STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345024	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

(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 242 SS=D	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 record review, resident and staff interviews and observations, the facility failed to allow residents to make bathing choices that were significant to the resident for 2 of 4 residents (Resident #70 and Resident #47) reviewed for Activities of Daily Living (ADL ' s). Finding Included: 1.) Resident #70 was admitted to the facility on 1/23/12 with the following diagnoses which included: heart failure, hypertension and dementia. The Minimal Data Set (MDS) dated 8/6/15 revealed that resident was severely cognitively impaired. Resident # 70 required extensive assistance in bed mobility, transfers, locomotion, dressing, and personal hygiene. Resident #70 also required physical help with bathing. Nursing Note dated 10/25/15 stated that resident #70 was alert and oriented times four and able to make needs known to staff verbally. Staff provided total care of Activities of Daily Living (ADL ' s) for resident using two person assistance and a mechanical lift. Resident #70 was interviewed on 10/28/15 at 2:50 PM. Resident stated that she had not received a whirlpool bath for three weeks. She	F 242	1. Residents #70 and #47 have been made aware they are allowed to make bathing choices (whirlpool, shower) and are comfortable with CNA assigned to provide such care. Residents #70 and #47 have each received their bathing choices, whirlpool, shower or bed bath, as evidenced by documentation in task care plan. 2. Each resident and/or family (for a resident unable to express choices) is made aware on admission and during the interview they can make choices about aspects of his or her life in this facility that is significant to them by the Social Workers. Significant interests and preferences are honored to the extent possible. The Facility actively seeks information from the resident and/or family (for a resident unable to express choices) regarding preferences and these choices are documented in section F of the MDS. A Resident□s Rights Questionnaire has been implemented to ensure resident satisfaction and	11/18/15

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

Electronically Signed | 11/23/2015

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F 242	Continued From page 1 was given a bed bath everyday but liked to have a whirlpool bath on Monday instead. Monday was her scheduled day to get a whirlpool bath. If she was given a whirlpool bath on Monday as scheduled, then she was fine with getting a bed bath the other days. The last three weeks the Nursing Assistant (NA) informed her they were not doing whirlpool baths on Mondays. She received a sponge bath instead but wanted a whirlpool bath. The Whirlpool bath schedule (no date) was reviewed and revealed resident #70 was scheduled to get a whirlpool bath on Mondays. Review of the " Care Task " sheet revealed documentation which indicated Resident #70 had received one whirlpool bath, one shower and two bed baths between 10/1/15 and 10/26/15. The Nursing Assistant (NA) #1 was interviewed on 10/28/15 at 2:24 PM. She stated she was responsible for giving residents the whirlpool baths every other Monday and Friday. She had not given any whirlpools this month. Some days the daily schedule would say no whirlpools would be given that day. On those occasions, Nursing Assistants would notify residents that no whirlpools would be given that day. She also stated that if a resident was scheduled for a whirlpool bath and it were cancelled, they would not be moved to a different day to receive a whirlpool bath. The Nursing Assistant (NA) #2 was interviewed 10/29/15 at 9:53 AM. He stated that the shower schedule was posted on the inside door of the shower room and also in the chart, which was how he knew the day and type of bath the resident was to receive. NA #2 reviewed the schedule and was aware Resident #70 was supposed to get a whirlpool bath on Mondays. Nurse #2 was interviewed on 10/28/15 at 2:28	F 242	completed by the Social Workers monthly. Residents Rights/Choices are discussed at the monthly Resident Council meeting by the Activities Department and Social Workers. Residents Council was held on 10/28/2015 with activities, social worker and ombudsman. 3. All staff is in-serviced on Residents Choice by the Social Worker and SDC during the annual Skills Fair and an additional Residents Rights & Abuse in-service annually. If a bathing preference cannot be fulfilled, the resident will be given an alternate bathing choice. This will be noted on the task plan by the CNA. Residents Rights are posted in every resident s room. The questionnaire was implemented in addition to interviewing resident on admission and quarterly and documented in Section F on the MDS by the activity department; then given to MDS Coordinator who makes appropriate changes to task care plan. The task care plan alerts the CNA to any changes regarding their preferences. 4. Residents Rights/Choices Questionnaire will be is reviewed at the monthly Resident s Council Meeting and random questionnaire monthly to residents who do not attend the meeting. Results will be monitored at the QA meeting monthly for 6 months to ensure resident satisfaction.	

