. The national database revealed an Entry Tracking dated 07/10/2018 had been transmitted and accepted within 14 days of completion. A Discharge Return Not Anticipated MDS (Minimum Data Set) was completed on 07/13/2018 and there was no transmittal validation of the discharge MDS for Resident # 1. On 09/12/2018 at 6: 35 PM an interview with the Regional MDS Nurse revealed that the MDS had been completed but had not been transmitted within the required 14 days. On 09/13/ 2018 at 6:15 PM an interview with the facility administrator revealed the expectation was	F 640	The plan for correcting the specific deficiency: The alleged deficient practice occurred when the Minimum Data Set MDS) nurse did not follow the Resident Assessment Instrument (RAI) guidelines on transmitting the Minimum Data set to the CMS data base for a discharge assessment for resident #1. The assessment for resident #1 was transmitted on 9-12-18. Procedure for implementing the plan: An audit of transmissions for 90 days by the Regional MDS consultant nurse was completed on 10-2-18. All other assessments were found to be transmitted per RAI guidelines. Education was provided to the MDS nurse on 10-2-18, by the Regional MDS nurse with emphasis on timely transmitting of the MDS assessments to the CMS data base. Monitoring process:	

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F 640	Continued From page 14 that all MDSs be completed and transmitted as required by the Resident Assessment Manual (RAI).	F 640	The regional MDS nurse will audit all completed MDS assessments weekly for four weeks for transmission, then a sample of five completed assessments monthly for two months to ensure timely transmission to the CMS data base. Findings of the audits will be reported by the Director of Nursing in the monthly Quality Assurance performance improvement committee for recommendations and modifications as needed. Title of person responsible for implementing the plan: Director of Nursing	
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 medical record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for 2 of 5 residents reviewed for unnecessary medications (Resident #47 and Resident #60). Findings included: 1. Resident #47 was admitted to the facility 6/15/18. The resident's admission diagnoses included: Pneumonia, sepsis, respiratory failure, Congestive Heart Failure (CHF), heart disease, Chronic Obstructive Pulmonary Disease (COPD), diabetes, and depression.	F 641	The plan for correcting the specific deficiency: The deficiency occurred because the facility failed to accurately code the Minimum Data Set (MDS) for resident #47 and #60. The MDS coordinator modified the assessment for resident #47 and #60 to reflect the correct coding on 9-12-18. Procedure for implementing the plan: Section N of the Minimum Data Set (MDS), for all current residents, for	10/10/18

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F 641	Continued From page 15 A review of Resident #47's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 6/22/18. The MDS assessment indicated Resident #47 was coded as having received the following medications during the assessment period: Insulin, antidepressant, hypnotic (sleeping medication), anticoagulant (blood thinner), diuretic (fluid pill), and opioid (pain medication). The resident was coded as having had received 0 antipsychotic medications during the assessment period. Further review of the MDS assessment revealed the resident was coded as having had received antipsychotic medications on a routine basis since admission. A review was completed of Resident #47's care plan which had been most recently updated on 9/11/18. The care plan was discovered to include focus areas for the following: Diuretic use (fluid pill), diabetes, Gastro Esophageal Reflux Disorder (GERD) medication, pain medication, anticoagulant (blood thinner) medication, antidepressant medication, and sedative/hypnotic (sleeping) medication. A review was completed of Resident #47's June Medication Administration Record (MAR). The review revealed the resident's MAR had no recorded administration of an antipsychotic medication during the assessment period, or the rest of the month of June. An interview was conducted on 9/13/18 at 2:59 PM with the MDS Coordinator. The MDS Coordinator stated the antipsychotic medication should not have been coded on Resident #47's	F 641	census date September 10 2018 will be audited for accuracy by the regional nurse consultant. Opportunities will be corrected by the MDS Coordinator and submitted. MDS staff will be re-educated by 10/10/18 on the regional MDS consultant on the importance of accurately coding the MDS, specifically, medications. The Regional MDS consultant will audit section N by comparing the medication administration record during the Assessment Reference Date with the coding information under section N of 5 Minimum data sets per week times 12 weeks to ensure accuracy. Monitor process: Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and performance improvement committee by the Director of nursing monthly X 3 months. At that time, the Quality assurance and performance improvement committee will evaluate the effectiveness of the interventions to determine if the continued auditing is necessary to maintain compliance. Title of the person responsible for implementing the plan: Director of Nursing	

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6/22/18 admission MDS assessment because the resident was not on an antipsychotic medication.

An interview was conducted with the Administrator on 9/13/18 at 4:53 PM. The Administrator stated it was his expectation for the MDS assessments to be coded accurately.

2. Resident #60 was admitted to the facility on 7/4/18 with diagnoses that included: Epilepsy, generalized weakness, encephalopathy (brain dysfunction), communication deficit, glaucoma, and conjunctivitis.

A review of Resident #60's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 7/11/18. The MDS assessment indicated Resident #60 was coded as having received the following medications during the assessment period: Antipsychotic, antidepressant, and an opioid (pain medication). The resident was coded as having had received 0 antibiotic medications during the assessment period.

A review was completed of Resident #60's hospital History and Physical (H & P) dated 6/24/18. The review revealed the resident had a diagnosis of conjunctivitis. Further review of the H & P revealed the resident had seen neurology and the neurology notes indicated the resident was undergoing workup for ophthalmoplegia (paralysis of the muscles surrounding the eyes) with suspicion for a mitochondrial myopathy.

Review of Resident #60's discharge summary from the hospital dated 7/4/18 revealed the

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F 641	Continued From page 17	F 641		

resident was to follow up with ophthalmology.

Review of Resident #60's admission orders dated 7/4/18 revealed the resident had a physician order for Moxifloxacin Hydro Chloride (HCl) Solution 0.5%, instill one drop in the left eye four times a day for Glaucoma. There was no stop date for this order.

Review of the description of Moxifloxacin eye drops on WWW.rxlist.com revealed it is a sterile solution for topical application to the eye which is used to treat bacterial infections of the eyes. Moxifloxacin is a fluoroquinolone (flor-o-KWIN-o-lone) antibiotic that fights bacteria. Dosage and administration was listed as one drop in the affected eye three times a day for seven days.

Review of Resident #60's Medication Administration Record for July 2018 revealed the resident received Moxifloxacin HCl Solution 0.5%, one drop in the left eye for Glaucoma at least one time each day from 7/5/18 through 7/31/18.

An interview was conducted on 9/12/18 at 7:20 PM with the MDS Consultant. The MDS Consultant stated Resident #60 was receiving an antibiotic medication during the assessment period. The MDS Consultant stated the admission assessment with an ARD of 7/11/18 should have been coded that the resident received an antibiotic each day during the assessment period. The MDS Consultant stated the MDS assessment had been coded inaccurately. The MDS Consultant further stated it was her expectation for the MDS assessments to be coded accurately.

