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	345464	A. BUILDING _____ B. WING _____	C 01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 #MLNE11.	F 000		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to honor the rights to choose to smoke without supervision and at nondesignated times for 2 of 2 sampled residents (Resident #84 and #94) deemed safe to smoke without supervision and honor food choices for 1 of 7 sampled residents (Resident #40) reviewed for choices. Findings included: 1. A record review of Minimum Data Set dated 11/17/14 revealed Resident #94 was admitted on 06/19/14 with diagnoses of cerebral vascular accident, asthma, cardiopulmonary disease and hyperlipidemia. Resident #94 was coded as cognitively intact. A review of the facilities undated smoking policy revealed in part "The ability of a resident to have in their possession smoking materials (cigarettes,	F 242	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. F242 1. Resident #84 no longer resides at the facility. Resident #94 was not injured related to this citation. Resident #94 was reassessed for smoking safety and assistance on 02/13/15 by the MDS coordinator. Resident #94□s care plan and kardex were updated to reflect resident□s smoking assessment by the MDS coordinator on 02/13/15. Resident #40 was not injured related to	2/17/15

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

Electronically Signed | 02/15/2015

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F 242	Continued From page 1 cigars, lighters, matches, etc.) will be identified in the resident care plan. Smoking materials will be retained and stored by the nursing staff for residents identified by their care plans as not being responsible to possess materials without supervision. Designated staff will supervise smoke times for residents needing supervision. A resident will be allowed to smoke without supervision if they are deemed appropriate by the care plan." A record review of resident #94's admission assessment dated 06/19/14 indicated resident was assessed and determined to be a safe smoker and supervision was not needed while smoking. A record review of Resident #94's care plan implemented on 09/09/14 revealed problem: The resident has the potential for injury related to being a smoker. Interventions included: Instruct resident on smoking protocol. Keep smoking materials locked at nurse's station. Monitor for continued safe smoking. Provide scheduled staff supervised smoking times. An interview was conducted with the Director of Nursing (DON) on 01/21/15 at 3:15 PM who stated resident had to follow the smoking policy. Resident had scheduled times for staff to take resident out to smoke. The DON stated if resident wanted to smoke other than scheduled times, then would not be allowed to smoke unless family member brought resident out to smoke or resident waited for next smoking time for staff to accompany resident to smoke. An interview was conducted with resident #94 on 01/21/15 at 3:35 PM who shared he was taken	F 242	this citation. Resident #40 was interviewed by the Dietary Manager on 01/23/15 to identify food preferences. Resident #40 care plan and meal tray card were updated to reflect resident preferences on 01/23/15 by the Dietary Manager. 2. All residents have the potential to be affected by this citation. On 02/13/15, the MDS nurse assessed current residents who smoke for safety and required assistance. The residents' care plan and kardex were updated by MDS coordinator on 02/13/15. On 01/26/15 to 02/15/15, the interdisciplinary team interviewed residents and/or responsible party about the residents' food preferences. The residents' care plans and meal tray cards were updated by the Dietary Manager on 01/26/15 to 02/15/15. New admissions to facility that choose to smoke will be assessed by a nurse for smoking safety and required assistance. The Dietary Manager will interview new admissions for food preferences. 3. Licensed Nurses and Certified Nursing Assistants were in-serviced by the Director of Clinical Services and/or Nursing Supervisor, between the dates of 02/09/15 to 02/15/15. Licensed nurses were in-serviced on assessing residents who smoke for safety and assistance on admission, quarterly and with a change in	

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F 242	Continued From page 2 out of the building by staff to smoke at designated times. Resident #94 indicated the designated smoking times were posted on the refrigerator in his room. Resident #94 stated he was not allowed to smoke unless a staff member was with him. Resident #94 revealed his smoking materials were kept at the nurse's station and were provided to him by staff when he went out to smoke. Resident #94 stated he was not allowed to go out of the building and smoke alone. An Interview was conducted on 1/22/15 at 7:33 PM with the Administrator and DON. The DON stated a safe smoker was able to hold a cigarette independently and had 15 minutes to smoke the cigarette during the designated times. The DON revealed if a resident was deemed a safe smoker and wanted to go out side and smoke during non-designated times then the resident would not be allowed to go alone. The Administrator stated that no resident would be allowed to smoke without supervision even if deemed safe smoker because resident might burn self or set fire to self or burn the building. 2. Resident #84 was admitted to the facility 12/31/14 with diagnoses which included chronic obstructive pulmonary disease (COPD) and heavy smoker. Resident #84 was assessed by the facility social worker on 12/31/14 to be cognitively intact. A safe smoking evaluation was completed for Resident #84 on 12/31/14. This evaluation was part of the admission nursing assessment. This assessment noted Resident #84 was able to 1) communicate why oxygen must always be shut off prior to lighting a cigarette, 2) communicate the risks associated with smoking, 3) light a cigarette safely with a lighter, 4) smoke safely, 5)	F 242	condition. Information collected from that assessment is to be transcribed to the residents care plan and kardex by the Director of Clinical Services and/or Nursing Supervisor. In addition, Licensed Nurses and Certified Nursing Assistance were in-serviced on the facility resident smoking policy that states residents who are deemed safe to smoke unassisted per the smoking assessment may smoke as desired. Staff members were instructed to review kardex for residents safe smoking status. On 02/12/2015, the Dietary Manager was in-serviced by the Corporate Regional Dietician regarding obtaining residents' preferences and updating the care plans and meal tray cards. On 02/12/15 to 02/15/15, the Dietary Manager in-serviced the dietary staff and cooks on honoring resident s identified preferences with each meal. Quality Improvement monitoring of residents' smoking preferences as it relates to the individual residents smoking assessment and facility policy will be conducted 5 times a week for 1 month, 3 times a week for 2 months, 2 times a week for 2 months and then 1 time a week for 1 month and/or until substantial compliance is obtained. The Dietary Manager and/or Executive Director will perform Quality Improvement Monitoring of 5 residents' food preferences per meal conducted 5 times a	

