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
	345283	A. BUILDING _____ B. WING _____	07/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to maintain one (1) of two (2) shower rooms in good repair and with good sanitation. The findings are: Observation on 07/27/2012 of the shower room for the 200/600 halls revealed the following: 1. Shower Stall #1 - broken tile around the drain, brown/black grime build-up in grooves of tile on bottom and lower wall of shower and brown stain running down side of shower; loose metal plate on end of grab bar near back wall of shower and thick, yellow substance around end of grab bar nearest shower entrance; 2. Shower Stall #2 - two (2) missing tiles from shower floor and brown/black grime build-up in grooves of tile on bottom and lower wall of shower; 3. Shower Stall #3 - twenty-one (21) missing tiles from shower floor and eight (8) missing tiles on back of shower; brown/black grime build-up in grooves of tile on bottom & lower wall of shower An interview on 07/27/2012 at 2:53 PM with the Maintenance Director revealed he wasn't aware of the missing tiles on the wall. He stated the tiles are no longer available so the areas on the shower floors with missing tiles had been filled in	F 253	The center provides the following plan of correction (POC) without admitting or denying the validity or existence of the alleged deficiencies. The POC is prepared and executed solely because it is required by provisions of Federal State law. The facility reserves all rights to contest the survey findings through dispute resolution, final appeal proceedings or any administration or legal proceedings. Corrective action for those affected: Shower room was immediately cleaned again without successful removal of discolorations. The metal plate was tightened immediately. Corporate property management was notified on July 27, 2012 to evaluate the opportunity to move the shower renovations from next years capital list to renovate the shower now. The facility quote already received for the shower renovation was pulled forward on 7/27/12.	8/24/12

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

Administrator 8/17/12

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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BY:

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F 253	Continued From page 1 with cement filler. He stated it was his understanding that renovation of the shower was in the next phase of the budget. He stated he wasn't aware of the loose metal plate on the end of the grab bar and hadn't been notified of the problem by staff. An interview on 07/27/2012 at 2:56 PM with the Housekeeping Director revealed all the showers are cleaned every morning with a Clorox solution and every Sunday the floor technicians clean the bottom & sides of the showers. She stated the discoloration of the tile grooves could not be removed. An interview on 07/27/2012 at 4:25 PM with the Administrator revealed she was aware of the missing tile in the shower stalls and had hoped renovation of the showers would be included with the recent renovation but it wasn't.	F 253	The decision was made to renovate the shower utilizing this company on August,1, 2012. The estimated renovation cost of $49779.00 is scheduled to begin August 31, 2012 and to be complete no later than the first week in October 2012. Corrective action for those potentially affected: Patients utilizing the shower room on the 200 and 600 hall was addressed as stated above. Systemic changes: Until renovations begin the shower room will be cleaned daily and will be detail cleaned weekly to include scrubbing the tiles with a deck brush. Environmental staff was inserviced on shower cleaning procedure and schedule. Maintenance staff was inserviced to check the shower rooms weekly and document findings on the audit sheet. Nursing staff was inserviced to notify the	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		

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F 329	Continued From page 2 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and the consultant pharmacist and medical record review the facility failed to assess one (1) of two (2) sampled residents on an antipsychotic medication for abnormal movements utilizing an AIMS (abnormal involuntary movement) test. (Resident #114) The findings are: Resident #114 had diagnoses which included dementia with hallucinations. Review of the medical record of Resident #114 revealed she had been on Risperdal (an antipsychotic medication) the past year with the current dose of .25 milligrams twice a day since 01/23/2012. The Care Area Assessment (CAA) for psychotropic medication for Resident #114 dated 04/16/2012 included review triggered due to resident receiving antipsychotic, antianxiety, antidepressent medications in the past seven days. A decision was made to "care plan with goal of avoiding complications/adverse effects from medications."	F 329	maintenance staff with any repair needs. The Environmental Services Director or designee will audit the shower rooms daily to assure cleaning has occurred for 2 weeks, weekly times 2 weeks, monthly times 3 months and quarterly thereafter. Until renovations begin the Maintenance Director or designee will check shower room to assure grip bars are tightly secured to the wall and document findings on the audit sheet weekly. Results of audits will be reviewed in QA monthly times 3 months then quarterly thereafter. <u>Quality Assurance and Monitoring:</u> The Environmental Services Director or designee will audit the shower rooms daily to assure cleaning has occurred for 2 weeks, weekly times 2 weeks, monthly times 3 months and quarterly thereafter. Until renovations begin the Maintenance Director or designee will check shower room to assure grip bars are tightly secured to the wall and document findings	

