STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(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 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 record review and staff and Family Nurse Practitioner (FNP) interviews, the facility failed to obtain laboratory blood tests as ordered for 1 of 1 sampled residents (Resident #55) whose record was reviewed. Findings included: Resident #55's Quarterly Minimum Data Set (MDS) dated 03/03/16 revealed she was re-admitted to the facility on 02/19/16 with diagnoses of anemia, hypertension, and peripheral vascular disease. Resident #55 was severely cognitively impaired. Review of the Hospital Discharge Summary dated 02/19/16 revealed discharge diagnoses of anemia and hyperkalemia (a high potassium level). The Hospital Discharge Summary showed Resident #55 would need a complete blood count (CBC) and electrolytes drawn weekly. Review of the Physician Orders dated 02/19/16-02/29/16 revealed a handwritten note under Labs: CBC/Lytes + Q WK (every week). Review of the February 2016 Laboratory Log from 02/19/16-02/29/16 revealed no entries for labs to be drawn for Resident #55. Review of the Physician Orders dated 03/01/16-03/31/16 revealed Lab: (area blank). Review of the March 2016 Laboratory Log from 03/01/16-03/10/16 revealed no entries for labs to be drawn for Resident #55. In an interview on 03/09/16 at 2:45 PM the Administrator indicated he was unable to locate any results for the ordered weekly labs.	F 281	F281 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident number 55 was placed on hospice on 3/9/16 and expired in the facility on 3/20/16. 2. Interventions for residents identified as having the potential to be affected: Any resident requiring lab blood test can be affected by this practice. The DON, Unit Managers and MDS will audit the facility's medical records from Jan 1, 2016 forward to assure labs that were ordered were drawn by 4/7/16. Any labs that are not present will be discussed with	4/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/29/2016

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F 281	Continued From page 1 In a telephone interview on 03/09/16 at 3:55 PM Nurse #1 (who transcribed Resident #55's admission orders) stated admission orders were either brought to the facility with the resident or the orders were taken from the Hospital Discharge Summary. She indicated the orders were placed on the Medication Administration Record (MAR) and if labs were ordered they were written in the lab book at the nursing station. In an interview on 03/09/16 at 4:10 PM Unit Manager #1 stated when the nurse received admission orders that included labs the lab orders should be written in the lab book which was kept at the desk. In an interview on 03/10/16 at 9:30 AM the FNP stated if labs were ordered they should have been drawn. He indicated if the physician did not want the labs the order could have been discontinued. The FNP indicated that not drawing the labs did not cause any harm to Resident #55. In an interview on 03/10/16 at 10:10 AM the Director of Nursing (DON) stated it was her expectation that if ordered, labs be placed in the lab book to be drawn. She stated it was a problem that the labs for Resident #55 were not drawn as ordered.	F 281	attending physician and facility will act on new orders. DON will initiate a new lab tracking form to begin 4/1/16. 3. Systematic Change: Facility nurse managers and licensed nurses will be in-serviced by 4/7/16 by DON on the new lab process and completion of lab tracking form. Unit Managers will be in-serviced by DON on 4/7/16 regarding the accurate completion of the lab tracking log. All new nurses will be trained on new lab protocol during orientation. 4. Monitoring of the change to sustain system compliance ongoing: DON will check lab tracking log 5 times a week for 4 weeks, then three times a week for two weeks then weekly for two months. The results of these audits will be taken by DON to the Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		4/7/16

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F 315	Continued From page 2 treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain urinalysis results for 1 of 1 sampled residents (Resident #4) who had physician orders to draw a urinalysis due to suspicion of a urinary tract infection (UTI). Findings included: Resident #4 was admitted to the facility on 01/08/16. The resident's documented diagnoses included sepsis due to UTI and pneumonia (PNA), chronic renal failure, history of pneumonia, and chronic obstructive pulmonary disease. A hospital discharge summary documented Resident #4 was hospitalized from 12/29/15 until 01/08/16. The primary discharge diagnosis was "sepsis secondary to UTI and suspected healthcare associated pneumonia." The report also documented the resident was "treated with intravenous antibiotics." The resident's 01/15/16 admission minimum data set (MDS) documented her cognition was intact, she was frequently incontinent of bowel and bladder, and she had a UTI in the last 30 days per her diagnosis list. On 01/18/16 Resident #4's care plan identified "____ (name of resident) is at risk for dehydration or potential fluid deficit r/t (due to) diuretic use and h/o (history of) UTIs" as a problem.	F 315	F315 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #4 was on antibiotics from 3/2/16 to 3/7/16. DON spoke with Medical Director regarding further orders on 3/29/16. No further orders were given after the course of ABTs. 2. Interventions for residents identified as having the potential to be affected: Any resident receiving ABT related to a lab result can be affected by this practice. Therefore, current lab orders will be reviewed by DON, Unit Managers and MDS for timeless, physician notification and initation of any orders from the	