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F 242	Continued From page 3 utilize an ashtray safely and properly and 6) extinguish cigarette safely and completely when finished smoking. As a result of the assessment, Resident #84 was determined to be a "safe smoker". The care plan dated 01/13/15 for Resident #84 included a problem area, The resident has the potential for injury because resident is a smoker. The goal for this problem area was, Resident will not pose threat to self/others or surroundings during smoking and Resident will comply with facility smoking protocols. Approaches to address the problem included: -encourage resident to limit time outside in adverse weather conditions -provide education to resident and/or responsible party on safety needs -1:1 supervision while smoking -safe smoking assessment on admission and quarterly -instruct resident on smoking protocol -keep smoking materials locked at nurses station -provide designated smoking area for residents -monitor for continued safe smoking -provide scheduled staff supervised smoking times -redirect resident during non smoking times -family may assist resident outside and supervise smoking On 01/20/15 at 10:00 AM signage was posted in a common area of the facility with the following information: Resident Smoking Schedule 7:30 AM, 9:30 AM, 11:30 AM, 1:30 PM, 4:00 PM, 7:45 PM "Thank you for your cooperation. Please only assist residents out to smoke in the smoking area of the main dining room. Do not take resident	F 242	week for 1 month, 3 times a week for 2 months, 2 times a week for 2 months and then 1 time a week for 1 month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained by the Dietary Manager and Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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outside any of these smoking times. Staff must stay with residents until they are assisted back inside. All cigarettes and lighters must be returned to the nurse to be locked up. If for any reason you cannot take residents out for the assigned smoke break you must tell the Unit Manager, Director of Nursing (DON) or Administrator".

On 01/21/15 at 8:45 AM Resident #84 stated he was aware of the six times he was allowed to smoke every day and had the smoke break times provided by staff and posted in his room. Resident #84 stated a staff member comes to his room prior to the smoke break and assisted him to the designated smoking area. Resident #84 stated staff kept his cigarettes and lighter in a locked box and provided it to him at the smoke break. Resident #84 stated staff supervised all smokers during the 15 minute time allotted at the smoke break.

On 01/21/15 at 3:40 PM the administrator provided the facility smoking policy from the electronic record. This undated policy read, "The company facilities are an established non-smoking facility, unless allowed by state and local regulations. Residents are notified on admission that the facility is a non smoking facility or allowed to smoke only in designated areas, and that they must adhere to the Smoking Policy. Each resident will be assessed on admission and quarterly to determine if the resident is a safe smoker.
Procedure:
1. Residents will be evaluated for safety regarding smoking upon admission and quarterly.
2. The facility will maintain a list of all smokers identifying them as safe or unsafe smokers.

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F 242	Continued From page 5 3. The facility will establish smoking times for residents. The facility will post the smoke times throughout the facility. The posting will also be present in the room of each resident who is identified as a smoker. 4. The facility will establish designated smoking areas. The facility will clearly mark areas as designated smoking area. Outside smoking areas are to be located as designated by local and state requirements from entrances into the building. 5. The ability of a resident to have in their possession smoking materials (cigarettes, cigars, lighters, matches, etc.) will be identified in the resident care plan. Smoking materials will be retained and stored by the nursing staff for residents identified by their care plans as not being responsible to possess materials without supervision. 6. Designated staff will supervise smoke times for residents needing supervision. The facility will establish a schedule of who will supervise the posted smoke times. 7. A resident will be allowed to smoke without supervision if they are deemed appropriate by the care plan. Unsafe smokers will wear smokers will wear smoking aprons while smoking. 8. Visitors will be allowed to assist residents smoking needs only if they have been approved by the facility and the approval is in the resident care plan. On 01/22/15 at 7:30 PM the administrator and DON stated all residents that smoke must be supervised by staff when they go out to the smoking area at the six designated times. The DON stated outside of that, a family member of the resident can take a resident out to smoke at the designated smoking area. The DON stated at	F 242		

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the designated smoking time residents get 15 minutes to smoke. The administrator stated the safe smoker assessment is geared towards whether a resident needs to wear a smoking apron, not whether they can smoke independently and unsupervised. The administrator stated though the policy indicates "a resident will be allowed to smoke without supervision if they are deemed appropriate" the facility did not allow residents to smoke independently. The administrator and DON stated they had not implemented the Resident Smoking Schedule taking into account if a resident was designated a safe smoker they should have the right to smoke independently and without supervision.

In a follow-up interview on 01/23/15 at 10:00 AM Resident #84 stated in the 15 minutes allotted at the smoke break he smokes one cigarette. Resident #84 stated he is a chain smoker and could probably smoke 2-3 cigarettes back to back if allotted. Resident #84 stated he accepted the smoking policy but was always ready to go back outside to smoke at the scheduled smoking times.

3. Resident #40 was admitted to the facility on 11/28/14 with diagnoses including cerebral artery occlusion, hemiplegia affecting her nondominant side and diabetes.

Review of the Food Preference List dated 12/01/14 revealed Resident #40 dislikes included lima beans, lettuce, peaches, and fruit cocktail.

The admission Minimum Data Set dated 12/05/14 coded Resident #40 as being cognitively intact, scoring 13 out of a possible 15 on the brief interview for mental status and needing no

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supervision with eating.

The care area assessment dated 12/08/14 relative to nutritional status noted food preferences had been obtained.

The care plan developed and reviewed during the care conference held on 12/31/14 for the problem of the resident having the potential for imbalanced nutrition due to diabetes had the goal to maintain adequate nutritional status with no significant weight changes. One of the interventions included provide food preferences and where the blank spot available to list the likes the resident will eat, was the handwritten notation to "see chart."

On 01/20/15 at 11:57 AM, Resident #40 was observed with her lunch tray, eating in her room. The tray contained a corn/lima bean mix and fruit cocktail. The tray card included the dislikes of lettuce, lima beans, and fruit cocktail. Highlighted by hand in yellow was the lettuce. When asked about her dislikes, she stated she received dislikes often but could not say how often she received dislikes on her tray.