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F 329	Continued From page 3 The current care plan for Resident #114 last updated 07/12/2012 included the problem area, "Resident exhibits behavior. Resists care or treament. Resident refuses to get out of bed and refuses care and refuses to have labs drawn." Approaches to this problem area included, "Medicate resident as ordered by physician and monitor for side effects." Review of the medical record of Resident #114 revealed the last time an AIMs test was completed was from readmission June 2010. On 07/27/2012 at 1:20 PM the Director of Nursing (DON) stated AIMs tests are done for any resident on a psychoactive medication on admission and every six months. The DON stated the AIMs test was completed in the electronic system utilized by the facility and, once completed, subsequent tests would be triggered by the system. The DON reviewed the medical record of Resident #114 and confirmed the last AIMs test completed was 06/16/2010. In a follow-up interview on 07/27/2012 at 3:30 PM the DON stated if a resident is discharged from the facility greater than 24 hours it clears the trigger for the AIMs test and the AIMs assessment has to be completed on readmission within the electronic system. The DON stated when Resident #114 was readmitted on 06/27/2010 an AIMs test was not completed which would have triggered the need for an AIMs test every six months. The DON stated it was the responsibility of the unit managers to complete the AIMs test. The DON stated she could not determine why the AIMs test was not completed for Resident #114 on readmission because she was not working at	F 329	on the audit sheet weekly. Results of audits will be reviewed in QA monthly times 3 months then quarterly thereafter. F 329 Corrective action for those affected: Resident number 114 was immediately assessed using the AIMS test. Corrective action for those potentially affected: A review of 100% of patients receiving antipsychotic medications was complete. Every resident was assured to have an AIMS test performed and in the medical record. Systemic changes: When a resident is discharged and returns to the facility receiving antipsychotic medication an AIMS test will be performed within 24- 72 hours and entered into the computer to set the computer tickler file schedule. The DON or designee will also keep a log of all patients receiving antipsychotic medications. When an antipsychotic	8/24/12

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F 329	Continued From page 4 the facility at that time and the unit manager in place 06/27/2010 was no longer employed by the facility. The DON stated she would have expected the MDS coordinator or consultant pharmacist to identify the need for AIMs tests when doing their assessments of residents. Review of monthly consultant pharmacy reviews for Resident #114 revealed the need for an AIMs test had not been identified as a concern. On 07/27/2012 at 2:40 PM the consultant pharmacist stated he used to look for AIMs tests but since the facility began using the electronic system (for AIMs tests) two to three years ago he quit looking for AIMs tests. The consultant pharmacist stated staff had informed him the electronic system triggered when AIMs tests were due and he trusted the electronic system was ensuring AIMs tests were done as needed for residents on antipsychotic medication.	F 329	medication is ordered the DON or designee will record the medication and date of the AIMS test on the antipsychotic log. The DON or designee will review the log monthly to assure an AIMS test has been completed on admission and every 6 months while a patient is receiving an antipsychotic medication. DON or designee will audit all telephone orders in facility's morning meeting and assure any orders for a patient's antipsychotic medications has an AIMS test performed, is in the medical record, and logged on the antipsychotic tracking tool. Staff will be inserviced to complete an AIMS test with	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on staff interviews and observations of the kitchen and pantry refrigerators the facility failed	F 371	any antipsychotic medication and every 6 months as long as a patient continues to receive the medication. Inservices were provided on the process of tracking antipsychotic medications and AIMS testing. Quality Assurance and Monitoring:	