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F 242	Continued From page 2	F 242		

PM. She stated there had been some issues with staffing on Mondays and they had to pull the Nursing Assistants to work the floor instead of giving whirlpool baths. She stated a resident could get a shower and any NA could give a shower to the resident. Only certain staff members could give whirlpool baths to residents. The NA would inform residents that they were not going to have a whirlpool bath that day. Nurse #2 said she remembered Resident #70 had complained to her before about not being able to have a whirlpool bath.
An interview was conducted on 10/28/15 at 11:20 AM with the person responsible for scheduling the Nursing Assistants. She stated staff who give whirlpool baths were the last to be pulled to work the floor, and her expectation would be for the residents to get a whirlpool bath.
The Administrator was interviewed on 10/29/15 at 9:29 AM. She stated her expectation was if they have the staff, then to provide whirlpool baths to residents.

Resident # 47 was admitted to the facility on 1/10/15 with diagnosis of peripheral vascular disease. The most recent quarterly Minimum Data Set (MDS) dated 9/25/15 revealed the resident was coded with no problems with short and long term memory (BIMS 15), had no mood or behavior problems, bathing required physical help with one person physical assist, transfers required extensive assist with 2 plus persons physical assist and ambulated in room with limited assist with 1 person physical assist.

Review of the Task Care Plan dated 1/17/15 listed the following approaches:
Whirlpool every Monday.
Shower every Thursday 7-3.

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F 242	Continued From page 3	F 242		

Interview with Resident #47 on 10/28/15 at 1:30 PM revealed that no one had ever asked her about a shower. She continued that she did not want a man giving her a shower. Asked for whirlpool because it helped her legs feel better. She would like the whirlpool twice a week.

Interview on 10/28/15 at 11:30 AM with NA #3 (who was assigned to care for resident) revealed that Resident #47 did not like to have him do her showers. NA #3 continued that he could not find another NA to give her a shower. He had not thought about switching another resident for Resident #47 on shower days. He reported that he did not know what day her shower was scheduled. NA #3 indicated he had not notified the nurse about the resident ' s choice of not having males care for her.

Interview on 10/29/15 at 10:29 AM with NA #3 revealed, when asked if Resident #47 received her routine whirlpool and showers, he replied, " I think so. " He continued that he did not know about the whirlpool. There was a certain person who only did the whirlpool bath.

Interview on 10/28/15 at 10:32 AM with NA #4,(the whirlpool bath person), revealed that Resident # 47 was to get the whirlpools on Mondays and she had not had one in 3 weeks. NA #4 reported that she didn't work every Monday. She continued that when she arrived for work on Mondays, she just went in to see what her schedule said and did her job. Sometimes if someone called out, she would be the replacement for the call out.

Interview on 10/28/15 at 10:43 AM with Nurse #5,

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F 242	Continued From page 4	F 242		

(Resident # 47 ' s nurse), said she usually did not work on the 600 hall so she did not know why the resident was not getting her whirlpool baths.

Interview on 10/28/15 at 11:05 AM with Nurse #6 revealed the whirlpool was not done. No reason had been provided.

Interview on 10/28/15 at 11:10 AM with Nurse #7 revealed that she was the scheduler each week. If there was a call out, NA #4 would have to take care of the residents. We have staff members that we can pull from and sometimes staff who provided whirlpool baths have to be pulled. If staff was pulled, the resident will not get the whirlpool that day. NA #4 was the last person on the floor to be pulled. The whirlpool is an extra. They could be done a different day of the week. Nurse #7 indicated she had not realized that it had been 3 consecutive Mondays without a whirlpool bath. Further interview revealed her expectation and goal was to have whirlpools provided to residents by staff with special training to use the equipment.

Interview on10/29/15 at 8:25 AM with Nurse #8 revealed that Resident #47 was alert and oriented, but was never told at Resident #47 did not want a male caregiver to give baths. Nurse #8 continued Resident #47 complained to her last week or week before and knew that she did not have her bath. NA #4 was working on the floor and no one was assigned to the whirlpool that day.