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F 641	Continued From page 18 An interview was conducted with the Administrator on 9/13/18 at 4:53 PM. The Administrator stated it was his expectation for the MDS assessments to be coded accurately.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to follow physician orders as evidenced by a nurse who did not check a resident ' s apical pulse prior to administering medications with pulse parameters for 1 of 4 residents observed for medication administration (Resident #69). Findings included: Resident #69 was admitted to the facility on 3/16/2017 with diagnoses to include hypertension, atrial fibrillation and peripheral vascular disease. Physician orders were reviewed for Resident #69 and an order for Lisinopril 5 milligrams (mg) by mouth daily for hypertension; hold medication if heart rate is less than 50 (beats per minute). The start date for this order was 12/19/2017 and there was no stop date. Additionally, Resident #69 had an order for Metoprolol Tartrate 25 mg by mouth twice per day for atrial fibrillation; Nurse to check apical pulse, hold medication if heart rate less	F 658	Plan for correcting the specific deficiency: The alleged deficient practice occurred when the nurse failed to follow a physician order which required an apical pulse prior to administration of medications. A radial pulse was obtained after the medication was delivered to the resident. The physician was notified immediately of the failure to obtain an apical pulse. The nurse that failed to obtain the apical pulse was reeducated by the Director of Nursing on 9-14-18 on following physician orders. Procedure for implementing the plan: An audit of current residents was conducted on 9/15/18 to determine that medication parameters are in place and to determine if those parameters are being followed. The physician reviewed current orders with medication parameters on 10-1-18. The Director of Nursing and unit	10/10/18

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F 658	Continued From page 19 than 60 (beats per minute). The start date was 1/16/2018 and there was no stop date. A medication administration was observed on 9/12/2018 at 9:38 AM for Resident #69. Nurse #2 prepared medications for Resident #69, including Lisinopril and Metoprolol Tartrate. Nurse #2 checked Resident #69 ' s blood pressure (BP) before administering his medications. Nurse #2 did not check Resident #69 ' s pulse. An interview was conducted with Nurse #2 on 9/12/2018 at 9:55 AM. She read the order for the medications Lisinopril and Metoprolol Tartrate and returned to Resident #69 ' s room and placed a pulse oximeter on his finger. She reported she should have checked his pulse before she administered the Lisinopril and the Metoprolol. The nurse was unable to obtain a pulse rate from the oximeter and she took his pulse rate radially (wrist). The nurse reported she was not aware she should have checked Resident #69 ' s pulse apically (chest). The nurse reported Resident #69 had a pulse rate of 64. Nurse #2 was interviewed again on 9/12/2018 at 11:29 AM. She reported she was nervous and forgot to check the pulse of Resident #69. The Director of Nursing (DON) was interviewed on 9/13/2018 at 1:11 PM. She reported it was her expectation that nurses followed physician orders for administering medication with vital sign parameters.	F 658	coordinators will complete 100% re-education of current facility licensed nursing staff. This education will include following physician orders with emphasis on obtaining apical pulse prior to administrating medications. This education will be completed 9-28-18. Monitoring Process: A monitoring tool was developed to monitor and audit all new physician orders for vital sign parameters and observation of mediation med pass to ensure vital signs are obtained per physician orders and medication is delivered per parameters three times a week for 4 weeks and weekly for 2 months. This audit and observation will be conducted by unit manager, admission nurse and Director of nursing. The results of the audit will be reviewed and recommendations made as necessary monthly by the Quality Assurance Performance Improvement committee for 3 months. Title of person responsible for implementing the plan: Director of Nursing Services.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		10/10/18

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F 732	Continued From page 20 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to keep daily nursing	F 732	The plan for correcting the specific deficiency:	

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F 732	Continued From page 21 staffing records for at least eighteen months and failed to post daily nurse staffing. Findings included: An observation on 9/11/18 at 8:43 AM revealed no posted nurse staffing on either A or B Units. An observation on 9/13/2018 at 8:34 AM revealed no posted nurse staffing on either A or B Units. An interview on 9/11/18 at 8:50 AM with the Administrator revealed that the nurse staffing was posted on both A and B Unites. An interview and tour on 9/11/18 at 8:52 AM with the Staff Development Nurse/Former Director of Nursing revealed A and B Units did not have nurse staffing posted. The Staff Development Nurse/Former Director of Nursing revealed that the nurse staffing should be posted. An interview on 9/12/18 at 3:17 PM with the Staff Coordinator revealed she was tracking staffing but not keeping the comprehensive nurse shift staffing and census. The Staff Coordinator further revealed she discarded the daily nurse staffing forms, was unable to produce eighteen months of documentation and was the only staff member updating the daily nurse staffing. A follow up interview on 9/13/18 at 5:41 PM with the Administrator revealed that a nurse would now update the nurse staffing. The Administrator revealed he expected that the nursing staff will update and post the daily staffing and the postings will be kept per the regulations of eighteen months.	F 732	The alleged deficient practice occurred when the facility failed to post staffing daily and failed to maintain nursing staffing posting for at least 18 months. The staffing coordinator was re-educated by the Administrator on 9-11-18 regarding the daily posting of nursing hours, census and maintaining 18 months of posting. Procedure for implementing the plan: License staff will be re-educated 10/3/18 by the Director of Nursing on checking the daily posting of nurse staffing form, each shift to ensure proper census and staff hours at correct. The Daily staffing form from the prior day will be reviewed daily by the unit manager or nursing supervisor to ensure accurate care hours were posted for nursing staff. Daily staffing forms will be maintained in the staffing coordinators office for 18 months. Monitoring procedure: Copies of the daily nurse staffing will be submitted to the Quality Assurance Performance Improvement committee by the staffing coordinator monthly for 3 months for recommendations or modifications as necessary. Title of person responsible for implementing the plan: Administrator and Director of Nursing.	

