DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345303	A. BUILDING ______ B. WING ______	C 03/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	**70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803**

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E 000	Initial Comments An unannounced recertification survey was conducted on 03/25/19 through 03/29/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 1VG611.	E 000		
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 record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of discharge status for 1 of 3 sampled residents reviewed for closed records (Resident #89). Findings included: Resident #89 was admitted to the facility on 02/23/19 from acute hospital with diagnoses included lung cancer, arthritis, anxiety, and depression. Review of progress notes dated 03/19/19 indicated Resident #89 was discharged home from facility on 03/19/19 with order for home health to follow up at home. Discharge instructions and medication orders were given to Resident #89 prior to her departure. Review of physician order dated 03/19/19 revealed Resident #89 was discharged home on 03/19/19 with home health and continued with palliative care services.	F 641	The facility will continue to complete assessments that accurately reflect the resident□s status. Resident #89 had an MDS correction completed at the time of discovery. No negative outcome was identified relating to this observation. Residents who have been discharged from the facility have the potential to be affected. All residents who were discharged from the facility since 3/1/19 were audited to ensure that discharge MDS assessments had been completed that accurately reflect each resident□s discharge disposition. No negative outcomes were identified. The MDS Coordinator was in serviced on 4/15/19 by the Clinical Resource Specialist on completing discharge MDS assessments that accurately reflect the resident□s discharge disposition.	4/26/19

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

Electronically Signed — 04/20/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 Review of Resident #89's discharge summary dated 03/19/19 indicated she had met her inpatient therapy goals and was ready to discharge home with home health services. Review of Resident #89's discharge assessment MDS dated 03/19/19 revealed section A2100 under "Discharge Status", she was coded as "03 - Acute hospital". During an interview conducted on 03/26/19 at 2:40 PM the MDS Coordinator confirmed that Resident #89 was discharged home on 03/19/19. She acknowledged that it was an error to code Resident #89's discharge status as "acute hospital" as the correct coding should have been "Community". The MDS Coordinator indicated she was the one who had made the incorrect coding. She added she would correct the error and re-submit the correction as soon as possible. During an interview on 03/26/19 at 4:48 PM the Director of Nursing (DON) stated it was her expectation for all the MDS to be coded correctly and submitted in a timely manner. The DON also expected the MDS Coordinator to complete a correction and re-submitted the corrected MDS.	F 641	All MDS Coordinators were in serviced on 4/15/19 by the Clinical Resource Specialist on completing discharge MDS assessments that accurately reflect the resident�s discharge disposition. A QA monitoring tool will be utilized starting on 4/16/19 to ensure ongoing compliance by the DON. The DON will randomly audit three discharge MDS assessments weekly x 4 weeks then randomly x 1 month to ensure that discharge MDS assessments are being completed that accurately reflect the resident�s discharge disposition. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 2 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits of discharge MDS assessments and through the facility�s Quality Assurance Program. Compliance will be monitored by the QA Committee for 2 months or until resolved and additional education/training will be provided for any issues identified.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/26/19

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F 658 Continued From page 2

§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 observations, record review, resident and staff interviews, the facility failed to correctly transcribe an order for 1 of 3 residents reviewed for providing according to professional standards (Resident #54) and administer 3 inhaled medications prior to documenting they were administered for 1 of 5 residents reviewed for unnecessary medications (Resident #29).

The findings included:

1. Resident #54 was admitted to the facility on 01/25/19 with a diagnosis of diabetes among others. The significant change Minimum Data Set (MDS) dated 02/22/19 revealed Resident #54 was alert and oriented and required limited to extensive assistance for all activities of daily living. The MDS further indicated Resident #54 required daily insulin injections.

Record review of a physician's order dated 01/14/19 revealed an order for to check capillary blood glucose (CBG) twice a day for 7 days.

Review of the Medication Administration Record (MAR) for January 2019 revealed an order start date of 01/14/19 to check CBG's as needed for one week. Review of the MAR revealed no documented CBG's for 01/14/19 through 01/21/19.

Record review of nurse's notes revealed Resident

F 658

The facility will continue to ensure that the services provided or arranged by the facility as outlined by the comprehensive care plan meet professional standards of quality.

