STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, family interviews and staff interviews, the facility failed to notify immediate family members of a new	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider	1/16/15

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

Electronically Signed | 01/16/2015

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F 157	Continued From page 1 antipsychotic medication regimen for 1 of 1 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 03/04/14, discharged to the hospital on 08/12/14 and readmitted on 08/14/14 with diagnoses including a history of multiple left pelvic ring fractures, non-Alzheimer's dementia, psychosis and hospice care. Review of the admission cover sheet revealed the resident to be her own responsible person (RP) and the name of immediate family member #1 as a second contact. Taped inside the cover of the binder of the resident's chart was the name and phone number immediate family member #2. Review of the resident's most recent Minimum Data Set (MDS) dated 11/17/14 indicated Resident #1 was severely cognitively impaired with delirium, verbal behaviors towards others and rejecting care during 1 to 3 days of the MDS assessment period. Resident #1 received antipsychotic medications for 6 of the 7 days of the MDS assessment period. Review of a psychiatric mental health nurse practitioner (PMHNP) consult dated 11/11/14 revealed that since a prior assessment, staff had reported Resident #1 not eating food or taking medications but rather pocketing them in her mouth and the resident whimpering to herself, with these behaviors likely as secondary to paranoia. The PMHNP recommended a trial of the antipsychotic olanzapine 2.5 milligrams by mouth at hour of sleep (QHS) for psychotic disorder. Review of orders revealed this same order on 11/11/14 by the PMHNP with no	F 157	with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #1 no longer resides in the facility. 2. Resident□s on anti-psychotic medication have the potential to be affected by this citation. Current residents and/or responsible parties will have their anti-psychotic medications reviewed by the Director of Clinical Services and/or Nursing Supervisor 1/6/2014-01/15/2015. A review of current resident□s medical records to determine physician and responsible party notification was completed on 1/11/2015 by the Director of Clinical Services and/or Nursing Supervisor. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on Notification in Change of Condition to the physician and responsible party on 01/08/2015-01/15/2015. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of 10 resident medical records reviewing for documentation of notification to responsible party for change of condition and/or medication changes five times a week for two months, three times a week for two months, two times a week for one month then one time a week for one month and/or substantial compliance is	

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F 157	Continued From page 2 discernable nurse signature as transcribing the order. No documentation of family notification was noted in the PMHNP consult, on the medication order or in the nursing notes. A phone interview on 12/16/14 at 2:14 PM with family member #1 revealed the family did not know the facility was administering olanzapine to the resident. The family member stated the facility never called him nor family member #2. An interview on 12/17/14 at 1:15 PM with family member #2 revealed he did not recall receiving a phone call from staff in November regarding notification of the resident starting olanzapine.	F 157	obtained. 4.The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review the facility failed to provide Activities of Daily Living (ADL) for 1 of 3 sampled residents who needed extensive assistance with toileting and personal hygiene. (Resident #29) The findings included: Resident #29 was admitted to the facility on 08/13/14 with a diagnosis which included	F 312	1. Resident #29 was not injured related to this citation. Observations of resident # 29 bowel and bladder pattern was completed 1/13/15-1/15/15, care plan and kardex updated by the Director of Clinical Services. 2. All residents have the potential to be affected by this citation. An audit of current residents was completed	1/16/15

