STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345478	A. BUILDING _____ B. WING _____	05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARNETT WOODS NURSING AND REHABILITATION CENTER	604 LUCAS ROAD DUNN, NC 28334

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 5/28/19 to 5/31/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1RL811.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		6/21/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/17/2019

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, the facility failed to maintain the dignity of a resident by not responding to the resident's repeated calls for assistance (Resident #57) for 1 of 21 residents observed. Findings included: A review of the medical record revealed Resident #57 was admitted 10/14/2016 with diagnoses that included stroke, dementia, anxiety and depression. The Annual Minimum Data Set (MDS) dated 5/2/2019 noted Resident #57 was severely impaired for cognition and had no rejection of care. The MDS noted Resident #57 did have verbal symptoms like screaming but not every day. Resident #57 required extensive to total assistance for all Activities of Daily Living with one person's help. The MDS noted Resident #57 was care planned for behaviors. On 5/30/2019 at 4:15 PM on the 200 hall a resident was loudly screaming for help. No staff were noted in the hallway. Staff were seen sitting	F 550	Harnett Woods Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Harnett Woods Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Harnett Woods Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 On 05/30/2019, nursing staff responded to	

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F 550	Continued From page 2 at the nurse's station desk. No one came to the resident's room and the resident continued to scream. Upon entering Resident #57's room the Resident stopped screaming. Resident #57 was asked what she needed, and the Resident replied she wanted something to eat. Resident #57 was told the staff would be informed and the interviewer would return. When the interviewer left the room, Resident #57 yelled out "please don't leave and not come back, that is what they always do." At the nurse's station staff were informed Resident #57 had asked for a snack. Nursing Assistant (NA) #1 stated "trays will be out in a little bit." Nurse #4 indicated Resident #57 had Obsessive Compulsive Disorder and every day the Resident knew when it was time for dinner and had this behavior. Nurse #4 stated she would bring Resident #57 some pudding. Nurse #2 brought a fruit cup into Resident #57, and the Resident thanked her and blessed her. On 5/31/2019 at 8:38 AM, Resident #57 stated staff ignore her, and she feels so bad when they do that. Resident #57 stated it happened a lot. Resident stated Activities staff came to her room sometimes and she liked that. In an interview on 5/31/2019 at 2:00 PM, Nurse #5 was asked if there were any residents on the 100 hall, where Nurse #5 was assigned, that yelled out loudly. Nurse #5 sated there was one resident who had that behavior. When asked what staff did when that resident yelled out, Nurse #5 stated "We go in and see what the resident wants." On 5/31/2019 at 3:19 PM, NA #2 stated she was usually assigned to Resident #57, and Resident #57 yells almost every day. NA #2 noted	F 550	Resident #57 calls for assistance and addressed the resident□s needs. On 05/30/2019, the DON in-serviced Nurse #5 on timely responding to resident□s calls for assistance and maintaining resident dignity. On 05/30/2019, the DON in-serviced Nursing Assistant (NA) #1 on timely responding to resident□s calls for assistance and maintaining resident dignity. On 05/30/19, the DON in-serviced NA #2 on timely responding to resident□s calls for assistance and maintaining resident dignity. On 06/12/19, an in-service was initiated by the director of nursing (DON) and staff development coordinator (SDC) with all staff on resident rights to include dignity, and service response. In-service will be completed by 06/21/2019. An audit of 10 residents will be conducted by the unit manager and/or designee utilizing the Call Response Tool to ensure timelines of staff response to resident□s calls for assistance and dignity to resident. The audit will be completed weekly for four (4) weeks and then monthly for one (1) month. The unit manager and/or designee will address all identified areas of concern immediately. The DON will review and initial the Call Response Tool weekly for four (4) weeks and monthly for one (1) month to ensure any areas of concerns have been addressed. The DON will forward the results and trends of the Call Response Tool to the	

