STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to develop and implement nonpharmalogical interventions to prevent 2 of 5 sampled residents (Residents #70 and #72) from exhibiting aggressive behaviors towards 9 other residents (Residents #6, #38, #148, #75, #78, #93, #94, #119 and #153). The findings included: 1. Resident #70 was admitted to the facility on 09/17/12 with diagnoses including Alzheimer's Disease and anxiety. The physician's progress note dated 09/20/12 noted the resident came from a geriatric psychiatric facility where he was treated for confusion and agitation. The care area assessment for behaviors dated 09/21/12 stated there was no immediate intervention needed. He was on the secured unit for safety and supervision. It was noted that the resident may wander into other residents' rooms and was at risk of confrontation with other residents and increased agitation during redirection from staff. The current care plan developed 11/21/12	F 250	*This Plan of Corrections is the facilities credible allegation of compliance.* *Preparation of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 250 1-Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident # 70 and resident #72 had the new Behavioral Assessment Tool completed to determine specific behaviors, probable triggering events, interventions that decrease behaviors. a) Resident #70 and resident #72 care plan was created to include specific behaviors, probable triggering events, interventions that decreased behaviors.	7.12.13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Verna W McEntire — TITLE: Administrator — (X6) DATE: 7-10-2013

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.

ORIGINAL SIGNATURE DATE: 7-8-13

DHSR Asheville Mountain Region Received JUL 10 2013 by: SKH

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F 250	Continued From page 1 addressed behaviors of wandering aimlessly on the hall and in other resident rooms. This care plan's interventions included providing close supervision, redirect and reorient when needed, and if agitation occurs during care allow a bit of time to pass and retry to complete tasks, encourage him to rest if he seems fatigued or anxious, intervene to increase safety and well being. The quarterly Minimum Data Set (MDS) dated 12/12/12 coded the resident with severely impaired cognitive skills, having other behaviors 1-3 days and wandering 1-3 days. It was noted that he received antipsychotic and antianxiety medications daily. Review of abuse reports revealed on 12/31/12 at 6:00 AM, Resident #70 was hit by Resident #148 when he wandered into her room. Staff were present in the room at this time. Resident #70 was to be observed. The investigation did not analyze or determine what caused this altercation or how to avoid another altercation. Review of nursing notes dated 01/07/13 at 9:20 PM revealed Resident #70 pulled a resident out of his bed. The nursing notes indicated he was upset earlier and talking about people being in his house. This resident was not identified and there was no indication of any followup or investigation to analyze or determine what caused this altercation or how to avoid another altercation. Review of abuse reports revealed on 01/21/13 at 12:45 AM, Resident #70 pushed Resident #93 up against the door frame and balled his fists at him. It was noted Resident #70 had been following the	F 250	2- Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice. An audit of residents with behaviors in the facility was completed on 07/05/2013 by the Social Services Department for all residents that exhibited behaviors, their plan of care reviewed to ensure that it contained: the type of behaviors, possible triggering events and specific interventions that decrease the behavior episodes.. 3-Measures will be put in place or systemic changes made to ensure that the alleged deficient practice will not occur: a) The Social Services Director was in-serviced by the Clinical Consultant on 06/26/2013 on the following: a) The facilities New Behavioral Assessment Tool	

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F 250	Continued From page 2 resident and yelling at him. Resident #70 was placed on 15 minute checks. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. Nursing notes dated 01/23/13 at 2:10 AM revealed another (unknown) resident accused Resident #70 of hitting him. He remained on 15 minute checks from 01/21/13. A medication change (Depakote was added) was made 01/28/13 due to behaviors. There was no investigation regarding this incident or any analysis to determine what caused this altercation or how to avoid another altercation. Review of abuse reports revealed on 03/01/13 at 7:00 AM Resident #70 was pulling on the feet of Resident #153 who then punched Resident #70 in the eye. 15 minute checks were then implemented. The next day the physician took him off the 15 minute checks and requested a psychiatric evaluation. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. The quarterly MDS dated 03/06/13 coded the resident with severely impaired cognitive skills, having physically abusive behaviors 1-3 days, having other behaviors 1-3 days and wandering daily. He received antipsychotic medications daily. There was no care plan established to address Resident #70's physical aggressive behaviors. The psych consult notes dated 03/20/13 noted no recent aggression.	F 250	b) How to and when to complete the tool. c) Documenting and implementing the behavior and interventions used to decrease the behaviors d) The Social Services Director was again in-serviced by the Director of Nursing on 07-02-2013, On the following: a) properly investigating each behavior to ascertain the type of behavior, the possible triggering event and what interventions work to decrease the behaviors and documentation of the behavior. b) The New Behavioral Assessment Tool will be completed upon admission, quarterly and upon any behaviors. c) The Social Service Director will complete the New Behavior Quality Assurance tool per occurrence of behaviors and create care plans. 4-Monitoring of the facilities performance to make sure the solution is	

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F 250	Continued From page 3 Review of abuse reports revealed on 03/21/13 at 10:40 PM, Resident #70 slapped Resident #6 in the face. He was placed on 15 minute checks and the physician ordered an intramuscular antipsychotic (Haldol 5mg) injection. On 03/22/13 Depakote was increased and the 15 minute checks were terminated by the physician. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. Review of abuse reports revealed on 03/30/13 at 4:30 PM Resident #70 became frustrated, raised a chair and during staff intervention, Resident #70 lowered the chair but hit Resident #119's finger in the process. Plans were to monitor Resident #70 with no description as to what type of monitoring was provided. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. Nursing notes dated 04/30/13 revealed Resident #70 was agitated and abusive to Resident #153 and #6. The notes did not describe the exact abusive behavior. He was placed on one to one supervision and given a snack and he calmed down. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. Review of abuse reports revealed on 05/21/13 Resident #70 was picking up chairs and bedside tables, and throwing books on the floor. Ativan (ordered on an as needed basis) was given with little effect and the physician ordered an	F 250	sustained will be accomplished by: a) The IDT (Interdisciplinary Team) will review daily (Monday-Friday) at the morning QA meeting each Behavioral Assessment and Behavioral Quality Assurance Tool for compliance. This will be done as a permanent part of this QA process Any discrepancies, trends or/and triggers, identified will be documented with corrective revisions. b) Monthly QA Committee meeting to assess monitoring needs, discrepancies, trends and/or triggers and continued compliance in this area. Monitoring by the monthly QA Committee will be done monthly for 12 months then quarterly there after. Director of Nurses or designee will be responsible for maintaining compliance.	

