STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(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 result of the complaint investigation. Event ID # 4ZYH11	F 000		
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.	F 157		9/3/15

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

Electronically Signed | 08/29/2015

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on resident, staff and physician interview, the facility failed to notify the physician regarding refusal of daily Lasix (a diuretic) for 1 of 5 sampled residents who receive medication (Resident #34). The findings included: Resident #34 was admitted to the facility on 03/09/14 with diagnoses which included hypertension. Review of Resident #34's quarterly Minimum Data Set (MDS) dated 05/08/15 revealed an assessment of intact cognition and daily administration of a diuretic. Review of physician's orders dated 05/18/15 revealed direction to administer Lasix 40 milligrams (mg.) daily. Review of Resident #34's June 2015 Medication Administration Record (MAR) revealed Resident #34 refused the daily Lasix on 06/02/15, 06/15/15, 06/16/15 06/17/15, 06/18/15 06/22/15, 06/23/15, 06/24/15 and 06/30/15 (9 days). Review of Resident #34's July 2015 MAR revealed Resident #34 refused the daily Lasix on 07/01/15, 07/02/15, 07/03/15, 07/05/15, 07/13/15, 07/14/15, 07/23/15, 07/27/15 and 07/29/15 (9 days). Review of Resident #34's August 2015 MAR revealed Resident #34 refused the daily Lasix on 08/3/15, 08/04/15, 08/05/15 and 08/06/15 (4 consecutive days).	F 157	F157 Notify of Changes (injury/Decline/Room, Etc.) 1.) It is the practice of the facility to notify the physician regarding resident refusals of ordered medications. The physician was notified on 8/6/15 by the Director of Clinical Services (DCS) of resident #34 Lasix refusals and no new orders were received at that time. The residents care plan was also updated on 8/6/15 to reflect the residents¿ refusal of medications. On 8/7/15, the physician ordered that Lasix be discontinued, weights weekly for 8 weeks and labs to monitor. The resident has not had a significant weight loss or gain, labs are within normal range and resident remains at baseline. 2.)Residents who refuse their medications are at risk of the alleged deficient practice. Medication Administration Reports (MARs) for current facility residents were audited by the DCS on 8/12/15 for the current month of August to identify additional residents who refused medications. Residents who refused medications were identified and the physician was notified and new orders and care plans updated if indicated, by the licensed nurse. 3.) Licensed nurses were reeducated on 8/12/15 by the DCS regarding the company policy to notify physician timely for resident refusals of ordered medications. Newly hired licensed nurses	

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F 157	Continued From page 2 Interview with Nurse #1 on 08/06/15 at 3:09 PM revealed Resident #34 refused the Lasix routinely. Nurse #1 explained she asked Resident #34 each morning before she prepared the medication for administration. Nurse #1 reported she did not know the reason for the refusal. Nurse #1 reported she did not know if Resident #1's physician received notification of the frequent refusals. Interview on 08/06/15 at 3:35 PM with Resident #34 revealed the Lasix caused her to urinate multiple times. Resident #34 explained she did not want to have to keep getting up and going to the bathroom. Interview with the Director of Nursing (DON) on 08/06/15 at 3:44 PM revealed she was not aware of Resident #34's frequent refusal of Lasix. The DON reported she expected staff to notify the physician when a medication was refused on a regular basis. Telephone interview with Resident #34's physician on 08/06/15 at 4:07 PM revealed he expected facility staff to notify him of frequent refusals of medication. The physician reported he was not aware of Resident #34's refusal of the Lasix and if notified, would consider changes in treatment such as weight monitoring and observations for edema.	F 157	will be educated upon hire. The licensed nurse will notify the physician timely of resident medication refusals and document notification in the nurses¿ notes. 4.) The RN Unit Manager/licensed nurse designee will audit MARs 3x/week for 1 month, 1x/week for 2 months then, monthly for 3 months to validate that the physician has been notified of residents who refuse medications and applicable recommendations have been followed. The Director of Clinical Services will report audit results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. 5.) AOC date- 9/3/15	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272		9/3/15

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F 272	Continued From page 3 functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments	F 272	F272 Comprehensive Assessments 1) It is the practice of the facility to	

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F 272	Continued From page 4 (CAA) that addressed the underlying causes, contributing factors, and risk factors for 9 of 9 sampled residents reviewed for the most recent comprehensive Minimum Data Set (MDS) assessment (Residents #65, #104, #64, #34, #56, #60, #54, #38, and #16). The findings included: 1) Resident #65 was admitted to the facility 05/23/13. Her diagnoses included depressive disorder and generalized muscle weakness. Resident #65's annual Minimum Data Set (MDS) assessment dated 08/08/15 indicated Resident #65 was cognitively intact and ambulatory with supervision. Resident #65's MDS assessment dated 08/08/15 also indicated Resident #65 extensive assistance with toileting and was frequently incontinent of both bowel and bladder. Resident #65's quarterly MDS assessment dated 02/27/15 indicated Resident #65 required only supervision with toileting, was always continent of bowel and occasionally incontinent of bladder. Resident #65's Care Area Assessment (CAA) analysis of findings related to urinary incontinence dated 08/05/15 recorded Resident #65 had a decline in self toileting skills related to requiring extensive assistance with ADLs. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the CAA Summary. A staff interview was conducted with MDS Nurse on 08/06/15 at 12:08 PM. MDS Nurse verbalized understanding the CAA analysis of findings should contain a comprehensive assessment	F 272	complete Care Area Assessments (CAA) that address the underlying causes, contributing factors, and risk factors from the comprehensive Minimum Data Set (MDS) assessment. Residents #65, #104, #64, #34, #56, #60, #54, #38 and #16 did not experience any harm as a result of the alleged deficient practice. Subsequent CAA¿s will be completed during the next scheduled comprehensive MDS assessment per Resident Assessment Instrument (RAI) guidelines. 2) All current residents are at risk of the alleged deficient practice. The MDS Registered Nurse (RN) completed an audit of active resident CAA¿s on 8/6/15 to validate that no harm resulted from the alleged deficient practice. The MDS RN will complete subsequent CAA¿s that are triggered from the comprehensive MDS assessment to address the underlying causes, contributing factors, and risk factors. Comprehensive MDS assessments and CAA¿s will be completed timely upon admission, annually and with significant changes per RAI guidelines. 3.) The Regional MDS RN reeducated the MDS Interdisciplinary Team (IDT) inclusive of the MDS RN, Dietary Manager, Activities Director, Social Worker and Director of Clinical Services (DCS) on 8/12/15 regarding the RAI guidelines for CAA completion. Newly hired MDS Interdisciplinary Team Members will be educated upon hire. The MDS nurse has also reviewed the educational material on CAA¿s provided by CMS on 8/10/15 and will maintain an	