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F 312	Continued From page 3 congestive heart failure and depressive disorder. . The most recent annual Minimum Data Set (MDS) dated 08/20/14 indicated that Resident #29 was cognitively intact. The MDS further indicated Resident #29 required extensive assistance from staff with transfers, bed mobility toileting, bathing and personal hygiene. The MDS further stated Resident #29 was coded as always incontinent of bladder and bowel. Review of Resident #29's care plan dated 10/28/14 indicated she was unable to participate in her usual daily routine, at risk for side effects related to antidepressant medication, potential for skin breakdown due to incontinence of bladder and bowel and chronic pain. Approaches included, sponge baths only, monitoring resident's mood state, daily observation of skin with routine care, assess for signs/symptoms of depression, crying, isolation, decrease appetite, and promote dignity. During an interview with a family member on 12/16/14 at 2:14 PM stated they were present when Resident #29 rang her call bell and staff answered her light on 12/15/14. The family member further stated Resident #29 told the staff member she needed assistance as she was wet and needed to be changed. The staff member unknown to the family member left the room and returned with Resident #29's meal tray. The family member stated Resident #29 was not changed until after her meal time. During an interview with Resident #29 on 12/17/14 at 1:12 PM stated staff no longer took her to the bathroom but leave her in a brief and clean her when she is incontinent. She further	F 312	1/8/2014-01/15/2015 by The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities) for reviewing and updating kardex and care plans for ADL care including any toileting plan that has been identified. 3. Licensed Nurses were in serviced by the Director of Clinical Services and/or Nursing Supervisor on providing ADL and peri care on 01/08/2015 □ 01/23/2015. Certified Nursing Assistance were in serviced by the Director of Clinical Services and/or Nursing Supervisor on 01/15/2015 on providing ADL and peri care. The Director of Clinical Service and/or Nursing Supervisor will perform Quality Improvement monitoring/observations of 10 residents requiring ADL direct care care with focus on residents with a planned toileting plan 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. 4.The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of clinical services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of	

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F 312	Continued From page 4 reported Nurse Aide (NA) entered her room and told her she could not change her during meal time as it was cross contamination. Resident #29 stated that she was left wet during her meal. Resident #29 stated she was not incontinent and could tell staff when she needs to go to the bathroom. Resident #29 stated she was left in brief as she requires a mechanical lift to get her up and has been told to use her brief. Resident #29 was unable to identify the NA who answered her call light. During an interview on 12/17/14 with Nurse Aide (NA) #1 at 2:18 PM stated staff are available during the meal times to assist residents with their activities of daily living (ADL). NA #1also stated she usually has someone assist her with providing incontinence care for Resident #29 due to her medical condition and pain. NA#1further stated staff were expected to answer call lights during meals times, ask the resident there need and assist if they are incontinent. NA #1 reported Resident #29 was incontinent because she cannot get up to go to the bathroom anymore. Resident #29 requires a hoyer lift to get her up and staff can ' t take the lift into the bathroom. She further reported that Resident #29 was able to tell staff when she needs to go to the bathroom and when she needed assistance with her ADL care. NA#1 said Resident #29 was probably left wet as she usually rings her call light during lunch due to incontinence. During an interview on 12/17/14 with Nurse Aide #4 at 2:36 PM who cared for Resident #29 and is familiar with this resident reported the resident was alert, oriented, did not exhibit any cognitive impairment and was able to verbalize her needs. She further reported staff was assigned to the	F 312	Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse	

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F 312	Continued From page 5	F 312		

halls during meals times to answer call lights and assist with residents ADL ' s including incontinence care. She could not say if she provided incontinence care prior to lunch for Resident #29.

During an interview with on 12/17/14 with the Assistant Director of Nursing (ADON) at 3:25PM revealed the facility has an NA or everyone to watch call lights during meal times and answer call lights. All staff are expected to provide assistance with ADL care as the resident needs it. She further revealed it was her expectation that no resident would be incontinent during a meal and should be provided with assistance with ADL ' s. She stated Resident #29 was known to need incontinence care prior to meals and she had asked her staff to check her prior to Resident #29's meals.

During an interview on 12/17/14 with the Director of Nursing (DON) and the Administrator at 4:37 PM reported that there expectation was that no resident would eat a meal in a wet brief. The Administrator further stated he would expect Resident #29 to have her ADL ' s provided.