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F 250	Continued From page 4	F 250		

antipsychotic intramuscular injection (Haldol 1 mg) to calm him. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation.

The quarterly MDS dated 05/29/13 coded the resident with severely impaired cognitive skills, having physically abusive behaviors 1-3 days, having other behaviors 1-3 days and wandering daily. He received antipsychotic medications daily and an antianxiety medication once in the last 7 days. There still was no care plan developed to address abusive behaviors. Care plan notes dated 06/05/13 stated there were no increased behaviors noted.

On 06/14/13 at 10:04 AM, Resident #70 was observed sitting in a female's room on the bed and another gentleman was sitting in a nearby chair. There were no other residents in the room.

On 06/14/13 at 2:50 PM Nurse #4 described Resident #70 as easy going and fairly easy to redirect. She stated he was hearing impaired and you had to make sure he heard you.

On 06/14/13 at 3:05 PM Nurse Aide #5 stated when Resident #70 got agitated you just let him be and reapproached him later. She further stated that he was irritated by a couple of residents and named Resident #153.

On 06/14/13 at 5:06 PM, the MDS nurse stated the social worker handled the behavior section in the MDS, subsequent assessments and the development of care plans addressing behaviors.

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F 250	Continued From page 5 On 06/14/13 at 5:36 PM Nurse #5 stated Resident #70's behaviors were triggered by different things. The staff watched him close, and redirected him with snacks, television and talking with him about his wife. On 06/14/13 at 5:44 PM while eating dinner in the dining room, Resident #70 yelled at the female tablemate when she hit his foot with hers. Staff did not seem to notice or intervene. Interview with the Social Worker (SW) on 06/14/13 at 5:11 PM revealed Resident #70 did have abusive behaviors which were not care planned. He also said he had been responsible for investigating abuse reports up until 2 weeks ago which informed him of Resident #70's behaviors. The SW further stated that when an altercation occurred the social worker staff would go and talk to the resident and note the conversation. When asked about checking into triggers and trends of behaviors, the SW stated he felt that was more the role of the psychologist/psychiatrist. 2. Resident #72 was most recently readmitted to the facility on 12/15/10. His diagnoses included dementia with behavior disturbances, anxiety disorder, bipolar disorder and depression. A quarterly Minimum Data Set (MDS) dated 12/19/12 coded Resident #72 with severe cognitive impairment, having verbally abusive behaviors and requiring extensive assistance with most activities of daily living skills and supervision with locomotion. It was noted he took antidepressants, antianxiety and antipsychotic medications daily.	F 250		

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F 250	Continued From page 6 A care plan had been developed on 07/11/11 which identified Resident #72 having agitation with other residents and/or staff. On 04/10/12 it was noted that he hit out at others sometimes making contact. Interventions included to attempt to solve problem if able to decrease his irritability, remove him from the area if irritable, provide close supervision, if agitated attempt to distract with new or change of topic, spend time allowing the resident to talk about his thoughts and feelings when irritable, and remove resident if anger arises to level of concern. Review of abuse reports revealed on 02/03/13 at 1:16 PM, Resident #72 hit Resident #38 while waiting to go outside and smoke. Resident #72 received a skin tear to his hand and the other resident was not injured. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. Another abuse report revealed on 02/20/13 at 3:45 PM, Resident #72 hit Resident #38 twice with his reacher device, again while waiting to go outside and smoke. Resident #72 was not injured and Resident #38 sustained several bruises on her arm. On 02/20/13 the physician ordered a psychiatric evaluation for Resident #72 and started Namenda (for treatment of dementia). The psychiatric evaluation was never completed. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. The quarterly MDS dated 03/13/13 coded	F 250		

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F 250	Continued From page 7 Resident #72 with severe cognitive impairment, having physically abusive behaviors, rejection of care for one to three days, requiring extensive assistance with most activities of daily living skills and supervision with locomotion. It was noted he took antidepressants, antianxiety and antipsychotic medications daily. Another abuse report noted on 04/17/13 at 4:15 PM Resident #72 was outside smoking when Resident #72 hit Resident #17 in the mouth. Nursing notes for 04/17/13 indicated no staff were present during this altercation and they were noted swinging fists at each other and making racial comments. Neither resident was injured and Resident #72 was placed on one to one supervision. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. Another abuse report revealed on 04/28/13 at 8:45 PM Resident #72 yelled, kicked and hit Resident #75, his roommate. Staff had been in the room at this time and had turned her back when the altercation occurred. Neither resident was injured and Resident #72 was placed on one to one supervision. There was no evidence of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. Another abuse report revealed on 04/29/13 at 3:00 PM, staff saw Resident #72 kicking Resident #94 because she moved in front of him. Neither resident was injured and his Depakote was increased in the evenings and three days of Risperdal were ordered. There was no evidence	F 250		