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F 272	Continued From page 5 including descriptions, risks and contributing factors for each triggered area of concern. Upon review of Resident #65's CAA analysis of findings MDS Nurse verbalized the CAA analysis of findings should have contained more information. A staff interview was conducted with the Director of Nursing (DON) on 08/06/15 at 2:55 PM. The DON verbalized it is her expectation the MDS Nurse follow the federal guidelines completing the CAA summaries analysis of findings completely and accurately. 2) Resident #104 was admitted to the facility on 06/04/15. Diagnoses included post motor vehicle accident with multiple rib and vertebrae fractures, left humerus fracture, respiratory failure and pulmonary contusion. Resident #104's admission MDS dated 06/11/2015 recorded Resident #104 had received anti-depressant medication 7 of 7 days during the 7 days preceding the MDS admission assessment. Resident #104's CAA analysis of findings related to psychotropic drug use referenced the potential for side effects related to the use of anti-depressant medication and recorded Resident #104 had severely limited mobility and multiple fractures which resulted from a motor vehicle accident. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the CAA Summary. A staff interview was conducted with MDS Nurse on 08/06/15 at 12:08 PM. MDS Nurse verbalized understanding the CAA analysis of findings	F 272	updated copy for reference. 4.) The Director of Clinical Services (DCS) will audit residents CAA¿s for admission, annual and significant change comprehensive MDS assessments prior to submission x 1 month then, 3 x/week for 2 months then, 1 x/week for 3 months to validate accuracy and completeness. Any discrepancy will be reported to the MDS IDT members for review and reeducation and/or disciplinary action where appropriate. The DCS will report audit results monthly in QAPI for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary. 5.) AOC date- 9/3/15	

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should contain a comprehensive assessment including descriptions, risks and contributing factors for each triggered area of concern. Upon review of Resident #104's CAA analysis of findings MDS Nurse verbalized the CAA analysis of findings should have contained more information.

A staff interview was conducted with the Director of Nursing (DON) on 08/06/15 at 2:55 PM. The DON verbalized it is her expectation the MDS Nurse follow the federal guidelines completing the CAA summaries analysis of findings completely and accurately.

3) Resident #64 was admitted to the facility on 07/03/15 with diagnoses which included lung cancer, anxiety, depression and a tracheostomy. Admission medications included Prozac (an anti-depressant) 20 milligrams (mg.) daily, hydrochlorothiazide (a diuretic) 25 mg daily and Xanax 0.5 mg. three times daily for anxiety.

Review of Resident #64's admission Minimum Data Set (MDS) dated 07/10/15 revealed an assessment of intact cognition. The MDS indicated Resident #64 required the limited assistance of one person with walking. The MDS indicated Resident #64 fell once since admission with no injury.

Review of Resident #64's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/11/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes, contributing factors, and risk factors related to the psychotropic medication. The CAA did not contain the name, dose or

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frequency of the psychoactive medications used by Resident #64. The CAA indicated Resident #64 exhibited adverse consequences of anxiety, sedation, and disturbances of gait with no documented description or analysis of adverse consequences. There was no documentation of an input from Resident #64. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

Review of Resident #64's Fall CAA dated 07/11/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes, contributing factors and risk factors related to falls. The CAA did not describe the fall which occurred after resident #64's admission to the facility. The CAA did not contain the name, dose or frequency of the psychoactive and diuretic medications used by Resident #64. The CAA indicated pain as a factor in Resident #64's fall risk. The CAA did not describe Resident #64's pain and potential impact on the risk for falls. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

Observation on 08/05/15 at 8:55 AM revealed Resident #64 ambulated independently with a walker in the room. Resident #64 picked up the walker and stepped over the tracheostomy tube.

Interview with Resident #64 pm 08/05/15 at 8:58 AM revealed staff offered assistance with ambulation as needed. Resident #64 explained the tracheostomy tube tripped her once but now she had the strength to lift the walker over the tubing.

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Interview with the MDS Coordinator on 08/06/15 at 11:37 AM revealed she was not aware documentation of an analysis of findings regarding Resident #64's fall risk and psychoactive medication was required. The MDS Coordinator reported she did not document the potential environmental hazard of Resident #64's care equipment such as the tubing used for the tracheostomy. The MDS Coordinator explained the software program worksheet automatically populated the section entitled analysis of findings so she thought it was complete.

Interview with the Regional MDS Coordinator on 08/06/15 at 11:45 AM revealed she expected CAAs to contain a documentation of the analysis of findings.

4) Resident #34 was admitted to the facility on 03/09/14 with diagnoses which included anxiety and nonspecific psychiatric disorders.

Review of Resident #34's annual Minimum Data Set (MDS) dated 03/20/15 revealed an assessment of intact cognition and the use of daily anti-depressant and anti- anxiety medications.