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F 315	Continued From page 3 Interventions to this problem included "Obtain and monitor lab/diagnostic work as ordered. Report results to MD (physician) and follow up as indicated." A 01/28/16 complete blood count (CBC) documented the resident's white blood cell count was 7.5 with the normal range being 4 - 10. A 02/16/16 CBC documented the resident's white blood cell count was high/elevated at 16.8 with the normal range being 4 - 10. It was documented on the lab results that the physician wanted a urinalysis and chest x-ray completed. A 02/16/16 physician order documented a urinalysis and culture and sensitivity (C & S) was to be completed for Resident #4. A 02/17/16 physician order documented it was okay to use an in/out catheter to collect the resident's urine for the urinalysis and C & S. A 02/17/16 chest x-ray documented, "Slight right upper lobe infiltrate new sine 02/04/16." A 02/17/16 physician order started Resident #4 on Levaquin 500 milligrams (mg) daily for seven days due to possible pneumonia and UTI. A 02/18/15 11:45 PM progress note documented, "Urine specimen taken to lab this shift by ____ (name of staff member) waiting on results, resident continue on ABT (antibiotic) with no adverse reactions and is afebrile, voiced no complaints and denies pain." A 2/19/16 2:28 PM progress note documented, "ABT in progress for PNA and UTI. No adverse	F 315	physician by 4/7/16. 3. Systematic Change: Licensed nurses will be in-serviced by DON/Unit Managers by 4/7/16 regarding the new lab process and procedure. Revised lab process will be placed into new licensed nurse orientation. 4. Monitoring of the change to sustain system compliance ongoing: Daily for two weeks, then 5 days a week for two weeks and weekly for a minimum of three (3) months, the Director of Nursing/SDC/Unit Manager will audit labs for timeless of lab draw, return labs, physician notification and following through on physician orders. DON will present the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 315	Continued From page 4	F 315		

side effect noted. No reports of hematuria. No complaints of dysuria. PO (by mouth) fluids encouraged. No distress noted."

Review of the resident's medical record revealed there were no urinalysis lab results from the 02/18/16 collection of urine.

At 10:12 AM on 03/10/16 Resident #4's family nurse practitioner (FNP) stated there were no lab results present in the electronic hospital lab system for the resident's February 2016 urinalysis. The FNP stated technically the facility should have collected urine and obtained urinalysis results because of the 02/16/16 physician order to obtain a urinalysis and C & S. However, he reported he thought the facility covered its obligation to treat a possible UTI by administering a broad spectrum ABT (Levaquin) as long as the resident's white blood cell count declined back down into the normal range (record review revealed no CBC was drawn for Resident #4 after 02/16/15). He also commented the resident was not presenting with physical signs and symptoms of a UTI. However, the FNP stated without the urinalysis lab results the facility could not tell for sure if bacteria in the urine exceeded 100,000 colony-forming units (CFUs) and if that bacteria was susceptible to being treated with the Levaquin.

At 11:43 AM on 03/10/16 Unit Manager #2 stated when lab specimens were sent to the hospital lab the hospital faxed the facility the results. She reported clinical alerts should warn the staff when lab results were not received. However, she commented if she had not received lab results after two days she called the hospital to find out if there were problems. In general she stated a unit

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F 315	Continued From page 5	F 315		

manager or hall nurse could call the hospital to inquire about tardy lab results, but the unit manager always needed to be kept in the loop about what was going on. According to Unit Manager #2, it would be very important to have urinalysis results and C & S data when a resident had a diagnosis of sepsis due to UTI and PNA. She reported it would be important to head off infection as quick as possible with an ABT that was effective against the specific bacteria found in the urine sample. She commented she could not explain why no one in the facility called to find out why lab results and the C & S were not available for Resident #4. The unit manager stated it might have been the sample was contaminated or the bacterial flora was very mixed, but if this was the case, she commented there still should have been a record of the attempted urine analysis in the hospital electronic lab system.