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F 250	Continued From page 8 of any investigation to analyze or determine what caused this altercation or how to avoid another altercation. On 06/13/13 at 4:21 PM, Nurse Aide #6 stated he got agitated when residents bumped into him and he would get combative at times. On 06/14/13 at 7:20 PM, the Social Worker (SW) was interviewed. The SW stated that before the psychologist would meet with a resident, the responsible party had to sign an agreement for services. The SW stated he sent the agreement to the responsible party requesting psychiatric services for Resident #72 on 02/21/13. The SW stated that he never got a response from the responsible party and did not recall any attempts to follow up with the responsible party. He further stated he just "forgot" about the psychiatric evaluation because Resident #72's behaviors improved. The SW stated social service staff were responsible for all abuse investigations up until 2 weeks ago. The SW also stated that when an altercation occurred the social worker staff would go and talk to the resident and note the conversation. When asked about checking into triggers and trends of behaviors, the SW stated he felt that was more the role of the psychologist/psychiatrist.	F 250		
F 253 SS=B	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	F 253		

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F 253	Continued From page 9 by: Based on observations, staff interviews and review of maintenance logs, the facility failed to identify and repair wood molding (Room 120) and linoleum on resident room and bathroom doors (Rooms 126, 121, 105, 219, 215, 213, 209, 204, 321, 320, 319, and 315) for 13 of 34 residents' rooms observed. The findings included: During an initial tour of the facility on 06/10/13 from 10:30 AM - 11:00 AM and follow-up observations on 06/14/13 from 2:45 PM to 3:00 PM the following resident rooms were identified with repairs needed to wood molding, resident room doors and bathroom doors: a. Room 126 was observed with a wood stained linoleum strip missing along the left side of the room door extending approximately 4 inches. b. Room 121 was observed with a wood stained linoleum strip missing along the left side of the room door extending approximately 8 inches. c. Room 120 was observed with wood molding detached from the wall extending approximately 2.5 feet with approximately a 1 inch gap and 3 nails exposed. d. Room 105 was observed with a wood stained linoleum strip missing along the left side of the room door extending approximately 3 inches. e. Room 219 was observed with a wood stained linoleum strip missing on the left side of the room door extending approximately 3 feet.	F 253	F 253 1- Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by getting a quote for the resident room doors, resident bathroom doors and resident room molding to be repaired from the home office. Quote has been approved by the home office. Work on the doors has been started, molding was fixed on 06/13/2013. 2- Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice was accomplished by: a) the Maintenance Director assessing resident rooms for needed repair.	7-12-13

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F 253	Continued From page 10 f. Room 215 was observed with a wood stained linoleum strip missing from the left edge of the room door extending approximately 3 feet. g. Room 213 was observed with a wood stained linoleum strip missing along the left side of the room door extending approximately 3 inches. h. Room 209 was observed with a wood stained linoleum strip missing along the left side of the room door extending approximately 3 inches. i. Room 204 was observed with a wood stained linoleum strip missing and peeling along the left side of the room door extending approximately 3 inches. j. Room 321 was observed with a wood stained linoleum strip missing from the left side of the room door extending approximately 3 feet. k. Room 320 was observed with a wood stained linoleum strip missing from the left side of the room door extending approximately 7 feet and the left side of the bathroom door extending approximately 4 feet. l. Room 319 was observed with a wood stained linoleum strip missing from the left side of the room door extending approximately 2 inches. m. Room 315 was observed with a wood stained linoleum strip missing from the left side of the room door extending approximately 3 feet. An interview on 06/14/13 at 3:00 PM with the maintenance director revealed that he was not	F 253	3-Measures will be put into place or systemic changes made to ensure that the alleged practice will not occur: a) Identifying needed repairs of doors, molding, walls and floor of the resident rooms has been added to the revised Department Heads daily (Monday –Friday) QA rounds sheet. b) Nurses and CNAs were in-serviced by the Clinical Consultant on 07/03/2013 on: a) the facility repair notification form b) Staff should immediately notify maintenance and nursing of needed repair. c) The Maintenance Director was in-serviced on 07/08/2013 by the Facility Administrator on: a) The facility notification form. b)The need to make repairs to building immediately.	

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F 253	Continued From page 11 aware of these areas in need of repair. The maintenance director stated that he relied on staff to document repairs that were needed in resident rooms. He stated each nurses station included a log for documentation by staff when repairs were identified. Review of the maintenance logs revealed these repairs were not documented. The maintenance director stated he checked these logs daily during daily rounds, but had not noticed the room doors, bathroom doors or wood molding. He further stated "things don't get like this over night, we should have identified this and fixed it." An interview on 06/14/13 at 6:30 PM with the administrator revealed she expected the maintenance department to involve all department heads to help identify any repairs that were needed in resident rooms during their daily rounds. She further stated that she would revise the form used by staff during rounds to include identifying repairs needed in residents rooms.	F 253	4- Monitoring of the facilities performance to make sure the solution is sustained will be accomplished by: The IDT review daily (Monday-Friday) of the QA round sheets and repair request forms at morning QA meeting. This will be a permanent part of morning QA meeting. Results of the review of the QA Round sheets and repair request forms will be reviewed monthly by the Quality Improvement Committee to assess for any discrepancies, monitoring needs and continued compliance in this area. This will be done every month for 12 months and quarterly there after. Director of Maintenance or designee will be responsible for maintaining compliance.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272		

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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 272	Continued From page 12 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to assess a decline in continence for 1 of 5 sampled residents (Resident #57). The findings included: Resident #57 was admitted to the facility on 02/06/13 with diagnoses including dementia, gout and heart murmur. The admission Minimum Data Set (MDS) dated 02/13/13 indicated Resident #57 was independent with ambulation and toilet use and was occasionally incontinent of bladder. A	F 272	F 272 1- Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by: a) Resident #57 was assessed per the new revised Incontinence Management policy regarding the Incontinence Assessment Tool from the newly implemented manual. b) It was identified on 6/17/13 that #57's incontinence was a result of BPH. Uroxatrol HCL ER 10 mg was started on 6/17/13. On 6/20/13 #57 experienced a acute change in condition (pneumonia) in which he was being treated. At this time due to increased confusion #57 was unable to participate in a formal toileting program. #57 needs were met by staff with toileting and check and change every 2 hours PRN. On 7/2/13 #57 was	7-12-13