Review of Resident #34's March 2015 monthly physician's orders revealed direction to administer Ativan (for anxiety) 0.5 milligrams (mg.) three times daily, Ativan 0.25 mg. at bedtime, and Trazodone (an anti-depressant) 300 mg. at bedtime.

Review of Resident #34's Psychotropic Drug Use Care Area Assessment (CAA) dated 04/03/15 revealed there was no documentation of an analysis of the findings with a description of the

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problem, causes, contributing factors, and risk factors related to the psychotropic medication. The CAA did not contain the name, dose or frequency of the psychoactive medications used by Resident #64. The CAA indicated Resident #64 exhibited adverse consequences of anxiety and disturbances of gait with no documented description or analysis of these adverse consequences. There was no documentation of an input from Resident #34. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

Interview with the MDS Coordinator on 08/06/15 at 11:37 AM revealed she was not aware documentation of an analysis of findings regarding Resident #34's psychoactive medication use was required. The MDS Coordinator explained the software program worksheet automatically populated the section entitled analysis of findings so she thought it was complete.

Interview with the Regional MDS Coordinator on 08/06/15 at 11:45 AM revealed she expected CAAs to contain a documentation of the analysis of findings.

5) Resident #56 was admitted to the facility on 03/06/15 with diagnoses which included bladder disorders, dementia, depression, and coronary artery disease. Admission medications included Zoloft (an antidepressant) 100 milligrams (mg) daily, Remeron (an antidepressant) 15 mg every night at bedtime used for depression, and Seroquel (an antipsychotic) 100 mg daily used for dementia.

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Review of Resident #56's admission Minimum Data Set (MDS) dated 04/24/15 indicated an assessment of intact cognition. The MDS revealed Resident #56 required extensive assistance of one person with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further indicated Resident #56 had a fall since admission.

Review of Resident #56's Psychotropic Drug Use Care Area Assessment (CAA) dated 03/19/15 indicated there was no documentation of an analysis of the findings with a description of the problem, causes, contributing factors, and risk factors related to the psychotropic medication. The CAA did not contain the dose or frequency of the psychoactive medications used by Resident #56. There was no documentation of an input from Resident #56 and no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

Review of Resident #56's Fall CAA dated 03/19/15 indicated there was no documentation of an analysis of findings with a description of the problem, causes, contributing factors, and risk factors related to falls. The CAA did not describe the fall which occurred after Resident #56 was admitted to the facility. The CAA did not contain the name, does or frequency of the antipsychotic and antidepressant medications used by Resident #56. The CAA did not indicate pain as a factor in Resident #56's fall risk. The CAA did not describe Resident #56's pain and/or potential impact on the risk of falls. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

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Resident #56 was observed on 08/05/15 at 10:03 AM setting in a wheelchair in the room and had requested to go to bed. Resident #56 was observed to push the call light, stand from the wheelchair, pivot, and set down on the side of the bed

An interview was conducted with Resident #56 on 08/05/15 at 10:05 AM. Resident #56 stated staff was slow to respond sometimes and she preferred to do things on her own. Resident #56 indicated when she would hold onto something she was capable to pivot.

An interview was conducted with the MDS Coordinator on 08/06/15 at 1:10 PM. The MDS Coordinator revealed she was not aware documentation of an analysis of findings regarding Resident #56's fall risk and psychotropic medication use was required. The MDS Coordinator explained the software program worksheet automatically populated the section entitled analysis of findings so she thought it was completed. The MDS Coordinator further indicated she had company training but had not had any formal MDS/CAA training.

Interview with the Regional MDS Coordinator on 08/06/15 at 1:15 PM revealed she expected the CAAs to contain a documentation of the analysis of findings.

6) Resident #60 was admitted to the facility on 11/21/14 with diagnoses which included diabetes mellitus, end stage kidney disease, and coronary artery disease.

Review of Resident #60's admission Minimum Data Set (MDS) dated 11/28/14 indicated the

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resident was cognitively intact and required extensive assistance with activities of daily living (ADLs).

Review of Resident #60's ADL function Care Area Assessment (CAA) dated 12/04/14 revealed there was no documentation of an analysis of the findings with a description of the problems, causes, contributing factors, and risk factors related to the ADL functional status. The CAA indicated Resident #60 had physical limitations related to weakness, limited range of motion, poor coordination, poor balance visual impairment, and pain regarding dressing, bathing, toileting, and transfers with no documented description or analysis of these limitations. There was no documentation of an input from Resident #60. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

An interview was conducted with the MDS Coordinator on 08/06/15 at 1:10 PM. The MDS Coordinator revealed she was not aware documentation of an analysis of findings regarding Resident #60's ADL function was required. The MDS Coordinator explained the software program worksheet automatically populated the section entitled analysis of findings so she thought it was completed. The MDS Coordinator further indicated she had company training but had not had any formal MDS/CAA training.

Interview with the Regional MDS Coordinator on 08/06/15 at 1:15 PM revealed she expected the CAAs to contain a documentation of the analysis of findings.

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7) Resident #54 was admitted to the facility on 03/18/11 with diagnoses which included dementia, chronic pain, Alzheimer's disease, mood disorder, psychosis, and anxiety. Resident #54's medications included Depakote (an antipsychotic) 125 milligrams (mg) twice daily for mood disorder, Ativan (an antianxiety) 0.5 mg twice daily for anxiety, and Remeron (an antidepressant) 7.5 mg every night at bedtime for depression.

Review of Resident #54's annual Minimum Data Set (MDS) dated 03/09/15 indicated an assessment of severe cognitive impairment. The MDS revealed Resident #54 required extensive assistance of two persons with bed mobility, dressing, eating, and personal hygiene and was totally dependent on staff for transfers, toileting, and bathing. The MDS further indicated Resident #54 had falls since admission.