On 01/20/15 at 12:14 PM, Resident #40 was observed picking the corn out and leaving the lima beans on her tray. She stated she disliked canned fruit so she did not taste the fruit cocktail.

On 01/20/15 at 12:18 PM Nurse Aide (NA) #1 verified she delivered the tray to Resident #40 at lunch. The surveyor asked her if she looked at the tray cards at the time of tray delivery. NA #1 stated the kitchen staff normally checked the tray cards for dislikes. She further stated if a resident tells her that they dislike something on their tray,

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she will obtain an alternate or something else for the resident. She ended by saying the dietary staff handled the likes and dislikes of a resident.

On 01/22/15 at 11:51 AM, NA #1 served Resident #40 the lunch tray. On the tray was a bowl of mixed fruit. When asked about the fruit cocktail, NA #1 looked at the tray card which listed fruit cocktail as a dislike and said, "I see what you mean."

Interview on 01/22/15 at 12:40 PM with Nurse #1, who worked on the hall with Resident #40, revealed he expected nurse aides to look at the tray card when they deliver the tray "to make sure all is in order." He stated his aides did a good job of checking the tray cards. When learning of the served dislikes for Resident #40, Nurse #1 stated that the first order of checking the tray cards for dislikes started in the kitchen.

The Dietary Manager (DM) was interviewed on 01/22/15 at 2:57 PM. DM stated on admission, after a hospitalization, yearly and as needed, she interviewed residents about their likes and dislikes. She then enters them in the computer. She stated that on the serving line was a cook and 2 assistants. The first assistant will read off the tray card the diet and dislikes. The second aides will check the tray before covering it and placing it in the cart for the hall. DM stated that when they served mixed items, such as soups or fruit mixes, staff should look at the tray card and food and determine if there is a dislike mixed in with the food. If there is an item mixed in that is listed as a dislike, an alternate should be provided. In relation to the fruit cocktail, the fruit cocktail on Tuesday 01/20/15 was canned fruit cocktail and should not have been served to

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F 242	Continued From page 9 Resident #40. The fruit cocktail served on 01/22/15 was tropical fruit cocktail and was not considered the same. DM stated Resident #40 should not have received the lima beans on 01/20/15. Review of the fruit cocktail ingredients listed on the can, the fruit cocktail contained peaches (another dislike for Resident #40). The tropical fruit salad ingredients did not contain any disliked fruit per Resident #40's preferences. DM stated on 01/22/15 at 3:35 AM that although this was canned, she was alright to receive the tropical fruit cocktail as it was different than fruit cocktail and did not include any of her stated dislikes.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the care plan interventions to assist in the healing of a pressure ulcer for 1 of 3 sampled residents reviewed for pressure ulcers. (Resident #33). The findings included: Resident #33 was admitted to the facility on 12/09/14 with diagnoses including sepsis, diabetes, and multiple skin wounds. The Nursing Admission Data Collection dated 12/09/14 noted	F 282	F282 1. Resident #33 no longer resides at the facility. 2. Residents with pressure ulcers have the potential to be affected by this citation. The Director of Clinical Services completed an audit of residents with wounds matching interventions on care plans and kardex to the resident on 01/21/15.	2/17/15

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F 282	Continued From page 10 an unstageable pressure ulcer on the right heel measuring 1 centimeter (cm) x 1.2 cm x 0.1 cm. Resident #33's admission Minimum Data Set (MDS) dated 12/15/14 coded her as being moderately cognitively impaired (scoring an 8 out of 15 on the brief interview for mental status), requiring extensive assistance for all activities of daily living skills, being nonambulatory and having an unstageable pressure ulcer measuring 1.5 cm x 1.5 cm x 2.5 cm. Interventions checked as being provided on the MDS included nutritional intervention, pressure ulcer care, application of dressings and ointments and a pressure reduction device for the chair. The Care Area Assessment (CAA) for pressure ulcers dated 12/22/14 stated Resident #33 was admitted with a pressure ulcer to her right heel. She was at risk for further breakdown and staff were to check her skin daily and nurses were to assess her skin weekly. The CAA also stated staff were to elevate her heels for pressure relief and provide supplements for wound healing. A care plan was developed and reviewed during the care conference held on 01/06/15 that addressed pressure ulcers indicating Resident #33 would show signs and symptoms of healing. Interventions listed included to float her heels. In addition, the facility maintained a kardex on each resident for nurse aide references which noted individual care needs. Resident #33's kardex, undated noted to float heels. Resident #33 was observed lying on her back in bed, the mattress was scooped at the sides to define parameters, wearing regular white socks	F 282	3. The Director of Clinical Services and/or Nursing Supervisor in-serviced licensed nurses and certified nursing assistants 02/09/2015- 02/15/2015 on reviewing and following the care plan/kardex on interventions used to assist in healing of pressure ulcers. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of interventions for residents with wounds care plan to kardex to resident 5 times a week for 1 month, 3 times a week for 2 months, 2 times a week for 2 months, and then 1 time a week for 1 month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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on both feet, and both of her heels rested in direct contact with the mattress on 01/21/15 at 1:59 PM, at 3:12 PM; at 4:05 PM. On 01/22/15 Resident #33 was again noted laying on the made bed on her back with white socks on both feet and both feet resting directly on the scoop mattress at the following times: at 8:27 AM with Nurse Aide (NA) # 3 present in the room; at 8:31 AM with NA # 2 in the room; on 01/22/15 at 8:37 AM; at 9:24 AM with NA #3 in the room to obtain blood pressure; at 9:29 AM when NA #3 returned to obtain oxygen saturation levels; at 9:32 AM when both NA #3 and Nurse #2 entered to obtain a oxygen level; at 10:08 AM; at 10:57 AM; at 11:40 AM; at 11:58 AM; at 12:22 PM; at 12:26 when staff delivered her lunch tray; and at 1:27 PM. At no time did the surveyor observed any evidence that there was a pillow or any device on or near the bed to help float Resident #33's heels.