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	345197	A. BUILDING _____ B. WING _____	C 06/14/2013

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F 272	Continued From page 13 Care Area Assessment (CAA) summary dated 02/14/13 indicated the contributing factors to the occasional incontinence were the use of antipsychotic medication and dementia. The type of incontinence was listed as stress incontinence with urgency. A quarterly MDS dated 05/15/13 indicated Resident #57 was dependent on staff for toileting and was frequently incontinent of bladder. An observation on 06/12/13 at 12:45 PM of Nurse Aide (NA) #1 and NA #2 providing incontinence care revealed the incontinence brief was wet. The NA's washed, rinsed and dried the resident's perineal area and applied barrier protective cream. Resident #57 did not have any skin breakdown or signs of irritation. An interview with NA #1 on 06/12/13 at 1:20 PM revealed that she provided incontinence care for Resident # 57 before breakfast. She stated she checked him again mid-morning and his incontinence brief was dry. She stated his brief wasn't always wet when she checked him. She stated she routinely checked him about every 2 hours for incontinence and provided incontinence care if he was wet. She did not take him to the bathroom or offer him the urinal. During an interview on 06/14/13 at 4:45 PM the MDS Assessment Nurse was asked about any additional assessment that would be conducted for a resident who had a decline in continence from the admission MDS to the next quarterly MDS. The nurse revealed she did not do any additional assessment of a resident who had a decline in continence from one assessment to the	F 272	discharged to the hospital with a Diagnosis of Exacerbation of Pneumonia and a asymptomatic Urinary Tract infection, which could have also contributed to his increased incontinence. A 3 day bladder diary was unable to be performed to obtain a baseline due to #57 acute decline in condition. To date #57 remains in the hospital and will be re-assessed upon his re-admission for a proper toileting program. 2-Corrective action will accomplished for those residents having potential to be affected by the alleged deficient practice by: a) Per the new Incontinence Management policy all residents will be assessed using the 24 Hour Voiding Diary for 3 days upon admission, quarterly or when a resident experiences change in bladder continence status.	

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F 272	Continued From page 14 next. When asked if she notified the charge nurse or a supervisor to do any further assessment, she stated she did not because the facility didn't have a special type of program for assessing a resident to determine the cause for the decline or the type of incontinence. When asked if the facility did any type of monitoring for a 7 day or 14 day period to determine if there was a pattern to the incontinence, she stated they did not. She stated the facility did not utilize any type of toileting program such as scheduled toileting or prompted toileting. She stated they only had a "check and change" program which meant residents were checked every 2 hours for incontinence and care was provided as needed. During an interview on 06/14/13 at 5:00 PM with the Chief Clinical Officer, he stated the facility didn't have a program in place to assess residents for the cause of incontinence or the need for an individualized bladder program such as bladder re-training or a scheduled toileting program.	F 272	b) Incontinent residents were assessed regarding continence by the Unit Nurse Managers using the new incontinence assessment tool. c) Specific resident care plans and interventions were derived and implemented. Special incontinence toileting schedules were implemented for those residents that meet the criteria per the manual. 3-Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur:	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279	a) The policy of Incontinence Management regarding Bladder incontinence was reviewed and revised by the Clinical Consultant b) Nursing Supervisors, Nursing and CNAs were in-serviced on the policy and the utilization of 24 Hour Voiding Diary 06/19/2013 and the Interact Early warning Tool on 07/03/2013. Nurse	

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F 272	Continued From page 14 next. When asked if she notified the charge nurse or a supervisor to do any further assessment, she stated she did not because the facility didn't have a special type of program for assessing a resident to determine the cause for the decline or the type of incontinence. When asked if the facility did any type of monitoring for a 7 day or 14 day period to determine if there was a pattern to the incontinence, she stated they did not. She stated the facility did not utilize any type of toileting program such as scheduled toileting or prompted toileting. She stated they only had a "check and change" program which meant residents were checked every 2 hours for incontinence and care was provided as needed. During an interview on 06/14/13 at 5:00 PM with the Chief Clinical Officer, he stated the facility didn't have a program in place to assess residents for the cause of incontinence or the need for an individualized bladder program such as bladder re-training or a scheduled toileting program.	F 272	Managers were in-serviced by the Clinical Consultant on 06/19/2013 regarding the following: a) The facility's new Incontinence Program/Manual and the Interact "Early Warning Tool" b) Completing a comprehensive Incontinence assessment. c) How to use the 72 hour voiding diary to obtain a baseline. d) Care plan specific B&B interventions. e) Care plan on whether or not the incontinence is reversible. f) Completing these assessments upon admission or upon change in continence patterns and at least quarterly. 4- Monitoring of the facilities performance to make sure the solution is sustained will be accomplished by: a) Use of the Interact "Early Warning Signs Tool, when any change in condition or incontinence is noted.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

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F 272	Continued From page 14 next. When asked if she notified the charge nurse or a supervisor to do any further assessment, she stated she did not because the facility didn't have a special type of program for assessing a resident to determine the cause for the decline or the type of incontinence. When asked if the facility did any type of monitoring for a 7 day or 14 day period to determine if there was a pattern to the incontinence, she stated they did not. She stated the facility did not utilize any type of toileting program such as scheduled toileting or prompted toileting. She stated they only had a "check and change" program which meant residents were checked every 2 hours for incontinence and care was provided as needed. During an interview on 06/14/13 at 5:00 PM with the Chief Clinical Officer, he stated the facility didn't have a program in place to assess residents for the cause of incontinence or the need for an individualized bladder program such as bladder re-training or a scheduled toileting program.	F 272	b) All assessments and care plans will be reviewed by the IDT at the care plan meeting, to ensure that all components of the Incontinence program are assessed and the results of documented and care planned. c) The Interact tool will be reviewed daily by the IDT at morning QA meeting as a permanent process to the morning QA meeting and reviewed monthly by the Quality Improvement Committee for 12 months then quarterly there after to assess for discrepancies, monitoring needs and continued compliance. This will be done every month for 12 months then quarterly there after. Director of Nurses or designee will be responsible for continued compliance.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