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F 550	Continued From page 3 sometimes Resident #57 wanted something to eat and sometimes Resident #57 wanted her medicine. When asked what she did when Resident #57 yelled and screamed, NA #2 stated" I go in and see what she wants. Even if it is her medicine, I still check and see." The Director of Nursing (DON) was interviewed on 5/31/2019 at 3:40 PM and stated she expected staff to respond in a timely manner to see what the residents need was.	F 550	Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the Call Response Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the use of an "as needed" (PRN) opioid pain reliever for 1 of 21 residents (Resident #11), the use of a diuretic medication for 1 of 21 residents (Resident #17), and the use of an anticoagulant medication for 1 of 21 residents (Resident #59) whose MDS assessments were reviewed. The findings included: 1. Resident #11 was admitted to the facility on 11/27/18 from a hospital. His cumulative diagnoses included a history of a left above knee	F 641	F641 Accuracy of Assessments On 06/13/2019, the Minimum Data Set (MDS) nurse corrected Resident #11 MDS assessment to accurately reflect as needed (PRN) pain medication use. On 06/13/2019, the MDS nurse corrected Resident #17 MDS to accurately reflect diuretic medication use. On 05/30/2019, the MDS nurse corrected Resident # 59 MDS to accurately reflect anticoagulant use. On 06/03/19, a 100% audit of all current residents most recent MDS was initiated by the Corporate MDS Consultant, Director of Nursing (DON) and/or	6/21/19

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F 641	Continued From page 4 amputation. A review of Resident #11 ' s physician medication orders included an order dated 2/20/19 for 5 milligrams (mg) / 325 mg oxycodone / acetaminophen (a combination opioid pain medication) to be given as one tablet by mouth every 6 hours as needed (PRN) for pain. A review of Resident #11 ' s quarterly Minimum Data Set (MDS) assessment dated 5/24/19 was completed. Section J (Health Conditions) of the MDS indicated the resident did not receive PRN pain medication at any time during the last 5 days for pain management. Section N of the MDS reported the resident received an opioid medication on 7 out of 7 days during the look back period. A review of the resident ' s May 2019 Medication Administration Record (MAR) was conducted. Documentation on the MAR revealed Resident #11 received the oxycodone/acetaminophen medication on an as needed basis each day from 5/18/19 through 5/24/19. In the absence of the MDS Coordinator, an interview was conducted on 5/31/19 at 1:30 PM with MDS Nurse #2. Upon request, MDS Nurse #2 reviewed Resident #11's quarterly MDS (dated 5/24/19) and his May 2019 MAR. She confirmed the 7-day look back period for this MDS assessment was 5/18/19 through 5/24/19. MDS Nurse #2 reported the resident ' s MAR indicated oxycodone/acetaminophen (a PRN or "as needed" order) was given on 7 out of 7 days during 7-day look back period and was coded as such in Section N. However, the MDS nurse stated Section J of the MDS should have been	F 641	designee to ensure that PRN pain medication use, diuretic medication use and anticoagulant medication use are coded correctly on the MDS. The DON and/or designee will immediately address any areas of concern. Audit will be completed by 06/21/2019. On 06/03/19, an in-service was initiated on by the Corporate MDS Consultant with the MDS nurses to ensure all MDS assessments are completed accurately to include all PRN pain medication; diuretic medication use and anticoagulant use are coded correctly on the MDS. In-service will be completed by 06/03/19. An audit of 10 completed MDS assessments will be reviewed by the DON and/or designee utilizing the MDS Accuracy Tool to ensure MDS accuracy for PRN pain medication, diuretic medication use, and anticoagulant medication use. The audit will be completed weekly for four (4) weeks and then monthly for one (1) month. The DON and/or designee will address all identified areas of concern immediately. The DON will review and initial the MDS Accuracy Tool weekly for four (4) weeks and monthly for one (1) month to ensure any areas of concerns have been addressed. The DON will forward the results and trends of MDS Accuracy Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the MDS Accuracy Tool to determine trends and/or issues that may need further interventions put into place	