On 01/22/15 at 1:29 PM, NA #2 was interviewed. NA #2 stated she learned how to care for each resident when the nurses informed the nurse aides of changes in a resident's care. When asked if she referred to the kardex, NA #2 did not understand what the kardex was or where it was. Together the surveyor and NA #2 observed the kardex at the nursing desk. NA #2 stated she referred to the computer on the hall. NA #2 stated she was not assigned to Resdient #33 this date. On follow up interview on 01/22/15 at 1:53 PM, NA #2 stated staff try to keep a pillow under Resident #33's feet when she is assigned to her.

NA #3 was interviewed on 01/22/15 at 1:45 PM. She stated she referred to the kardex for individual resident needs. When asked if there were special positioning needs for Resident #33, NA #3 stated staff check on her at least every 2

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F 282	Continued From page 12 hours to ensure she is comfortable and she liked to be on her back. When asked if there was anything special done for her feet, NA #3 stated staff used a pillow under her feet when she complains they hurt or if swelling or skin irritation was observed. NA #3 further stated that the kardex instructions to float heels meant to put on a pillow or make the bottom of the bed higher. On 01/22/15 at 1:55 PM Nurse #2 was interviewed. Nurse #2 stated she expected staff to prop up Resident #33's feet when she was in bed. She stated she thought there was a pillow under the resident's feet this morning when she checked the dressing on her foot to make sure it was intact. On 01/22/15 at 4:32 PM an interview was conducted with NA #4 who worked with Resident #33 on 01/21/15. NA #4 stated staff try to put a pillow under her legs to float her heels. When asked about not seeing Resdient #33's heels floated yesterday, NA #4 stated she can move the pillow and having it hang over the side of the bed. Observations of Resident #33's heels could not be made as the dressing was ordered to be changed every 5 days and it was not due to be changed during the surveyors observation period. The record revealed the right heel was improving and as of 01/19/15 the heel measured 2.0 cm x 2.3 cm and no depth listed and was now slough.	F 282		
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final	F 283		2/17/15

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F 283	Continued From page 13 summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge summary for 3 of 3 sampled residents who went home after staying at the facility. (Residents #65, #86, and #120). The findings included: 1. Resident #65 was admitted to the facility on 09/11/14 and discharged home on 09/23/14. Her diagnoses included asthma, hypertension, glaucoma, respiratory failure and diabetes. The medical record was reviewed and noted that Resident #65 had received occupational and physical therapies and received nebulizer breathing treatments. The medical record included a discharge plan of care with home health care for skilled therapy set up and medications were reviewed. There was no recapitulation of Resident #65's stay in the facility or a final summary of the resident's status at the time of discharge. On 01/22/15 at 3:14 PM the social worker (SW) stated during interview that she initiated the discharge planning by setting up home care, outpatient therapy, obtaining equipment prescriptions and follow up physician	F 283	F283 1. Resident #65 no longer resides at facility. A recapitulation of stay was completed on 2/13/15 by interdisciplinary staff. Resident #86 no longer resides at facility. A recapitulation of stay was completed on 2/13/15 by interdisciplinary staff. Resident #120 no longer resides at facility. A recapitulation of stay was completed on 2/13/15 by interdisciplinary staff. 2. All residents have the potential to be affected by this citation. On 02/09/15 to 2/13/2015 the Administrator and Director of Clinical Services completed an audit of the recapitulation forms for residents discharged to home since 01/01/15. Issues identified with these forms were corrected by the interdisciplinary staff on 02/13/15 to 02/17/15. 3. The Executive Director in-serviced interdisciplinary team on 02/09/2015 through 02/13/2015 regarding the	

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F 283	Continued From page 14 appointments. She also stated she completed the discharge summary. When asked about the recapitulation of stay she indicated she knew that the form involved summaries from each discipline in the facility regarding the resident's stay but was not sure about who initiated and completed the form. On 01/22/15 at 3:24 PM the Administrator with the SW present stated that the facility's corporation had a form in place for the recapitulation of stay. She stated that the previous administrator had decided to change the form, found in the medical record, that just covered the discharge plan not the recapitulation of stay. SW stated that when she came to work at this facility, she had used the company's recapitulation form until the previous administrator instructed her to use the discharge summary form which did not include a recapitulation of stay. The current Administrator stated she was unaware that the incorrect form for the recapitulation of stay was being used until this date. 2. Resident #86 was admitted to the facility on 08/18/14 discharged to the community on 10/15/14. Her diagnoses included surgical wound care for a fractured leg, depression disorder, diabetes, hypertension, and anxiety disorder. The medical record revealed Resident #86 received sliding scale insulin and physical and occupational therapies while in the facility. The medical record included a discharge plan of care. There was no recapitulation of Resident #86's stay in the facility or a final summary of the resident's status at the time of discharge.	F 283	completion of the recapitulation forms for residents discharged. The Executive Director will audit the medical records of discharged residents for completion of the recapitulation three times a week for 2 months, two times a week for 2 months, 1 time a week for two months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained by the Executive Director. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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On 01/22/15 at 3:14 PM the social worker (SW) stated during interview that she initiated the discharge planning by setting up home care, outpatient therapy, obtaining equipment prescriptions and follow up physician appointments. She also stated she completed the discharge summary. When asked about the recapitulation of stay she indicated she knew that the form involved summaries from each discipline in the facility regarding the resident's stay but was not sure about who initiated and completed the form.

On 01/22/15 at 3:24 PM the Administrator with the SW present stated that the facility's corporation had a form in place for the recapitulation of stay. She stated that the previous administrator had decided to change the form, found in the medical record, that just covered the discharge plan not the recapitulation of stay. SW stated that when she came to work at this facility, she had used the company's recapitulation form until the previous administrator instructed her to use the discharge summary form which did not include a recapitulation of stay. The current Administrator stated she was unaware that the incorrect form for the recapitulation of stay was being used until this date.