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F 279	Continued From page 15 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan for aggressive behaviors for 1 of 5 sampled residents who exhibited behaviors. (Resident #70). The findings included: Resident #70 was admitted to the facility on 09/17/12 with diagnoses including Alzheimer's Disease and anxiety. The physician's progress note dated 09/20/12 noted the resident came from a geriatric psychiatric facility where he was treated for confusion and agitation. The care area assessment for behaviors dated 09/21/12 stated there was no immediate intervention needed. He was on the secured unit for safety and supervision. It was noted that the resident may wander into other residents' rooms and was at risk of confrontation with other residents and increased agitation during redirection from staff. The current care plan developed 11/21/12 addressed behaviors of wandering aimlessly on the hall and in other resident rooms. This care	F 279	F 279 1-Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by: a) Resident #70 had the new Behavioral Assessment Tool completed to determine specific behaviors, probable triggering events, interventions that decrease behaviors. Interventions implemented through the care plan process. b) Resident #70 and residents care plan was created to include specific behaviors, probable triggering events, interventions that decreased behaviors. 2-Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice. An audit for residents with behaviors in the facility was completed 07/04/2013 by:	7/2/13

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F 279	Continued From page 16 plan lacked any goal and the interventions included providing close supervision, redirect and reorient when needed, and if agitation occurred during care allow a bit of time to pass and retry to complete tasks, encourage him to rest if he seems fatigued or anxious, intervene to increase safety and well being. The quarterly Minimum Data Set (MDS) dated 12/12/12 coded the resident with severely impaired cognitive skills, having other behaviors 1-3 days and wandering 1-3 days. It was noted that he received antipsychotic and antianxiety medications daily. Review of abuse reports revealed on 12/31/12 at 6:00 AM, Resident #70 was hit by Resident #148 when he wandered into her room. Staff were present in the room at this time. Resident #70 was to be observed. No other specifics were available. Review of nursing notes dated 01/07/13 at 9:20 PM revealed Resident #70 pulled a resident out of his bed. This resident was not identified and there was no indication of any followup. Review of abuse reports revealed on 01/21/13 at 12:45 AM, Resident #70 pushed Resident #93 up against the door frame and balled his fists at him. It was noted Resident #70 had been following the resident and yelling at him. Resident #70 was placed on 15 minute checks. Nursing notes dated 01/23/13 at 2:10 AM revealed another (unknown) resident accused Resident #70 of hitting him. He remained on 15 minute checks from 01/21/13. A medication	F 279	a) The Social Services Department for all residents that exhibited behaviors, their plan of care reviewed by the IDT at morning QA meeting to ensure that it contained: the type of behaviors, possible triggering events and specific interventions that decrease the behavior episodes.. 3-Measures will be put in place or systemic changes made to ensure that the alleged deficient practice will not occur: a) The Social Services Director was in-serviced by the Chief Clinical Officer on 06/26/2013 on the following: b)The facilities New Behavioral Assessment Tool c) How to and when to complete the tool. d) Documenting and implementing the behavior and interventions used to decrease the behaviors	

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F 279	Continued From page 17 change was made 1/28/13 due to behaviors (Depakote was added). Review of abuse reports revealed on 03/01/13 at 7:00 AM Resident #70 was pulling on the feet of Resident #153 who then punched Resident #70 in the eye. 15 minute checks were then implemented. The next day the physician made medication changes and took him off the 15 minute checks and requested a psychiatric evaluation. The quarterly MDS dated 03/06/13 coded the resident with severely impaired cognitive skills, having physically abusive behaviors 1-3 days, having other behaviors 1-3 days and wandering daily. He received antipsychotic medications daily. There was no behavior care plan established. Review of psych consults dated 03/20/13 revealed no recent aggression. Review of abuse reports revealed on 03/21/13 at 10:40 PM, Resident #70 slapped Resident #6 in the face. He was placed on 15 minute checks and the physician ordered an intramuscular antipsychotic (Haldol) injection. On 03/22/13 Depakote sprinkles was increased and the 15 minute checks were terminated. Review of abuse reports revealed on 03/30/13 at 4:30 PM Resident #70 became frustrated, raised a chair and during staff intervention, Resident #70 lowered the chair but hit Resident #119's finger in the process. Plans were to monitor Resident #70. There were no specifics regarding what monitoring was in place.	F 279	e) The Social Services Director was again in-serviced by the DON on 07/02/2013 on the following: a) Properly investigating each behavior to ascertain the type of behavior, the possible triggering event and what interventions work to decrease the behaviors. b) The New Behavioral Assessment Tool will be completed upon admission, quarterly and upon any behaviors. c) The Social Service Director will complete the New Behavior Quality Assurance tool per occurrence and upon admission.	

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F 279	Continued From page 18 Nursing notes dated 04/30/13 revealed Resident #70 was agitated and abusive to 2 other residents. The note was nondescript regarding the abusive behavior. He was placed on one to one supervision and given a snack and he calmed down. The length of time one to one supervision lasted was not determined. Review of abuse reports revealed on 05/21/13 Resident #70 was picking up chairs and bedside tables, and throwing books on the floor picking up chairs, bedside tables throwing books on floor. As needed Ativan was given with little effect and the physician ordered an antipsychotic intramuscular injection (Haldol) to calm him. The quarterly MDS dated 05/29/13 coded the resident with severely impaired cognitive skills, having physically abusive behaviors 1-3 days, having other behaviors 1-3 days and wandering daily. He received antipsychotic medications daily and an antianxiety medication once in the last 7 days. There still was no care plan developed to address abusive behaviors. On 06/14/13 at 2:50 PM Nurse #4 described Resident #70 as easy going and fairly easy to redirect. On 06/14/13 at 3:05 PM Nurse Aide #5 stated when Resident #70 got agitated you just let him be and reapproach him later. She further stated that he was irritated by a couple of residents and named Resident #153. On 06/14/13 at 5:06 PM, the MDS nurse stated the social worker handled the behavior section in	F 279	4- Monitoring of the facilities performance to make sure the solution is sustained will be accomplished by: a) The IDT (Interdisciplinary Team) will review each Behavioral Assessment Tool for compliance with any discrepancies, trends or/and triggers identified at the morning QA meeting as a permanent process of the morning QA meeting b) The Behavioral Assessment Tool will be reviewed by the Quality Improvement Committee to assess for any discrepancies, monitoring needs and continued compliance. This will be done monthly for 12 months and quarterly there after. Director of Nurses or designee will be responsible for continued compliance.	