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F 759	Continued From page 22	F 759		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer medications with a 5% or less medication error rate as evidenced by 2 medication administration errors out of 25 opportunities for a medication error rate of 8% when 2 out of 4 nurses crushed medications for residents without a physician order to crush medications (Resident #56 and #31). Findings included: 1. According to mayoclinic.org, omeprazole delayed-release (a drug used for gastroesophageal reflux and other conditions) should not be crushed. Resident #56 was admitted to the facility on 6/21/2018 with diagnoses to include pneumonia, abnormality of gait and hypertension. A review of the physician medication orders revealed an order for omeprazole delayed release 20 milligrams (mg) 1 tablet once per day by mouth for gastroesophageal reflux disease. A review of the physician orders for Resident #56 did not show an order to crush medications. A medication administration was observed on 9/12/2018 at 9:38 AM with Nurse #1. Nurse #1	F 759	The plan for correcting the specific deficiency: The alleged deficiency occurred when the licensed nurse crushed medications for two residents #56 and #31 without a physician's order. There was no negative outcome to resident #56 and #31. The Physician was notified immediately and an order was received to be able to crush meds for resident #56 and #31. The licensed nurse that gave the crushed medications prior to receiving the order was re-educated on medication administration and that an order must be obtained prior to crushing medications. The Director of Nursing performed this education on 9-14-18. Procedure for implementing the plan: On 9-21-18 licensed nurses will be re-educated by the Director of Nursing on administering medications as ordered with emphasis on requiring a physician order prior to crushing medications. Beginning on 10-3-18 Medication pass competencies will be validated for each licensed nurse by the Director of nursing	10/10/18

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ACCORDIUS HEALTH AT LEXINGTON	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

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F 759	Continued From page 23 prepared medications for Resident #56 and crushed the medications together, including the omeprazole, then placed the medications in medicine cup with yogurt and administered the medications to the resident. Nurse #1 was interviewed on 9/12/2018 at 11:20 AM. She reported that Resident #56 expressed a preference to have her medications crushed and she thought there was a standing order in place to crush the medications. Nurse #1 was unable to find a physician order to crush medications for Resident #56. An interview was conducted with the Nurse Practitioner (NP) on 9/12/2018 at 4:29 PM. The NP reported orders for crushing medications should be resident specific and medications that should not be crushed should be noted. She went on to explain that generic standing orders for residents should be personalized based on their medication orders and needs. An interview via phone call was conducted with the facility physician (MD) on 9/13/2018 at 12:20 PM. He reported he could remember reviewing the medications for Resident #56 and he felt he had given an order to crush medications, however he was unable to recall the date of the review and it was his expectation that each resident ' s medications were evaluated to determine appropriateness of crushing the medications. The Director of Nursing (DON) was interviewed on 9/13/2018 at 1:11 PM. She provided a copy of the standing orders for review and reported that each standing order was reviewed by the physician and each order was checked if	F 759	or Unit managers/supervisors. Monitoring process: Medication administration observation audits will be performed by the Director of nursing and/or Unit managers/supervisors on six licensed nursess weekly for 12 weeks to include all shifts and weekends. The Director of nursing will report the findings of the audits to the Quality Assurance Performance Improvement Committee monthly for 3 months for recommendations or modifications as needed. Title of person responsible for implementing the plan: Director of nursing.	

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appropriate for the resident. "May crush medications unless contraindicated" was part of the standing orders. The DON reported it was her expectation that nursing staff administered medications according to physician orders and requested a physician order to crush medications if the resident wanted crushed medications. The DON did not know why the standing orders for Resident #56 were not completed.

The Administrator was interviewed on 9/13/2018 at 4:25 PM. He reported it was his expectation that medications were administered per physician orders.

2. According to drugs.com, Ferrous sulfate (a type of iron) is administered for people with anemia and the instructions included to not crush, chew, break or open a tablet.

Resident # 31 was admitted to the facility on 4/5/2018 with diagnoses to include cerebral infarction, hypertension and high cholesterol. A review of the physician orders for Resident #31 did not show an order to crush medications. Medications for Resident #31 included ferrous sulfate 325 milligrams by mouth twice per day.

A medication administration was observed on 9/13/2018 at 9:32 AM with Nurse #3. Nurse #3 prepared medication for Resident #31 and crushed them together, placed them in a medicine cup with apple sauce and administered the medication to the resident. Included in the medication administration was 1 enteric-coated ferrous sulfate tablet that was crushed with the other medications.

Nurse #3 was interviewed on 9/13/2018 at 9:35

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AM. She reported Resident #31 had difficulty swallowing her medications and had requested her medications to be crushed. Nurse #3 went on to explain that she felt it was safe to crush all the medications because there was not a warning on the packaging to tell her not to crush.

An interview was conducted with the Nurse Practitioner (NP) on 9/12/2018 at 4:29 PM. The NP reported orders for crushing medications should be resident specific and medications that should not be crushed should be noted. She went on to explain that generic standing orders for residents should be personalized based on their medication orders and needs.

An interview via phone call was conducted with the facility physician (MD) on 9/13/2018 at 12:20 PM. He reported he could remember reviewing the medications for Resident #31 and he felt he had given an order to crush medications, however he was unable to recall the date of the review. The MD went on to explain that he would need to review the precautions for ferrous sulfate for available forms to administer, but he was certain that the tablet form of ferrous sulfate with an enteric coating should not be crushed. The MD concluded that it was his expectation that each resident ' s medications were evaluated to determine appropriateness of crushing the medications.

The Director of Nursing (DON) was interviewed on 9/13/2018 at 1:11 PM. She reported it was her expectation that nursing staff administered medications according to physician orders and request a physician order to crush medications if the resident requested crushed medications. She provided a copy of the standing orders for review

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F 759	Continued From page 26 and reported that each standing order was reviewed by the physician and each order was checked if appropriate for the resident. "May crush medications unless contraindicated" was part of the standing orders. The DON reported it was her expectation that nursing staff administered medications according to physician orders and requested a physician order to crush medications if the resident wanted crushed medications. The DON did not know why the standing orders were not completed for Resident #31. The Administrator was interviewed on 9/13/2018 at 4:25 PM. He reported it was his expectation that medications were administered per physician orders.	F 759		
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 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	F 761		10/10/18

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F 761	Continued From page 27 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 date an opened multi dose vial of Tuberculin purified protein derivative (used to test for Tuberculosis) in 1 of 1 medication storage rooms (100, 200 and 300 Hall) and nine bottles of Artificial Tears eye drops (used for eye lubrication), two inhalers (used for respiratory care) and one bottle of Nitrostat (used as an emergency drug for chest pain) on 2 of 2 medication carts (400, 500 and 600 Hall). Findings: 1. On 9/13/2018 at 12:42 PM an observation of the refrigerator on Unit A (100, 200 and 300 Hall) revealed an opened multi dose vial of Tuberculin purified protein derivative (PPD). An interview on 9/13/18 at 12:44 PM with Nurse #1, who worked on 100 and 300 Hall revealed the PPD vial should have been dated when opened. Nurse # 1 further revealed that the manufacturers insert was missing and the vial should be discarded. Additionally, Nurse # 1 was unable to determine when PPD should be discarded after opening. 2. On 9/13/2018 at 1:03 PM an observation of the 400 Hall medication cart revealed eight opened bottles of artificial tear drops and one and	F 761	The plan for correcting the specific deficiency: The alleged deficiency occurred when the facilities licensed nursing staff failed to date 1bottle of TB solution, nine bottles of artificial tears, two inhalers and two bottles of nitro stat when they were opened. As of 9-19-18, the Director of nursing removed all medications from both the medication rooms and medication carts that were not dated and opened. These medications were discarded and re-ordered by the director of nursing. Procedure for implementing the plan: An initial audit will be completed by the unit coordinators and/or the Director of nursing to identify any other unlabeled open medication in medication carts and medication rooms by 9-26-18. All unlabeled open medication were discarded and re-ordered. All current licensed staff were re-educated starting on 9/21/18 by the Director of nursing on storing and dating medications. With emphasis on dating medication when opened and clearly marking the date. Licensed nurses are	