Review of Resident #54's Psychotropic Drug Use Care Area Assessment (CAA) dated 03/19/15 indicated there was no documentation of an analysis of the findings with a description of the problem, causes, contributing factors, and risk factors related to the psychotropic medication. The CAA did not contain the dose or frequency of the psychoactive medications used by Resident #54. There was no documentation of an input from Resident #54's family and/or representative and no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

Review of Resident #54's Fall CAA dated 03/19/15 indicated there was no documentation of an analysis of findings with a description of the problem, causes, contributing factors, and risk

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factors related to falls. The CAA did not describe the falls which occurred after Resident #54 was admitted to the facility. The CAA did not contain the name, dose or frequency of the antianxiety, antipsychotic, and antidepressant medications used by Resident #54. The CAA did not indicate pain as a factor in Resident #54's fall risk. The CAA did not describe Resident #54's pain and/or potential impact on the risk of falls. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

An interview was conducted with the MDS Coordinator on 08/06/15 at 1:10 PM. The MDS Coordinator revealed she was not aware documentation of an analysis of findings regarding Resident #54's fall risk and psychotropic medication use was required. The MDS Coordinator explained the software program worksheet automatically populated the section entitled analysis of findings so she thought it was completed. The MDS Coordinator further indicated she had company training but had not had any formal MDS/CAA training.

Interview with the Regional MDS Coordinator on 08/06/15 at 1:15 PM revealed she expected the CAAs to contain a documentation of the analysis of findings.

8) Resident #38 was admitted to the facility on 04/30/12 with diagnosis of end stage renal disease (ESRD), dementia with behavioral disturbance, psychosis, dysphagia and chronic kidney disease.

Review of the Annual Minimum Data Set (MDS) dated 06/14/15 revealed Resident #38 had short and long term memory loss and severely impaired to daily decision making. The MDS

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further specified Resident #38 required total dependence with toilet use and extensive assistance with dressing and personal hygiene.
A review was conducted of the Care Area Assessment (CAA) associated with the MDS regarding falls. The CAA dated 06/14/15 revealed under the heading was Analysis of Findings. Written under this heading was "the problem/need was actual". Written under the nature of the problem/condition was "82 year old gentleman with dx (diagnosis) of dementia Alzheimer's type, psychosis, dysphagia, ERSD (end stage renal disease) who is nonverbal and unable to make his needs known". Further review of the Fall CAA revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors related to the care plan.
An interview was conducted with the MDS Coordinator on 08/06/15 at 2:30 PM. The MDS Coordinator revealed she was not aware documentation of an analysis of findings regarding Resident #38's fall risk was not completed. The MDS Coordinator explained the software program worksheet automatically populated the section entitled analysis of findings so she thought it was completed. The MDS Coordinator further indicated she had company training but had not had any formal MDS/CAA training.
An interview was conducted with the Director of Nursing (DON) on 08/06/15 at 2:55 PM. She stated her expectation was for the MDS Coordinator to follow the federal guidelines and complete the CAA summaries accurately and completely.

9) Resident #16 was admitted to the facility on 06/30/15 with diagnosis of cerebral vascular

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disease, vascular dementia, acute renal failure and chronic obstructive pulmonary disease.
Review of the Admission Minimum Data Set (MDS) dated 07/16/15 revealed Resident #16 had short and long term memory loss and severely impaired to daily decision making. The MDS indicated Resident #16 triggered the Care Area Assessment (CAA) in the area of psychoactive medications. The MDS indicated Resident #16 received antipsychotic and antianxiety medications.
Review of Resident #16's CAA dated 07/16/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors related to the care plan.
The CAA's analysis of findings assessment dated 07/16/15 concerning psychotropic drug use informed that Resident #16 was prescribed psychotropic medication Seroquel 1.25 milligram (mg) twice a day. Resident #16 was prescribed antianxiety medication Lorazepam 0.5 milligram (mg) tablet three times by mouth as needed for agitation and Lorazepam 2 milligram (mg) 1 milliliter (ml) injection 0.5 milliliter (ml) intramuscularly three times daily as needed for agitation.
The analysis of findings stated Resident #16 was admitted with antidepressant and (dx) diagnosis vascular dementia is currently on antipsychotic BID (twice a day) and antianxiety prn (as needed). Comments under the heading of care plan consideration recorded in part, "will monitor for any side effects of medications".
An interview was conducted with the MDS Coordinator on 08/06/15 at 2:30 PM. The MDS Coordinator revealed she was not aware documentation of an analysis of findings regarding Resident #16's psychotropic medication

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F 272	Continued From page 17 use was not completed. The MDS Coordinator explained the software program worksheet automatically populated the section entitled analysis of findings so she thought it was completed. The MDS Coordinator further indicated she had company training but had not had any formal MDS/CAA training. An interview was conducted with the Director of Nursing (DON) on 08/06/15 at 2:55 PM. She stated her expectation was for the MDS Coordinator to follow the federal guidelines and complete the CAA summaries accurately and completely.	F 272		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to clarify with the physician the route of a medication for 1 of 10 residents reviewed during medication administration (Resident #94). The findings included: Resident #94 was admitted to the facility on 06/30/15 with diagnoses which included a traumatic brain injury, mood disorder, depression, dysphagia, and cervical discectomy. The admission Minimum Data Set (MDS) dated 07/07/15 indicated Resident #94 was cognitively intact and was capable of making his needs known.	F 281	F281 Services Provided Meet Professional Services 1) It is the practice of the facility to clarify with the physician, the appropriate route of medication administration. Resident #94 is receiving medications orally per physician orders received on 8/5/15. 2.) Residents with medications are at risk for the alleged deficient practice. Residents with medication orders were audited by the Director of Clinical Services by 8/24/15 (DCS) to validate that medications are being administered by the appropriate route ordered and that the order is indicated on the Medication	9/3/15