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F 641	Continued From page 5 coded to indicate the resident received a PRN pain medication for pain management. An interview was conducted on 5/31/19 at 2:15 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the MDS to be coded correctly. 2. Resident #17 was admitted to the facility on 9/3/18 with a cumulative diagnoses which included hypertension. A review of Resident #17 ' s physician medication orders included an order dated 3/12/19 for 100 milligrams (mg) spironolactone (a diuretic) to be given as one tablet by mouth in the morning every Tuesday for edema. A review of Resident #17 ' s quarterly Minimum Data Set (MDS) assessment dated 4/1/19 was completed. Section N (Medications) of the MDS indicated the resident did not receive a diuretic on any of 7 days during the 7-day look back period (3/26/19 - 4/1/19). A review of the resident ' s March and April 2019 Medication Administration Records (MARs) was conducted. Documentation on the MARs from 3/26/19 through 4/1/19 revealed Resident #17 received one dose of spironolactone on 3/26/19 in accordance with the physician ' s order. In the absence of the MDS Coordinator, an interview was conducted on 5/31/19 at 1:30 PM with MDS Nurse #2. Upon request, MDS Nurse #2 reviewed Section N of Resident #17's quarterly MDS dated 4/1/19. She also reviewed the resident ' s March 2019 and April 2019 MARs.	F 641	and to determine the need for further and/or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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F 641	Continued From page 6	F 641		

MDS Nurse #2 confirmed the 7-day look back period for this MDS assessment was 3/26/19 through 4/1/19 and confirmed Resident #17 ' s MARs indicated spironolactone was given on 3/26/19 (on 1 out of 7 days during 7-day look back period). When asked, the MDS nurse stated Section N of the MDS should have been coded to indicate the resident received a diuretic on 1 out of 7 days during the MDS look back period.

An interview was conducted on 5/31/19 at 2:15 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the MDS to be coded correctly.

3. A review of the medical record revealed Resident #59 was admitted 12/29/2015 with diagnoses that included Coronary Artery Disease, Dementia and Parkinson's Disease.

The Quarterly Minimum Data Set (MDS) dated 5/4/2019 noted Resident #59 to be severely impaired for cognition and needed extensive assistance for all daily care with the help of one person. A review of the medications in the MDS noted Resident #59 received an anticoagulant daily.

A review of the Medication Administration Record (MAR) for April and May 2019, revealed Resident #59 had received an anti-platelet medication daily, but not an anticoagulant.

In an interview on 5/30/2019 at 3:00 PM, the MDS nurse coordinator stated the Quarterly MDS was incorrect, and she would correct it immediately.

On 5/31/2019 at 1:40 PM, the Director of Nursing

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F 641	Continued From page 7 stated her expectation was the MDS would be coded correctly.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		6/25/19

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F 656	Continued From page 8 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan which addressed the use of psychotropic medications (any drug capable of affecting the mind, emotions, and/or behavior) for 1 of 5 residents (Resident #11) reviewed for unnecessary medications; and failed to ensure the comprehensive care plan was accurate when it addressed the use of a diuretic for 1 of 21 sample residents (Resident #68) whose care plans were reviewed. The findings included: 1. Resident #11 was admitted to the facility on 11/27/18 from a hospital with cumulative diagnoses which included major depressive disorder. A review of the resident ' s current medications included the following, in part: --10 milligrams (mg) escitalopram (an antidepressant medication) to be given as one tablet by mouth once daily for depression (last ordered on 2/21/19); and, --1 mg lorazepam (an antianxiety medication) to be given as one tablet by mouth twice a day for anxiety/anxiousness (last ordered on 3/14/19). Review of Resident #11 ' s annual Minimum Data	F 656	F656 Development/Implementation of Comprehensive Care Plan On 06/03/19, the Minimum Data Set (MDS) nurse updated Resident #11 care plan to include the use of psychotropic medications. On 06/03/19, the MDS nurse updated Resident #68's care plan to accurately reflect no diuretic medication use. On 06/03/19, 100% audit of all residents on psychotropic medication was initiated by the corporate MDS consultant to ensure that all residents with psychotropic medications have a comprehensive care plan that addresses the use of psychotropic medications. All areas of concern were immediately addressed by the DON and/or designee. Audit was completed on 06/10/19. On 06/03/19 100% audit of all residents was initiated by the corporate MDS consultant to ensure that all residents have a comprehensive care plan that accurately reflects the use of diuretic medications. All areas of concern were immediately addressed by the DON and/or designee. Audit was completed on 06/25/19.	