Interview on 10/28/15 at 2:47 PM with the Administrator indicated the facility would have switched the assignment so that a male would not be caring for the resident. Further interview

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F 242	Continued From page 5 revealed NA #3 spoke to his peers only about Resident#47 not receiving showers or whirlpool.	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to: 1) accurately code on the	F 278	F278 1. The accurate PASRR code for Resident	11/13/15

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F 278	Continued From page 6 Minimum Data Set (MDS) assessment to reflect Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident in the sample reviewed for PASRR. (Resident #184), and 2) failed to accurately code the admission Minimum Data Set (MDS) to reflect the administration of the pneumococcal vaccination to 1 (Resident #190) of 5 residents reviewed for pneumococcal vaccination. Findings included: 1.) Resident #184 was admitted on 08/4/15 with cumulative diagnoses which included: Intellectual Disability, depression, anxiety, and dementia. Review of the PASRR Determination notification form revealed that Resident #184 was determined to be a PASRR level II since 08/4/2015 with an expiration date of 10/3/2015. Resident #184 PASRR was renewed on 10/2/15 with an expiration date of 11/1/2015. Review of Resident #184 ' s Admission Minimum Data Set (MDS) assessment dated 08/14/15 revealed Section A of the MDS was not coded to reflect PASRR determination. The Social Worker was interviewed on 10/28/15 at 10:43 AM. She stated that Resident #184 had a PASRR before he entered the facility and it was good for 60 days. The PASRR was completed on 08/4/15. Resident #184 ' s PASRR expired on 10/2/2015 and was admitted to the facility on 08/4/15. She also stated it was the MDS coordinator ' s responsibility to code the PASRR section on the MDS. The Director of Nursing (DON) was interviewed on 10/28/15 at 11:24 AM. She stated that she was responsible for coding Resident #184 ' s MDS. She stated that Resident #184 ' s PASSR was not coded on the MDS, which was an oversight. That the MDS coordinators are typically responsible for coding section A of the MDS.	F 278	#184 was entered on the MDS on 10/28/2015 and the accurate pneumococcal vaccine code for Resident #190 was entered on the MDS on 10/28/2015 by the MDS Nurse. An attestation was completed on both on 10/28/2015. 2. An audit of the PASRR Level 2 Residents MDS has been completed by the DON and MDS Nurses to ensure they accurately reflect the residents status on 10/29/2015. All residents who have received the pneumococcal vaccine have been reviewed and have accurate coding on the MDS by Nursing Management on 11/13/2015. 3. Resident information, including user defined assessments for pneumococcal vaccination and PASRR level, is gathered on admission and entered in the electronic charting system by Nursing Managers. MDS s are reviewed to ensure all assessments are coded correctly prior to submission by the MDS Nurses. 4. The MDS Nurses audit the PASRR and Pneumococcal vaccination coding on the MDS admission assessment monthly for accuracy prior to submission. The MDS Coordinator will audit the MDS Nurses' work monthly for 6 months. The audits of the PASRR and Pneumococcal vaccinations are presented at the monthly QA meeting by the MDS Nurses. The QA Committee will monitor the audits for 6 months.	

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F 278	Continued From page 7	F 278		

The Administrator was interviewed on 10/29/15 at 9:28 AM. She stated that whoever is completing the assessment on the MDS is responsible for coding the PASSR section of the MDS. She stated that her expectation is for the MDS to be coded accurately.

2.) Resident #190 was admitted to the facility on 9/9/2015 with admission diagnoses which included toxic encephalopathy and non-Alzheimer ' s dementia.
A review of the physician orders dated 9/17/15 revealed: " Pneumovac (pneumococcal vaccine) 0.5 milliliters (ml) intramuscularly (IM) x 1 today (9/17/15). "
A review of the medication administration record (MAR) for Resident #190 revealed the pneumococcal vaccine was administered to Resident #190 per the physician order on 9/17/15.
A review of the 14 day admission Minimum Data Set (MDS) dated 9/22/15. Section O0300B, revealed the resident did not receive the pneumococcal vaccine because of " medical contraindication " .
An interview with the MDS coordinator on 10/28/15 at 10:15 AM revealed information related to pneumococcal vaccine administration for residents was obtained from the hospital discharge summary or physician orders. The MDS coordinator stated, " I think (Resident #190 ' s) pneumococcal vaccine information came from the hospital discharge note. It was contraindicated for some medical reason. Our facility reviewed the hospital discharge summary and ordered the pneumovac to be given. After we get permission from the facility doctor (MD) and the resident ' s family we have standing orders to give vaccines. This resident (Resident

