STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID # CKW011.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to comprehensively assess a change in condition for 1 of 14 residents sampled for comprehensive assessments. Resident #64 had a decline in cognition, bed mobility and transfers. The findings included: Resident #64 was originally admitted to the facility on 03/19/12 and most recently readmitted to the facility on 12/03/13 following a hospitalization for a gastrointestinal bleed. Her other diagnoses included vascular insufficiency of the intestine,	F 274	F-274 Resident #64: An immediate significant change assessment was done on 01/31/2014 and validated. Resident #64 was assigned PT as of 12/04/2014 to address decline in condition. All residents are currently being reviewed and assessed for significant changes began by MDS nurse immediately and will be completed by 02/25/2014. Residents to include #64 will be reviewed continually during routine scheduled care plan meetings occurring quarterly based on	2/25/14

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

Electronically Signed | 02/20/2014

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

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F 274	Continued From page 1 abdominal pain, stage 3 kidney disease, metabolic encephalopathy, cardiovascular disease, chronic airway obstruction, a knee replacement and diabetes. The last comprehensive Minimum Data Set(MDS), an annual dated 02/15/13, coded her with a score of 9 of 15 on the Brief Interview for Mental Status (BIMS) indicating she had moderately impaired cognition. Resident #64 was coded as having no behaviors, and requiring limited assistance with bed mobility, supervision with walking and supervision with transfers. She was noted with one fall without injury. The Care Area Assessment (CAA) dated 02/21/13 for cognition noted she made decisions for herself and had mild short term memory loss. The CAA for activities of daily living dated 02/21/13 stated she required assistance to maintain her maximum function for activities of daily living. This CAA indicated the care plan would include: remind her to use rolling walker for ambulation, set up for dressing and hygiene, encourage her to use call bell. The fall CAA dated 02/21/13 noted she was able to stabilize herself for balancing. Care plans were developed for cognition, activities of daily living skills and falls. The next quarterly MDSs dated 05/17/13 and 08/14/13 noted no changes in the areas of cognition, bed mobility or transfers. She had one fall without injury noted in the 05/17/13 MDS and no falls in the 08/14/13 MDS. A quarterly MDS dated 10/31/13 coded Resident #64 with a BIMS of 4 of 15, indicating she had severely impaired cognition and required extensive assistance with bed mobility and transfers. She was noted with 2 falls without	F 274	date of admission by the Interdisciplinary Team for significant changes in condition with assessments completed as appropriate. Residents to include #64 will be also assessed by the MDS nurse after re-admitting from hospital care since last comprehensive assessment date. A 100% audit for residents to include resident #64 who have had significant changes to ensure compliance that assessments are complete will be done weekly X 4, then monthly X 2 by MDS nurse utilizing a QI tool.The MDS nurse will be notified by nursing staff of potential significant changes in residents condition for completion of assessments as necessary. MDS and DON were inserviced by MDS consultant on 01/31/2014 regarding significant change and completion of timeframes of the SCSA MDS assessment for completion as presented in the RAI manual. Audit results will be reviewed during monthly QI meetings and then reviewed quarterly during Executive Committee meetings for the identification of potential trends, follow up as necessary, and to determine the need for and/or frequency of continued monitoring.	

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F 274	Continued From page 2	F 274		

injury during this period.

Review of the nursing notes revealed Resident #64 had more falls as follows:
*on 11/14/13 from her wheelchair at the drinking fountain hitting her head;
*on 12/07/13 she slid off the bed onto the floor mattress;
*on 12/20/13 she fell from the wheelchair in her room in front of the closet; and
*on 01/27/14 she fell while transferring herself from the wheelchair to the bed.
New interventions were planned after each fall.

Resident #64 was observed during the survey sitting in her wheelchair on 01/27/14 at 11:48 AM; on 01/29/14 at 11:10 AM, 11:28 AM, 12:05 PM, 4:13 PM, and 4:45 PM; and on 01/30/14 at 8:16 AM. She was not observed ambulating during this survey.