Resident #54 and Resident #29 will continue to receive services provided or arranged by the facility as outlined by the comprehensive care plan that meet professional standards of quality.
Resident #54 was treated briefly in the hospital and did return to the facility. No further negative outcome was identified relating to this observation.

A root cause analysis was conducted on 1/24/19.

Current residents that have orders for CBG□s or inhalers have the potential to be affected. Current residents meeting this criteria had medication record and physician order reviews. No negative observations were identified.

Nurse #4 no longer works at the facility.

All licensed nurses were in serviced on 1/28/19 by the DON on the importance of having two nurses verify the accuracy of all physician orders transcribed to the

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F 658	Continued From page 3 #54 had been diagnosed with bronchitis on 01/14/19 with orders noted for a chest x-ray, breathing treatments and an antibiotic for 7 days. An addition of a steriod was added once daily for 3 days beginning 01/15/19. A nurse's note dated 01/20/19 revealed "patient continues on antibiotic for respiratory infections, no adverse reactions noted." A nurse's note dated 01/22/19 revealed Nurse #5 had attempted to check Resident #54's CBG twice, with different glucometers, but had received an error message. Nurse #5 notified the physician and received an order for immediate labs. Lab results revealed a critical CBG lab result. A physician's order was received to transfer Resident #54 to the Emergency Room (ER) for evaluation and treatment. During an interview with Nurse #5 on 03/28/19 at 2:21PM, Nurse #5 revealed she was working with Resident #54 the day she was sent out to the hospital. Nurse #5 stated Resident #54 had been on a steroid and was close to completing an antibiotic for pneumonia. Nurse #5 further stated that Resident #54 had started vomiting and she attempted to check her CBG using 2 different glucometers that both gave error messages. Nurse #5 then stated she contacted the Family Nurse Practitioner (FNP) and received an order for stat labs and to start intravenous (IV) fluids. When the lab results were called in to Nurse #5 from the hospital, the CBG level was elevated and the FNP gave the order to send Resident #54 to the ER. During an interview with the Director of Nursing (DON) on 03/28/19 at 3:40PM, she stated the	F 658	medication record. All licensed nurses were inserviced on 3/27/19 the importance of signing off medications on the medication record only after the resident has received the medications. A QA monitoring tool will be utilized starting on 4/1/19 to ensure ongoing compliance by the DON. The DON will randomly audit physician orders for CBG□s to ensure that two nurses verify the accuracy of CBG orders weekly x 4 weeks then randomly x 4 weeks. Variances will be corrected at the time of the audit and additional education provided when indicated. A QA monitoring tool will be utilized starting on 4/1/19 to ensure ongoing compliance by the DON. The DON will randomly audit medication records to ensure that licensed nurses are signing off medications as given on the medication record after the resident has received the medications weekly x 4 weeks then randomly x 4 weeks. Variances will be corrected at the time of the audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 2 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored	

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F 658	Continued From page 4 nurse who transcribed the order incorrectly no longer works at the facility. The DON further stated the Unit Manager should have provided a second medication check to verify the order was correct and she also no longer worked at the facility. The DON also stated after this incident occurred she completed an analysis of medication event which revealed the nurse who transcribed the order for the CBG to be checked as needed should have transcribed it to be checked twice a day per the order. The DON stated she was notified of the error by the Medical Director on 01/23/19. She began an investigation and root cause analysis on 01/24/19 and reviewed all other guest with orders for CBG's to ensure accuracy of CBG monitoring with no other issues identified. On 01/25/19 there was an in-service for all licensed nurses regarding the importance of order verification with a 2nd nurse for every order received to ensure accuracy. On 01/29/19, monitoring began by the DON of five times per week for four weeks, weekly for four weeks, then randomly for four weeks. The DON stated her expectation was for licensed nurses to accurately transcribe medication orders. 2. Resident #29 was readmitted to the facility on 03/19/19 following a hospitalization for Chronic Obstructive Pulmonary Disease (COPD) with acute hypoxemic respiratory failure. The admission Minimum Data Set (MDS) dated 03/26/19 revealed Resident #29 was alert and oriented and required limited to extensive assistance for all activities of daily living. The MDS further indicated Resident #29 had shortness of breath with exertion and was using oxygen.	F 658	through random record reviews and audits and through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 2 months or until resolved and additional education/training will be provided for any issues identified.	