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F 278	Continued From page 8 #190) did receive the vaccine during the look back period and it should be on the MDS, but isn ' t. " An interview with the facility ' s administrator on 10/28/15 at 10:50 AM revealed her expectation was the MDS would be accurate.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan to prevent falls for 1 (Resident # 190) of 3 residents assessed for fall risks. Findings included:	F 279	F279 1. The interdisciplinary care plan team reviewed Resident #190□s care plan. The care plan was revised and updated to reflect the interventions for all falls.	10/29/15

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	345024	A. BUILDING _____ B. WING _____	10/29/2015

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F 279	Continued From page 9 Resident #190 was admitted to the facility on 9/9/15 with admission diagnoses which included toxic encephalopathy and non-Alzheimer ' s dementia. A review of the 14 day admission Minimum Data Set (MDS) dated 9/22/15 revealed Resident #190 had severe cognitive impairment. Resident #190 required extensive assistance of 2 or more persons with all activities of daily living (ADLs), including walking in the corridor and locomotion on and off the unit. The MDS also reflected 1 fall without injury since admission to the facility. A review of the nursing notes included entries related to Resident #190 falling on 9/17/15 at 10:43 PM, 9/22/15 at 12:54 AM, 10/2/15 at 2:51 PM, and 10/4/15 at 4:25 PM. No interventions were put into place after any of the falls. A review of the care area assessments (CAA) dated 9/9/15 and 9/10/15 revealed a CAA for "Falls" which read in part, "Analysis of Findings-Resident is at risk for falls related to her delirium, her cognitive impairment related to her recent surgery with anesthesia as well as her incontinence. She is working with therapy at this time to improve her balance as well as her cognitive abilities. Will care plan to keep her safe and to have no significant injury from falls." A review of the care plans 9/9/15 and 9/10/15 revealed no care plan related to falls or falls risks. A care plan was initiated on 10/21/15 related to falls for Resident #190. During an interview with the MDS coordinator on 10/28/15 at 10:15 AM she stated, " A care plan should be done immediately after, or within 1-2 days after a fall. If the fall happened on the weekend, or on Friday after we all have left the facility, the care plan should be done within 3 days. A 14 day assessment was completed for	F 279	Documentation was completed and attestation was submitted by the MDS Nurse on 10/28/2015. 2. All care plans for residents with a fall have been reviewed to ensure appropriate care planning and interventions were documented on the care plan by the Nurse Managers on 10/28/2015. 3. All incidents/falls and interventions are discussed at the morning meeting. Interdisciplinary care plan team members attend the meeting. After review of the falls and circumstances the team decides the best individualized interventions which are then entered on the care plan by the MDS Nurse and/or QA Nurse. 4. The incident/falls log will be cross referenced with the care plan by the QA Nurse and MDS Nurse to ensure all falls and interventions are updated and documented on the current care plan. Care Plans of residents with falls are reviewed and monitored monthly for 6 months by the QA Committee to verify documentation and interventions are current and accurate.	

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F 279	Continued From page 10 (Resident #190) on 9/22/15 and it was coded as (Resident #190) having had 1 fall without injury during the look back period. Her care plan for falls was initiated on 10/21/15. There was no care plan for falls before then, but there should have been. " An interview with the facility ' s administrator on 10/28/15 at 10:50 AM revealed the expectation was for care plans to be accurate and updated as needed. The administrator also stated, " After the first fall we look at options to prevent another fall. I would expect the care plan to be updated to reflect those options. After 4 falls I would expect a care plan for falls to have been started, or I would expect an existing care plan for falls to be updated. " During an interview with Nurse #1 on 10/28/15 at 11:20 AM, she revealed Resident #190 was a falls risk. She also stated Resident #190 knew how to make her needs known, and used the call bell appropriately. Nurse #1 also stated the nursing assistants (NA) could find all resident care needs in their kiosks (computer systems used by NAs to locate resident information and place charting entries) or ask the nurses questions related to resident care needs. An interview on 10/28/15 at 3:46 PM with the director of nursing (DON) revealed residents who fell received more frequent rounds or monitoring by the staff. The facility did not use an alarm system for fall risk residents, and falls were discussed in daily stand up meetings. The DON also stated a care plan should be updated after each fall.	F 279		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		10/29/15