At 1:16 PM on 03/10/16 the director of nursing (DON) stated the hospital faxed the facility their lab results. She reported it would be documented on the electronic dashboard that urine was collected, and it was up to unit managers to follow up and make sure results were obtained. She commented if no fax was received from the hospital, facility staff should call the hospital in 24 - 72 hours from specimen delivery for urinalysis results, maybe having to wait 5 - 7 days to call back for C & S results. The DON stated urinalysis results were required to definitively know that greater than 100,000 CFUs of bacteria had been treated with an ABT that was effective. She commented this would be very important if resident had a history of UTIs or was exhibiting physical signs and symptoms of a UTI.

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F 329	Continued From page 6	F 329		
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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete an AIMS assessment (abnormal involuntary movement scale used to identify involuntary body movements caused by long term treatment with medications such as antipsychotics) as recommended by the consultant pharmacist for 1 of 5 sampled residents (Resident #162) who were reviewed for	F 329	F329 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain	4/7/16

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F 329	Continued From page 7 unnecessary medications. Findings included: Resident #162 was admitted to the facility on 03/26/15 and readmitted on 06/05/15. The resident's documented diagnoses included dementia, depression, periods of verbal aggression, and history of paranoid delusions. A 08/17/15 physician order increased the resident's Seroquel (antipsychotic medication) to 50 milligrams (mg) daily. A 08/17/15 AIMS assessment documented the resident was experiencing involuntary movements to his lower extremities. The resident's 12/14/15 initial psychiatric evaluation documented, "Recent history of some interpersonal difficulties with roommates, including verbal aggression, rummaging through roommates' belongings and turning the heat on/off, but no issues reported with his new roommate. He also has a history of paranoid delusions, but symptoms have improved per staff with current dose of Seroquel." The resident's 12/17/15 quarterly minimum data set (MDS) documented his cognition was severely impaired, the resident presented with no psychosis/no behaviors/no wandering/no resistance of care, and received antipsychotic medication during all seven days of the lookback period. Resident 162's care plan, last revised on 02/05/16, identified "___ (name of resident) is on psychotropic medications r/t (due to) dementia with behavior disturbance, physical aggression toward others, agitation" as a problem.	F 329	in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #16 had AIMS completed on 3/10/16 by MDS Nurse. 2. Interventions for residents identified as having the potential to be affected: Any resident requiring AIMS can be affected. Therefore, the DON, Unit Managers and MDS nurses audited residents requiring AIMS testing for timely completion on 3/7/16. Any resident requiring a new AIMS was completed by the MDS nurses on 4/7/16. 3. Systematic Change: In-service was conducted by Regional Clinical Director, on 4/04/16 for Unit Managers and MDS Nurses on proper completion of the AIMS. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the MDS Nurses will audit AIMS for timely completion and report these findings to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to	

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F 329	Continued From page 8 Interventions to this problem included "AIMS assessment on initiation of med, with changes, and Q (every) 6 months." A 02/16/16 consultation report completed by the facility's consultant pharmacist documented Resident #162 was continuing to receive Seroquel. Her recommendation was, "Please ensure AIMS is done every 6 months." The former director of nursing (DON) signed the report on 02/17/16, and documented that the resident's last AIMS assessment was completed on 08/17/15. At 9:30 AM on 03/10/16 Unit Manager #1 stated AIMS assessments were completed on appropriate residents upon admission, and then MDS nurses set the frequency electronically so the computer would flag when subsequent assessments were due. At 9:43 AM on 03/10/16 MDS Nurse #1 stated AIMS assessments were completed every six months, and reminders to complete these assessments showed up on the electronic dashboard. At 11:30 AM on 03/10/16 MDS Nurse #1 stated Resident #162 was due an AIMS assessment in February 2016, but electronic medical records documented it was not completed. She reported she was not sure how the AIMS assessment got missed. She explained usually the electronic dashboard notified staff that the AIMS was due, and the hall nurse completed the assessment, but if he/she were unable to do so, then the MDS nurses or DON would step in to make sure the task was done.	F 329	ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 329	Continued From page 9 At 11:43 AM on 03/10/16 Unit Manager #2 stated the MDS nurses input time frames for the completion of AIMS assessments. She reported when these assessments were due they appeared on the clinical alert list. According to the unit manager, AIMS assessments were completed to monitor the toleration of antipsychotic medications and make sure these medications were not causing side effects. At 1:16 PM on 03/10/16 the current DON stated when the former DON received the pharmacist recommendation and signed it on 02/17/16 she should have immediately seen that Resident #162's AIMs was completed and that the AIMs assessments were scheduled to be completed every six months thereafter. She also reported there should have been an alert on the electronic dashboard that the AIMS was overdue so she was not sure what happened. The DON commented AIMS assessments should be completed regularly to make sure medications such as antipsychotics were not causing increased side effects that could affect quality of life.	F 329		
F 371 SS=F	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	F 371		4/7/16