3. Resident #120 was admitted to the facility on 11/07/14 and discharged to home with home heath care services on 11/21/14. Her diagnoses included cancer, atrial fibrillation, hypertension, and cerebral vascular accident.

Review of the medical record revealed Resident #120 received skilled speech therapy, physical

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therapy and occupational therapy, had a change in diets with supplements added on 11/12/14, and was seen by a neurologist.

The medical record included a discharge plan of care with home health care for skilled therapy set up and medications were reviewed. There was no recapitulation of Resident #120's stay in the facility or a final summary of the resident's status at the time of discharge.

On 01/22/15 at 3:14 PM the social worker (SW) stated during interview that she initiated the discharge planning by setting up home care, outpatient therapy, obtaining equipment prescriptions and follow up physician appointments. She also stated she completed the discharge summary. When asked about the recapitulation of stay she indicated she knew that the form involved summaries from each discipline in the facility regarding the resident's stay but was not sure about who initiated and completed the form.

On 01/22/15 at 3:24 PM the Administrator with the SW present stated that the facility's corporation had a form in place for the recapitulation of stay. She stated that the previous administrator had decided to change the form, found in the medical record, that just covered the discharge plan not the recapitulation of stay. SW stated that when she came to work at this facility, she had used the company's recapitulation form until the previous administrator instructed her to use the discharge summary form which did not include a recapitulation of stay. The current Administrator stated she was unaware that the incorrect form for the recapitulation of stay was being used until

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F 283	Continued From page 17 this date.	F 283		
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 facility failed to maintain side rails securely fastened and tightened for 4 of 4 sampled residents reviewed for loose side rails (Residents #13, #33, #56 and #72). The findings included: 1. Resident #13 was admitted to the facility on 11/01/11. Her diagnoses included peripheral neuropathy, difficulty walking, atrial fibrillation and lack of coordination. The annual Minimum Data Set dated 09/14/14 coded Resident #13 with severely impaired cognitive abilities, requiring extensive assistance with bed mobility and transfers, requiring human assistance to balance between surface to surface transfers and being nonambulatory. The Care Area Assessment (CAA) dated 09/19/14 stated staff needed to anticipate her needs due to impaired decision making. The	F 323	F323 Resident #13 was not injured related to this citation. The Maintenance Director tightened the side rail on 1/22/15. Resident #33 was not injured related to this citation. The Maintenance Director tightened the side rail on 1/22/15. Resident #56 was not injured related to this citation. The Maintenance Director tightened the side rail on 1/22/15. Resident #72 wasn't injured related to this citation. The Maintenance Director tightened the side rail on 1/22/15. 2. Residents with side rails have the potential to be affected by this citation. On 01/23/15, the Maintenance Director completed an audit of all side rails, tightening all loose side rails.	2/17/15

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F 323	Continued From page 18 CAA for activities of daily living skills (ADLs) dated 09/19/14 noted she required extensive assistance with ADLs, had weakness and stiffness to bilateral legs and did not ambulate. The CAA dated 09/19/14 relating to falls stated she was at risk for fall due to a history of having falls, her diagnosis of atrial fibrillation, cognition and medications. A care plan was developed on 02/06/13 which addressed her history of falls and and requiring assistance with mobility and transfers was last updated on 01/02/15. Interventions to meet the goal for her not to experience any major injuries from falls included half bilateral side rails for positioning. Hand written next to this intervention was "prn" meaning as needed. Review of the undated kardex for Resident #13 maintained at the nursing station for nursing staff to reference individual resident needs revealed half side rails were to be used as needed for positioning. Resident #13's half side rails were observed as follows: *On 01/21/15 at 10:03 AM, Resident #13 was in bed with bilateral half side rails in the upright position. The right half side rail was loose and easily moved parallel (head to foot) to the bed at least 12 inches. *On 01/21/15 at 2:02 PM the right half side rail remained loose although the resident was not in bed. *On 01/21/15 at 4:06 PM Resident #13 stated she could turn herself in bed without assistance and used the side rails at times. Observations of the side rails at this time, as the resident was in the wheelchair, revealed the side rail remained very	F 323	The Maintenance Director in-serviced the interdisciplinary team, licensed nurses and certified nursing assistants, and housekeeping on 02/09/2015 -02/15/2015, on reporting loose side rails. 3. The Maintenance Director will perform Quality Improvement monitoring of 10 resident beds with side rails 5 times a week for 1 month, 3 times a week for 2 months, 2 times a week for 2 months and then 1 time a week for 1 month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained by the Maintenance Director. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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loose.
*On 01/22/15 at 9:34 AM, Nurse Aide (NA) #3 assisted Resident #13 to bed in order to change her slacks. Once the resident was in bed, NA #3 pulled up on the right side rail, which was loose. During changing the resident held on to the left side rail but never needed to hold on to the right side rail as she turned from side to side. At the end of the observation, NA #3 stated Resident #13 used the side rails when she is in bed to turn and reposition. NA #3 made no attempt to readjust the loose right side rail.

Interview with NA #4 on 01/22/15 at 4:30 PM revealed Resident #13 used her half side rails at times.

Interview with NA #2 on 01/23/15 at 9:22 AM revealed that she made sure residents were in the middle of the bed and not too far up in bed or too far down in the bed. She stated that if she noticed a loose side rail, she tightened it via a knob on the side of the side rail. If the side rail could not be tightened she notified maintenance staff. Staff then accompanied the surveyor to the resident's room and noticed the side rail were loose on the right side. She stated she did not pay attention when she used the side rails but should have paid more attention.

On 01/23/15 at 9:38 AM, the maintenance staff stated he did preventative maintenance per a schedule. The schedule had him check all the side rails in the building once per month. The last time he checked the side rails was about 2 weeks ago. Staff stated that he also checked side rails for tightness and fit when he worked in a room for other issues or as reported by staff. Together the maintenance staff and surveyor checked

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Resident #13's side rail and maintenance staff was able to tighten the side rail securely. He further stated at this time he had to tighten many of the side rails during his monthly checks. When asked if he ever thought to check the side rails more frequently and he said no but that he probably should check them for frequently than once a month.