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	345024	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 11 (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 by: Based on observations, staff interviews, interview with the dietitian and record review of the policy and procedure, the facility failed to date and label food items stored in the walk in dairy refrigerator. (2) The facility failed to date and label food item stored in the walk in refrigerator #2. (3) The facility failed to date and label food item stored in the dry storage area. These were evident during 1 of 2 observations in the kitchen. Findings included: Review of the facility policy entitled, "Food Receiving and Storage," revised 12/08, revealed in part: Under " Policy Interpretation and Implementation Step " 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated. " Observations during the initial tour of the kitchen conducted on 10/26/2015 at 2:46:07 PM with Cook #1 revealed the following identified concerns: 1. Dairy refrigerator: a. There were 26 ramekins which contained a thick white substance stored that were unlabeled and undated. Interview on 10/26/2015 at 2:46:07	F 371	F371 1. All food items in the walk-in dairy refrigerator, walk-in refrigerator #2 and dry storage area that were unlabeled and undated have been discarded by the cook on 10/26/2015. 2. All areas in the Dietary Department, where food is stored, have been inspected for appropriate labels, dating and method of storage by the dietary department. All unlabeled, undated, and uncovered food items have been removed by the dietary staff on 10/27/2015 All Dietary staff has been in-serviced on “Food Receiving, Storage, Labeling and Dating” by the Dietician and CDM. 10/29-11/11-2015 3. A “Food Labeled & Dated Log” has been implemented and posted on all areas where food is stored in the dietary department. All areas are checked daily and documented on the log by cook #1. The cook #2 double-checks the log daily. The CDM will audit the areas where food is stored weekly and sign the log to	

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	345024	A. BUILDING _____ B. WING _____	10/29/2015

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F 371	Continued From page 12 PM with Cook #1 identified the substance as sour cream. b. There was a 1/3 full (3 quart) container of turkey salad (identified by Cook #1) stored and dated 10/16/15 but unlabeled. c. There were 3 plastic containers of fruit (one each of peaches, pears and pineapples) stored but not in their original containers. These containers were unlabeled and undated. d. There were 2 opened 80 ounce containers of " fresh all breast chicken salad " stored. One container was 3/4 full and one container was 1/2 full. These containers were undated. e. There was a ½ full 5 pound (lb.) container of pimento spread stored undated. f. There was a 5 lb. container of cottage cheese 3/4 full stored undated. g. There was a gallon size container of sliced ham stored out of the original package undated and unlabeled. h. There was shredded cheese out of the original container stored in a 1 gallon plastic bag unlabeled and undated. Interview on 10/29/2015 at 10:07:56 AM with the consultant dietitian and Certified Dietary Manager (CDM) was conducted. The CDM indicated his expectations were food items stored in the refrigerator and dry storage area be labeled and dated. The dietitian confirmed his expectation. Continued interview with the CDM revealed he recently (no date provided) conducted an in-service on dating and labeling stored food items. Interview on 10/29/2015 at 11:31:08 AM with the administrator and assistant administrator was held. The administrator and assistant administrator revealed their expectations were food items be labeled, dated and properly stored.	F 371	ensure compliance. 4. The dietary logs were reviewed 11/12/2015 during monthly QA meeting and will continue to be reviewed monthly for 6 months. The QA committee will monitor to make certain improvement is maintained.	

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F 371	Continued From page 13	F 371		

2. Walk in Refrigerator #2
a. There were 3 trays of plastic wrapped handmade sandwiches. One tray stored 13 sandwiches. Interview on 10/26/15 at 3 pm with Dietary aide #2 identified on one tray (3) peanut butter, (5) pimento cheese and (5) chicken salad sandwiches. One tray stored (1) peanut butter and jelly, (5) pimento cheese and (5) chicken salad sandwiches. The third tray stored (11) sandwiches (3) peanut butter and (8) cheese sandwiches. These trays or sandwiches were undated and unlabeled. Continued interview with Dietary aide #2 revealed food items once opened should be dated and labeled.
b. There were 6 (6 inch) facility made pizzas stored in an unsealed plastic bag undated and unlabeled.
Interview on 10/29/2015 at 10:07:56 AM with the consultant dietitian and Certified Dietary Manager (CDM) was conducted. The CDM indicated his expectations were food items stored in the refrigerator and dry storage area be labeled and dated. The dietitian confirmed his expectation. Continued interview with the CDM revealed he recently (no date provided) conducted an in-service on dating and labeling stored food items.