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F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interviews, and record review, facility staff neglected to provide incontinence care to 1 of 3 residents (Resident #29) before serving the resident a meal. The findings included: Resident #29 was admitted to the facility on 08/13/14 with a diagnosis which included congestive heart failure and depressive disorder. . The most recent annual Minimum Data Set (MDS) dated 08/20/14 indicated that Resident #29 was cognitively intact. The MDS further indicated Resident #29 required extensive assistance from staff with transfers, bed mobility, and toileting, bathing and personal hygiene. The MDS also stated that personal preferences were very important to the resident. The MDS further stated Resident # 29 was coded as being always incontinent of bladder and resident stated she preferred to be toileted. Review of Resident #29's care plan dated 10/28/14 indicated she was unable to participate	F 224	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #29 was not injured related to this citation. The facility submitted a 5 day report to the North Carolina Department of Health on 1/7/2015 when the facility was made aware of the allegation. 2. All residents have the potential to be affected by this citation. The facility Interdisciplinary Team initiated interviews with inter-viewable residents to determine if there were any additional allegations of abuse and neglect and staff was interviewed regarding abuse and neglect; no other concerns were voiced was completed 01/07/2015 □ 01/11/2015. An audit reviewing kardex and care plans of all current residents for toileting plan was completed on 01/08/2015 □ 01/15/2015.	1/16/15

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

Electronically Signed

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 224	Continued From page 1 in her usual daily routine, potential for skin breakdown due to incontinence of bladder and bowel and chronic pain. Approaches included, sponge baths only, monitoring resident's mood state, daily observation of skin with routine care, assess for signs/symptoms of depression, crying, isolation, decrease appetite, and promote dignity. During an interview with a family member on 12/16/14 at 2:14 PM the family member stated they were present when Resident #29 rang her call bell and staff answered her light on 12/15/14. The family member further stated Resident #29 told the staff member she needed assistance as she was wet and needed to be changed. The staff member unknown to the family member left the room and returned with Resident #29's meal tray. The family member stated Resident #29 was not changed until after her meal time. During an interview with Resident #29 on 12/17/14 at 1:12 PM she reported that a Nurse Aide (NA) entered her room and told her she could not change her during meal time as it was cross contamination. The NA further told her she would have to wait to be changed until after the meal and gave her tray. Resident #29 stated that she was left wet during the whole meal. Resident #29 also stated that it made her angry and mad that she was left wet. Resident #29 was unable to identify the NA who answered her call light. During an interview on 12/17/14 with Nurse Aide (NA) #1 at 2:18 PM the NA stated Resident #29 was incontinent because she cannot get up to go to the bathroom anymore. NA#1 stated Resident #29 was probably left wet as she usually rings her call light during lunch due to incontinence. Nurse Aide #1 reported depending on what staff	F 224	An audit of all current residents was completed 01/14/2015 by The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities) reviewing and updating kardex and care plans for ADL care. 3. Licensed Nurses, Certified Nurse Assistant□s, Dietary Staff, Housekeeping staff, Maintenance Director, Business Office Manager, Therapy department were in serviced on Abuse, types of abuse, who to call, what to do by the Director of Clinical Services and/or Nursing Supervisor on 01/08/2015 □ 01/15/2015. The Director of Clinical Service and/or Nursing Supervisor will perform Quality Improvement monitoring of 10 residents requiring ADL direct care including peri care observing that dignity and respect are maintained during cares 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor, Social Services Director will interview 10 inter-viewable residents and/or family members on if staff is treating them with respect and maintaining their or their loved ones dignity during care 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained.	

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F 224	Continued From page 2 member answers her call light would depend on her being changed or not during the meal service. During an interview on 12/17/14 with Nurse Aide #4 at 2:36 PM who cared for Resident #29 and is familiar with this resident, the NA reported the resident was alert, oriented, did not exhibit any cognitive impairment and was able to verbalize her needs. She further reported Resident #29 gets very upset about being incontinent and apologizes the entire time she is being cleaned up. During an interview on 12/17/14 with the Assistant Director of Nursing at 3:25PM she stated the facility has an NA or all staff to watch call lights during meal times and answer call lights. If the person who answers the light is unable to assist with the need then they should let someone know who can meet the reesident ' s needs and leave the light on until the resident is assisted. She further revealed it was her expectation that no resident would be left wet during a meal. She stated Resident #29 was known to need incontinence care prior to meals and she had asked staff to check her prior to Resident #29's meals. During an interview on 12/17/14 with the Director of Nursing (DON) and the Administrator at 4:37 PM they reported that their expectation was that no resident would be left to eat a meal in a wet brief. The Administrator further stated he would expect Resident #29 to have been cleaned up first and her meal reheated.	F 224	4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of clinical services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	{F 241}		1/16/15