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to have in its possession strips which measured the presence of chlorine-based and quaternary sanitizing agents, yet continued to perform food preparation and low-temperature dish machine tasks which involved the use of solutions containing these agents. Findings included: Review of the low-temperature dish machine and three-compartment sink sanitizer log revealed through evening shift on 03/07/16 strips used to check the chlorine-based sanitizing solution dispensed into the dish machine were registering 50 parts per million (PPM) and strips used to check the quaternary sanitizing solution in the three-compartment sink were registering 150 PPM. At 9:15 AM on 03/09/16 the strips used to check the strength of the quaternary sanitizing solution in the three-compartment sink did not register the presence of any sanitizing agent. The water in the sanitizing sink had a pink cast which was usually typical when a quaternary sanitizer was present. At this time the dietary manager (DM) stated she thought moisture had possibly altered the reliability of the strips. At 9:29 AM on 03/09/16 the AM cook used a spray bottle of quaternary sanitizing solution to wipe down her food preparation counter. At 9:40 AM on 03/09/16 a dietary aide used a spray bottle of quaternary sanitizing solution to wipe down a food preparation counter. At 10:02 AM on 03/09/16 a strip used to check the strength of the chlorine-based sanitizing solution dispensed into the low-temperature dish	F 371	F371 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: No residents were named in citation. 2. Interventions for residents identified as having the potential to be affected: Any residents dining in facility could be affected by this practice. 3. Systematic Change: Dietary Manager, DM, obtained new test strips from Ecolab on 3/7/16. Strip Holding Station was installed by Ecolab on 3/7/16. Ecolab Rep in-serviced dietary staff on proper storage and use of strips on 3/7/16. New dietary employees will be educated on sanitizing solution testing on the dish machine and 3 compartment sink during orientation as well as the	

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(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 371	Continued From page 11 machine did not register the presence of any sanitizing agent. However, the jug of sanitizing solution feeding into the dish machine had a bleach smell to it. At 10:08 AM on 03/09/16 a dietary aide operating the dish machine stated she used a strip when the dish machine process started up, and it did not change color, indicating there was no sanitizer present. Between 9:56 AM and 10:08 AM on 03/09/16 nine racks of kitchenware were run through the dish machine. Three of those racks were emptied with the kitchenware being placed in storage. At 10:15 AM on 03/09/16 a spray bottle of quaternary sanitizing solution was used to wipe down meal carts which were emptied. At 10:18 AM on 03/09/16 the PM cook began running kitchenware through the three-compartment sink system. At 10:25 AM on 03/09/15 the AM cook stated the facility was out of strips to check the three-compartment sink system so about a week ago the dish machine service representative replenished the facility's supply of strips. At 10:28 AM on 03/09/16 a dietary aide retrieved the blade to the robot coupe from the draining board of the three-compartment sink, and obtained milk from the refrigerator in order to prepare a puree dessert using vanilla wafers. After surveyor intervention further preparation of the puree dessert was halted. At 10:38 AM on 03/09/16 the DM arrived with strips she purchased in the community to check the strength of the sanitizing solution in the three-compartment sink. The strip registered 150 - 200 PPM when she inserted it in the quaternary solution. At 10:40 AM on 03/09/16 the DM found the strips used to check the strength of the dish machine	F 371	importance of the strip holding station. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of five (5) months, the DM will conduct audits 7 times a weeks for one month, then 5 times a week for 30 days then weekly thereafter time 3 months. DM will report the results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the five (5) months.	

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	345260	A. BUILDING _____ B. WING _____	03/10/2016

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F 371	Continued From page 12	F 371		