Interview on 10/29/2015 at 11:31:08 AM with the administrator and assistant administrator was held. The administrator and assistant administrator revealed their expectations were food items be labeled, dated and properly stored.

3. Dried Storage area:
a. There was a 1/2 full gallon plastic bag unlabeled and undated which contained a food item. On 10/26/2015 at 3:46:59 PM Cook #1 indicated the food item in the plastic bag was uncooked rice pilaf. Cook #1 indicated open food

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F 371	Continued From page 14 items should be stored with a label and date. Interview on 10/29/2015 at 10:07:56 AM with the consultant dietitian and Certified Dietary Manager (CDM) was conducted. The CDM indicated his expectations were food items stored in the refrigerator and dry storage area be labeled and dated. The dietitian confirmed his expectation. Continued interview with the CDM revealed he recently (no date provided) conducted an in-service on dating and labeling stored food items. Interview on 10/29/2015 at 11:31:08 AM with the administrator and assistant administrator was held. The administrator and assistant administrator revealed their expectations were food items be labeled, dated and properly stored.	F 371		
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	F 431		10/29/15

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F 431	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the pharmacist and the pharmacy nurse, the facility failed to remove outdated medications from the medication rooms for 2 of 2 medication rooms. (Gold Hall and Green Hall). The findings included: Record review of the policy and procedure for Storage of Medications, undated, under the title of " Monitoring for Expiration Dates of Stock Medication " revealed, stock medications will be checked by third shift nurses nightly for expiration dates. Stock medications will be removed at least one month prior to expiration date. For example - If medication expires in October, remove medication in September. Observations on 10/29/15 at 8:40 AM of the Gold Hall medication room containing the stock	F 431	F431 1. Expired medications were removed from the Medication Rooms on the Gold and Green Halls on 10/29/2015 by the Nurse Supervisor. The unopened expired stock medications were sent back to the pharmacy on 10/29/2015. 2. Nurse Managers inspected both medication rooms for expired medications on 10/29/2015. There were no additional expired medications in the facility. 3. Third shift nurses check for expired medications nightly. Any expired medications are sent back to the pharmacy nightly. SDC and DON began additional in-servicing the nurses on the procedure of checking for expired medications, including stock meds on	

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F 431	Continued From page 16 medications for halls 500, 600, 700 and 800 halls revealed the following medications stored in the medication room, out of date: 3 bottles of Multivitamins with minerals, 100 tablets, expired 9/15/15. Interview on 10/29/15 at 8:45 AM with Nurse #3 revealed that the supply person checked the stock medications. The pharmacist checked them monthly. The nurses were to check the expiration dates when they pulled the medication to use. Nurse #3 placed the expired bottles of multivitamins in the pharmacy tote for pick up to be returned to the pharmacy. Observations on 10/29/15 at 9:09 AM of the Green Hall medication room containing the stock medications for halls 100, 200, 300 and 400 halls revealed the following medications were stored in the medication room, out of date: 2 bottles of Acetaminophen 325 mg. (milligram) tablets, 100 tablets, expired 7/15/15. Omeprazole 20 mg, 2 boxes, 42 tablets in each box, expired 2/15/15. On 10/29/15 at 9:14 AM gave the expired medications to Nurse #4. She said she was new and would take care of the medications. Interview on 10/29/15 at 9:16 AM with the supply clerk revealed that she usually looked at the stock mediations on Fridays when she put the newly received stock medications up. She continued that the pharmacist also looked at the stock medications. Interview on 10/29/15 at 9:25 AM with the	F 431	10/29/2015. Nurse Managers check medication rooms every Monday. The Pharmacy Nurse checks for expired medications on both halls during monthly on-site Pharmacy QA. Additional inspections of medications by Pharm D consultant during monthly QA visit, RN supervisor on weekends, and QA nurse monthly for 1 year. This information is documented on the monthly QA report and the DON receives a copy of findings. The Pharm D Consultant reports at monthly QA meetings. Monitoring for expired medications will be a continuously ongoing task for each discipline assigned. 4. A QA (Revised) Expired Medication Log has been implemented to document the inspection of expired medications. Nurse Managers monitor the log weekly as well as check medications weekly to ensure compliance. QA Nurse and Pharm D Consultant report at monthly QA meetings for 1 year.	

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F 431	Continued From page 17	F 431		

Assistant Administrator revealed that her expectation was to not have any expired medications.