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F 761	Continued From page 28 undated Flovent HFA inhaler (used to reduce airway inflammation) with 34 doses remaining. An interview on 9/13/2018 at 1:10 PM with Nurse #4, who worked 400 Hall, revealed the eight opened and undated Artificial Tears eye drop bottles had the residents last name written on the bottle but she was unsure when the Artificial Tear eye drops were opened. Nurse #4 further revealed that she was unsure of when the Flovent HFA inhaler was opened. Nurse #4 further revealed that she did not know the recommended discard date of the Artificial Tear drops once opened. Additionally, Nurse #4 revealed there was only a policy on hand for medications taken by mouth in the front of the Medication Administration Record (MAR) notebook. 3. On 9/13/2018 at 1:18 PM an observation of the 500/600 Hall medication cart revealed an opened and undated bottle of Nitrostat, one opened and undated Artificial Tears eye drop bottle and one open and undated Pro Air HFA inhaler (used to treat and prevent airway flow) with 69 doses remaining. An interview on 9/13/2014 at 1:20 PM with Nurse #3, who worked 500 and 600 Hall, revealed the Artificial Tears eye drops were opened on yesterday but would be discarded. Nurse #3 was not able to determine when the Pro Air HFA inhaler was opened. Nurse #3 revealed the Nitrostat would be discarded immediately. An interview on 9/13/18 at 05:52 PM with the DON revealed she expected all nurses to date all open medications, check the medication carts and medication storage rooms daily for expired medications and remove or return expired	F 761	responsible for checking the medication carts each shift and signing a validation sheet that all medications are labeled and dated when opened. This education will be added to the new hire process for new licensed nurses and medication aides. Monitoring process: The director of nursing/unit coordinators and weekend supervisor will monitor medication carts and medication rooms 5 days a week to ensure all opened medications are clearly labeled with the date opened. This monitoring will be conducted 5 days a week for 4 weeks then weekly for 8 weeks. Findings will be reported by the Director of nursing to the Quality Assurance Performance committee monthly for 3 months for recommendations or modifications until compliance is achieved. Title of person responsible for implementing this plan: Director of nursing	

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F 761	Continued From page 29 medications. An interview on 9/13/18 at 5:54 PM with the Administrator revealed he expected nurses to date and label medications when opened per nursing standards.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to sanitize food service surfaces, date and label food, restrain facial hair, clean hand contact surfaces, label chemicals, properly thaw frozen orange juice, dispose of expired food, and maintain clean water in steam table wells. The facility failed to sanitize three of three food contact surface counters. The facility failed to	F 812	The plan for correcting the specific deficiency: The facility failed to maintain sanitary conditions in the kitchen by not ensuring food was labeled and dated for three days; to clean the handles on a two door reach in cooler and a two door convection oven, to properly thaw two frozen orange	10/10/18

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F 812	Continued From page 30 date and label food on three out of three days when observations were made. The facility failed to ensure two of two male employees restrained facial hair. The facility failed to maintain clean handles on four of four handles on a two-door reach in cooler and a 2-door convection over which were observed for cleanliness. The facility failed to label a chemical in one of one unlabeled pitcher observed. The facility failed to properly thaw two of two observed frozen orange juice boxes received from delivery. The facility failed to dispose of six of six green peppers observed to have been partially black in color and had a visible white cotton like matter on them. The facility failed to maintain clean water in 5 of 5 steam table wells. Findings Included: 1. An observation of the kitchen and interviews with Dietary Staff were conducted on 9/10/18 at 3:52 PM revealed the following: a. An uncovered pitcher was observed on the left side of the three compartment sink with a yellow liquid which smelled like bleach. During an interview conducted with DA #1 she stated it was bleach. b. There was a visible buildup of debris on the handles of both doors of the two-door convection oven. c. There was visible food debris in the both door handle bases on the two-door reach in cooler. d. The following was observed in the two-door reach in cooler: 46 fluid ounce carton of thickened cranberry juice-opened not dated, 46 fluid ounce carton of thickened sweat tea-opened not dated, 46 fluid ounce carton of thickened apple juice-opened not dated, thickened milk carton-opened not date. On a tray there were	F 812	juice boxes, to dispose of six green peppers, to have clean water in five steam table wells; and two male employees not having restrained facial hair. All unlabeled and undated food was discarded immediately by the dietary staff. Handles on the doors of the reach in cooler and convection oven were cleaned immediately by the dietary staff. The two frozen orange juice boxes and six green peppers were trashed immediately by the dietary staff. The two male employees were re-educated on facial hair being restrained. The unlabeled chemical bottle was discarded immediately by the dietary staff. The cited items observed in the two door reach in cooler were discarded immediately by the dietary staff. A drink station sitting on top of the counter next to the 2 door cooler was cleaned immediately by the Maintenance Director. The ice machine was immediately emptied and cleaned by the Maintenance Director. Dented cans in the dry storage were removed from the usable items rack to a return to vendor rack. Dietary aide #1 was re-educated by the Food Service Manager on obtaining food temps prior to plating food. Dietary aide #2 was re-educated on the proper techniques for cleaning kitchen surfaces by the Food Service Manager on 9/12/18. Procedure for implementing plan: Beginning on 9-17-18 monitoring tools	