On 01/30/14 at 8:59 AM, the MDS nurse stated MDSs should be compared each quarter to catch significant change assessments. She stated that she had been doing MDS assessments for about a month and the previous MDS nurse was no longer working in the facility. The MDS nurse stated that Resident #64 had declined significantly over the past several months but was currently improving because of receiving therapy. She confirmed a change in condition had occurred and the quarterly MDS dated 10/31/13 should have been handled as a significant change assessment and subsequently had comprehensive assessments completed.

On 01/30/14 at 11:55 AM, the Rehabilitation Manager stated Resident #64 had been receiving physical therapy since 07/31/13 and was picked

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F 274	Continued From page 3 up again after her gastrointestinal bleed and hospitalization readmission in December. She further revealed Resident #64 had been declining for months due to decreasing cognition and lack of safety awareness.	F 274		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to update the plan of care for 1 of 2 sampled residents reviewed for falls. Resident #64's fall care plan was not updated to include the new intervention of a chair alarm which was not in place when Resident #64	F 280	F-280 The MDS nurse updated the care plan of resident #64 on 01/31/2014 to include new intervention of chair alarm. A 100% audit of each resident was begun	2/25/14

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F 280	Continued From page 4 fell. The findings included: Resident #64 was originally admitted to the facility on 03/19/12 and most recently readmitted to the facility on 12/03/13 after a gastrointestinal bleed. Her other diagnoses included vascular insufficiency of the intestine, abdominal pain, stage 3 kidney disease, metabolic encephalopathy, cardiovascular disease, chronic airway obstruction, a knee replacement and diabetes. The last comprehensive Minimum Data Set(MDS), an annual dated 02/15/13, coded her with a score of 9 out of 15 on the Brief Interview for Mental Status (BIMS) indicating she had moderately impaired cognition. Resident #64 was coded as having no behaviors, and requiring limited assistance with bed mobility, supervision with walking and supervision with transfers. She was noted with one fall without injury. The Care Area Assessment (CAA) dated 02/21/13 for cognition noted she made decisions for herself and had mild short term memory loss. The CAA for activities of daily living dated 02/21/13 stated she required assistance to maintain her maximum function for activities of daily living. This CAA indicated the care plan would include: remind her to use rolling walker for ambulation, set up for dressing and hygiene, encourage her to use call bell. The fall CAA dated 02/21/13 noted she was able to stabilize herself for balancing. Care plans were developed for cognition, activities of daily living skills and falls. The next quarterly MDSs dated 05/17/13 and 08/14/13 noted no changes in the areas of	F 280	by the QI nurse and MDS nurse immediately on 01/31/2014 to review all interventions resulting from falls completed on 02/15/2014. This audit verified that the care plan corresponds with interventions put in place and that the interventions were timely based on occurrence. The Interdisciplinary Team meets daily to double-check the care guide and care plan corresponds with interventions to include resident #64 beginning 01/31/2014 to ensure compliance. This 100% audit of each resident will occur weekly X 4, then monthly X 2 to ensure compliance utilizing a QI tool. The Interdisciplinary Team will follow up on any concern upon identification. The MDS and DON were retrained on care plan and care guide correspondance with interventions and updates of chair alarms by MDS consultant on 01/31/2014. All results of these audits/reviews will be reviewed monthly by the QI Committee and quarterly by the Executive Committee for the identification for potential trends, follow up as deemed necessary, and to determine the need for and/or frequency of continued monitoring.	

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F 280	Continued From page 5	F 280		

cognition, bed mobility or transfers. She had one fall without injury noted in the 05/17/13 MDS and no falls in the 08/14/13 MDS.

A quarterly MDS dated 10/31/13 coded Resident #64 with a BIMS of 4 of 15, indicating she had severely impaired cognition and required extensive assistance with bed mobility and transfers. She was noted with 2 falls without injury during this period.

