STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

(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 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159		4/6/16

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

Electronically Signed | 04/15/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to make available resident fund account money on the weekends for 2 of 5 sampled residents (Residents #33 & #67). Findings included: Observation was made on March 21, 2016 at 9:00 AM of a sign posted on the outside wall of the Assistant Business Office Manger office that read " Resident Fund Hours are: 8:00 am - 3:00 pm Monday - Friday, Withdrawals & Deposits can only be made during these hours. Thank you. " Observation was made on March 22, 2016 at 7:30 AM of a sign posted on the outside wall of the Assistant Business Office Manger office that read " Resident Fund Hours are: 8:00 am - 3:00 pm Monday - Friday, Withdrawals & Deposits can only be made during these hours. Thank you. " Observation was made on March 23, 2016 at 7:30 AM of a sign posted on the outside wall of the Assistant Business Office Manger office that read " Resident Fund Hours are: 8:00 am - 3:00 pm Monday - Friday, Withdrawals & Deposits can only be made during these hours. Thank you. "	F 159	Plan of Correction for Annual Survey 3/21/16 through 3/25/16 F483.10: Facility Management of Personal Funds Area of Concern: According to the 2567, two of five residents were affected by business office assistants posted hours of 7am-3pm Monday through Friday. When asked business office assistant how residents get access to their trust accounts after 3pm, business office assistant assured that the Business Office Manager could assist residents. Surveyor asked business office assistant how do residents get access to resident funds on the weekend, business office assistant and Administrator ensured surveyor that managers on duty for Saturday and Sunday contact herself if issues arise. Business office assistant and Administrator ensured surveyor that weekend fund access has never been an issue. For the resident affected: According to the surveyor during	

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F 159	Continued From page 2 1. Review of the Quarterly Minimum Data Set for Resident #67 dated on 02/25/16 revealed that the resident is cognitively intact. During an interview with the Resident #67 on 03/22/16 at 11:20 AM she stated that she did not have access to her resident fund account on the weekends. Resident #67 further stated that if she needed money on the weekends she would get it from her family. During an interview with the Assistant Business Office Manager on 03/23/16 at 11:00AM revealed that she leaves work at 3:00 PM Monday through Friday and if the residents needed access to their funds after 3:00 PM they could go to the Business Manager up until 5:00 PM. The Assistant Business Office Manager further stated that she was available to come in on the weekends if a resident requested funds. During an interview with the Administrator on 03/23/16 at 11:35 AM stated that a Department Head is on duty 4 hours on the weekends and can call the Business office Manager to access the resident's funds. The Administrator stated that there had been no concerns related to this matter. During an interview with the Director of Nursing on 03/24/16 at 2:20 PM she stated she never had a resident to request money from their fund account on the weekend. Interview with the Administrator on 03/24/16 at 4:30 PM revealed that it is her expectation that when a resident request funds from their account there needs would be met.	F 159	interviews with two of five residents, these residents were unaware that the facility provides access to resident trust fund accounts on the weekend. For the residents with the potential to be affected: All residents in the facility have a potential to be affected by resident access to trust funds on the weekends. Business Office re-educated residents in Resident council on 4/4/16 at 3pm that residents have access to their trust fund accounts on Monday- Friday and Starting on Saturday and Sundays, residents can inform nursing staff if funds are needed during the weekend and Nurses will report to Weekend Nurses responsible for access to funds. Funds will be locked up in the B Hall medication room with only the 400 hall nurse to have access to the funds during the weekend. Nurses were in-serviced on 4/6/16 by Administrator regarding the procedure of handling funds for residents on the weekend. Measures put in to place: All nursing staff were in-serviced beginning on 3/31/16 regarding procedure of handling funds for residents on the weekend and completed on 4/6/16. All Department Heads were in-serviced beginning 3/31/16 and completed on 3/31/16 regarding procedure of handling funds for residents on the weekend during their manager of duty hours (Saturday and Sunday). An allotment of funds will be locked on B Hall medication room in the E-Kit every Friday and picked up every Monday by Business Office. During the	