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F 812	Continued From page 31 poured cups of beverages with no dates or labels which included: 2 thickened yellow drinks, 1 opaque white drink, 2 brown colored drinks, 2 orange colored drinks, and 3 red colored drinks. e. A drink station sitting on top of the counter next to the two-door cooler was observed to have had a metal guard protecting a fan and other mechanical parts. The fan and mechanical parts were observed to have had a buildup of dust and debris. f. Five of five wells of the steam table were observed to have had food particles in the wells. g. Male staff member with unrestrained facial hair was observed participating in preparing food. h. Black and pink substance buildup on the drop-down deflector inside of the ice machine. i. In the dry storage room the following was observed: Two of six cans of tropical fruit had dents on the sides of the can impacting the top seam of the can, one of three cans of beets had a dent on the side of the can impacting the top seam of the can, one of two cans of mashed potatoes had a dent on the top seam of the can, and one of four cans of chili verde had a dent on the top seam of the can. j. A box of 96 4 fluid ounce (oz) orange juice containers was observed to have been placed sitting on top of a milk crate to the right of the walk in cooler door. The box was marked in large font black letters "keep frozen." Another box of 96 4 fluid ounce (oz) orange juice containers was observed to have been placed in a position to prop the dry storage room door open. The box was marked in large font black letters "keep frozen." An interview was conducted with the Dietary Manager (DM) who stated the box of orange juice weas probably placed on the crate outside of the freezer to thaw. The DM checked the temperature of one of the orange juice	F 812	were put in place to monitor the dating and labeling of food, the cleanliness of the door handles on the convection oven and reach in cooler, that frozen orange juice is thawed correctly, disposal of expired foods, proper storage of left overs, appropriate container for food storage; and proper sanitizing of all kitchen surfaces. A cleaning schedule was modified and posted to follow up on equipment cleaning on 10/05/18. Dietary cooks and aides were re-educated on all aspects of a clean work environment, proper use of gloves and hair restraints, taking and recording temps after food items are prepared, checking that dented cans are stored on a dented can shelf, that chemicals are clearly marked and labeled if in a bottle. The Maintenance Director developed a cleaning schedule for the ice machine and fan in the kitchen to be documented on the maintenance documentation system. The Administrator will re-educate the maintenance director on scheduling equipment cleaning and monitoring. Daily rounds sheets are completed by the manager or cook to ensure compliance. Monitoring process: The daily rounds sheets will be reviewed by the administrator, regional dietary manager, and/or regional nurse consultant 2 times a week for 12 weeks to ensure all areas remain in compliance. The results of this review will be reported to the Quality assurance Performance improvement committee for any additional monitoring or modifications for three	

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F 812	Continued From page 32 containers by piercing the foil top with a thermometer probe down into the orange juice. The observed temperature of the orange juice was 60 degrees Fahrenheit (F). The DM stated leaving a frozen product out at room temperature was not the proper way to thaw a product for service. The DM checked the temperature of an orange juice container from the box which had been observed propping the dry storage door open and the temperature was observed to be 60 degrees F. The DM stated he was going to dispose of both boxes of the orange juice which had been thawed improperly. k. In the walk in cooler the following was observed: Beets were in an undated and unlabeled clear plastic storage container, opened pimento cheese was undated, an opened one gallon jar of mayonnaise was undated, an opened tube of hamburger was undated, and 6 green peppers were observed to have a black areas on them, were partially sitting in a liquid, and had a white cotton like substance on them. 2. An observation of the kitchen conducted on 9/12/18 at 9:30 AM revealed the following: a. There was a visible buildup of debris on both handles of both doors of the two-door convection oven. b. There was visible food debris in the both door handle bases on the two-door reach in cooler. c. The following was observed in the two-door reach in cooler: On a tray there were poured cups of beverages with no dates or labels which included: 1 thickened yellow drink and 2 red colored drinks. d. A drink station sitting on top of the counter next to the two-door cooler was observed to have had a metal guard protecting a fan and other mechanical parts. The fan and mechanical parts were observed to have had a buildup of dust and	F 812	months. Title of person responsible for implementing plan: Food services manager Maintenance Director Administrator	

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debris.
e. Five of five wells of the steam table were observed to have had food particles in the wells.
f. Male staff member with unrestrained facial hair was observed washing dishes.
g. Black and pink substance buildup on the drop-down deflector inside of the ice machine.
h. In the dry storage room the following was observed: One of eight cans of sliced apples had a dent on the top seam of the can, one of five cans of Mandarin oranges had a dent on the top seam of the can, two of six cans of tropical fruit had dents on the sides of the can impacting the top seam of the can, and three of seventeen cans of cut sweet potatoes had dents impacting the top seam of the cans.
3. An observation of the kitchen and interview was conducted on 9/12/18 at 11:45 AM revealed the following:
a. There was a visible buildup of debris on both handles of both doors of the two-door convection oven.
b. There was visible food debris in the both door handle bases on the two-door reach in cooler.
c. A drink station sitting on top of the counter next to the two-door cooler was observed to have had a metal guard protecting a fan and other mechanical parts. The fan and mechanical parts were observed to have had a buildup of dust and debris.
d. Five of five wells of the steam table were observed to have had food particles in the wells after the removal of the steam table pans.
e. A bag of crisped rice on the top shelf of the shelf unit next to the prep table did not have an observed date or label.
f. 50 of 50 gelatin deserts with whipped toppings were observed to have had no dates or labels.

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g. The DM was observed plating food with unrestrained facial hair and no hair net.
h. Male staff member with unrestrained facial hair observed was pouring beverages into cups and placing plate covers on plated food.
i. DM observed stirring food at the stove with unrestrained facial hair and not wearing a hair net.
j. Thickened liquids beverages which had been poured into covered disposable plastic cups were observed on a tray. Two beverages were observed to have been marked with an H. An interview with Dietary Aide (DA) #2 revealed the beverages marked with an H were for honey thickened liquids. The DA further stated the nectar thickened liquids were not labeled as nectar thick and they did not date or label the beverages as to what they were. The DA stated the beverages were 3 nectar tea, 1 honey tea, 1 honey water, 4 nectar teas, and 4 nectar apples.
k. Dietary Aide #1 failed to obtain food temperatures for mashed potatoes, pureed hamburger, and pureed peas prior to plating food.
l. Black and pink substance buildup on the drop-down deflector inside of the ice machine.
m. DA #2 was observed to have prepared a pimento cheese sandwich on the bare counter of the prep table. Upon finishing the pimento cheese sandwich, the DA obtained a towel from a milk crate which had been sitting on the floor. The DA moistened the towel with warm water and then proceeded to wipe down the prep table, the steam table, and the prep table in front of the cook line. The DA then placed the damp towel on the three compartment sink, not in the sanitizer compartment of the sink. A red bucket labeled for sanitizer was observed on the bottom shelf of the prep table, under the toaster, with clear to cloudy liquid in it.

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n. A can with the label of instant mashed potatoes was observed on the spice rack. The can was covered aluminum foil with a date and label. When the aluminum foil was removed, original can lid remained attached to the can and there were instant mashed potatoes observed on the can lid.