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F 371	Continued From page 5 to ensure 1) the final rinse temperature of the dish machine was 180 degrees F., 2) food items were stored in a sanitary manner and 3) equipment was properly cleaned. The findings are: During the initial tour of the facility kitchen on 07/24/2012 from 10:30 AM -11:45 AM the following concerns were identified: 1.a. The dish machine was observed in use just prior to the final racks of breakfast dishes being washed. Three separate racks were run through the dish machine and the highest temperature of the final rinse cycle was 140 degrees F. The Assistant Food Service Director (AFSD) was present at the time of the observation and stated he had not observed the dish machine final rinse temperature that morning because he had been busy putting up stock. The AFSD stated he relied on staff assigned to washing dishes to monitor the final rinse temperature of the dish machine and inform him or the FSD of any concerns. The AFSD flipped the on/off switch of the dish machine booster heater and ran another rack of dishes through the dish machine with highest temp of the final rinse cycle observed at 150 degrees F. At approximately 11:10 AM the Food Service Director (FSD) was present and observed another rack of dishes with the highest temperature of the final rinse cycle of the dish machine observed at 150 degrees F. The FSD stated she was not aware of any problems with the dish machine and had not observed the final rinse temperature that morning because she had been busy with other functions in the kitchen. After the observations the log book to record the	F 371	DON or designee will audit all telephone orders in facility's morning meeting and assure any orders for a patient's antipsychotic medications has an AIMS test performed, is in the medical record, and logged on the antipsychotic tracking tool. Results of audit, review of log and telephone order for antipsychotic meds will be reported in QA meeting monthly times three months then quarterly thereafter. F 371 Corrective action for those affected: 1)As stated in the deficiency statement the Maintenance Director was notified immediately and pushed the button to reset the booster heater. The rinse temperature returned to 180 degrees F and has continued at least 180 degrees F. 2) Food items without labels were immediately discarded, food thawing in dietary refrigerator was placed in a non-perforated pan immediately, sprinkler head in refrigerator was checked immediately and insulation added in the attic at the sprinkler head. 3) The fan in the dish room was immediately cleaned and the	8/24/12

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F 371	Continued From page 6 final rinse temperature of the dish machine was reviewed and the last recorded final rinse temperature was 180 degrees F, at lunch on 07/23/2012. The log book was designed for temperatures to be monitored and recorded after every meal. At approximately 11:15 AM the FSD asked the dietary aide (that was working in the position responsible for checking and recording the final rinse temperature) if the final rinse temperature of the dish machine had been checked while dishes were washed that morning. The aide reported she had not checked the final rinse temperature that morning and had not planned on checking the final rinse temperature until all dishware had been washed. The aide stated she only had a few racks of dishes left to wash from the morning meal service and was not aware the final rinse temperature was less than 180 degrees F. The FSD stated her expectation was for staff to check the final rinse temperature of the dish machine at every meal and at the start of washing dishes in the event there were problems with the final rinse temperature. The FSD stated the aide (that was in the position to check the final rinse temperature that morning) did not typically work with dishwashing but should have known to check the final rinse temperature at the beginning of doing dishes as it was part of their training. The AFSD contacted the maintenance director prior to resuming use of the dish machine. At approximately 11:30 AM the maintenance director reported the booster heater had to be reset as he thought an element had blown. 1.b. A wall mount fan positioned at ceiling level was observed in the room where clean dishes were washed by staff utilizing the three	F 371	stainless steel enclosed box for pest control was immediately cleaned. Corrective action for those potentially affected: 1)Staff will check dish machine temperature prior to beginning use of the dish machine and record temperature on log. If the temperature is noted to be less than 180 Degrees F staff will push the reset button for the booster heater. If the temperature does not increase to at least 180 degrees F on the last rinse cycle dietary staff will notify the maintenance department using the maintenance request form. Maintenance will respond to the work order and address the situation to assure the dish machine is working properly. 2) Nourishment refrigerators will have a florescent colored sign indicating all food must be dated, labeled with patient name or it will be thrown away. The Environmental Services staff or designee will check the refrigerator daily and document compliance and	