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F 658	Continued From page 5 During an observation on 03/25/19 at 10:42AM, Resident #29 was noted to have 3 inhalers on her bedside table. Resident #29 stated she had self-administered 2 of the inhalers (Spiriva and Symbicort) after 9:00AM but did not use the 3rd (Ventolin) because it was a new medication and she had not used it before. During an interview with Nurse #4 on 03/25/19 at 10:54AM, Nurse #4 revealed when she had brought Resident #29 her medications this morning, Resident #29 was eating breakfast. Nurse #4 further stated she did not want to interrupt her meal, so she left the 3 medications at the bedside. Nurse #4 also stated she had signed off that all 3 medications had been administered between 8:00AM and 8:15AM although she did not assist with or witness the medication administration at that time. Record review of the Medication Administration Record for March 25, 2019 revealed the following: Spiriva scheduled at 8:00AM, administration time of 7:58AM, documented as given at 8:08AM Symbicort scheduled at 8:00AM, administration time of 7:58AM, documented as given at 8:08AM Ventolin scheduled at 9:00AM, administration time of 8:08AM, documented as given at 8:08AM. During an observation with Nurse #4 and Resident #29 on 03/25/19 at 10:57AM, Resident #29 told Nurse #4 she had already self-administered 2 of the medications but had not used the 3rd medication yet. Nurse #4 explained the new medication (Ventolin) to Resident #29 and administered the inhaled medication at that time.	F 658		

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F 658	Continued From page 6 During an interview with the Director of Nursing (DON) on 03/25/19 at 11:05AM, she stated her expectations were for no medications to be signed off on until after they had been administered.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to apply a support device to the wheelchair as ordered by the physician for 1 of 1 residents reviewed for positioning and mobility (Resident #50). Findings included: Resident #50 was admitted to the facility on 07/27/16 with diagnoses which included hemiplegia and/or hemiparesis (muscle weakness or partial paralysis on one side of the body), seizure disorder, and traumatic brain injury. A review of the physician order written 02/16/19 directed staff place a left arm trough/support to be used when Resident #50 was up in the wheelchair with an elbow protector on and	F 684	The facility will continue to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident□s choices. Resident #50 will continue to wear the left arm trough/support when up in the wheelchair per therapy recommendation and MD order. No negative outcome was identified relating to this observation. Current residents with orders for support devices have the potential to be affected. Current residents with orders for support devices were audited to ensure that they are receiving treatment and care in accordance with professional standards of	4/26/19

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F 684	Continued From page 7 strapped at forearm. Review of the quarterly Minimum Data Set dated 02/18/19 assessed Resident #50 cognitive abilities were moderately impaired and required extensive assistance by two person for bed mobility, transfers, and dressing. Review of the medical record revealed Resident #50 received Occupational Therapy services from 01/15/19 through 02/15/19. The care plan updated for activities of daily living (ADL) on 02/18/19 identified Resident #50 required supervision to weight bearing assist with ADL's related to impaired mobility, impaired cognition, and impaired range of motion with diagnoses of traumatic brain injury, cerebrovascular accident with left hemiplegia, dementia, and seizure disorder. The goal was to continue to assist with ADL task completion within limitations of disease process through next review. An intervention initiated on 02/15/18 to place a left arm trough/support when up in wheelchair with elbow protector on and strap at forearm per order. An observation on 03/25/19 at 3:13 PM revealed Resident #50 was seated in his wheelchair with no arm trough/support device attached to the wheelchair. An observation on 03/26/19 at 5:44 PM revealed Resident #50 seated in a reclined position in the wheelchair with no arm trough/support device. An observation on 03/28/19 at 11:32 AM revealed Resident #50 was seated in his wheelchair with no arm trough/support device attached to the	F 684	practice. No negative outcome was identified relating to this audit. All therapy staff, licensed nurses, and CNA□s were in serviced on 4/1/19 by the DON on ensuring that support devices were in place per therapy recommendations, physician orders and resident care guides. A QA monitoring tool will be utilized starting on 4/2/19 to ensure ongoing compliance by the DON. The DON will randomly observe support devices and audit therapy recommendations, physician orders, and resident care guides for those residents weekly x 4 weeks then randomly x 1 month. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 2 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 2 months or until resolved and additional education/training will be provided for any issues identified.	