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F 281	Continued From page 18 A review of the physician orders dated 06/30/15 included an order to administer: "Seroquel 200 milligrams (mg) 1 tablet along with 1 tablet of Seroquel 25 mg to equal 225 mg via tube twice daily." A review of the Medication Administration Record (MAR) for the month of August 2015 revealed the physician's order was transcribed correctly and Resident #94 was administered 1 tablet of Seroquel 200mg and 1 tablet of Seroquel 25mg to equal 225 mg twice daily from 08/01/15 through 08/05/15. On 08/05/15 at 4:01 PM observed Nurse #2 removed 1 tablet of Seroquel 200 mg and 1 tablet of Seroquel 25 mg from Resident #94's pharmacy filled bubble packets ad placed them into a cup to be administered to Resident #94. Nurse #2 reviewed the physician order and administered the Seroquel 225 mg medication to Resident #94 by mouth. On 08/05/15 at 4:20 PM Nurse #2 was interviewed. Nurse #2 confirmed the physician's order and the transcription of the physician's order onto the MAR. Nurse #2 stated the Seroquel was supposed to be administered via Resident #94's peg tube and that she had been administering Resident #94's medications by mouth since he was capable of eating food. Nurse #2 indicated she was expected to follow the physician's orders and had no explanation as to why the physician's order had not been changed for Resident #94 to have the medications by mouth rather than by peg tube. Nurse #2 stated she had not called the resident's physician for clarification of the route of the	F 281	Administration Record (MAR). 3.) The DCS reeducated licensed nurses on 8/12/15 regarding comprehensive resident assessments and obtaining the appropriate order for route of medication administration. Newly hired licensed nurses will be educated upon hire. Physician orders for residents¿ route of medication administration will be obtained upon admission and with changes in condition where indicated, and placed on the MAR. 4.) The RN Unit Manager/licensed nurse designee will audit new admissions and 10% of active residents 3x/week for 1 month, 1x/week for 2 months, and then 1x/month for 3 months to validate that the licensed nurse is administering medications by the ordered route and that the order is indicated appropriately on the MAR. The DCS will report audit results monthly in QAPI for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary. 5.) AOC date- 9/3/15	

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F 281	Continued From page 19 medication. On 08/05/15 at 4:51 PM the Director of Nursing (DON) was interviewed. She stated she expected the nurses to follow the physician's order. She also indicated Resident #94 had to have the Seroquel medication regardless of how it was to be administered but also stated her expectation of the nurse was to follow the physician's order or to have obtained clarification from the physician of how the medications were to be administered. On 08/06/15 at 4:15 PM a telephone interview was conducted with Resident #94's physician. The physician stated he would have expected the medications to have been administered by mouth. The physician further stated he would have expected a telephone call for clarification of the medication administration route rather than the nurses assuming the resident was capable of taking his medications by mouth.	F 281		
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff	F 310	F310 ADLs Do Not Decline Unless	9/3/15

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F 310	Continued From page 20 interviews the facility failed to maintain a resident's ability to perform activities of daily living (ADL) by not providing services or treatment to maintain the resident's functional abilities for 1 of 3 residents reviewed for ADL's (Resident #65). The findings included: Resident #65 was admitted to the facility 05/23/13. Her diagnoses included depressive disorder and generalized muscle weakness. Resident #65's annual Minimum Data Set (MDS) assessment dated 08/08/15 indicated Resident #65 was cognitively intact and ambulatory with supervision. Resident #65's MDS assessment dated 08/08/15 also indicated Resident #65 required limited assistance with dressing, extensive assistance with toileting and was frequently incontinent of both bowel and bladder. Resident #65's quarterly MDS assessment dated 02/27/15 indicated Resident #65 required only supervision with dressing and toileting, was always continent of bowel and occasionally incontinent of bladder. Resident #65's Care Area Assessment (CAA) analysis of findings related to urinary incontinence dated 08/05/15 recorded Resident #65 had a decline in self toileting skills related to requiring assistance with ADLs and was referred to a toileting program. On 08/05/15 at 1:30 PM Resident #65 was observed using her call light to request assistance. Nursing Assistant (NA) #1 was observed entering Resident #65's room to assist Resident #65 complete toileting and assist Resident 65 to get dressed following toileting.	F 310	Unavoidable 1.) It is the practice of the facility to provide services and treatments that maintain the residents functional abilities for Activities of Daily Living (ADL). The facility will continue to provide pull-ups for resident #65 to promote independence with toileting. 2.) Residents with incontinence needs are at risk of the alleged deficient practice. 100% of residents were assessed by the Material Data Set (MDS) nurse on 8/24/15 to determine if the appropriate incontinence products and assistance levels are being provided to promote the residents highest functional status. Appropriate incontinence products and assistance levels will be identified and provided to meet the individual toileting needs of the residents. 3.) All facility employees were reeducated on 8/12/15 by the Administrator on resident rights related to dignity. Licensed Nurses were reeducated on 8/12/15 by the Director of Clinical Services (DCS) on accurate bowel and bladder assessments and determining the appropriate incontinence products and assistance levels to promote the residents highest functional status related to toileting. Newly hired employees will be educated as indicated upon hire. A bowel and bladder assessment will be completed by the licensed nurse upon admission, quarterly and with significant changes in condition. Assistance levels and incontinence	