Maintenance reports revealed the last check on the secureness of the side rails was completed on 12/17/14. This was a general statement and did not delineate what maintenance needs had to be completed on the side rails.

On 01/23/15 at 11:29 AM, NA #1 stated during interview she checked the side rails when she put them in the upright position. She stated she made sure they were locked in place. If the side rails were loose or didn't work properly she stated she placed a request for repair on the maintenance request form. She further stated she was unable to tighten side rails herself. NA #1 had not been assigned to this hall during the survey until this date.

On 01/23/15 at 11:46 AM the Director of Nursing (DON) stated that administrative rounds were done daily Monday through Friday and if staff saw an issue with a loose side rail they were to report it to maintenance. She stated that room rounds were not set up to check specific items such as side rails. If a nurse aide noticed side rails were loose, she expected them to put in maintenance requests or tell the nurse. She further stated she expected the side rails to be secure.

2. Resident #72 was most recently readmitted to the facility on 06/25/14 with diagnoses including

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abnormal posture, history of falls, and flaccid hemiplegia on the nondominant side.

The admission Minimum Data Set (MDS) dated 07/02/14 coded her as being cognitively intact (scoring a 14 out of 15 on the brief interview for mental status) and requiring extensive assistance with bed mobility and transfers and having no falls.

The Care Area Assessment dated 07/08/14 relating to falls noted she was at risk due to muscle weakness.

The most recent quarterly MDS dated 12/01/14 coded her as cognitively intact, being nonambulatory, and requiring extensive assistance with bed mobility and transfers. She was coded as having had a fall with no injury since the previous assessment (09/16/14).

A care plan was developed on 06/25/14 and last updated on 12/15/14 which addressed her risk and history of falling. One of the goals was for her to be free of falls. One of the interventions was for half side rails to be on the bed to aide in bed mobility.

The undated kardex used by nursing staff for individual care needs was reviewed for Resident #72. According to the kardex half side rails were to be used for positioning as needed.

On 01/21/15 at 3:10 PM, Resident #72 was observed in bed asleep on her right side with 2 half side rails upright. The side rails moved front to back parallel to the bed freely.

On 01/22/15 at 8:07 AM, Resident #72 was

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observed in bed, awake with both half side rails upright. Resident #72 stated that she used her side rails for positioning and they were always loose but she felt safe when she used them. Observed that the right half side rail moved parallel to the bed (head to foot) at least a foot in each direction and the left side moved 2-3 inches.

On 01/22/15 at 11:37 Am, Resident #72 was in bed with both side rails upright. the right side rails remained loose and easily moved up and down. As the surveyor checked the side rails Resident #72 stated the side rails needed to be tightened.

Interview with Nurse Aide (NA) #5 on 01/22/15 at 4:34 PM revealed Resident #72 was able to use her side rails to move in the bed.

Interview with NA #2 on 01/23/15 at 9:22 AM revealed that she made sure residents were in the middle of the bed and not too far up in bed or too far down in the bed. She stated that if she noticed a loose side rail, she tightened it via a knob on the side of the side rail. If the side rail could not be tightened she notified maintenance staff. Staff then accompanied the surveyor to the resident's room at 9:27 AM and noticed the side rail was loose on the right side. She tried to tighten it but stated she could not tighten it. She stated she did not pay attention when she used the side rails but should pay more attention.

On 01/23/15 at 9:38 AM, the maintenance staff stated he did preventative maintenance per a schedule. The schedule had him check all the side rails in the building once per month. The last time he checked the side rails was about 2 weeks ago. Staff stated that he also checked side rails

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for tightness and fit when he worked in a room for other issues or as reported by staff. Together the maintenance staff and surveyor checked Resident #72's side rail and maintenance staff was able to tighten the side rail securely. He further stated at this time he had to tighten many of the side rails during his monthly checks. When asked if he ever thought to check the side rails more frequently and he said no but that he probably should check them more frequently than once a month.

Maintenance reports revealed the last check on the secureness of the side rails was completed on 12/17/14. This was a general statement and did not delineate what maintenance needs had to be completed on the side rails.

On 01/23/15 at 11:29 AM, NA #1 stated during interview she checked the side rails when she put them in the upright position. She stated she made sure they were locked in place. If they were loose or didn't work properly she stated she placed the request for repair on the maintenance request form. She further stated she was unable to tighten side rails herself. NA #1 had not been assigned to this hall during the survey until this date.

On 01/23/15 at 11:46 AM the Director of Nursing (DON) stated that administrative rounds were done daily Monday through Friday and if staff saw an issue with a loose side rail they were to report it to maintenance. She stated that room rounds were not set up to check specific items such as side rails. If a nurse aide noticed side rails were loose, she expected them to put in maintenance requests or tell the nurse. She further stated she expected the side rails to be secure.

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3. Resident #33 was admitted to the facility on 12/09/14 with diagnoses including sepsis, acute respiratory failure, atrial fibrillation and osteoarthritis.

Resident #33's admission Minimum Data Set (MDS) dated 12/15/14 coded her as being moderately cognitively impaired (scoring an 8 out of 15 on the brief interview for mental status), requiring extensive assistance for all activities of daily living skills, and being nonambulatory.

The Care Area Assessment (CAA) for activities of daily living skills (ADLs) dated 12/22/14 noted Resident #33 had impaired balance, weakness, impaired cognition and required assistance with ADLs. The fall CAA dated 12/22/14 noted she had difficulty maintaining sitting balance, had impaired balance during transitions, and was at risk due to ADL function.

Resident #33 was observed in bed on 01/21/15 at 8:42 AM. The left half side rail was not tight and wiggled side to side (into the bed) and back and forth (parallel to the bed). The right half side rail wiggled sideways. Interview with the resident at this time revealed she used the side rails when in bed and she stated she would feel more secure if they were tightened.