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F 371	Continued From page 7 compartment sink and dish machine. The fan was on high speed with air blowing throughout the room. The front grill of the fan was noted to have long strands of dust-like matter blowing from the fan. The AFSD was present at the time of the observation and the fan was turned off. When turned off both the front and back grills were observed with dust-like strands and there was a significant amount of black matter on the outer surface of each fan blade. The AFSD stated maintenance staff was responsible for cleaning the fan and did this about once a month. The AFSD stated usually dietary staff would inform maintenance staff about the need to clean the fan and the AFSD agreed the fan needed to be cleaned. 1c. A pan of raw chicken was observed stored on the bottom shelf of open three tiered shelving in the walk in refrigerator. The pan of chicken was covered with plastic wrap that was tautly secured to the pan. In the center of the plastic wrap was an approximately half cup of pooled clear liquid. Directly above the pan of raw chicken (on open shelving) was a perforated pan housing two hams and a bag of chopped turkey. The AFSD was present at the time of the observation and stated the chicken and turkey had been placed in the walk in refrigeration to thaw prior to use for an upcoming meal. The AFSD suspected the liquid pooled on the plastic wrap covering the chicken had come from the bag of thawing turkey stored on the perforated pan directly above the chicken. The AFSD stated staff would be inserviced on placing thawing meat in a non perforated pan when placed in the walk in refrigerator. 2. On 07/26/2012 at 10:00 AM observations were	F 371	dispose of any unlabeled undated foods. Families will be notified and staff will be inserviced that all foods are to be labeled with the patients name and the date food is placed in the refrigerators. 3) The dietary refrigerator sprinkler head will be added to the weekly cleaning schedule. Dietary employees will check for water drops and notify maintenance if water drops are noted when they complete their weekly cleaning schedules. The Maintenance Director or designee will follow up to assure the situation is corrected. 4) Food items will be stored in non-perforated pans while food is thawed. Staff will be inserviced regarding thawing food in perforated pans. 5) The fan in the dietary dish room and the pest control box will be added to the weekly cleaning schedule Systemic changes: 1) Staff will check dish machine and take corrective action if needed as specified above. Maintenance will conduct weekly audits of the dish machine to assure it continues to reach at least 180 degrees F during the last rinse cycle and document these weekly checks. Working	

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F 371	Continued From page 8 made of the walk in refrigerator. A sprinkler was observed in the ceiling and an open cart with trays of individual servings of covered food was stored below the sprinkler. Water was observed slowly dripping from the sprinkler onto covered food items on the open cart. The AFSD was present at the time of the observation and stated he wasn't aware of the dripping water from the sprinkler. The AFSD called the maintenance director to assess the sprinkler in the walk in refrigerator. The maintenance director stated since the sprinkler had been installed in the walk in refrigerator there had been problems with it dripping water when outside temperatures got too high. 3. On 07/26/2012 at 10:15 AM a significant amount of dust was observed coating the top of a wall mounted stainless steel box used to electronically eradicate flying insects. The electrodes on the front of the unit were coated with a significant amount of dust. This unit was above a work table where beverages were prepared. The AFSD was present at the time of the observation and stated dietary staff should have cleaned the top and wiring of the unit. 4. Observation on 07/26/2012 at 10:15 AM of the 100/300 Nourishment Refrigerator revealed two (2) bowls of a yellow pudding-type substance that were not labeled or dated and two (2) 1/2 sandwiches that appeared to be egg salad which were not labeled or dated. A bag with a restaurant label containing a sandwich, which was not dated or labeled, was on a shelf of the refrigerator. A cake labeled with a resident's name and room number was not dated as to when it was placed in the refrigerator. The top shelves in the refrigerator door were coated with	F 371	condition of the dish machine will be reported in QA meetings monthly times 3 months and quarterly thereafter by the maintenance department. 2) Nourishment refrigerators will have a florescent colored sign indicating all food must be dated, labeled with patient name or it will be thrown away. The Environmental Services staff or designee will check the refrigerator daily and document compliance and dispose of any unlabeled undated foods. Families will be notified and staff will be inserviced that all foods are to be labeled with the patients name and the date food is placed in the refrigerators. 3) The dietary refrigerator sprinkler head will be added to the weekly cleaning schedule. Dietary employees will check for water drops and notify maintenance. Maintenance will take corrective action as needed as stated above. The Food Service Director or designee will audit the cleaning schedules weekly times 3 weeks, monthly times 3 months then	