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F 656	Continued From page 9 Set (MDS) assessment dated 3/14/19 indicated the resident had intact cognitive skills for daily decision making. Section N of the MDS assessment revealed the resident received both antianxiety and antidepressant medications on 7 out of 7 days during the look back period. A review of the resident ' s Care Area Assessment (CAA) Worksheets (dated 3/15/19) revealed the care area for Psychotropic Drug Use was triggered due to the use of antianxiety and antidepressant medications. The CAA Worksheet indicated psychotropic drug use would be addressed in Resident #11 ' s care plan. A review of Resident #11 ' s most recent quarterly MDS assessment dated 5/24/19 was conducted. Section N of the MDS reported the resident continued to receive an antianxiety medication on 7 out of 7 days and an antidepressant medication on 7 out of 7 days during the look back period. . A review of Resident #11 ' s current comprehensive care plan (last revised 5/29/19) was conducted. The care plan did not address the use of psychotropic medications. An interview was conducted on 5/31/19 at 1:30 PM with MDS Nurse #2. Upon request, the nurse reviewed Resident #11's annual MDS dated 3/14/19, quarterly MDS dated 5/24/19, and 3/15/19 CAA Worksheet for psychotropic medications. She also reviewed the resident ' s current care plan and stated the care plan did not address the use of psychotropic medications, but should have done so. When asked, the MDS nurse stated the MDS Coordinator was typically responsible to complete the resident's care plans. The MDS Coordinator was not available for an	F 656	On 06/03/19, an in-service was initiated by the Corporate Nurse Consultant and the administrator with all members of the interdisciplinary care plan team to include but not limited to the dietary manager, Minimum Data Set (MDS) nurses, social services director, admissions coordinator, activities director, restorative nurses and unit managers on the requirements for completing a comprehensive care plan for each resident to include, but not limited to residents receiving psychotropic medication and diuretic medication. An audit will be completed on 10 residents receiving psychotropic medication by the DON and/or designee utilizing the Care Plan Audit Tool weekly for four (4) weeks and then monthly for one (1) month to ensure all residents receiving psychotropic medication have a comprehensive care plan that includes psychotropic medication use. All areas of concerns will be immediately addressed by the DON and/or designee. The DON will review and initial the Care Plan Audit Tool weekly for four (4) weeks and then monthly for one (1) months to ensure any areas of concern have been addressed. An audit will be completed on 10 residents by the DON and/or designee utilizing the Care Plan Audit Tool weekly for four (4) weeks and then monthly for one (1) month to ensure all residents have a comprehensive care plan that is accurate when it addresses the use of diuretic medications. All areas of concern will be immediately addressed by the DON and/or designee. The DON will review and initial the Care Plan Audit Tool weekly	

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F 656	Continued From page 10 interview. An interview was conducted on 5/31/19 at 2:15 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported that if a care area triggered from the MDS assessment information, she would expect a care plan to be completed and implemented for the resident. Upon further inquiry, the DON stated this expectation did apply to the care area for psychotropic medications. 2. Resident #68 was admitted to the facility on 3/8/19 from a hospital with cumulative diagnoses which included hypertension. A review of Resident #68 ' s current comprehensive care plan was conducted. The care plan included an area of focus which indicated the resident received a diuretic medication and was at risk for dehydration. Documentation on the care plan revealed this area of focus related to a diuretic was initiated on 3/11/19 and last revised on 3/11/19. Review of Resident #68 ' s admission Minimum Data Set (MDS) dated 3/21/19 indicated the resident had moderately impaired cognitive skills for daily decision making. Section N of the MDS assessment reported the resident did not receive a diuretic during the 7-day look back period. A review of the resident ' s physician orders and March 2019 Medication Administration Record (MAR) was conducted. The documentation revealed Resident #68 did not receive a diuretic. An interview was conducted on 5/31/19 at 1:30 PM with MDS Nurse #2. During the interview, the	F 656	for four (4) weeks and then monthly for one (1) month to ensure any areas of concern have been addressed. The DON will forward the results of the Care Plan Audit Tool to the Quality Assurance Committee monthly for two (2) months. The Quality Assurance Committee will meet monthly for two (2) months and review the Care Plan Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	