Review of the nursing notes revealed Resident #64 stood from her wheelchair at the drinking fountain on 11/14/13 hitting her head. An anti-roll back device was placed on her wheelchair. On 12/07/13 she slid off the bed onto the floor mattress and a winged mattress was placed on the bed. On 12/20/13 Resident #64 fell from the wheelchair in her room in front of the closet. A chair alarm was placed in the wheelchair.

The current care plan which addressed the resident's risk for falls, dated 12/10/13 included the interventions to assist with transfers and mobility, keep assistive ambulation device in reach, low bed, alarming floor mat, nonskid strips on floor by bed, wear nonskid footwear and remind to call for help. The care plan did not include a chair alarm.

Resident #64 was observed during the survey sitting in her wheelchair on 01/27/14 at 11:48 AM in her room. There was no chair alarm in place but alarmed floor mats were observed in the room. Then on 01/27/14 at 12:29 PM, a nurse yelled for assistance for Resident #64 and a nurse aide responded. No alarm was heard sounding. Resident #64 was observed on 01/28/14 at 10:00 AM outside the activity room

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F 280	Continued From page 6	F 280		

eating ice cream. There was no alarm noted in her chair. Additional observations revealed Resident #64 was sitting in her wheelchair on 01/29/14 at 11:10 AM. An anti-roll back device was on the wheelchair. The room was noted to have alarmed mats under the bed, nonskid strips on the floor by the bed, a scoop mattress on the bed and the resident was dressed in nonskid shoes. No alarm was noted on the wheelchair on 01/29/14 at 12:05 PM, 2:39 PM, 4:13 PM and when Resident #64 was dozing at 4:45 PM.

On 01/30/14 at 8:16 AM, Resident #64 was noted in her wheelchair with chair alarm in place. At 8:16 AM on 01/30/14 Nurse Aide #1 stated the alarm was placed on the wheelchair either last night or early this morning as she had not seen the alarm on Resident #64's wheelchair before this date.

Interview with the Quality Assurance (QA) nurse on 01/30/14 at 8:34 AM revealed she was responsible for reviewing falls. She stated when there was a fall, an alert on the communication chart was noted and an incident report or charting occurred which flagged the fall for review. The QA nurse then reviewed the incident report, nursing notes and interviewed staff, resident, and/or family to determine circumstances of the fall. The first staff on the scene also was to write a statement related to findings. All falls were discussed at the morning meetings and interventions reviewed. If additional interventions were implemented, then the MDS nurse, who attended these meetings would add them to the care plan. The QA nurse further stated the alarm was implemented after the fall on 12/20/13. The QA nurse stated, following her investigation of the 01/27/14 fall, she noticed the alarm was not in

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F 280	Continued From page 7 place and replaced it yesterday afternoon . She stated she also noticed that the care plan had not been updated to reflect the implementation of the alarm on 12/20/13 and she updated the care plan when she placed the alarm on the wheelchair yesterday. She stated she suspected the chair alarm had been removed when the wheelchair was last cleaned. Interview with the MDS/interim Director of Nursing (DON) on 01/30/14 at 8:59 PM revealed that the MDS nurse was responsible for updating the care plan. She stated often an email goes out from the QA nurse to update the care plan. The MDS nurse could not locate the email and stated she was not aware Resident #64 was to have an alarm and therefore did not place it on the care plan. She confirmed that when she looked yesterday, the chair alarm was not on the care plan.	F 280		
F 323 SS=D	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 facilty failed to implement the planned intervention of a chair alarm for 1 of 2 sampled residents reviewed for falls. Resident #	F 323	F-323 Resident #64 care plan and resident care guide was reviewed by the MDS nurse on 01/31/2014 to ensure both agreed with	2/25/14