4. An observation and round of the kitchen were conducted in conjunction with an interview with the DM on 9/13/18 at 9:13 AM revealed the following:

a. The DM stated the red buckets are for sanitizer for wiping down the counters. The DM tested the sanitizer concentration in the sanitizer bucker on the bottom shelf of the prep table under the toaster and the DM stated the concentration of quaternary sanitizer was less than 100 part per million (PPM). The DM stated the sanitizer should be between 200 to 400 PPM. There was no observed sanitizer bucket under the steam table. There was a discovered sanitizer bucket under the prep table across from the cook line but the bucket was empty. The DM stated it was his expectation for sanitizer to be available for use for employees, the sanitizer concentration for quaternary be 200 to 400 PPM, and for the dietary staff to use sanitizer to wipe down food preparation surfaces in the kitchen with sanitizer.

b. The DM stated it was his expectation for chemicals to be stored in appropriate containers and dated and labeled.

c. In the dry storage room the following was observed: Two of six cans of tropical fruit had dents on the sides of the can impacting the top seam of the can. A can with the label of instant mashed potatoes was observed to be in a plastic bag. The original can lid remained in the can and there were instant mashed potatoes observed on

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the can lid. The DM stated he expected dented cans to be removed from usable stock and placed with on the shelf for dented cans. The DM also stated he expected food products to be placed in proper storage containers, dated, and labeled.

d. There was a visible buildup of debris on both handles of both doors of the two-door convection oven. The MD stated hand contact surfaces such as the convection oven door handles should be kept clean.

e. There was visible food debris in the both door handle bases on the two-door reach in cooler. The MD stated hand contact surfaces such as the two door reach in cooler door handles should be kept clean.

f. Five of five wells of the steam table were observed to have had food particles in the wells after the removal of the steam table pans. The DM stated he was not aware of when the steam table water had been changed but it was his expectation the steam table well water should be clean.

g. A bag of crisped rice on the top shelf of the shelf unit next to the prep table did not have an observed date or label. The DM stated food should be dated and labeled.

h. The DM was observed to have not worn a hair net or beard guard during the round through the kitchen. The DM stated he was not aware if the facility had beard guards and he stated he had not been advised to wear a beard guard in the past.

i. Black and pink substance buildup on the drop-down deflector inside of the ice machine. The DM stated it was his expectation for the ice machine to be kept clear of black and pink substance buildup.

j. A second can with the label of instant

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mashed potatoes was observed on the spice rack. The can was covered aluminum foil with a date and label. When the aluminum foil was removed, original can lid remained attached to the can and there were instant mashed potatoes observed on the can lid. The DM stated it was his expectation for food to be stored in appropriate storage containers.

An observation conducted on 9/13/18 at 10:32 AM revealed the Maintenance Director requested and received a beard guard when he entered the kitchen.

An observation was conducted of 100/200/300 hall's nutrition room on 9/13/18 at 11:48 AM. The observation revealed two 8 fluid ounce diabetic supplement 1.0 calorie with blood sugar management containers. Each container had an expiration date of 7/1/18. In the freezer in the nourishment room there was an opened half gallon sized carton of ice cream which was undated.

An observation was conducted of t\he 400/500/600 hall's nutrition room on 9/13/18 at 11:55 AM. There was an undated opened bag of potato chips and the inside top of the microwave was observed to have had what appeared to be food particles on it. Observation of the refrigerator revealed the following: An opened and undated 32 oz container of medication pass 2 calorie vanilla nutritional supplement, an undated and unlabeled to go container with a hot dog, coleslaw, and baked beans, a bag with food from a local convenience store, an undated and unlabeled pitcher which was one third full of a red drink, an undated and unlabeled brown paper bag with a carton of milk, peanut butter and jelly

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F 812	Continued From page 38 sandwich, and a cookie, and an undated and unlabeled bag of grapes. An interview was conducted with Unit Manager (UM) 2 on 9/13/18 at 12:55 PM. The UM stated she usually checked the refrigerator in the nourishment room when she arrived to the unit in the morning. The UM stated she was unable to check the refrigerator on 9/13/18 due to having had to work on the floor. The UM stated it was her expectation for food items in the nourishment room and in the refrigerator to have been dated and labeled. The UM further stated it was her expectation for food which had not been dated and labeled to be discarded An interview was conducted with the Director of Nursing (DON) on 9/13/18 at 4:53 PM. The DON stated it was her expectation for the Unit Managers and the Weekend Supervisors to check the cabinets and the refrigerators in the nourishment rooms daily. In addition, the DON stated if expired product is discovered or if undated and unlabeled food is discovered it is to be discarded. During an interview conducted on 9/13/18 at 4:53 PM the Administrator stated it was his expectation for the employees of the facility to comply with the regulations related to food storage, preparation, and storage. The Administrator further stated the DM who had been at the facility during the recertification was the DM for another facility and there was a new DM scheduled to start on 9/20/18.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		10/10/18

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F 867	Continued From page 39 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor and revise these interventions as needed for the recertification survey dated 11/16/2017. The facility had repeat deficiencies in two areas. The first area was associated with the provision of assessment accuracy (F 641) and the second area was associated with the facility ability to ensure that hair coverings and facial hair coverings be worn by the kitchen staff while handling and preparing food (F 812). These deficiencies were cited on the recertification survey of 11/16/2017 and again on the recertification survey conducted on 09/13/2018. Findings included: This tag is cross referenced to F 641. The facility failed to have audit tools in place to audit assessment accuracy. An interview conducted with the facility administrator on 09/13/2018 at 6:15 PM revealed that he was the contact person for the Quality Assessment and Assurance Committee (QA and A) and it was the expectation of the QA and A Committee that all assessments be coded accurately to reflect resident status.	F 867	The plan for correcting the specific deficiency: The deficiency occurred because the facility failed to accurately code the Minimum data set(MDS)for resident #47 and #60. MDS coordinator modified the assessment for resident #47 and #60 to reflect the correct coding on 9-12-18. The deficiency occurred because the two male dietary employees failed to have facial hair restrain while in the kitchen. Re-education of the two male employees was completed and facial hair was restrained on 9-13-18. Procedure for implementing the plan: Section N of the MDS, for all current residents for census date September 10, 2018 will be audited for accuracy by regional MDS consultant .Opportunities corrected by the MDS submitting modifications. MDS staff were re-educated by the Regional MDS consultant on the importance of coding the MDS, specifically, medications by 10/10/2018. Regional MDS consultant will audit section N of 5 Minimum data sets per week by comparing the medication	

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F 867	Continued From page 40 This tag is cross referenced to F 812. The facility failed to monitor that all kitchen staff wear facial hair and head hair coverings while handling and serving food. An interview conducted with the facility administrator on 09/13/2018 at 6:15 PM revealed that he was the contact person for the Quality Assessment and Assurance Committee (QA and A) and it was the expectation that all kitchen staff utilize hair nets to cover facial hair and any hair on their heads.	F 867	administration record during the assessment reference date with the coded section N on the MDS X 12 weeks to ensure accuracy. Food Service manager will audit males in the kitchen weekly for 12 weeks to ensure facial hair is restrained. Monitoring process: Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement committee by MDS coordinator and Food services manager monthly X 3 months. At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Title of the person responsible for implementing the plan: MDS coordinator Food Services manager Administrator	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 881		10/10/18