On 01/22/15 at 10:57 AM Nurse Aide (NA) #3 stated Resident #33 used her side rails to turn and reposition herself in bed.

Interview with NA #2 on 01/23/15 at 9:22 AM revealed that she made sure residents were in the middle of the bed and not too far up in bed or too far down in the bed. She stated that if she

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noticed a loose side rail, she tightened it via a knob on the side of the side rail. If the side rail could not be tightened she notified maintenance staff. Staff then accompanied the surveyor to the resident's room and noticed the side rail was loose. She stated she did not pay attention when she used the side rails but should pay more attention.

On 01/23/15 at 9:38 AM, the maintenance staff stated he did preventative maintenance per a schedule. The schedule had him check all the side rails in the building once per month. The last time he checked the side rails was about 2 weeks ago. Staff stated that he also checked side rails for tightness and fit when he worked in a room for other issues or as reported by staff. Together the maintenance staff and surveyor checked Resident #33's side rail and maintenance staff was able to tighten the side rail securely. He further stated at this time he had to tighten many of the side rails during his monthly checks. When asked if he ever thought to check the side rails more frequently and he said no but that he probably should check them more frequently than once a month.

Maintenance reports revealed the last check on the secureness of the side rails was completed on 12/17/14. This was a general statement and did not delineate what maintenance needs had to be completed on the side rails.

On 01/23/15 at 11:29 AM, NA #1 stated during interview she checked the side rails when she put them in the upright position. She stated she made sure they were locked in place. If they were loose or didn't work properly she stated she placed a request for repair on the maintenance request

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F 323	Continued From page 26 form. She further stated she was unable to tighten side rails herself. NA #1 had not been assigned to this hall during the survey until this date. On 01/23/15 at 11:46 AM the Director of Nursing (DON) stated that administrative rounds were done daily Monday through Friday and if staff saw an issue with a loose side rail they were to report it to maintenance. She stated that room rounds were not set up to check specific items such as side rails. If a nurse aide noticed side rails were loose, she expected them to put in maintenance requests or tell the nurse. She further stated she expected the side rails to be secure. 4. Resident #56 was admitted on 10/05/14 with diagnoses including muscle weakness and history of a hip fracture. A side rail evaluation completed on 10/05/14 stated side rails were indicated and served as an enabler to promote independence with positioning in bed.	F 323		

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The annual Minimum Data Set data 12/07/14 revealed Resident #56 had severely impaired cognition and required extensive assistance with bed mobility and transfers.

Review of a care plan addressing Resident #56's activities of daily living dated 12/17/14 revealed a goal for Resident #56 to receive appropriate staff support with bed mobility and transfers. Included on the care plan was an undated intervention for half side rails to the bed to assist with bed mobility as needed.

Observations of Resident #56's side rails revealed the following:
- An initial observation of Resident #56's side rails on 01/21/15 at 8:56 AM revealed both side rails in the up position. The top of left side rail leaned away from the bed approximately 6 inches and could also move approximately 12 inches if you pulled on the left side rail towards the head or foot of the bed.
- A subsequent observation on 01/21/15 at 10:44 AM revealed Resident #56 was asleep and positioned in the middle of her bed. The top of left side rail leaned away from the bed approximately 6 inches and could also move approximately 12 inches if you pulled on the left side rail towards the head or foot of the bed.
- An observation on 01/22/15 at 8:22 AM revealed Resident #56 was eating breakfast in bed. The top of left side rail leaned away from the bed approximately 6 inches and could also move approximately 12 inches if you pulled on the left side rail towards the head or foot of the bed.

During an interview on 01/22/15 at 3:40 PM Nurse Aide (NA) #5 stated Resident #56 did use the side rails to assist with turning and positioning

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in bed.

Interview with NA #2 on 01/23/15 at 9:22 AM revealed that she made sure residents were in the middle of the bed and not too far up in bed or too far down in the bed. At the time of the interview the top of left side rail leaned away from the bed approximately 6 inches and could also move approximately 12 inches if you pulled on the left side rail towards the head or foot of the bed. NA #2 observed Resident #56's left side rail during the interview and confirmed it was loose. NA #2 stated she did not pay much attention to the side rails but if she noticed a loose side rail she would attempt to tighten it using the knob on the side of the side rail. NA #2 further stated if she was not able to tighten a side rail herself she notified maintenance staff.

On 01/23/15 at 9:38 AM, the maintenance staff stated he does preventative maintenance per a schedule. The schedule has him check all the side rails in the building once per month. The last time he checked the side rails was about 2 weeks ago. Staff stated that he would also check side rails for tightness and fit when he worked in a room for other issues or as reported by staff. He further stated he typically had to tighten many of the side rails during his monthly checks. When asked if he ever thought to check the side rails more frequently and he said no but that he probably should check them more than once a month.

Maintenance reports revealed the last check on the secureness of the side rails was completed on 12/17/14. This was a general statement and did not delineate what maintenance needs had to be completed on the side rails.

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F 323	Continued From page 29 On 01/23/15 at 11:46 AM the Director of Nursing (DON) stated that administrative rounds were done daily Monday through Friday and if staff saw an issue with a loose side rail they should report it to maintenance. She stated that room rounds were not set up to check specific items such as side rails. If a nurse aide noticed side rails were loose, she expected them to put in maintenance requests or tell the nurse. She further stated she expected the side rails to be secure.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer the correct dose of Levemir to 1 of 7 sampled residents with medications reviewed. (Resident #131) The findings included: Resident #131 was admitted to the facility 01/05/15 with diagnoses which included diabetes. Admission physician orders included Levemir insulin, 10 units twice a day. The initial care plan dated 01/12/15 for Resident #131 included a problem area, The resident has potential for imbalanced nutrition due to diabetes. An approach to this problem area included, administer medications as ordered.	F 333	F333 1. Resident #131 suffered no injury related to this citation. On 01/21/15 the Director of Clinical Services clarified the insulin order and transcribed this order to the medication administration record. A medication error report was completed on 01/21/115 with notification to responsible party and physician by Director of Clinical Services. On 01/29/15, the physician assessed the resident. No new orders noted. 2. Residents receiving insulin have the potential to be affected by this citation. On 01/21/15, the Director of Clinical Services completed an audit of the MARs	2/17/15