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F 310	Continued From page 21 Resident #65 was observed to be sitting on the toilet when she requested assistance. Resident #65 was interviewed on 08/05/15 at 1:46 PM. Resident #65 verbalized she used her walker to ambulate and would be able to go to the bathroom and get dressed independently except she was unable to put the wrap around diaper on properly and secure it without assistance. Resident #65 reported the facility had stopped providing pull up protective briefs and replaced them with wrap around diapers which were secured with tape. Resident #65 reported she had spoken to NAs about her concerns related to not being provided pull up protective briefs. Resident #65 added her sister had spoken with the facility administrator complaining about the pull up protective briefs not being provided for Resident #65. A staff interview was conducted with NA#1. NA#1 reported Resident #65 was able to ambulate, dress and toilet independently when provided the pull up briefs. NA#1 also reported Resident #65 had expressed she would feel more independent if the facility provided pull up briefs. NA#1 verbalized she documented Resident #65 as toileting independently with no set up required when Resident #65 had pull up briefs. NA#1 verbalized she started documenting Resident #65 required assistance with toileting and dressing due to Resident #65's inability to manage the wrap around diapers which are secured with tape. NA#1 added she had noticed a negative change in how Resident #65 felt about herself since Resident #65 was less independent with ADLs. A staff interview was conducted with NA#2 on 08/05/15 at 2:23 PM. NA#2 reported Resident	F 310	products will be determined and implemented to ensure resident dignity and to maintain the residents¿ functional abilities with ADL¿s related to toileting. 4.) The MDS nurse/licensed nurses designee will audit newly admitted residents and 10% random active residents weekly for 3 months, then monthly for 3 months to validate that residents are receiving appropriate incontinence products and assistance levels to promote their dignity and meet toileting needs. The DCS will report audit results monthly in QAPI for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary. 5.) AOC date-9/3/15	

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#65 was able to dress and toilet independently when she had the pull up briefs. NA#2 also reported Resident #65 was unable to properly position and secure the wrap around diapers which are secured with tape so Resident #65 required assistance with toileting and dressing.

A staff interview was conducted with the Administrator on 08/05/15 at 2:50 PM. The Administrator reported that in late December of 2014 or early January 2015 he was informed by a corporate representative pull up briefs would no longer be provided to residents. The Administrator verbalized Resident #65's sister had spoken with him concerning Resident #65's inability to properly position and secure the wrap around diapers which are secured with tape. The Administrator reported Resident #65's sister was told the facility would no longer provide pull up protective briefs. The Administrator added residents and their families who inquired concerning pull up protective briefs were told the facility would not provide pull up protective briefs. The Administrator verbalized it is his expectation residents be encouraged to be as independent with ADLs as possible.

A staff interview was conducted with the Director of Nursing on 08/05/15 at 2:47 PM. The DON verbalized pull up protective briefs would increase Resident #65's ability to toilet independently adding she was unaware residents were not being provided pull up protective briefs. The DON also verbalized it is her expectation residents be provided pull up protective briefs if the pull up briefs enable a resident to be more independent by increasing participation in ADLs. The DON reported the facility's toilet training program was only designed to ensure residents received

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F 310	Continued From page 23 assistance with toileting and was not a program to increase a resident's independence with ADLs.	F 310		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a continuous tube feeding for 1 of 2 sampled residents who required tube feedings (Resident #109). The findings included: Resident #109 was admitted to the facility on	F 322	F322 NG Treatment/Services-Restore Eating Skills 1.) It is the practice of the facility to provide nasogastric tube feedings per physicians¿ orders. Resident #109 continues to receive her nasogastric tube feeding per physician orders.	9/3/15

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F 322	Continued From page 24 07/29/15 with diagnoses which included a jejunostomy tube placement on 07/13/15 for dysphagia. Admission orders included direction for continuous tube feeding at 40 cubic centimeters (cc.) per hour with 250 cc. water flushes every 6 hours. Review of a physician's order dated 08/05/15 revealed direction to increase the rate of the tube feeding to 50 cc. per hour with 200 cc. water flushes every 6 hours in response to a Registered Dietitian's recommendation to increase calories and protein. Review of a physician's progress note dated 08/04/15 revealed the facility notified the physician of a clogged tube. The physician documented he unclogged the tube and changed medications to a liquid form if possible. Observation on 08/04/15 at 9:15 AM revealed Resident #109 asleep and the tube feeding pump turned off. The tube feeding bottle was marked hung at 4:00 AM on 08/04/15. There were approximately 900 cc. of tube feeding product in the bottle. Observation on 08/04/15 at 10:27 AM revealed the tube feeding pump remained off. Observation on 08/04/15 at 11:07 AM and at 11:24 AM revealed the tube feeding pump remained off. Interview with Nurse #1 on 08/04/15 at 11:25 AM revealed the physician unclogged the feeding tube at approximately 8:30 AM that morning. Nurse #1 reported the feeding should be infusing into the tube without difficulty.	F 322	2.) Residents with tube feedings are at risk for the alleged deficient practice. Residents with orders for feedings via nasogastric tube were audited by the Director of Clinical Services (DCS) on 8/4/15 to validate that residents were receiving tube feedings per physicians¿ orders. 3.) The Director of Clinical Services (DCS) reeducated licensed nurses on 8/12/15 regarding the policy of medication administration via nasogastric tube per physician¿s orders. Newly hired licensed nurses will be educated upon hire. 4.) The DCS/licensed nurse designee will observe tube feedings weekly x 3 months then, monthly x 3 months to validate that residents are receiving nasogastric tube feeds per physician orders. The DCS will report audit results monthly in QAPI for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary. 5.) AOC date-9/3/15	

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F 322	Continued From page 25 Observation on 08/04/15 at 11:26 AM with Nurse #1 revealed Resident #109's tube feeding pump was turned off. Nurse # 1 reported she forgot to turn the pump on after the physician's visit approximately 3 hours earlier in the morning. Nurse #1 explained she forgot. Nurse #1 checked the tube's placement and turned the pump on to 50 cc. per hour. Interview with the Director of Nursing on 08/04/15 at 11:54 AM revealed she expected the nurse to reconnect and resume the tube feeding after the physician unclogged the tube.	F 322		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/3/15

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This REQUIREMENT is not met as evidenced by:
Based on staff, pharmacist and physician interviews, and record review, the facility failed to monitor laboratory values for 2 or 5 sampled residents who received medications (Residents #34 and #54).