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{F 241}	Continued From page 3 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review the facility failed to promote dignity for 1 of 3 residents by leaving a resident in a wet brief during her noon meal. (Resident #29) The findings included: Resident #29 was admitted to the facility on 08/13/14 with a diagnosis which included congestive heart failure and depressive disorder. The most recent annual Minimum Data Set (MDS) dated 08/20/14 indicated that Resident #29 was cognitively intact. The MDS further indicated Resident #29 required extensive assistance from staff with transfers, bed mobility, and toileting, bathing and personal hygiene. The MDS also stated that personal preferences were very important to the resident. The MDS further stated Resident # 29 was coded as being always incontinent of bladder and resident stated she preferred to be toileted. Review of Resident #29's care plan dated 10/28/14 indicated she was unable to participate in her usual daily routine, at risk for side effects related to antidepressant medication, potential for skin breakdown due to incontinence of bladder and bowel and chronic pain. Approaches included, sponge baths only, monitoring resident's mood state, daily observation of skin with routine care, assess for signs/symptoms of depression, crying, isolation, decrease appetite,	{F 241}	1. Resident #29 was not injured related to this citation. Observations of resident # 29 bowel and bladder pattern was completed 1/13/15-1/15/15, care plan and kardex updated by the Director of Clinical Services. 2. All residents have the potential to be affected by this citation. An audit of current residents was completed 1/8/2014-01/15/2015 by The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities) for reviewing and updating kardex and care plans for ADL care including any toileting plan that has been identified. Observations for staff being respectful and providing dignity was completed by the Director of Clinical Services and/or Executive Director 1/15/2015. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses and certified nurse assistants on Residents Rights and providing ADL care for residents in a way that maintains and enhances dignity and respect 01/08/2015 -01/15/2015. Executive Director, Certified Nurse Assistants, Licensed Nurses, The	

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{F 241}	Continued From page 4 and promote dignity. During an interview with a family member on 12/16/14 at 2:14 PM stated they were present when Resident #29 rang her call bell and staff answered her light on 12/15/14. The family member further stated Resident #29 told the staff member she needed assistance as she was wet and needed to be changed. The staff member unknown to the family member left the room and returned with Resident #29's meal tray. The family member stated Resident #29 was not changed until after her meal time. During an interview with Resident #29 on 12/17/14 at 1:12 PM who reported that Nurse Aide (NA) entered her room and told her she could not change her during meal time as it was cross contamination. Resident #29 stated that she was left wet during her meal. Resident #29 also stated that it makes her angry and mad when they tell her she is incontinent and leave her wet. Resident stated she is able to tell staff when she needs to go to the bathroom but is left in brief as she requires a mechanical lift to get her up and has been told to use her brief. Resident #29 was unable to identify the NA who answered her call light. During an interview on 12/17/14 with Nurse Aide (NA) #1 at 2:18 PM stated Resident #29 was incontinent because she cannot get up to go to the bathroom anymore. She further stated that Resident #29 was able to tell staff when she needs to go to the bathroom. NA#1 stated Resident #29 was probably left wet as she usually rings her call light during lunch due to incontinence. Nurse Aide #1 reported depending on what staff member answers her call light	{F 241}	Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities) and all other staff attended a directed in service sensitivity training Walk a Mile in My Shoes □ on 01/15/2014 by Smoky Mountain LME/MCO. . The Director of Clinical Service and/or Nursing Supervisor will perform Quality Improvement monitoring of 10 residents requiring ADL direct care including peri care observing that dignity and respect are maintained during care 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor, Social Services Director will interview 10 inter-viewable residents and/or family members on if staff is treating them with respect and maintaining their or their loved ones dignity during care 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. 4.The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of clinical services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director	