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F 323	Continued From page 8 64 did not have the chair alarm in place when she fell from the wheelchair on 01/27/14. The findings included: Resident #64 was originally admitted to the facility on 03/19/12 and most recently readmitted to the facility on 12/03/13 after a gastrointestinal bleed. Her other diagnoses included vascular insufficiency of the intestine, abdominal pain, stage 3 kidney disease, metabolic encephalopathy, cardiovascular disease, chronic airway obstruction, a knee replacement and diabetes. The last comprehensive Minimum Data Set(MDS), an annual dated 02/15/13, coded her with a score of 9 out of 15 on the Brief Interview for Mental Status (BIMS) indicating she had moderately impaired cognition. Resident #64 was coded as having no behaviors, and requiring limited assistance with bed mobility, supervision with walking and supervision with transfers. She was noted with one fall without injury. The Care Area Assessment (CAA) dated 02/21/13 for cognition noted she made decisions for herself and had mild short term memory loss. The CAA for activities of daily living dated 02/21/13 stated she required assistance to maintain her maximum function for activities of daily living. This CAA indicated the care plan would include: remind her to use rolling walker for ambulation, set up for dressing and hygiene, encourage her to use call bell. The fall CAA dated 02/21/13 noted she was able to stabilize herself for balancing. Care plans were developed for cognition, activities of daily living skills and falls. A Quality Improvement Fall review dated	F 323	intervention of a chair alarm and that the alarm was in place on the wheelchair of resident #64. A 100% audit of each resident was begun by the QI nurse and MDS nurse immediately on 01/31/2014 to review all interventions resulting from falls with completion on 02/15/2014. This audit addressed all wheelchair alarms put in place from the care plan and care guide interventions to ensure compliance that all alarms assigned from care plans and care guides are in place as directed and functional. The Interdisciplinary Team meets daily to double-check the care guide and care plan monitoring of chair alarm compliance to include resident #64 beginning 01/31/2014. This 100% audit of each resident will occur weekly X 4, then monthly X 2 to ensure compliance utilizing a QI tool that all assigned alarms are in place and functional. The Interdisciplinary Team will follow up on any concern upon identification. The MDS nurse and DON were inserviced on 01/31/2014 on care plan and care guide compliance regarding alarm interventions for all residents to include resident #64 in a timely manner by MDS consultant. All results of these audits will be reviewed monthly by the QI Committee and quarterly by the Executive Committee for the identification of potential trends, follow up as deemed necessary , and to determine the need for and/or frequency	

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F 323	Continued From page 9 03/18/13 noted Resident #64 had an unobserved fall from bed on 03/16/13. A physical therapy screen was the action taken. A Quality Improvement Fall review dated 10/10/13 noted that she had an assisted fall on 10/06/13 when a nurse aide found her sliding from the chair and assisted her down to the floor. The action taken was a urinalysis and back stripping (nonskid) was placed at bedside. A Quality Improvement Fall review dated 10/24/13 noted Resident #64 got out of bed and was found on the bathroom floor on 10/19/13. The action taken was alarming floor mats were placed on the floor at bedside. A quarterly MDS dated 10/31/13 coded Resident #64 with a BIMS of 4 of 15, indicating she had severely impaired cognition, requiring extensive assistance with bed mobility and transfers. She was noted with 2 falls without injury during this period. A Quality Improvement Fall review dated 11/21/13 noted Resident #64 had an unobserved fall from chair on 11/14/13 when she stood to have a drink at the water fountain, lost her balance and tried to sit down. The chair moved backward and the resident fell hitting her head resulting in a large edematous knot on the back of her head. Maintenance subsequently ordered anti-roll backs for the wheelchair. A Quality Improvement Fall review dated 12/09/13 noted the resident fell from the low bed on 12/07/13. The floor mats were alarming. The action taken was for a winged mattress to be placed on the bed and continue with the alarming floor mats. A Quality Improvement Fall review dated 12/23/13 revealed Resident #64 had an unobserved fall from her chair on 12/20/13 when she was found on the floor in front of the closet. The anti-roll	F 323	of continued monitoring.	

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back chair device was observed working at that time. She was also noted as currently receiving therapies. The action taken was for a chair alarm to be placed in her chair.