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F 881	Continued From page 41 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff and physician, the facility failed to identify and address the use of prophylactic (preventative) antibiotics prescribed on an indefinite basis, without stop dates, for 1 of 5 residents (Resident #60) reviewed for unnecessary medications. The findings included: A review of the facility's Antibiotic Stewardship-Orders for Antibiotics policy, last revised December 2016, indicated appropriate indications for use of antibiotics included: "a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogens susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending)." The policy additionally stated that if an antibiotic was ordered that a start and stop date or number of days of therapy was to be indicated on the order. A review was completed of Resident #60's hospital History and Physical (H & P) dated 6/24/18. The review revealed the resident had a diagnosis of conjunctivitis. Further review of the H & P revealed the resident had seen neurology and the neurology notes indicated the resident was undergoing workup for ophthalmoplegia (paralysis of the muscles surrounding the eyes) with suspicion for a mitochondrial myopathy. Review of Resident #60's discharge summary	F 881	The plan for correcting the specific deficiency: The alleged deficient practice occurred when the infection control nurse failed to identify and address the use of preventative antibiotics prescribed for an indefinite period of time without a stop date for resident #60. The physician was contacted for resident #60 to obtain a stop date on 9/13/18 by unit manager and MD opted not to give stop date until next appointment. No negative outcomes for the antibiotic eye drops for resident #60 Procedure for implementing the plan: On 9/28/18 the Director of nursing and/or unit coordinators, infection control nurse re-educated the licensed nurses that antibiotics must have a stop date when ordered or explanation given in order as to why there is no stop date. The interdisciplinary team will have daily discussions during the morning clinical meeting of any resident receiving antibiotics to monitor the use of antibiotics to prevent unnecessary antibiotic use. An audit was completed on 10-4-18 of current residents receiving antibiotics to ensure stop dates were documented. No other residents were noted receiving antibiotics without stop dates.	

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F 881	Continued From page 42 from the hospital dated 7/4/18 revealed the resident was to follow up with ophthalmology. Resident #60 was admitted to the facility on 7/4/18 with diagnoses that included: Epilepsy, generalized weakness, encephalopathy (brain dysfunction), communication deficit, glaucoma, and conjunctivitis. Review of Resident #60's admission orders dated 7/4/18 revealed the resident had a physician order for Moxifloxacin Hydro Chloride (HCl) Solution 0.5%, instill one drop in the left eye four times a day for Glaucoma. There was no stop date for this order. Review of the description of Moxifloxacin eye drops on WWW.rxlist.com revealed it is a sterile solution for topical application to the eye which is used to treat bacterial infections of the eyes. Moxifloxacin is a fluoroquinolone (flor-o-KWIN-o-lone) antibiotic that fights bacteria. Dosage and administration was listed as one drop in the affected eye three times a day for seven days. Review of Resident #60's Medication Administration Record for July 2018 revealed the resident received Moxifloxacin HCl Solution 0.5%, one drop in the left eye for Glaucoma at least one time each day from 7/5/18 through 7/31/18. Review of Resident #60's Medication Administration Record for August 2018 revealed the resident received Moxifloxacin HCl Solution 0.5%, one drop in the left eye for Glaucoma at least one time each day from 8/1/18 through 8/3/18. The medication was discontinued on 8/3/18 and replaced by an order for Erythromycin	F 881	Monitoring the process: The director of nursing unit managers/supervisors will review antibiotic orders 5 days a week times 12 weeks to ensure a stop date is documented for antibiotics that are ordered. The director of nursing will present the results of the audits at the monthly Quality Assessment and performance improvement committee, for recommendations or modifications until compliance is achieved. Title of person responsible for implementing the plan Director of nursing	

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when she had an ophthalmology consult.

Further review of Resident #60's physician orders revealed an order written on 8/3/18 for Erythromycin Ointment 5 milligrams (mg)/gram (gm), instill one application in the left eye four times a day for conjunctivitis. There was no stop date for this order.

Review of the description of Erythromycin Ophthalmic (eye) Ointment on www.drugs.com revealed the medication was an antibiotic to be used on the eye(s).

Review of Resident #60's Medication Administration Record for August 2018 revealed the resident received Erythromycin Ointment 5 mg/gm, one application to the left eye for conjunctivitis at least one time each day from 8/4/18 through 8/31/18.

Review of Resident #60's Medication Administration Record for 9/1/18 through 9/11/18 revealed the resident received Erythromycin Ointment 5 mg/gm, one application to the left eye for conjunctivitis at least one time each day from 9/1/18 through 9/11/18.

An interview was conducted with the Nurse #3 on 9/12/18 at 3:58 PM. The nurse stated she was assigned to Resident #60. The nurse stated the resident had conjunctivitis of the left eye but was not aware of any other diagnoses related to the resident's eyes. The nurse stated the resident had several different eye drops. The nurse stated on 9/9/18 the resident had some purulent drainage from her left eye. The nurse stated the resident was able to independently maneuver herself throughout the facility. The nurse further

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stated the resident had cognitive loss and was not alert and oriented.

An interview was conducted with Nurse #1 on 9/13/18 at 12:06 PM. The nurse reviewed the medications on the MAR for Resident #60. The nurse stated the resident was erythromycin ointment for her left eye. The nurse stated erythromycin was an antibiotic. The nurse further stated sometimes it was normal to not have a stop date for antibiotics.

During an interview conducted with the facility Medical Director, who was also Resident #60's physician, on 9/13/18 at 12:15 PM, he stated erythromycin ointment which was ordered for Resident #60 should have had a stop date because it was an antibiotic.

An interview was conducted with the Unit Manager (UM) on 9/13/18 at 12:15 PM. The UM stated she had not been aware Resident #60 was an antibiotic which needed a stop date. The UM stated now that she had been made aware she stated she would contact the resident's physician to inquire if the medication should be stopped. The UM stated she was not aware a culture and sensitivity had been done on the drainage from the resident's eye to determine the efficacy of the antibiotic ordered.

An interview was conducted with the Infection Control (IC) Nurse on 9/13/18 at 2:18 PM. He reported he was new in the position of antibiotic steward. He went on to explain that tracking infections and antibiotic use had been assigned to him in July 2018 and he was trying to "catch up" the tracking of antibiotics for the facility. He stated he was not aware Resident #60 had

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antibiotic eye medication without a stop date.

A second interview was conducted with the UM on 9/13/18 at 2:28 PM. The UM reviewed Resident #60's medical record and discovered the resident had an ophthalmology consult on 8/3/18. The UM stated she contacted the eye doctor specialist who had ordered the erythromycin eye ointment not indefinitely, but long-standing, until the resident had an appointment for further examination or surgery.

A second interview was conducted with the Infection Control (IC) Nurse on 9/13/18 at 4:35 PM. The IC Nurse stated Resident #60 was started on erythromycin ointment for her eye in August and he had not followed up with anyone, there was no stop date for the erythromycin, and he stated he had not completed any paperwork regarding the use of erythromycin as part of the antibiotic stewardship program. The IC Nurse stated he had been very busy with wounds and if he had not been as busy with wounds he would have followed up regarding the lack of a stop date for the erythromycin. The IC Nurse stated an antibiotic, such as erythromycin, without a stop date is something which should be investigated and investigated immediately. The IC Nurse stated he had been unable to follow up on any residents with antibiotics. The IC Nurse stated he had been in the role of the IC Nurse for 2-3 months but had just received the Policies and Procedures for Infection Control on 9/13/18. The IC Nurse stated he had not recorded any information regarding the Moxifloxacin order in July.