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F 279	Continued From page 19 the MDS, subsequent assessments and the development of care plans addressing behaviors. Interview with the Social Worker (SW) on 06/14/13 at 5:11 PM revealed.Resident #70 did have abusive behaviors which were not care planned. He also said he had been responsible for investigating abuse reports up until 2 weeks ago which informed him of Resident #70's behaviors.	F 279	F 315 1- Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by: 1- Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by: a) Resident #57 was assessed per the new revised Incontinence Management from the newly implemented manual. b) It was identified on 6/17/13 that #57's incontinence was a result of BPH. Uroxatrol HCL ER 10 mg was started on 6/17/13. On 6/20/13 #57 experienced a acute change in condition (pneumonia) in which he was being treated. At this time due to increased confusion #57 was unable to participate in a formal toileting program. #57 needs were met by staff with toileting and check and change every 2 hours PRN. On 7/2/13 #57 was	7-12-13
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to develop interventions to maintain bladder function for 1 of 3 residents reviewed for incontinence (Resident #57). The findings included: Resident #57 was admitted to the facility on 02/06/13 with diagnoses including dementia, gout and heart murmur. The admission Minimum Data Set (MDS) dated 02/13/13 indicated Resident #57 was independent with ambulation and toilet use	F 315		

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F 315	Continued From page 20 and was occasionally incontinent of bladder. A Care Area Assessment (CAA) summary dated 02/14/13 indicated the contributing factors to the occasional incontinence were the use of antipsychotic medication and dementia. The type of incontinence was listed as stress incontinence with urgency. Review of a care plan dated 02/14/13 and updated 05/13/13 which addressed bladder incontinence included the following interventions: pericare when incontinent, remind resident to void, change clothes as needed, apply barrier cream after incontinent episodes and report changes in voiding pattern or appearance of urine to nurse. A quarterly MDS dated 05/15/13 indicated Resident #57 was dependent on staff for toileting and was frequently incontinent of bladder. A review of the Nursing Assistant Information Sheet did not indicate Resident #57 was incontinent but indicated the resident went to the bathroom and ambulated with the assistance of 1 staff. An observation on 06/12/13 at 12:45 PM of NA #1 and NA #2 providing incontinence care revealed the incontinence brief was wet. An interview with NA #1 on 06/12/13 at 1:20 PM revealed that she provided incontinence care for Resident # 57 before breakfast. She stated she checked him again mid-morning and his incontinence brief was dry. She stated his brief wasn't always wet when she checked him. She stated she routinely checked him about every 2	F 315	discharged to the hospital with a Diagnosis of Exacerbation of Pneumonia and a asymptomatic Urinary Tract infection, which could have also contributed to his increased incontinence. A 3 day bladder diary was unable to be performed to obtain a baseline due to #57 acute decline in condition. To date #57 remains in the hospital and will be re-assessed upon his re-admission for a proper toileting program. 2-Corrective action will be accomplished for those residents having potential to be affected by the alleged deficient practice by: a) Per the new Incontinence Management policy all residents will be assessed using the 24 Hour Voiding Diary for 3 days upon admission, quarterly or when a resident experiences change in bladder continence status.	

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F 315	Continued From page 21 hours for incontinence and provided incontinence care if he was wet. She did not take him to the bathroom or offer him the urinal. During an interview on 06/14/13 at 4:45 PM the MDS Assessment Nurse was asked about any additional assessment that would be conducted for a resident who had a decline in continence from the admission MDS to the first quarterly MDS. The nurse revealed she did not do any additional assessment of a resident who had a decline in continence from one assessment to the next. When asked if she notified the charge nurse or a supervisor to do any further assessment, she stated she did not because the facility didn't have a special type of program for assessing a resident to determine the cause for the decline or the type of incontinence. She stated the facility did not utilize any type of toileting program such as scheduled toileting or prompted toileting. She stated they only had a "check and change" program which meant residents were checked every 2 hours for incontinence and care was provided as needed. She stated a decline in a Resident #57's continence would not have prompted her to revise the care plan because she didn't develop a care plan that individually addressed incontinence. She stated any interventions that addressed incontinence were included in the care plan that addressed skin integrity. During an interview on 06/14/13 at 5:00 PM with the Chief Clinical Officer, he stated the facility didn't have a program in place to assess residents for the cause of incontinence or the need for an individualized bladder program such as bladder re-training or a scheduled toileting	F 315	b) Incontinent residents were assessed regarding continence by the Unit Nurse Managers using the new incontinence assessment tool. c) Specific resident care plans and interventions were derived and implemented. Special incontinence toileting schedules were implemented for those residents that meet the criteria per the manual. 3-Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur: a) The policy of Incontinence Management regarding Bladder incontinence was reviewed and revised by the Clinical Consultant b) Nursing Supervisors, Nursing and CNAs were in-serviced on the policy and the utilization of 24 Hour Voiding Diary 06/19/2013 and the Interact Early warning Tool on 07/03/2013. Nurse	