The current care plan which addressed the resident's risk for falls, dated 12/10/13, included the interventions to assist with transfers and mobility, keep assistive ambulation device in reach (rolling walker), low bed, alarming floor mat, nonskid strips on floor by bed, wearing nonskid footwear and remind to call for help. The care plan did not include a chair alarm.

Resident #64 was observed during the survey sitting in her wheelchair on 01/27/14 at 11:48 AM in her room. There was no chair alarm in place but alarmed floor mats were observed in the room and an anti-rollback device was on her wheelchair. Then on 01/27/14 at 12:29 PM, a nurse yelled for assistance for Resident #64 and a nurse aide responded. No alarm was heard sounding. The subsequent nursing note dated 01/28/14 stated the resident had been observed partially standing with knees bent trying to transfer from her wheelchair to the bed. The resident had pushed the floor mats under the bed with her foot, did not get turned around far enough and fell to the floor on her bottom and then fell on to her right side. The resident complained of pain in her left thumb and forefinger.

Nursing notes revealed Resident #64 had complaints of pain on:
*01/27/14 at 3:26 PM resident complained of her neck feeling sore
*01/28/14 at 2:30 PM resident having complaints of left hand, thumb and shoulder pain. X-rays

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were ordered.
*01/28/14 at 6:32 PM resident still complaining of pain in the left thumb, hand and shoulder.
*01/29/14 at 2:24 PM resident still complaining of pain in left hand, thumb and shoulder.
*01/29/14 X-rays revealed no breaks or dislocation of the left hand or shoulder.

Resident #64 was observed on 01/28/14 at 10:00 AM outside the activity room eating ice cream. There was no alarm noted in her chair. Additional observations revealed Resident #64 was sitting in her wheelchair on 01/29/14 at 11:10 AM. An anti-roll back device was on the wheelchair. The room was noted to have alarmed mats under the bed, nonskid strips on the floor by the bed, a scoop mattress on the bed and the resident was dressed in nonskid shoes. No alarm was noted on the wheelchair on 01/29/14 at 12:05 PM, 2:39 PM, 4:13 PM and Resident #64 was dozing in the wheelchair at 4:45 PM.

On 01/30/14 at 8:16 AM, Resident #64 was noted in her wheelchair with chair alarm in place. At 8:16 AM on 01/30/14 Nurse Aide (NA) #1 stated the alarm was placed on the wheelchair either last night or early this morning as she had not seen the alarm on Resident #64's wheelchair before this date.

Interview with the Quality Assurance (QA) nurse on 01/30/14 at 8:34 AM revealed she was responsible for reviewing falls. All falls were discussed at the morning meetings and interventions reviewed. If additional interventions were implemented, then the MDS nurse, who attended these meetings would add them to the care plan. The QA nurse further stated the chair alarm was implemented after the fall on 12/20/13.

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F 323	Continued From page 12 The QA nurse noticed yesterday, while investigating the fall of 01/27/14, the alarm was not in place and replaced it yesterday afternoon. She suspected it was removed when the wheelchair was last cleaned. Interview with NA #2 on 01/30/14 at 10:15 AM revealed she had seen the chair alarm in use before. She stated she recalled the chair alarm was in place, then removed and then put back on again. She could not recall dates she last saw the chair alarm in place before this date.	F 323		
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 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,	F 431		2/25/14