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{F 241}	Continued From page 5 would depend on her being changed or not during the meal service. During an interview on 12/17/14 with Nurse Aide #4 at 2:36 PM who cared for Resident #29 and is familiar with this resident reported the resident was alert, oriented, did not exhibit any cognitive impairment and was able to verbalize her needs. She further reported Resident #29 gets very upset about being incontinent and apologizes the entire time she is being cleaned up.	{F 241}	of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse	
{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, permanently affixed compartments for storage of	{F 431}		1/16/15

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{F 431}	Continued From page 6 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 observation, record review and staff interviews, the facility failed to discard expired medications in 1 of 5 medication carts. The findings included: A review of the manufacturer ' s Prescribing Information for Lantus Insulin read in part: " Vials must be discarded 28 days after being opened. " A review of the Pharmacy recommended storage parameters indicated Lantus expired 28 days after being opened and was to be discarded after the 28 days. During an observation of the 300 hall medication cart on 12/16/14 at 3:47 PM one vial of Lantus insulin was noted to be dated as opened on 11/07/14 and ready for use. Per manufacturer ' s recommendations, the lantus would expire on 12/05/14. An interview was conducted with Nurse #1 assigned to the 300 hall medication cart on 12/16/14 at 3:49 PM. During the interview Nurse # 1 acknowledged the medication was expired and that the resident had been receiving it daily since the expiration date of 12/05/14. She stated that Lantus insulin was opened on 11/07/14 and	{F 431}	1. No residents were affected by this citation. Expired medication Lantus was removed from medication cart on 12/16/2014 by the licensed nurse. Nurse #1 was in-serviced on 01/13/2015 by the Director of Clinical Services on removing expired medications from the medication carts immediately and insulin dated when the opened. 2. All residents have the potential to be affected by this citation. The pharmacist completed a complete audit of the medication carts for expired medications on 12/30/2014. The pharmacist completed a complete audit of the medication storage refrigerator for expired medications on 12/30/2014. A complete audit of all medication carts and medication storage refrigeration was completed by a licensed nurse on 01/07/2015 □ 01/09/2015. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on dating vials once opened and	

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{F 431}	Continued From page 7 should have been discarded 28 days after on 12/05/14. A review of the Medication Administration Record (MAR) confirmed that 18 units of Lantus insulin was administered daily at bedtime from 12/05/14 through 12/15/14. An interview was conducted on 12/16/14 3:56 PM with the pharmacy consultant. She verified that the Pharmacy recommended storage parameters indicated that Lantus insulin was expired and should be discarded 28 days after the date opened. An interview was conducted on 12/16/14 3:36 PM with the Assistant Director of Nursing (ADON). The ADON verified the vial of Lantus was dated opened on 11/07/14 and was expired. The ADON verified that the medication should have been discarded 28 days after the date it was opened. The ADON acknowledged the nurse on the cart should have disposed of it after verifying the 5 rights and prior to medication administration. The ADON indicated she completed medication cart audits and she should have disposed of the expired insulin when she had completed the medication cart audit for expired medications. An interview was conducted on 12/17/14 at 6:00 PM with the Director of Clinical Services (DCS). The DCS verified that the Lantus was expired since the medication was dated as opened on 11/07/14 and should have been discarded after 28 days. The DCS acknowledged the nurse on the cart should have disposed of it and or the ADON should have disposed of it when she had completed the medication cart audit for expired medications. The DCS indicated Insulin from	{F 431}	removing expired medications from medication carts 01/08/2015-01/15/2015. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication carts for expired medications 5 times a week for 2 months , 3 times a week for 2 month, 2 times a week for 1 month and 1 time a week for 1 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication storage refrigerator for expired medications 5 times a week for 2 month, 3 times a week for 2 month, 2 times a week for 1 month and 1 time a week for 1 months and/or until substantial compliance is obtained. 4.The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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{F 431}	Continued From page 8 multi-dose vials would not be given out of a vial that was opened for more than 28 days and nurses should have checked the opened date of the vial and performed the 5 rights checks prior to administering insulin to any resident.	{F 431}		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility ' s Quality Assessment and Assurance	F 520	1. No resident affected by this citation.	1/16/15