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F 315	Continued From page 22 program.	F 315	Director of Nurses or designee will be responsible for continued compliance.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain 2 of 2 sit to stand lifts in working order for 2 of 2 residents transferred with sit to stand lifts from bed to wheelchair. (Resident #25 and #33). The findings included: A review of a facility policy that was not dated and titled Mechanical Lifts indicated in part: any problems noted in the mechanical performance of the lift should be immediately reported to the maintenance department and the lift removed from service. Each lift is routinely inspected for safety by the maintenance department. A review of facility documents for monthly inspections for patient electric lifts from January 2013 through May 2013 revealed no repairs to sit to stand lifts. During an observation on 06/12/13 at 10:18 AM Nurse Aide (NA) #3 and Restorative aide (RA) #1	F 323	F 323 1- Corrective action will be accomplished for those residents found to have been affected of the alleged deficient practice: a) For resident #25 and #33 the standup lift in question was taken out of service and disposed of during the survey. b) The facility rented a functioning standup lift during the survey. Will continue to rent lift until one can be purchased. 2- Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice was accomplished by: a) All Hoyer and standup lifts were inspected and all were found to be functioning properly.	7.12.13

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F 323	Continued From page 23 assisted Resident #25 to the side of her bed and placed a sit to stand lift in front of her. The number 006 was written in black ink on the side of the lift. A cloth sling was placed around Resident #25's back and NA #3 hooked one side of the sling to a lift arm and hooked the other side of the sling to the other lift arm. NA #3 held a hand control in her hand and pushed a button on a hand control and raised Resident #25 off the bed. NA #3 removed her finger from the lift control but the lift arms continued to rise and lifted Resident #25 to a semi standing position and stopped. NA #3 stated "see this lift has a mind of its own, it just keeps going on its own." RA #1 positioned a wheelchair directly under Resident #25 and NA #3 pushed a button on the hand control and lowered Resident #25 into the wheelchair. During an interview on 06/12/13 at 11:17 AM with NA #3 she explained when she went to look for a sit to stand lift to transfer Resident #25 she saw a handwritten note on a piece of paper taped to the lift labeled 006 that said it was out of order. She stated she put a new battery in the lift and it seemed to work so she took it to Resident #25's room to use it to transfer her from her bed to a wheelchair. She further stated there was one other sit to stand lift that she usually used but she couldn't find it and that's why she used the one that had the out of order sign on it. NA #3 explained staff was supposed to write a note on the maintenance log when equipment didn't work or call maintenance to look at it but she did not know if it the problem with the hand control for lift 006 had been reported. During an interview on 06/12/13 at 11:32 PM with	F 323	3- Measures will be put into place or systemic changes made to ensure that the alleged practice will not occur: 1) The nurses and CNAs were educated by the Nurse Manager on 07/03/2013 on the following: a) The facility repair notification form. b) In no instance must any equipment that is malfunctioning be used. c) Staff should immediately notify maintenance and nursing of the malfunctioning equipment. d) The Maintenance Director was in-serviced on 06/19/2013 by the Clinical Consultant on: a) The facility's Hoyer lift/stand up lift inspection Policy and Quality Assurance tool. b) Inspections of the Hoyer and standup lift will occur at least monthly. c) If equipment is malfunctioning it must be taken out of service and stored in an area employees can not access.	

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F 323	Continued From page 24 RA #1 she stated they used to put signs on equipment when it was broken or needed repair but now they were supposed to write it on the maintenance log because if maintenance didn't know about it they couldn't fix it. She stated she did not know if maintenance had been notified about lift 006. During a review of maintenance logs on 06/12/13 at 11:41 AM at the nurse's station next to the lift storage area there were no notes on the logs regarding sit to stand lifts that needed repair. During an interview on 06/12/13 at 11:42 AM with NA #4 she explained they have two sit to stand lifts in the facility. She explained the hand control on one of the sit to stand lifts did not work properly. She further explained when the button on the hand control was pushed to lift the resident up it went all the way up but when you pushed the button on the hand control to lower the resident it wouldn't lower the resident down. She described that she had to push the emergency release switch on the side of the main column of the lift to lower the resident. She stated if a resident was in the lift at its maximum position and the lift wouldn't go down it would put a resident in an unsafe position. NA #4 stated she had told the nurses the lift control did not work properly but stated she did not know if maintenance had worked on it. During an observation on 06/12/13 at 2:33 PM NA #4 took a sit to stand lift with the number 007 written in black ink on the side of the lift into Resident # 33's room. Resident #33 was assisted to sit on the side of the bed and the sit to stand lift was placed in front of him. A solid	F 323	4-Monitoring of the facilities performance to make sure the solution is sustained will be accomplished by: 4- The Maintenance Quality Assurance tool will be monitored by the morning QA for compliance as permanent process of the morning QA meeting. The monthly Quality Improvement Committee will assess for discrepancies, monitoring needs and continued compliance, monthly for 12 months then quarterly on a permanent basis. 4- The Medical Director has reviewed the Plan of Corrections and has accepted it. The facility will continue to seek guidance and support from the Medical Director on facility practices. The Maintenance Director/designee is responsible for continued compliance.	

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F 323	Continued From page 25	F 323		

padded sling was placed behind the resident's back and NA #4 attached one side of the sling to one of the lift arms and then attached the other side of the sling to the other lift arm. NA #4 held the lift control in her hand and pushed a button to raise the lift arms and lifted Resident #33 into a semi-standing position. NA #4 pushed the down button on the hand control but the lift would not go down. NA #4 then reached down to the side of the lift and pushed a black switch on the side of the lift and the lift arms lowered Resident #33 into a wheelchair.

During an interview on 06/12/13 at 3:15 PM the Maintenance Director confirmed the facility had 2 sit to stand lifts. He explained the wires were loose on the hand control for the lift labeled 007 and it needed new electrical connections so the lift control would lower the resident. The Maintenance Director also verified the hand control was broken on the lift labeled 006. He confirmed he saw a note on the lift labeled 006 earlier that morning that said it was out of order and he took the note off and threw it in a trash can but he should have taken the lift out of service. He explained he meant to take the lift labeled 006 to the maintenance shop but he got busy and forgot about it. He stated he had to order a part to fix lift 006 and it should be out of service until it was repaired because it could be unsafe if it was used to transfer a resident.