The findings included:

1. Resident #34 was admitted to the facility on 03/09/14 with diagnoses which included peripheral neuropathy, hypertension, anxiety, Parkinson like symptoms, and depression.

Review of May 2015, June 2015, and July 2015 monthly physician's orders revealed medications included, Gabapentin 300 mg. twice daily for peripheral neuropathy, Ativan 0.5 mg. three times daily and 0.25 mg. at bedtime for anxiety, ropinirole hydrochloride 0.5 mg three times daily (used to treat Parkinson disease symptoms), atorvastatin calcium 20 mg at bedtime (used to lower cholesterol) and Trazodone 300 mg at bedtime for depression.

Further review of Resident #34's 2015 monthly physician's orders revealed a liver function test (LFT), lipid panel, basic metabolic panel (BMP) and complete blood count (CBC) were to be obtained every 6 months (September/March). These blood tests are used to monitor medications which are metabolized in the liver, medication effectiveness and the potential of

F329 Drug Regimen is Free From Unnecessary Drugs

1.) It is the practice of the facility to monitor labs per physician¿s orders to prevent residents from receiving unnecessary drugs. The licensed nurse received new physician orders for missed labs for Resident #54 and #34. The physician was notified of results and no new orders received. Labs will continue to be drawn timely per physician orders to prevent resident receiving unnecessary drugs.

2.) Residents with medications requiring lab monitoring are at risk for the alleged deficient practice. The Director of Clinical Services (DCS)/licensed nurse designee completed a 100% audit 8/17/15 to identify residents at risk for the alleged deficient practice. The physician was notified upon identification by the licensed nurse of labs that were not drawn as ordered and new orders were received and completed. There were no residents identified to be receiving unnecessary medications as a result of the audit findings.

3.) Licensed Nurses were reeducated by the DCS on 8/12/15 regarding the process

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F 329	Continued From page 27 adverse side effects. Review of a physician's order dated 05/28/15 revealed direction to obtain a BMP for dysuria (painful urination) in addition to a urinalysis with culture and sensitivity. Review of Resident #34's laboratory results revealed a BMP completed on 05/29/15 and on 06/01/15. The most recent LFT, CBC and lipid panel were dated 09/19/14. There were no results of a CBC, LFT or lipid panel available since 09/19/14. Review of a pharmacist's review note dated 03/31/15 revealed documentation of a recommendation to obtain ordered laboratory tests. On 04/27/15 and 05/26/15, the pharmacist documented no new laboratory results. On 06/23/15, the pharmacist documented review of the 05/29/15 laboratory work and the review dated 07/27/15 documented no new blood work to review. Interview with Nurse #1 on 08/06/15 at 10:52 AM revealed Resident #34 did not have a LFT, CBC and lipid panel drawn since September 2014. Nurse # 1 reported the laboratory computer system indicated the physician's orders for the blood tests were to be stopped on 12/31/14. Nurse #1 was not able to provide an explanation for the discontinuance. Interview with the Director of Nursing (DON) on 08/06/15 at 11:02 AM revealed Resident #34 should have had the blood tests done. The DON reported she expected staff to follow physician's orders and ensure the implementation of routinely scheduled blood work. The DON reported	F 329	of obtaining, processing and documenting lab orders to prevent unnecessary drugs. Newly hired nurses will be educated upon hire. The licensed nurse receiving lab orders will record order into lab book indicating lab and date to be drawn. After lab is drawn and results are received, the licensed nurse will notify physician and receive new orders if indicated. The results and new lab orders will then be recorded in the lab book by the receiving licensed nurse. The Unit Manager/licensed nurse designee will audit lab book against lab orders daily to verify labs are being obtained, processed and documented per physician orders. 4.) The DCS will audit 10% of active residents weekly for 3 months then, monthly for 3 months to validate that residents are receiving labs per orders. The DCS will report audit results monthly in QAPI for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary. 5.) AOC date- 9/3/15	

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routinely ordered tests were checked monthly when the Medication Administration Records received an audit.

Telephone interview with the facility's consultant pharmacist on 08/06/15 at 3:36 PM revealed he reviewed laboratory results monthly. The pharmacist reported he informed the facility of the need to obtain the blood work after his March 31, 2015 review. The pharmacist explained if Resident #34's test were not done by the third visit, the facility received a second written recommendation to obtain the blood work. The pharmacist explained he recommended discontinuance of the lipid panel last year but the CBC, LFT and BMP were indicated as part of medication monitoring.

Telephone interview with Resident #34's physician on 08/06/15 at 4:07 PM revealed he expected orders for blood tests to be implemented.

2) Resident #54 was admitted to the facility on 03/18/11 with diagnoses which included dementia, anxiety, mood disorder, chronic pain, and Alzheimer's disease.

Review of May 2015, June 2015, and July 2015 monthly physician's orders revealed medications which included, Depakote 125 milligrams (mg) twice daily for mood disorder, Ativan 0.5 mg twice daily and 1 mg every 4 hours as needed for anxiety, Remeron 7.5 mg at bedtime for depression, and Fentanyl patch 12 micrograms (mcg) per hour with one patch to be applied every 72 hours for pain.

Further review of the 2015 monthly physician's

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orders for Resident #54 indicated a basic metabolic panel (BMP) and complete blood count (CBC) were to be obtained every 6 months in September and March. These blood tests are used to monitor medications which are metabolized in the liver, medication effectiveness, and for the potential of adverse side effects.

Review of Resident #54's laboratory results indicated a BMP and a CBC was completed on 09/15/14. There were no results of a BMP or CBC available since 09/15/14.