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F 371	Continued From page 9 a yellow sticky residue and the bottom drawer had spots of yellow and brown sticky residue. The bottom of the refrigerator in front of the drawer also had spots of a yellow sticky residue. The inside of the freezer compartment was covered with a build-up of ice approximately 3/4 inch thick and there was also a thin layer of ice accumulated on the upper, back wall of the refrigerator. Observation on 07/26/2012 at 2:45 PM of the 200/600 Nourishment refrigerator revealed a bag of food labeled with a resident's name which was not dated; a cooler labeled with a resident's name which contained a plastic storage container of an unidentified substance with no date; and an opened container of skim milk with no date. An interview on 07/26/2012 at 3:40PM with LN #1 revealed any items put in the refrigerator are supposed to be dated with the date they are placed in the refrigerator. LN #1 stated she wasn't aware of who put food items in the refrigerator for the residents but that one of the residents had private sitters who could have put food in the refrigerator for him. LN # 1 stated dietary staff check the refrigerator for expired food items and that nursing staff is responsible for dating any food items placed in the refrigerator. An interview on 07/26/2012 at 5:28 PM with the Assistant Food Service Director revealed dietary staff check nourishment refrigerators about 10:00 AM every day. He stated all food items should be labeled with resident's name, contents and date. He stated all items brought from the kitchen should be labeled with contents and date. He stated the date on an item is the date it was put in	F 371	quarterly thereafter. 4) Food items will be stored in non-perforated pans while food is thawed. Staff will be inserviced regarding thawing food in perforated pans. The Food Service Director or designee will complete audits to assure foods are being thawed in non-perforated pans weekly times 4 weeks, monthly times 2 months and quarterly thereafter 5) The fan in the dietary dish room and the pest control box will be added to the weekly cleaning schedule. Food Service Director or designee will conduct audits of the cleaning schedules weekly times 4 weeks, monthly times 3 months then quarterly thereafter. Quality Assurance and Monitoring: Maintenance will conduct weekly audits of the dish machine to assure it continues to reach at least 180 degrees F during the last rinse cycle and document these weekly checks. Working condition of the dish machine will be reported in QA meetings monthly times 3 months and quarterly thereafter by the maintenance department. 2) The Environmental Services	

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F 371	Continued From page 10 the refrigerator. He further stated if dietary finds an item that is undated, the item should be discarded. He stated housekeeping is responsible for cleaning & defrosting the refrigerator.	F 371	staff or designee will check the refrigerator daily and document compliance and dispose of any unlabeled undated foods. Audits will be conducted	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interviews with staff/the consultant pharmacist and medical record review, the consultant pharmacist failed to identify and report the need for AIMs (Abnormal Involuntary Movement) testing for one (1) of two (2) sampled residents on an antipsychotic medication (Resident #114) The findings are: Resident #114 had diagnoses which included dementia with hallucinations. Review of the medical record of Resident #114 revealed she had been on Risperdal (an antipsychotic medication) the past year with the current dose of .25 milligrams twice a day since 01/23/2012.	F 428	weekly times 3 months and reported in monthly QA meetings and quarterly thereafter. 3) The Food Service Director or designee will audit the cleaning schedules weekly times 3 weeks, monthly times 3 months then quarterly thereafter. 4) The Food Service Director or designee will complete audits to assure foods are being thawed in non-perforated pans weekly times 4 weeks, monthly times 2 months and quarterly thereafter 5) Food Service Director or designee will conduct audits of the cleaning schedules weekly times 4 weeks, monthly times 3 months then quarterly thereafter. FF 428 <u>Corrective action for those affected:</u> Resident number 114 had an AIMS test done immediately.	8/24/12