During an interview on 06/14/13 at 3:47 PM the Director of Nursing stated it was her expectation for staff to fill out a maintenance report and notify maintenance when equipment needed repair. She further stated sit to stand lifts that were not working properly should be taken out of service

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F 323	Continued From page 26 immediately to prevent injury to residents.	F 323	F 431	
F 431 SS=E	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 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.	F 431	1-Corrective action will be accomplished for those residents found to have been affected of the alleged deficient practice by: a) All undated, improperly labeled and or expired medication identified in the 2567 were destroyed. 2- Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice was accomplished by: a) All medication carts , medication refrigerators and medication storage areas were immediately inspected and any open non-dated or expired medications were destroyed. 3-Measures will be put into place or systemic changes made to ensure that the alleged practice will not occur:	7-12-13

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F 431	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to remove expired medications from 3 of 3 medication storage rooms and 2 of 5 medication carts and failed to label a unit dose package of medication in 2 of 5 medication carts. The findings included: A review of the facility's policy on Medication Storage revealed the following statement: "No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed." A review of the manufacturer's instructions for Tuberculin Aplisol vials indicated vials in use for more than 30 days should be discarded. 1. Inspection on 06/13/13 at 4:39 PM of the A Hall medication room refrigerator revealed a box of hemorrhoidal suppositories in the refrigerator which contained 9 suppositories with an expiration date of April 2013. An interview on 06/13/13 at 4:40 PM with Nurse #1 on the A Hall regarding who was responsible for checking expiration dates on stock and refrigerated medications revealed all the nurses were responsible for checking expiration dates before they administered the medication. She was not aware of any specific person being assigned to check stock and refrigerated medications for expired medications. 2. a. Inspection on 06/13/13 at 4:51 PM of the B Hall medication room and refrigerator revealed a Tuberculin Aplisol 1 milliliter (ml) vial with a label which indicated it was opened on 05/03/13.	F 431	a) The Unit Managers were in-serviced 06/19/2013. The licensed nurses were in-serviced on 07/03/2013 on the following: b) Any time a medication is opened it must be dated. c) Omnicare's expiration date medication list. d) Expiration dates should be checked before administrating to any resident and if expired the medication/treatment should be destroyed. e) The need to keep the medication carts and medication room clean. f) The nurse managers will conduct weekly random rounds while in the facility and check all medication carts, medication refrigerators and medication storage areas and check for materials not dated when opened, expired medication, improper labels. These medications will be properly discarded. g) Medication administration and storage in-servicing will continue to be conduced at least quarterly.	

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F 431	Continued From page 28 Approximately 0.5 ml of solution was remaining in the vial. Another vial of Tuberculin Aplisol 1 ml did not have a label indicating when it was opened and contained approximately 0.25 ml of solution. Also, in the refrigerator were 6 hemorrhoidal suppositories with an expiration date of April 2013. b. An unopened bottle of Zinc Sulfate 220 milligrams (mg) containing 100 tablets with an expiration date of January 2013 was stored commingled with other unexpired over the counter medications on a shelf in the B hall medication room. An interview on 06/13/13 at 4:54 PM with Nurse #2 regarding the expiration date of Tuberculin Aplisol revealed it was good for 30 days from the date it was opened. When asked who was the person designated to check the stock of over the counter medications for expired medications, she stated she guessed it was the supply clerk and any nurse who removed medications from the medication room. 3. Inspection on 06/13/13 at 5:09 PM of the C Hall medication room and refrigerator revealed a lock box containing 2 plastic storage bags labeled for specific residents. One bag contained 6 syringes of Lorazepam 2 mg/ml with an expiration date of 06/01/13. The other bag contained 1 vial of Lorazepam 2 mg/ml with an expiration date of May 2013. 4. Inspection on 06/13/13 at 6:06 PM of the B-1 medication cart revealed 1 unit dose package of Prednisone 1 mg with an expiration date of April 2013, laying loose in the top drawer of the cart.	F 431	4-Monitoring of the facilities performance to make sure the solution is sustained will be accomplished by: a) The QA tools will be reviewed at the Morning Quality Assurance Meeting weekly as permanent process, when medication is reviewed. Any discrepancies noted will be identified and further education and or monitoring will be implemented. Discrepancies, education needed, monitoring will be reviewed by the monthly QA meeting for 12 months and quarterly there after. The Director of Nursing/designee will be responsible for compliance.	

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F 431	Continued From page 29 The package was not labeled with a resident's name or directions for use. An interview on 06/13/13 at 6:20 PM with Nurse #2 regarding the Prednisone on the B-1 medication cart revealed she was not aware of any resident on her hall who was currently receiving Prednisone. 5. Inspection on 06/13/13 at 6:33 PM of the B-2 medication cart revealed 1 Phenergan 12.5 mg suppository with an expiration date of October 2012, laying loose in the top drawer of the cart and not labeled with a resident's name or directions for use. An interview on 06/13/13 at 6:35 PM with Unit Manager #1 revealed the Phenergan 12.5 mg suppository should not have been on the medication cart and should have been discarded. An interview on 06/14/13 at 6:24 PM with the Chief Clinical Officer and the Director of Nursing (DON) revealed the Unit Managers were expected to check the medication rooms and refrigerators at least monthly to check for expired medications and to discard expired medications. The DON stated once a month the Unit Manager, pharmacist and/or nurse consultant checked the medication carts for expired medications. An interview on 06/14/13 at 7:24 PM with the Administrator revealed her expectation was for the Unit Managers to check the medication rooms and refrigerators weekly for expired medications. She stated she also expected the Unit Managers to check the medication carts after the medication nurses once weekly.	F 431		

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