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F 684	Continued From page 8	F 684		

wheelchair.

During an interview on 03/28/19 at 11:32 AM Resident #50 revealed the arm trough/support device wasn't attached due to it had fallen off and no one had reattached it to the wheelchair.

An interview with the Rehab Director on 03/28/19 at 11:32 AM revealed the nurse aides (NAs) and nursing staff were responsible for attaching and removing arm troughs and/or splint devices. The Rehab Director stated it was not the responsibility of the resident to ask nursing staff to replace the device. The interview further revealed if the device hurts the resident, or it's not in place the NA and/or nurse should report to therapy staff who were available 7 days a week.

On 03/28/19 at 12:19 PM Nurse #1 revealed NA or nursing staff apply residents' devices. Nurse #1 stated he didn't ask Resident #50 about the arm trough/support device and wasn't aware of the time and frequency the device was to be placed. Nurse #1 explained the device wasn't on the Medication Administration Record or triggered for the nurses to check and he would have to review physician orders.

During an interview on 03/28/19 at 1:12 PM NA #1 explained she was assigned to provide care for Resident #50 and dressed him this morning but didn't review the care guide with instructions on how to place the arm trough/support device to the wheelchair. She was aware care guides were located on the inside of the closet of each resident and provided information related to devices. NA #1 stated if she knew the resident had an arm trough/support device that was to be attached to the wheelchair she would've placed

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F 684	Continued From page 9 and if refused reported to the therapy department. An interview conducted on 03/29/19 at 10:55 AM, the Occupational Therapist explained Resident #50 had left-sided hemiparesis and she modified an arm trough/support to apply to a power wheelchair to prevent the arm from falling to the side of the chair causing strain to the shoulder. The modification of the arm trough was done to provide support when the resident tilted the chair back in a reclining position. She provided therapy from 01/15/19 through 02/26/19 and to her knowledge the arm trough/support device was working. She recommended the arm trough to prevent shoulder subluxation (pulling of the tendons and ligaments of the shoulder joint) and safe position of the arm to prevent injury. The Occupational Therapist stated she had trained NA staff who mostly assisted Resident #50 with morning care and a physician order was provided to nursing. The interview further revealed she would expect NA staff inform her and check with the resident to identify the root cause of why the arm trough wasn't being implemented such as NA staff weren't placing the device. During an interview on 03/29/19 at 3:04 PM the Director of Nursing explained it was her expectation NA staff would apply devices per physician orders and follow resident care guides. If the resident refused the NA should report to the nurse who reports to therapy. She explained going forward devices will be on the Treatment Administration Record for the treatment nurse to be prompted and check for device placement.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		4/26/19

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F 761	Continued From page 10 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to properly secure a medication for 1 of 5 residents reviewed for unnecessary medications (Resident #29). The findings included: Resident #29 was readmitted to the facility on 03/19/19 following a hospitalization for Chronic Obstructive Pulmonary Disease (COPD) with acute hypoxemic respiratory failure.	F 761	The facility will continue to label all drugs and biologicals in accordance with currently accepted professional principles. The facility will continue to store all drugs and biologicals in accordance with State and Federal laws. The three inhalers left at the bedside at the time of discovery were removed and stored according to facility policy. All other rooms were checked at the time	