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F 431	Continued From page 13 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to remove expired medications from 2 of 4 medication carts. The findings included: 1. Inspection on 01/30/14 at 11:04 AM of the South New Wing Medication Cart revealed the following expired medications: a) a partially used bottle of Calcium with Vitamin D 500 milligrams (mg) labeled as containing 60 capsules with most of the capsules gone which was stamped with a manufacturer's expiration date of November 2013, b) a partially used bottle of Aspirin 325 mg approximately half empty which was stamped with a manufacturer's expiration date of November 2013, c) a partially used bottle of Guaifenesin oral solution 100mg per 5 milliliters (ml) with approximately 10 ml remaining which was stamped with a manufacturer's expiration date of November 2013. An interview on 01/30/14 at 11:12 AM with Nurse # 1 revealed the medications were currently in use and available for any resident receiving those medications. When asked about the facility's	F 431	F-431 On 01/31/2014 the identified expired medications were removed and disposed of by QI nurse. An immediate 100% audit of all storage cabinets and carts for expired medications was made by QI nurse on 01/31/2014 with no concerns identified. A final audit of carts and storage cabinets was made by DON on 01/31/2014 with no issues identified. A mandatory inservice was provided to all nurses and medication aides by Staff Facilitator immediately on 01/31/2014 on the responsibility of nursing staff to check cart for compliance before accepting the cart by a drawer-by-drawer count and date verification. Monitoring of expired meds on all medication carts to include the South and North Wing is occurring through random audits on all shifts per med cart 3 X times per week X 4 weeks for 3 months by the	

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F 431	Continued From page 14 system for checking the medication carts for expired medications, she indicated each nurse administering medications from the cart was responsible for checking for expired medications and for removing them from the cart. An interview on 01/30/14 at 11:58 AM with the Director of Nursing (DON) about her expectation in regard to expired medications revealed she expected each nurse administering medications to check the medication carts for expired medications and to remove any expired medications from the cart. She further stated that expired medications should not be available for use on the medication carts. 2. Inspection on 01/30/14 at 11:45 AM of the North Wing Split Medication Cart revealed the following expired medications: a) one partially used bubble pack card with 26 pills labeled as containing 30 tablets of Norco 5-325 milligrams (mg) which was stamped with an expiration date of 12/24/13. b)) one bubble pack card with 30 pills labeled as containing 30 tablets of Norco 5-325 milligrams (mg) which was stamped with an expiration date of 12/24/13. An interview on 01/30/14 at 11:12 AM with Nurse # 1 revealed the medications were currently in use and available for the resident for whom they were dispensed. When asked about the facility's system for checking the medication carts for expired medications, Nurse #1 indicated each nurse administering medications from the cart	F 431	QI nurse, Staff Facilitator nurse, and DON. Removal of expired medication is occuring by the nurse upon identification. All results of these audits will be reviewed monthly by the QI Committee and quarterly by the Executive Committee for the identification of potential trends, follow up as deemed necessary , and to determine the need for and/or frequency of continued monitoring.	

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F 431	Continued From page 15 was responsible for checking for expired medications and for removing them from the cart. An interview on 01/30/14 at 11:58 AM with the Director of Nursing (DON) about her expectation in regard to expired medications revealed she expected each nurse administering medications to check the medication carts for expired medications and to remove any expired medications from the cart. The DON further stated that expired medications should not be available for use on the medication carts.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		2/25/14

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F 441	Continued From page 16 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide training to nursing staff to ensure blood glucose meters (glucometers) were disinfected/sanitized by the manufacturer's instructions during 3 of 3 observations of a glucometer being disinfected. The findings included: A facility policy entitled Cleaning and Disinfection of Glucometers dated 03/08/11 specified in part to disinfect the exterior surface with a germicidal agent after each use following manufacturer's direction. A review of the Instructions provided by the manufacturer of the germicidal disposable wipe utilized by the facility was conducted. The directions specified to accomplish disinfection of a hard surface, treated surface must remain visibly wet for a full 2 minutes. Use additional wipes if needed to assure continuous 2 minute wet contact time. Let air dry.	F 441	F-441 Immediate retraining by Staff Facilitator on the indication and recommendation of the manufacturor to be followed for use sanitation wipes in the disinfection/cleaning of glucometers to all nurses and medication aides began on 01/29/2014. This included a timed return demonstration of comprehension and ability of instructions of the manufacturor. This return demonstration was completed on 02/05/2014. Audits using a QI tool will be conducted by Staff Facilitator of nursing staff to include Nurse #1, Nurse #2, and Nurse #3 performing glucometer cleaning to ensure proper technique. The auditing will occur as follows: 4 staff members per week for 4 weeks, then 4 staff members every 2 weeks for 4 weeks, then 4 staff members per month X 3 months. The Staff Facilitator will provide re-training for the	