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F 333	Continued From page 30 The physician history and physical note dated 01/12/15 included: Seen for initial evaluation and complete exam. Resident #131 has a history of diabetes and has been on Glipizide (an oral medication to treat diabetes) in addition to Levemir. No hypoglycemic reactions have been reported. Plan: Diabetes mellitus without mention of complication, has been on oral hypoglycemics. Given the patient's age I think that this is a high risk medication that needs to be discontinued. I have discontinued the Glipizide, I have increased the Levemir by 2 units at bedtime. I have instructed nursing staff to monitor blood glucose three times daily. A physician's order dated 01/12/15 was written in the medical record of Resident #131 which included, discontinue Glipizide, increase Levemir to 12 units at bedtime and blood glucose checks three times a day. Review of the January 2015 Medication Administration Record (MAR) for Resident #131 noted the order for Levemir 10 units twice a day had been administered as ordered with administration times at 8:00 AM and 8:00 PM from 01/05/14 through the AM dose on 01/12/15. This order was highlighted with notation that it was changed on 01/12/15. A new order was written on this MAR for Levemir, 12 units at 2100. The 10 unit AM dose of Levemir was not rewritten on the MAR of Resident #131 after 01/12/15. On 01/21/15 at 4:30 PM the Director of Nursing (DON) reviewed the physician order dated 01/12/15 in the medical record of Resident #131 and stated the Levemir should have been changed to 10 units in the AM and 12 units in the	F 333	for residents receiving insulin matching orders to the MAR. The Director of Clinical Services and/or Nursing Supervisor in-serviced licensed nurses on 02/09/2015 through 02/15/2015, regarding transcribing physician orders to MARs and following physician orders. 3. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of the MARs for 10 residents receiving insulin 5 times a week for 1 month, 3 times a week for 2 months, 2 times a week for 2 months and then 1 time a week for 1 month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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PM.

On 01/21/15 at 4:35 PM the Assistant Director of Nursing (ADON) stated she was with the physician on 01/12/15 when he saw Resident #131 and wrote the physician order for medication changes. The ADON reviewed the 01/12/15 physician order for Resident #131 as well as the January 2015 MAR. The ADON stated she transcribed the 01/12/15 physician order for Resident #131 on the MAR and should have written it to continue the 10 units of Levemir in the AM and 12 units of Levemir at bedtime. The ADON stated a second nurse checks orders and the resident MAR to ensure medications are transcribed as ordered. The ADON identified Nurse #1 as the nurse that did the second check based on initials written by the 01/12/15 physician order and MAR. The ADON stated both she and Nurse #1 overlooked inclusion of the AM 10 unit dose of Levemir after the order was rewritten on 01/12/15.

On 01/22/15 at 9:45 AM the DON stated she contacted the physician of Resident #131 to inform him of the medication error with the Levemir and the physician wanted the 10 units of Levemir restarted at 10:00 AM. After this conversation the DON noted she wrote an order dated 01/21/15 in the medical record of Resident #131 for 10 units of Levemir in the AM and 12 units of Levemir at bedtime. The DON stated she was in the process of inservicing all nursing staff about transcribing physician orders to prevent errors.

On 01/22/15 at 12:00 PM Nurse #1 verified cosigning the 01/12/15 order and MAR for Resident #131. Nurse #1 stated he interpreted

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F 333	Continued From page 32 the order to discontinue the 10 unit AM dose of Levemir but noted the physician had been called 01/21/15 by the DON for clarification.	F 333		
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 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		2/17/15

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F 431	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to remove 10 of 10 single dose vials of expired Pneumococcal vaccine from 1 of 1 medication storage refrigerator. Findings included: On 01/22/15 at 2:50 PM, 10 of 10 single dose vials of Pneumococcal vaccine with an expiration date of 01/11/15 was observed in the facility medication storage refrigerator located in the medication storage room. On 01/22/15 at 3:33 PM an interview was conducted with Unit Manager who confirmed that 10 of 10 single dose vials of Pneumococcal vaccine were expired. The Unit Manager shared she did not know who was responsible for checking for expired medication in the medication storage refrigerator. On 01/22/15 at 3:48 PM an interview was conducted with the Director of Nursing (DON) who confirmed 10 of 10 vials of Pneumococcal vaccine were expired on 01/11/15. The DON stated it was the responsibility of the weekend Nursing Supervisor to check for expired medication in the medication storage refrigerator and medication storage room. The DON stated it was her expectation that the weekend Nursing Supervisor would check for expired medication and remove expired medication from the medication storage refrigerator and medication storage room.	F 431	F431 1. No residents were injury related to this citation. 2. All residents have the potential to be affected by this citation. On 01/22/15, the Director of Clinical Services completed an audit of the medication room and medication carts for expired and/or undated medications. The Director of Clinical Services and/or Nursing Supervisor in-serviced licensed nurses, on 02/09/2015 through 02/15/2015, regarding discarding expired medications and dating open vials/bottles. 3. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication room and medication carts for expired medicines 5 times a week for 1 month, 3 times a week for 2 months, 2 times a week for 2 months and then 1 time a week for 1 month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement	

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F 431	Continued From page 34 On 01/22/15 at 3:59 PM an interview was conducted with the Administrator who stated her expectations were that the facility would not keep expired medications in the medication storage refrigerator or medication storage room. The Administrator stated her expectations were that expired medication would be destroyed or sent back to pharmacy. The Administrator stated her expectations were nurses would check that expired medication was not available for resident use. On 01/22/15 at 5:44 PM a telephone interview was conducted with the weekend Nursing Supervisor who stated she checked for expired medication in the medication storage room but never in the medication storage refrigerator. The weekend Nursing Supervisor stated she was never oriented to check the medication storage refrigerator for expired medication.	F 431	Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	