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F 656	Continued From page 11 MDS nurse confirmed Section N of Resident #68 ' s MDS (dated 3/21/19) did not indicate the resident received a diuretic. She also reported upon review of Resident #68 ' s MAR, the resident did not receive a diuretic medication. However, MDS Nurse #2 confirmed Resident #68 ' s care plan included an area of focus addressing his use of a diuretic. The MDS Nurse reported the care plan was not correct as it should not have addressed the use of a diuretic. When asked, the MDS nurse stated the MDS Coordinator was typically responsible to complete the resident's care plans. The MDS Coordinator was not available for an interview. An interview was conducted on 5/31/19 at 3:35 PM with the facility ' s Director of Nursing (DON). During the interview, Resident #68 ' s care plan was discussed. The DON stated she would expect the care plan to be accurate and to reflect the appropriate care provided for the resident.	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		6/21/19

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F 761	Continued From page 12 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store medications at the refrigeration temperature specified by the manufacturer in 1 of 2 Medication Rooms (100 Hall Med Room). The findings included: Accompanied by Nurse #1, an observation was made of the 100 Hall Medication Room (Med Room) on 5/30/19 at 8:25 AM. A thermometer hanging from the interior door of the Med Room refrigerator indicated the temperature was 24 degrees Fahrenheit (oF). The nurse confirmed the temperature on the thermometer read 24 oF. An observation made at this time also revealed there was approximately 1 and 1/2 inches of ice built-up around the freezer portion of the refrigerator. A second observation of the 100 Hall Med Room refrigerator was conducted on 5/30/19 at 8:50 AM with the facility ' s Director of Nursing (DON). Upon request, the DON checked the refrigerator temperature and reported it was 25 oF. When asked, the DON stated the temperature was too	F 761	F761 On 5/30/19, the maintenance director replaced the thermometer in the 100 hall medication room refrigerator to ensure that temperature were between 36 to 46 degrees. All medications in the 100 hall medication room refrigerator were discarded and replaced with new medications ordered from the pharmacy. On 5/30/19, a 100% audit was completed the maintenance director to ensure that all other medication room refrigerators (100 hall, 200 hall, 300 hall) temperatures were between 36 and 46 degrees and temperatures were being checked twice daily with no concerns noted. Audit was completed the maintenance director on 5/30/19. On 6/12/19, the director of nursing (DON) initiated an in-service of licensed nurses and medication aides on the correct temperature of medication refrigerators, checks to be completed daily on	

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F 761	Continued From page 13 low and stated it should be in the range of 36 - 46 oF. At that time, the DON was asked if she would like the facility ' s maintenance staff to check and confirm the refrigerator temperature with another thermometer to ensure accuracy of the reading. Accompanied by Nurse #6, an inventory was taken of the contents of the refrigerator on 5/3/19 at 8:52 AM. The contents included: --2 unopened Basaglar insulin pre-filled pens; --1 60-count box of 20 micrograms (mcg) Perforomist vials of nebulization solution (an inhalation medication used in the treatment of asthma or chronic obstructive pulmonary disease); --4 opened vials of Novolog insulin; --1 unopened vial of Novolog insulin; --3 unopened vials of Humalog insulin; --1 unopened vial of Lantus insulin; and, --1 syringe of Prevnar 13 (an injectable pneumococcal vaccine). An observation was made of the temperature log for the 100 Hall Med Room refrigerator posted on the front of the refrigerator. The log indicated all "AM" (morning) and "PM" (afternoon/evening) temperature readings taken during the month of May from 5/1/19 through the morning of 5/30/19 were 36 oF, with the exception of two temperature readings noted as 37 oF. A review of the manufacturers ' product information for the individual medications stored in the 100 Hall Medication Room refrigerator included the following storage requirements: -- Unopened Basaglar pens may be stored refrigerated at 36 oF - 46 oF. Do not freeze or use if previously frozen; -- Perforomist vials may be stored in a refrigerator	F 761	refrigerator temperature and action to be taken if a medication refrigerator was not at correct temperatures. All newly hired licensed nurses and medication aides will be educated during orientation on the correct temperature of medication refrigerators, checks to be completed daily on medication refrigerator temperatures and actions to be taken in a medication refrigerator is not at correct temperature. Medication refrigerator temperatures will be checked and recorded twice daily by unit nurse. An audit will be completed by the Unit Manger and/or designee of all medication refrigerators to ensure the temperatures are correct and temperature logs are completed utilizing the Medication Refrigerator Temperature Audit Tool daily for four (4) weeks and then monthly for one (1) month. Any identified concerns will be addressed immediately by the Unit manager and/or designee. The Director of Nursing, Assistant Director of Nursing or Administrator will review and sign the Medication Refrigerator Temperature Audit Tool weekly for four (4) weeks and then monthly for one (1) month to ensure accuracy and that all areas of concern have been addressed. The Administrator, Director of Nursing, and/or assistant Director of Nursing will review and present the findings and trends of the Medication Refrigerator Temperature Audit Tool to the Quality Assurance and Performance	