Review of the pharmacist's reviews dated 03/31/15 revealed documentation of a recommendation to obtain laboratory tests of a CBC, BMP, and a hepatic (liver) function panel (LFT). On 04/27/15, 05/26/15, and 06/23/15 the pharmacist had documented no new laboratory results. On 07/27/15 the pharmacist had documented no new blood work available to review with repeated recommendations from 03/31/15 and Resident #54 had not had a LFT or CBC evaluation documented in the record within the previous 6 months.

An interview was conducted on 08/06/15 at 3:00 PM with Nurse #1. She stated Resident #54 had not had a BMP or CBC drawn since 09/15/14. Nurse #1 indicated the laboratory computer system indicated the physician's orders for the blood tests to be drawn March 2015. Nurse #1 was not able to provide an explanation as to why Resident #54's blood tests had not been obtained.

An interview was conducted on 08/06/15 at 3:30 PM with the Director of Nursing (DON). She confirmed Resident #54 was supposed to have

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F 329	Continued From page 30 blood tests done. The DON reported she expected the nursing staff to follow the physician's orders and to ensure the routine scheduled blood tests were implemented. A telephone interview was conducted on 08/06/15 at 3:45 PM with the facility's consultant pharmacist. He stated he reviewed the laboratory results monthly. The pharmacist further reported he had informed the facility of the need to obtain the blood work after he reviewed Resident #54's record on 03/31/15. The pharmacist explained if Resident #54's blood tests were not done by the third visit, the facility would have received a second written recommendation as to obtain the blood tests. The pharmacist indicated the blood tests were expected to be obtained as part of the medication monitoring. A telephone interview was conducted on 08/6/15 at 4:15 PM with Resident #54's physician. He stated he expected the orders for the blood tests to be implemented and obtained.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		9/3/15

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F 371	Continued From page 31 by: Based on observations and staff interviews the facility failed to monitor the expiration dates on food products and dispose of them after the manufacturer's expiration date had passed. The facility also failed to properly store food products to prevent contamination and properly label resident food items. The findings included: 1. Observations of the facility's kitchen on 08/03/15 at 10:15 AM revealed 9 48 ounce (oz) containers of beverages were stored for use with expired manufacturer's expiration dates. 2 containers of lemon thickened lemon water had a manufacturer's expiration date of 06/30/15. 5 containers of nectar thickened sweetened tea had a manufacturer's expiration date of 07/14/15. 2 additional containers of thickened sweet tea had an expiration date of 07/01/15. A staff interview was conducted with the Dietary Manager (DM) on 08/03/15 at 12:50 PM. The DM verbalized it was her expectation products should be disposed of when they have exceeded the manufacturer's expiration date. 2. Observations of the facility's nourishment room on 08/03/15 at 11:30 AM revealed the following food storage concerns: A. The following items were observed stored in the nourishment room's freezer on 08/03/15 at 11:30 AM; An opened box of waffles not labeled with a resident's name and the date it was opened. 4 opened half gallon containers of ice cream not labeled with a resident's name and the date they	F 371	F371 Food Procure, Store/Prepare/Serve-Sanitary 1.) It is the practice of the facility to store, prepare, distribute and serve food under sanitary conditions. On 8/4/15, the Dietary Manager disposed of expired; improperly sealed/stored and unlabeled items found in the kitchen and nourishment rooms and sanitized the food storage areas. 2.) All food items are at risk for the alleged deficient practice. The Dietary Manager/aide will audit kitchen and nourishment rooms to validate that no items are expired, improperly sealed/stored or mislabeled. Food items identified will be disposed of per company policy. 3.) The Dietary Manager reeducated all staff on 8/13/15 on the proper disposal of expired, improperly sealed/stored and unlabeled food items. Newly hired staff will be educated upon hire. The Administrator will audit kitchen and nourishment rooms 3x/week for 1 month, 2x/week for 2 months then, 1x/month for 3 months to ensure compliance with food storage. 4.) The Administrator will report audit results monthly in QAPI for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if	

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F 371	Continued From page 32 were opened. An unopened 4oz cup of vanilla creamy snax with no manufacturer's expiration date. A small plastic cup containing an unknown blue substance covered with a medical examination glove. The plastic cup was unlabeled and undated. The DM was unable to positively identify the substance in the plastic cup but thought it may be Gatorade. B. The following items were observed stored in the nourishment room's refrigerator on 08/03/15 at 11:30 AM; An unlabeled, undated food product wrapped in paper in a plastic bag. 2 unlabeled yogurt containers with expired manufacturers dates. 1 container's expiration date was 07/12/15 and the other container's expiration date was 07/20/15 2 blackened, rotten bananas. C. The following items were observed stored under the sink in the nourishment room on 08/03/15 at 11:30; An open cardboard box which contained 24 4oz thickened lemon flavor water containers each with an expired manufacturer's expiration date of 03/24/15. 2 open cardboard boxes containing 87 4oz cups of applesauce. One of the cardboard boxes of applesauce cups was noticeably wet and damaged from exposure to moisture. D. The following items were observed stored in a cabinet above the nourishment room's sink: One 8oz can of tomato soup with a manufacturer's expiration date of 03/01/15 and a dented 8oz can of vegetable soup.	F 371	necessary. 5.) AOC date-9/3/15	

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F 371	Continued From page 33 The Dietary Manager (DM) was interviewed on 08/05/15 at 11:48 AM. The DM verbalized it was her expectation all food products stored in the nourishment room and kitchen be properly labeled, dated and stored. The DM added products should be disposed of when they have exceeded the manufacturer's expiration date or become damaged. The DM further stated her expectation that food items belonging to residents be labeled with the resident's name and the date they were opened then disposed of if not consumed within 3 days.	F 371		