sanitizing solution inside a control box on top of the equipment. At this time she stated she thought these strips may have also been compromised due to exposure to moisture.
At 2:50 PM on 03/09/16 the dish machine service representative stated it was the facility's strips which were at fault in the dish machine system. He explained when he checked the strength of the chlorine-based sanitizer feeding into the dish machine with his own strips they registered 50 - 75 PPM which met manufacturer's recommendations.
At 10:12 AM on 03/10/16 the DM stated the strips to check the sanitizing solutions at the dish machine and the three-compartment sink should be stored as far away from moisture as possible. She reported her expectation was for staff to notify her if strips used to check sanitizing solutions did not register. She explained it was important to determine if the strips or the solutions were the problem. According to the DM, she expected the staff to stop using the sanitizing solutions until it could be determined why strips were registering the lack of sanitizing agents present in them.
At 10:30 AM on 03/10/16 a dietary aide who frequently participated in the dish machine process stated if rinse temperatures did not meet manufacturer's recommendations or strips did not register at least 50 PPM of the sanitizing agent then kitchenware should not be run through the low temperature dish machine. She reported these two criteria had to be met to ensure residents would not get sick from germs on contaminated kitchenware.
At 10:42 AM on 03/10/16 the AM cook stated if a strip did not register between 150 - 200 PPM in the quaternary solution in the three-compartment sink system then an alternate method needed to

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F 371	Continued From page 13 be found for sanitizing the kitchenware that would normally pass through that system. She reported if this criteria was not met then residents could get sick because kitchenware would not be clean and sanitized to kill bacteria.	F 371		
F 520 SS=F	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 staff interview and record review, the facility's Quality Assessment and Assurance (QA)	F 520	F520 QAA Committee/Meet Quarterly/plans	4/7/16

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F 520	Continued From page 14 Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for two recited deficiencies which were originally cited in April of 2015 on a Recertification survey. The deficiencies were in the areas of unnecessary medications and food procurement, storage, preparation and distribution. This continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: 1 a.F329: Unnecessary Drugs: Based on staff interview and record review the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment, used to identify involuntary body movements caused by long term treatment with medications such as antipsychotics, as recommended by the consultant pharmacist for 1 of 5 sampled residents (Resident #162) who were reviewed for unnecessary medications. During the recertification survey in April 2015, the facility failed to obtain an initial blood level for a medication. During the current recertification survey, the facility failed to complete an AIMS assessment. b. F371: Food Storage/Sanitation: Based on observation and staff interview the facility failed to have in its possession strips which measured the presence of chlorine-based and quaternary sanitizing agents, yet continued to perform food preparation and low-temperature dish machine tasks which involved the use of solutions	F 520	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 329 & 371 1. Interventions for affected resident: Resident #16 had AIMS completed on 03/10/2016 by MDS Nurse. 2. Interventions for residents identified as having the potential to be affected: Any resident requiring AIMS can be affected. Therefore, the DON, Unit Managers and MDS nurses audited residents requiring AIMS testing for completion on ___. Any resident requiring a new AIMS was completed by MDS on ___. 3. Systematic Change: In-service was conducted by Regional Clinical Director, on 4/4/16 for Unit Managers and MDS Nurses on proper completion of the AIMS. Regional Clinical Director educated QA Committee Members on properly maintaining and	

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F 520	Continued From page 15 containing these agents. During the recertification survey in April 2015, the facility failed to air dry tray pans before stacking them in storage, failed to clean a microwave and utensil drawer, and failed to label and date opened food items. On the current survey the facility failed to measure the effectiveness of sanitizing agents in the low-temperature dish machine. In an interview with the facility's Administrator on 3/10/16 at 1:30 PM, he stated that he had been made aware of the issues that were identified during this year's annual recertification survey related to the AIMS assessment and the sanitation solution testing strips and would be including those items in the facility's QA process. He acknowledged that the issues being cited under F329 and F371 were different from the issues previously cited under the same regulations during the recertification survey in April 2015, but understood that it was considered a QA program concern by federal standards when there were repeat citations regardless of the specific reasons for the deficiencies.	F 520	monitoring implemented procedures to address survey citations on 4/4/16. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (6) months, the MDS Nurses will audit AIMS for timely completion and report these findings to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the six (6) months. 329 & 371 1. Interventions for affected resident: No residents were named in citation. 2. Interventions for residents identified as having the potential to be affected: Any residents dining in facility could be affected by this practice. 3. Systematic Change: Dietary Manager, DM, obtained new test strips from Ecolab on 3/7/16. Strip Holding Station was installed by Ecolab on 3/7/16. Ecolab Rep in-serviced all dietary staff on proper storage and use of strips on 3/7/16. All new dietary employees will be educated on sanitizing solution testing on	

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F 520	Continued From page 16	F 520	the dish machine and 3 compartment during orientation. Regional Clinical Director will educate QA Committee Members on 4/4/16 regarding properly maintaining and monitoring implemented procedures to address survey citations and will discuss the scope and intent of F371. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the DM will conduct audits 7 times a week for one month, then 5 times a week for 30 days then weekly thereafter for 3 months. The results will be reported to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the six (6) months hs	