During an interview with the Director of Nursing (DON) on 9/13/18 at 12:56 PM the DON stated

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F 881	Continued From page 46 her expectation was for there to be a stop date for an antibiotic at the time the antibiotic order was written. The Administrator was interviewed on 9/13/18 at 4:25 PM. He reported it was his expectation the Infection Control Nurse would track infections and antibiotic use according to the protocols required for the Infection Control Nurse position. During an interview with the Administrator on 9/13/18 at 4:53 PM the Administrator stated it was his expectation antibiotics should have a stop date.	F 881		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a safe environment as evidenced by two of two floor mounted steam table electrical outlets having been found in disrepair, one outlet had no receptacle cover plate and the other outlet had a loose receptacle cover plate and receptacle exposing both hot and neutral terminals, in the kitchen. The findings included: An observation was conducted of the kitchen on 9/10/18 at 3:52 PM. The floor mounted single gang outlet box on the side of the steam table toward the dish machine was observed to have a	F 921	The plan for correcting the specific deficiency: The facility failed to ensure a safe environment in the kitchen as evidence by having two floor mounted steam table electrical outlets in disrepair; one outlet without a receptacle plate and one outlet with a loose receptacle plate. The electrical outlet in disrepair was repaired and the receptacles plates have been replaced immediately. Procedure for implementing the plan:	10/10/18

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(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 921	Continued From page 47 loose receptacle cover plate and the receptacle was mounted to the receptacle cover plate. The loose receptacle cover plate and receptacle were not mounted to the box and the hot (carrying voltage) and neutral terminals were visible on the receptacle due to the absence of the retaining screws. On the side of the steam table facing the cookline, the floor mounted single gang outlet box was observed to have had no face receptacle cover plate and a black foam insulation cover on the receptacle. The foam insulation was observed to be easily manipulated which exposed possible contact with the hot and neutral terminals. An observation was conducted of the kitchen on 9/12/18 at 9:30 AM. The floor mounted single gang outlet box on the side of the steam table toward the dish machine was observed to have a loose receptacle cover plate and the receptacle was mounted to the receptacle cover plate. The loose receptacle cover plate and receptacle were not mounted to the box and the hot (carrying voltage) and neutral terminals were visible on the receptacle due to the absence of the retaining screws. On the side of the steam table facing the cookline, the floor mounted single gang outlet box was observed to have had no receptacle cover plate and a black foam insulation cover on the receptacle. The foam insulation was observed to be easily manipulated which exposed possible contact with the hot and neutral terminals. An observation was conducted of the kitchen on 9/12/18 at 11:45 AM. The floor mounted single gang outlet box on the side of the steam table toward the dish machine was observed to have a loose receptacle cover plate and the receptacle was mounted to the receptacle cover plate. The	F 921	On 9-17-18 the maintenance director audited all outlets in the kitchen to determine if any needed to be replaced. No other outlets or plates needed to be replaced. Monitoring procedure: Audits of outlets and receptacles in the kitchen will be performed by the Maintenance director weekly for 12 weeks. The Maintenance director will report the findings of the audits to the Quality Assurance Performance improvement committee monthly for 3 months for recommendations or modifications until a pattern of compliance is achieved. Title of person responsible for implementing the plan Maintenance director Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	09/13/2018

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F 921	Continued From page 48	F 921		

loose receptacle cover plate and receptacle were not mounted to the box and the hot (carrying voltage) and neutral terminals were visible on the receptacle due to the absence of the retaining screws. A dietary aide was observed pushing a tray cart into contact with the loose receptacle and receptacle cover plate causing the receptacle and cover to move loosely from the floor mounted single gang box. On the side of the steam table facing the cookline, the floor mounted single gang outlet box was observed to have had no receptacle cover plate and a black foam insulation cover on the receptacle. The foam insulation was observed to be easily manipulated which exposed possible contact with the hot and neutral terminals.

An observation was conducted of the kitchen on 9/13/18 at 9:13 AM in conjunction of a round with the Dietary Manager (DM). The floor mounted single gang outlet box on the side of the steam table toward the dish machine was observed to have a loose receptacle cover plate and the receptacle was mounted to the receptacle cover plate. The loose receptacle cover plate and receptacle were not mounted to the box and the hot (carrying voltage) and neutral terminals were visible on the receptacle due to the absence of the retaining screws. On the side of the steam table facing the cookline, the floor mounted single gang outlet box was observed to have had no receptacle cover plate and a black foam insulation cover on the receptacle. The foam insulation was observed to be easily manipulated which exposed possible contact with the hot and neutral terminals.

An interview was conducted with the DM on 9/13/18 at 9:43 AM. The DM stated he was not

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F 921	Continued From page 49	F 921		

aware of the loose receptacle cover plate and loose receptacle next to the steam table on the side facing the dish machine. The DM stated he was not aware the electrical outlet next to the steam table on the side of the cookline did not have a receptacle cover plate and only had a foam insulation cover. The DM stated he was not aware of a work order which had been completed regarding the repairs which needed to be made for the electrical receptacles next to the steam table. The DM stated it was his expectation for a work order to be completed for the repair of the electrical receptacles next to the steam table.

A round and interview was conducted with the Maintenance Director (MD) on 9/13/18 at 10:32 AM. The round included an observation of the kitchen. The floor mounted single gang outlet box on the side of the steam table toward the dish machine was observed to have a loose receptacle cover plate and the receptacle was mounted to the receptacle cover plate. The loose receptacle cover plate and receptacle were not mounted to the box and the hot (carrying voltage) and neutral terminals were visible on the receptacle due to the absence of the retaining screws. On the side of the steam table facing the cookline, the floor mounted single gang outlet box was observed to have had no receptacle cover plate and a black foam insulation cover on the receptacle. The foam insulation was observed to be easily manipulated which exposed possible contact with the hot and neutral terminals. The MD stated he was not aware of the loose receptacle cover plate and receptacle on the receptacle facing the dish machine. The MD also stated he was not aware of the receptacle cover plate not being present on the electrical outlet facing the cookline. The MD stated it was his

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F 921	Continued From page 50 expectation he should receive a work order regarding repairs which needed to be made to electrical outlets. During an interview conducted with the Administrator on 9/13/18 at 4:53 PM he stated it was his expectation for receptacle outlets to be maintained in safe condition and should be properly protected. The Administrator further stated if a receptacle was found to be in disrepair a work order should be written to report the receptacle to the Maintenance Department so a repair can be completed.	F 921		