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F 520	Continued From page 9 Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2014. This was for two recited deficiencies which were originally cited in October of 2014 on a recertification and complaint investigation survey and on the current follow up and survey. The deficiencies were in the areas of medication storage and labeling and treating residents with dignity and respect. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Findings included: These tags were cross referred to: 1a. F 431: Medication storage and labeling: Based on observations and staff interviews the facility failed to discard expired medications in 1 of 5 medication carts. During a recertification and complaint investigation survey of October 2014, the facility was cited for F 431 for failing to discard expired medications in a medication cart and a medication storage room. On the current follow up and complaint investigation survey the facility was again recited for failing to discard expired medication from a medication cart. 1b. F 241: Treating residents with dignity and respect: Based observations, record review, and staff interviews the facility failed to promote dignity by leaving a resident in a wet brief during a noon meal. During a recertification and complaint	F 520	2. The Executive Director/Director of Clinical Services and Interdisciplinary Team have been re-educated on the regulation F 520 and the Facility□s Policy and Procedure for Quality Assurance and Performance Improvement by the Regional Director of Clinical Services and The Regional Vice President of Operations on 12/23/2014. The pharmacist completed a complete audit of the medication carts for expired medications on 12/30/2014. The pharmacist completed a complete audit of the medication storage refrigerator for expired medications on 12/30/2014. A complete audit of all medication carts and medication storage refrigeration was completed by a licensed nurse on 01/07/2015 □ 01/09/2015. An audit of current residents was completed 1/8/2014-01/15/2015 by The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities) for reviewing and updating kardex and care plans for ADL care including any toileting plan that has been identified. Observations for staff being respectful and providing dignity was completed by the Director of Clinical Services and/or Executive Director 1/15/2015. The Executive Director, Certified Nurse Assistants, Licensed Nurses, The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities) and all other staff attended a directed in	

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F 520	Continued From page 10 investigation survey of October 2014, the facility was cited for F 241 for failing to promote dignity by waking a resident for a blood sugar check and not checking the resident for incontinence care, waking residents early for morning care and leaving them partially dressed and not responding to a resident ' s call light. An interview was conducted with the Administrator and Director of Clinical Services (DCS) on 12/17/14 at 6:00 PM. Their expectation was for facility staff to complete random audits to measure effectiveness of action plans. The DCS was expected to be ultimately responsible for getting audits done and getting data reported to the Quality Assurance Committee. During these audits, things fell through the cracks. The DCS stated she had been monitoring nurse managers and having meeting with unit managers and weekend supervisors so that resident care was being consistently provided.	F 520	service sensitivity training Walk a Mile in My Shoes □ on 01/14/2014 by Smoky Mountain LME/MCO. 3. Recommended Minimum Medication The Director of Clinical Serviced placed the Storage Parameter (based on manufacturer guidance) received from the pharmacy on all medication carts and in the medication storage room and in serviced the nurses on 01/08/2015.The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication carts for expired medications 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication storage refrigerator for expired medications 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained.The Director of Clinical Service and/or Nursing Supervisor will perform Quality Improvement monitoring of 10 residents requiring ADL direct care including peri care observing that dignity and respect are maintained during care 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing	

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F 520	Continued From page 11	F 520	Supervisor, Social Services Director will interview 10 inter-viewable residents and/or family members on if staff is treating them with respect and maintaining their or their loved ones dignity during care 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. 4. The Director of Clinical Services/Nurse Manager will report results to the QAPI Committee monthly x 6 months for continued substantial compliance and/or revision.	