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

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	345283	A. BUILDING _____ B. WING _____	07/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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F 428	Continued From page 11 The Care Area Assessment (CAA) for psychotropic medication for Resident #114 dated 04/16/2012 included: review triggered due to resident receiving antipsychotic, antianxiety, antidepressant medications in the past seven days. A decision was made to "care plan with goal of avoiding complications/adverse effects from medications." The current care plan for Resident #114 last updated 07/12/2012 included the problem area, "Resident exhibits behavior: Resists care or treatment. Resident refuses to get out of bed and refuses care and refuses to have labs drawn." Approaches to this problem area included, "Medicate resident as ordered by physician and monitor for side effects." Review of the medical record of Resident #114 revealed the last time an AIMs test was completed was from readmission June 2010. On 07/27/2012 at 1:20 PM the Director of Nursing (DON) stated AIMs tests are done for any resident on a psychoactive medication on admission and every six months. The DON stated the AIMs test was completed in the electronic system utilized by the facility and, once completed, subsequent tests would be triggered by the system. The DON reviewed the medical record of Resident #114 and confirmed the last AIMs test completed was 06/16/2010. In a follow-up interview on 07/27/2012 at 3:30 PM the DON stated if a resident is discharged from the facility greater than 24 hours it clears the trigger for the AIMs test and the AIMs assessment has to be completed on readmission within the electronic system. The DON stated when	F 428	Corrective action for those potentially affected A 100% audit was conducted for all residents receiving antipsychotic medications. AIMS tests are in place for all patients receiving antpsychotics. The Pharmacist will obtain a list of all patients who are receiving antipsychotic medications and conduct a review of the meds during his monthly visits. These reviews will assure AIMS testing is in place. If the Pharmacist does not see an AIMS test in the medical record he will notify the DON or designee and one will be completed. The Pharmacist will conduct these reviews in addition to the computer system to assure an AIMS test is not missed. Pharmacist was educated that even though he may feel the computer is tracking the AIMS testing the above stated plan will be followed as a back up to assure AIMS testing is occurring. The DON or designee will log all antipsychotic medications when ordered	

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F 428	Continued From page 12 Resident #114 was readmitted on 06/27/2010 an AIMs test was not completed which would have triggered the need for an AIMs test every six months. The DON stated it was the responsibility of the unit managers to complete the AIMs test. The DON stated she could not determine why the AIMs test was not completed for Resident #114 on readmission because she was not working at the facility at that time and the unit manager in place 06/27/2010 was no longer employed by the facility. The DON stated she would have expected the MDS coordinator or consultant pharmacist to identify the need for AIMs tests when doing their assessments of residents. Review of monthly consultant pharmacy reviews for Resident #114 revealed the need for an AIMs test had not been identified as a concern. On 07/27/2012 at 2:40 PM the consultant pharmacist stated he used to look for AIMs tests but since the facility began using the electronic system (for AIMs tests) two to three years ago he quit looking for AIMs tests. The consultant pharmacist stated staff had informed him the electronic system triggered when AIMs tests were due and he trusted the electronic system was ensuring AIMs tests were done as needed for residents on antipsychotic medication.	F 428	utilizing the telephone order review process in morning meeting. This process will assure all antipsychotic meds are logged and tracked for compliance. Staff was inserviced on process for logging antipsychotic medications. Systemic changes The Pharmacist will obtain a list of all patients who are receiving antipsychotic medications and conduct a review of the meds during his monthly visits. These reviews will assure AIMS testing is in place. If the Pharmacist does not see an AIMS test in the medical record he will notify the DON or designee and one will be completed. The Pharmacist	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	will conduct these reviews in addition to the computer system to assure an AIMS test is not missed. Pharmacist was educated that the above	