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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 761	Continued From page 11 The admission Minimum Data Set (MDS) dated 03/26/19 revealed Resident #29 was alert and oriented and required limited to extensive assistance for all activities of daily living. The MDS further indicated Resident #29 had shortness of breath with exertion and was using oxygen. Review of the physician's orders for March 2019 revealed Resident #29 was to be administer 2 inhalers (a portable device for administering a drug that is to be breathed in) once a day for COPD and a third inhaler once a day for dyspnea (difficulty breathing) and/or wheezing. During an observation on 03/25/19 at 10:42AM, Resident #29 was noted to have 3 inhalers on her bedside table. Resident #29 stated she had self-administered 2 of the inhalers but did not use the 3rd because it was a new medication and she had not used it before. During an interview on 03/25/19 at 10:54AM, Nurse #4 stated when she had taken Resident #29 her medications that morning, she was eating breakfast. Nurse #4 further stated she did not want to interrupt her meal, so she left the 3 inhalers at the bedside. Nurse #4 further stated Resident #29 did not have orders to self-administer medication. During an observation and interview with Nurse #4 and Resident #29 on 03/25/19 at 10:57AM, Resident #29 told Nurse #4 she had already self-administered 2 of the inhaler's (Spiriva and Symbicort) but had not used the 3rd medication yet. Nurse #4 explained the new medication to Resident #29 and administered the inhaled medication.	F 761	of discovery and no further medications were found at the bedside. All drugs and biologicals will be labeled and stored according to facility policy. All licensed nurses were in serviced on 3/27/19 by the DON on the facility policy for labeling and storage of drugs and biologicals. All licensed nurses were also inserviced by the DON on the facility policy for self-administration of medications. A QA monitoring tool will be utilized starting on 4/1/19 to ensure that all drugs and biologicals are labeled and stored according to facility policy by the DON. The DON will randomly observe resident rooms weekly x 4 weeks then randomly x 1 month. Variances will be corrected at the time of observation and additional education provided when indicated. A QA monitoring tool will be utilized starting on 4/1/19 to ensure that residents are self-administering medications according to facility policy by the DON. The DON will randomly audit resident records weekly x 4 weeks then randomly x 1 month. Variances will be corrected at the time of audit and additional education provided when indicated. Observation and audit results will be reported to the Administrator weekly for the next 2 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.	

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	345303	A. BUILDING ______ B. WING ______	C 03/29/2019

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F 761	Continued From page 12 During an interview with the Director of Nursing (DON) on 03/25/19 at 11:05AM, she stated her expectations were for no medications to be left at the bedside unless there was an evaluation and physician's order for the resident to self-administer the medications.	F 761	Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 2 months or until resolved and additional education/training will be provided for any issues identified.	
F 812 SS=D	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 ensure food storage equipment was kept clean and sanitary. The facility failed to clean shelving with white colored debris buildup, to clean floor areas visibly wet and stained, and	F 812	The facility will continue to ensure that food storage equipment is kept clean and sanitary. The shelving, floor, and fan cooling unit in	4/26/19

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F 812

Continued From page 13

failed to clean the fan cooling unit where food was stored for 1 of 2 walk-in refrigerators.

Findings included:

An observation of the walk-in refrigerator on 03/25/19 at 8:50 AM with the Dietary Manager (DM) revealed a puddle of water in the corner entrance of the refrigerator with black stains and a 8 oz carton of milk on the floor. Multiple food storage shelving racks were visibly dirty with a white, dust-like debris buildup. Large, white areas which appeared to be dried milk stains on the floor underneath the shelving where crates of milk were stored.

An interview with the DM on 03/25/19 at 8:50 AM revealed she no idea when the shelving was last cleaned. She acknowledges the floor and shelving were dirty and appeared to have been a while since cleaned.

On 03/25/19 at 11:25 AM the DM explained she was assigned to her position for approximately one week. She was unable to produce a cleaning schedule or monitoring tools and was unsure when the refrigerator was last cleaned. She revealed it was her expectation shelving racks where food was stored should be clean. She confirmed there was build-up on multiple racks of the walk-in refrigerator and stated it took a long time for that much buildup to form. She explained the kitchen staff would be in-serviced and she was developing an audit tool to monitor and ensure food storage areas were regularly cleaned.

An interview on 03/25/19 at 11:32 AM the Administrator revealed it was his expectation

F 812

the walk-in refrigerator were cleaned at the time of discovery. No negative outcome was identified relating to this observation.

All other areas in the kitchen were inspected at the time of discovery and no further issues were identified. No negative outcome was identified relating to this observation.

All dietary staff were in serviced on 3/27/19 by the Dietary Manager on the facility policy for ensuring that food storage equipment is kept clean and sanitary.

A QA monitoring tool will be utilized starting on 4/1/19 to ensure that food storage equipment is kept clean and sanitary according to facility policy by the Dietary Manager. The Dietary Manager will randomly audit food storage equipment weekly x 4 weeks then randomly x 1 month. Variances will be corrected at the time of audit and additional education provided when indicated.

Audit results will be reported to the Administrator weekly for the next 2 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.