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F 761	Continued From page 14 at 36 oF - 46 oF; -- Unopened and opened vials of Novolog insulin may be stored under refrigeration at 36 oF - 46 oF; do not freeze. -- Unopened vials of Humalog insulin may be stored under refrigeration at 36 oF - 46 oF; do not freeze. -- Unopened vials of Lantus insulin may be stored refrigerated at 36 oF - 46 oF. Do not freeze. -- Prevnar-13 should be stored under refrigeration at 36 oF - 46 oF; do not freeze; discard if frozen. An observation was conducted on 5/30/19 at 8:54 AM in the 100 Hall Med Room as the facility ' s Maintenance Director came to the med room and adjusted the refrigerator ' s temperature control dial. The Maintenance Director was also observed as he placed a different (dial-type) thermometer on the interior bottom of the refrigerator and removed the original thermometer (an upright, liquid filled thermometer) that had been hanging on a wire inside the refrigerator door. Upon request, he replaced the original thermometer back inside the refrigerator to allow for a confirmation of its accuracy by the second thermometer. An interview was conducted on 5/30/19 at 8:55 AM with the Maintenance Director. Upon inquiry, he stated the nurses were responsible for routinely keeping the temperature logs and the maintenance staff checked the med room refrigerators once a week on Fridays for ice build-up. If ice was noted to be built up, they will move the medications, remove the ice and then return the refrigerator. When asked if he knew when the 100 Hall med room refrigerator was last defrosted, he stated he did not have a record to document this information. However, he	F 761	Improvement (QAPI) Committee monthly for two (2) months. The identification of trends, issues and concerns will be addressed by implementing changes as necessary to include continued frequency of monitoring.	

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F 761	Continued From page 15	F 761		

estimated it had been about 2 months since the refrigerator had been defrosted. The Maintenance Director reported no concerns had been shared with him in regards to the refrigerator ' s temperature being out of the recommended range.

A follow-up interview was conducted on 5/30/19 at 10:46 AM with the Maintenance Director. During the interview, the Maintenance Director reported the 100 Hall med room refrigerator temperature on 5/30/19 at 10:33 AM was 32 oF. When asked if both of the thermometers (including the original one which read 24 oF and 25 oF earlier in that morning) indicated the same temperature, he confirmed they did. Upon further inquiry, the Maintenance Director stated he felt the first thermometer originally found in the refrigerator likely provided an accurate reading when it indicated the refrigerator was as low as 24 oF. The Director further stated he would need to continue to adjust the thermostat of the refrigerator to get the temperature within the range of 36-46 oF.

An interview was conducted on 5/31/19 at 7:46 AM with the DON. During the interview, the DON stated her expectation was for the temperature of the med room refrigerators to be between 36 and 46 oF. She reported the thermometer in the refrigerator on 100 Hall had been replaced with a dial-type thermometer. The DON stated she felt the dial thermometer was easier to read and would maximize the accuracy of the temperature log kept by the nursing staff.