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F 431	Continued From page 13 reconciled. 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. 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. 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 inspection of medication room refrigerators, the facility failed to ensure an unlabelled, non-regulated alcoholic beverage was not available for resident consumption in one (1)of two (2) medication room refrigerators and failed to ensure an expired narcotic was not available for resident use in the emergency narcotic kit	F 431	stated plan will be followed as a back up to assure AIMS testing is occurring. The DON or designee will log all antipsychotic medications when ordered utilizing the telephone order review process in morning meeting. This process will assure all antipsychotic meds are logged. Staff was inserviced on process for logging antipsychotic medications. Monitoring and Quality Assurance A 100% audit was conducted for all residents receiving antipsychotic medications. The Pharmacist will obtain a list of all patients who are receiving antipsychotic medications and conduct a review of the meds during his monthly visits. If the Pharmacist does not see an AIMS test in the medical record he will notify the DON or designee and one will be completed. The DON or designee will audit all new	

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F 431	Continued From page 14 Inspection of the 100/300 hall medication room refrigerator on 07/27/2012 at 10:00 AM revealed one (1) full quart size Mason jar of clear liquid labeled with Resident #38's name but without the contents identified. Inspection of the facility's emergency narcotic kit on 07/27/2012 at 1:45 PM revealed one (1) tablet hydrocodone/acetaminophen 7.5/500mg with an expiration date of 06/15/2012. A review of the facility's policy on storage of alcoholic beverages revealed the policy allowed for resident consumption of alcoholic beverages and did not provide guidance on the use of non-regulated alcoholic beverages. The facility's policy on the storage and expiration dating of drugs specified: "Drugs and biologicals that have an expired date on the label or are after manufacturer/supplier guidelines/recommendations are stored separately away from use, until destroyed or returned to the provider." An interview on 07/27/2012 at 1:45 PM with Licensed Nurse (LN) #2 about the monitoring of medications in the emergency narcotic kit revealed the medications are counted every shift and the nurse administering any medication taken from the kit should check the expiration date before giving it. In an interview with Resident #38 on 07/27/2012 at 2:08 PM, he stated the quart jar contained "moonshine" and his daughter gave it to him last Thanksgiving. He stated he had not drank any of the moonshine	F 431	medication orders by utilizing the telephone order review process in morning meeting. DON or designee will report findings in QA meeting monthly times 3 months and quarterly there after F 431 Corrective action for those affected: The alcoholic beverage was immediately sent home with the daughter and the expired narcotic was immediately destroyed. Corrective action for those potentially affected: The medication rooms were immediately checked to assure no unlabeled alcoholic beverages or expired medications were present. Systemic changes: Medication refrigerators will be audited weekly for unlabeled substances or expired medications. These audits will be conducted weekly and logged. Staff was inserviced on the audit tool	8/24/12

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F 431	Continued From page 15 An interview on 07/27/2012 at 3:15 PM with LN #3 about the facility policy regarding alcoholic beverages revealed residents are allowed to have alcoholic beverages with a physician's order. LN #3 stated it must be labeled with the resident's name & stored in the medication room refrigerator. LN #3 stated she didn't know what the facility's policy was for receiving alcoholic beverages that weren't in a container with a manufacturer label. An interview with the Director of Nursing (DON) on 07/27/2012 at 3:23 PM about the facility policy for residents consuming alcoholic beverages revealed the policy allowed residents to have alcoholic beverages with a physician's order. An interview on 07/27/2012 with the Administrator revealed she was not aware of the quart jar of an unidentified alcoholic beverage for Resident #38 in the medication room refrigerator. She stated she would think if the resident wanted to drink moonshine and his family brought it in, the family should inform staff of what was in it and staff should get a physician's order for the resident to have it. She stated she knew Resident #38 had a doctor's order to have alcoholic beverages.	F 431	and to check medication expiration dates, destroy medications prior to expiration date and not to accept alcohol or any substances that are not labeled as to the content in the container. Monitoring and Quality Assurance Medication refrigerators will be audited weekly for unlabeled or expired medications and documented on the audit tool. Findings of audits will be reviewed in QA meeting monthly times 3 months then quarterly thereafter. Staff was inserviced on the audit tool and to check medication expiration dates, destroy medications prior to expiration date and not to accept alcohol or any substances that are not labeled as to the content in the container.	