Continued compliance will be monitored through the facility□s Quality Assurance Program.

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F 812	Continued From page 14 shelving used to store food were kept clean. He noted white, dust-like debris build-up on the shelves and the cooling fan system of the walk-in refrigerator and stated, "this needed to be cleaned". He revealed the previous DM was recently replaced due to this kind of problem. On 03/26/19 at 2:46 PM the DM explained kitchen staff were unaware of a cleaning schedule but would occasionally sweep and mop the walk-in refrigerators. She had been in the walk-in refrigerators prior and noted the buildup but since being new to the DM position hadn't setup a process or assigned a dietary aide to clean the walk-in refrigerator. She stated forthcoming the cleaning of walk-in refrigerators will be a daily cleaning assignment and were recently completely cleaned.	F 812	Compliance will be monitored by the QA Committee for 2 months or until resolved and additional education/training will be provided for any issues identified.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §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, record review and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the facility's 02/02/18 recertification and complaint survey. The failure related to one recited deficiency that was originally cited during the 02/02/18 recertification	F 867	The facility will continue to ensure that the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	4/26/19

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F 867	Continued From page 15 and complaint survey which was recited on the current recertification and complaint survey of 03/29/19. The recited deficiency was in the areas of label/store drugs and biologicals. The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: 1. F-761: Label/store drugs and biologicals. Based on observations, record review, resident and staff interviews the facility failed to properly secure a medication for 1 of 5 residents reviewed for unnecessary medications (Resident #29). During the recertification and complaint survey of 02/02/18 the facility was cited for failure to ensure medications were under direct observation by the administering nurse who left medications unattended at the bedside for 1 of 1 resident (Resident #76). During an interview on 03/29/19 at 3:56 PM the Administrator stated the nurse who failed to properly secure the medication was an inappropriate act. The nurse reported she left the medication in resident's room because the resident was eating when she tried to administer the medication. The Administrator stated the Quality Assurance and Performance Improvement (QAPI) plan had been reviewed by the Quality Assessment and Assurance (QAA) committee on regular basis at least once per month. Any negative trends in data would be addressed utilizing root cause analysis and	F 867	The facility will continue to label all drugs and biologicals in accordance with currently accepted professional principles. The facility will continue to store all drugs and biologicals in accordance with State and Federal laws. The three inhalers left at the bedside at the time of discovery were removed and stored according to facility policy. All other rooms were checked at the time of discovery and no further medications were found at the bedside. All drugs and biologicals will be labeled and stored according to facility policy. All licensed nurses were in serviced on 3/27/19 by the DON on the facility policy for labeling and storage of drugs and biologicals. All licensed nurses were also inserviced by the DON on the facility policy for self-administration of medications. The facility□s quality assurance committee will be in serviced on 4/10/19 by the Regional QA Manager/Regional Operator on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns. Education will include determining the root cause of the identified concern, identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised. A QA monitoring tool will be utilized starting on 4/1/19 to ensure that all drugs	

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F 867	Continued From page 16 quality improvement methodologies. The leadership and staff would use evidence-based strategies until the desired change was effective and the goals were achieved and sustained.	F 867	and biologicals are labeled and stored according to facility policy by the DON. The DON will randomly observe resident rooms weekly x 4 weeks then randomly x 1 month. Variances will be corrected at the time of observation and additional education provided when indicated. A QA monitoring tool will be utilized starting on 4/1/19 to ensure that residents are self-administering medications according to facility policy by the DON. The DON will randomly audit resident records weekly x 4 weeks then randomly x 1 month. Variances will be corrected at the time of audit and additional education provided when indicated. Observation and audit results will be reported to the Administrator weekly for the next 2 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. A QA monitoring tool will be utilized starting on 4/26/19 to ensure ongoing compliance by the Regional QA Manager/designee. The Regional QA Manager/Regional Operator will attend the facility quality assurance meeting monthly x 2 months to ensure committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality Assurance Program.	

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F 867	Continued From page 17	F 867	Compliance will be monitored by the QA Committee for 2 months or until resolved and additional education/training will be provided for any issues identified. The Regional Quality Assurance Nurse/Regional Operator will review the facility□s quality assurance action plans monthly for the next 2 months then randomly thereafter to ensure continued compliance.	