Interview on 10/29/15 at 11:30 AM with the Pharmacist revealed that she did not check the stock medications when she was at the facility. She continued that the pharmacy sent out a nurse to check for expired stock medications.

Interview on 10/29/15 at 11:45 AM with the pharmacy nurse revealed that she went through the medication rooms on Monday or Tuesday to check for expired stock medications. If she found any expired medications she would give them to the nurse on the hall.

Record review of the Compliance Reports dated 10/27/15, provided by the facility revealed that the pharmacy nurse had looked at the medication cart for 700 hall, medication cart for 300 hall, medication cart for 400 and 300 even room numbers and the Gold medication room.

Interview on 10/29/15 at 12:41 PM with the Director of Nursing (DON) revealed that the expired medications were sent back to the pharmacy. The DON continued that the night shift continued to check stock medications every night. She had two new nurses on third shift (night shift). The supply person ordered the stock medications and brought them to the supply room. The nurses were to check the expiration dates before use.

Interview on 10/29/15 at 12:55 PM with the Quality Assurance Nurse revealed that there were no problems with expired medications.

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F 520	Continued From page 18	F 520		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility ' s Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place in November 2014. This was for one recited deficiency, which was originally cited in November 2014 on a recertification survey and on the current recertification survey. The	F 520	F520 Immediate corrective actions are already in place for the cross reference tag F431. The QA committee and facility administration (ADM, ASST. ADM, DON, ADON, SDC, QA Nurse, Southern Pharmacy Director of Clinical Operations, etc.) have met to review the policies and	11/12/15

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F 520	Continued From page 19 deficiency was in the area of expired medications. The continued failure of the facility during two surveys showed a pattern of the facility ' s inability to sustain an effective Quality Assurance (QA) Program. Finding Included: This tag is cross referenced to F 431: Expired Medications: Based on observations, record review and interviews with facility staff, the pharmacist and the pharmacy nurse, the facility failed to remove outdated medications from the medication rooms for 2 of 2 medication rooms. (Gold Hall and Green Hall). This was originally cited during the November 2014 recertification survey when the facility failed to remove outdated medications from one of two medication room refrigerators. The Quality Assurance (QA) Nurse was interviewed on 10/29/15 at 10:54 AM. She stated that pharmacy checked the medication rooms once a month and no issues had been brought to her attention. The QA Nurse indicated the third shift nurses were supposed to check for expired medication. The checking for expired medications on third shift was put into place after the recertification survey last year, when expired medications were found. Medications were also reviewed by pharmacy.	F 520	procedures to examine potential contributing factors and/or root causes that may have led to the deficient practice. Based on the analysis by this special called meeting of the QA committee& A revised PoC for F431 has been implemented including immediate further training, a revised log, and additional inspections of medications by Pharm D Consultant during monthly QA visit, RN supervisor on weekends, and QA nurse monthly. F431 1. Expired medications were removed from the Medication Rooms on the Gold and Green Halls on 10/29/2015 by the Nurse Supervisor. The unopened expired stock medications were sent back to the pharmacy on 10/29/2015. 2. Nurse Managers inspected both medication rooms for expired medications on 10/29/2015. There were no additional expired medications in the facility. 3. Third shift nurses check for expired medications nightly. Any expired medications are sent back to the pharmacy nightly. SDC and DON began additional in-servicing the nurses on the procedure of checking for expired medications, including stock meds on 10/29/2015. Nurse Managers check medication rooms every Monday. The Pharmacy Nurse checks for expired medications on both halls during monthly on-site Pharmacy QA. Additional inspections of medications	

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F 520	Continued From page 20	F 520	by Pharm D consultant during monthly QA visit, RN supervisor on weekends, and QA nurse monthly for 1 year. This information is documented on the monthly QA report and the DON receives a copy of findings. The Pharm D Consultant reports at monthly QA meetings. Monitoring for expired medications will be a continuously ongoing task for each discipline assigned. 4. A QA (Revised) Expired Medication Log has been implemented to document the inspection of expired medications. Nurse Managers monitor the log weekly as well as check medications weekly to ensure compliance. QA Nurse and Pharm D Consultant report at monthly QA meetings for 1 year. The QA committee will review the Pharmacy report and compare it to the Facility Log to make certain all areas are thoroughly inspected for 1 year. The inspections are ongoing. The QA Committee will review for 1 year. 10/29/2015	