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F 441	Continued From page 17 An observation was conducted on 01/29/14 at 3:58 PM of Nurse #3 obtaining finger stick blood sugar (FSBS) readings. Nurse #3 was observed entering Resident #7's room and following proper procedure for obtaining a FSBS reading. Upon completion, Nurse #3 returned to the medication cart, wiped the glucose meter (glucometer) with a germicidal wipe, tossed the wipe into the trash bin, and placed the glucometer in a plastic cup on the medication cart. Nurse #3 did not ensure the glucometer remained wet with germicidal solution for a full 2 minutes. An observation was conducted on 01/29/14 at 4:33 PM of Nurse #2 obtaining finger stick blood sugar (FSBS) readings. Nurse #2 was observed entering Resident #52's room and following proper procedure for obtaining a FSBS reading. Upon completion, Nurse #2 returned to the medication cart, wiped the glucose meter (glucometer) with a germicidal wipe, tossed the wipe into the trash bin, and placed the glucometer in a plastic cup on the medication cart. Nurse #2 did not ensure the glucometer remained wet with germicidal solution for a full 2 minutes. An observation was conducted on 01/29/14 at 4:44 PM of Nurse #3 obtaining finger stick blood sugar (FSBS) readings. Nurse #3 was observed entering Resident #5's room and following proper procedure for obtaining a FSBS reading. Upon completion, Nurse #3 returned to the medication cart, wiped the glucose meter (glucometer) with a germicidal wipe, tossed the wipe into the trash bin, and placed the glucometer in a plastic cup on the medication cart. Nurse #3 did not ensure the glucometer remained wet with germicidal solution for a full 2 minutes.	F 441	involved staff upon the identification of any potential concern. All results of these audits will be reviewed monthly by the QI Committee and quarterly by the Executive Committee for the identification of potential trends, follow up as deemed necessary , and to determine the need for and/or frequency of continued monitoring.	

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F 441	Continued From page 18 An interview with Nurse #2 on 01/29/14 at 5:02 PM revealed it was facility procedure after utilizing a glucometer to wipe the glucometer down with a germicidal wipe. Nurse #2 confirmed the glucometer did not remain wet for the full 2 minutes but stated the glucometer was allowed to air dry for 2 minutes before it was utilized again. Nurse #2 further revealed she was unaware of ensuring the glucometer remained wet with germicidal solution for 2 minutes to complete the disinfecting process. An interview with Nurse #3 on 01/29/14 at 5:08 PM revealed it was facility procedure after utilizing a glucometer to wipe the glucometer down with a germicidal wipe. Nurse #3 confirmed the glucometer did not remain wet for the full 2 minutes but stated the glucometer was allowed to air dry for 2 minutes before it was utilized again. Nurse #3 further revealed she was unaware of ensuring the glucometer remained wet with germicidal solution for 2 minutes to complete the disinfecting process. During an interview on 01/29/14 at 5:24 PM the Director of Nursing (DON) stated nurses were instructed to clean the glucometer before and after each use. The DON further stated nurses were to sanitize and disinfect glucometers with a germicidal wipe according to manufacturer's directions before use for resident blood glucose monitoring. The DON was unaware of ensuring the glucometer remained wet with germicidal solution for 2 minutes to complete the disinfecting process. The DON confirmed the nurses were not disinfecting the glucometers per manufacture guidelines.	F 441		

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F 441	Continued From page 19 During an interview on 01/30/14 at 11:40 AM the Administrator stated nurses were to sanitize and disinfect glucometers with a germicidal wipe according to manufacturer's directions before use for resident blood glucose monitoring. The Administrator was unaware of ensuring the glucometer remained wet with germicidal solution for 2 minutes to complete the disinfecting process. The Administrator confirmed the nurses were not disinfecting the glucometers per manufacturer guidelines.	F 441		