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F 159	Continued From page 3 2. Review of the Quarterly Minimum Data Set for Resident #33 dated on 01/26/16 revealed that the resident is cognitively intact. During an interview with the Resident #33 on 03/22/16 at 1:35 PM she stated that she did not have access to her resident fund account on the weekends. During an interview with the Assistant Business Office Manager on 03/23/16 at 11:00AM revealed that she leaves work at 3:00 PM Monday through Friday and if the residents needed access to their funds after 3:00 PM they could go to the Business Manager up until 5:00 PM. The Assistant Business Office Manager further stated that she was available to come in on the weekends if a resident requested funds During an interview with the Administrator on 03/23/16 at 11:35 AM stated that a Department Head is on duty 4 hours on the weekends and can call the Business office Manager to access the residents ' funds. The Administrator stated that there had been no concerns related to this matter. During an interview with the Director of Nursing on 03/24/16 at 2:20 PM she stated she never had a resident to request money from their fund account on the weekend. Interview with the Administrator on 03/24/16 at 4:30 PM revealed that it is her expectation that when a resident request funds from their account there needs would be met.	F 159	weekend, 400 hall nurse will have access to resident□s funds. All other nurses will report to the 400 hall nurse to receive funds for residents requesting funds. Signatures of nurse and resident will be required upon receiving. Business Office informed residents in Resident Council Meeting regarding access to Resident Trust Funds during the weekend on 4/4/16. Monitoring: Administrator to re-educate residents in Resident Council Meeting regarding access to Resident Trust Fund Accounts during the weekend x 2 months for follow up. Administrator will audit weekend trust account availability weekly x 2 months for follow up. Any issues or violations of compliance will be discussed in the facilities Quality Assurance and Performance Improvement Meeting.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		4/6/16

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F 241	Continued From page 4 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to ensure a privacy bag was utilized for 1 of 2 residents with a urinary catheter (#159). Findings included: Resident #159 was admitted on 3/15/16 with diagnoses of hematuria, chronic kidney disease - stage III, and Diabetes Mellitus. He was admitted from the hospital with a discharge summary order to " skilled nursing facility with indwelling Foley catheter in place until seen by Urology as an outpatient " . Observation on 3/21/16 at 4:52 PM revealed Resident #159 lying in bed. The urinary catheter bag was attached to the bedframe on the side of the bed facing the door of the room. The uncovered catheter bag contained urine and was visible from the hall. Observation on 3/22/16 at 2:02 PM revealed Resident #159 sitting in the chair in his room with the door open and the urinary catheter bag was uncovered. During an interview on 3/23/16 at 3:39 PM with Nursing Assistant # 2, he stated he always puts a privacy bag on his assigned residents. During an interview on 3/23/16 at 5:29 PM with the Director of Nursing, she stated it was her expectation that the residents with indwelling catheters would have a privacy bag as mentioned in their care plans in regards to resident ' s	F 241	F241: Failure to ensure a privacy bag was utilized for resident with a urinary catheter. For the resident affected: Privacy bag was placed over urinary catheter bag on 3/23/2016. For the residents with the potential to be affected: All residents with urinary catheter bags were checked to ensure catheter bag was covered in a privacy bag. Measures put into place: All nurses and C.N.A.□s were re-educated and in-serviced by DON/SDC, beginning on 3/25/16 and completed on 4/6/2016, regarding urinary catheter bags must be covered in a privacy bag. The facility is now using the Fig Leaf catheter bags. Monitoring: Catheter bags will be audited on all residents with a urinary catheter to ensure catheter bags are covered (using Fig Leaf Catheter Bag). The DON, ADON, or Designee will audit weekly X 4 weeks. If substantial compliance is found, will decrease audit to bi-weekly X 4 weeks. If substantial compliance is found, will	

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F 241	Continued From page 5 dignity. During an interview on 3/24/16 at 4:10 PM, with Nurse #3 she stated usually a privacy bag is provided for residents with indwelling urinary catheter.	F 241	decrease audit to monthly X 2 months. Any issues or violations of compliance will be discussed in the facilities QAPI Meeting.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to maintain a safe water temperature on 1 of 3 hallways (C Hallway) where the temperature exceeded 116 Fahrenheit (F). Findings included: On March 21, 2016 at 12:30 P.M., water temperature observation was hot in two bathrooms on opposite sides of C Hallway-Rooms 608 & 608 and Room 603. C Hallway is a closed locked Alzheimer Unit. An initial temperature observation with Maintenance Man #1 was done at 12:33 PM. Thermometer was calibrated with a cup of ice water to 32.2 F. He checked room 606 & 608. It revealed a temperature of 122.5 F in bathroom. He quickly said, " I got to go tell my Boss." He stated - " that is too hot. My boss said this morning he turned it down. It was in the 120's. I	F 323	Plan of Correction for Annual Survey 3/21/16 through 3/25/16 F323: Free of Accident Hazards/Supervision/Devices For the patients affected and for those with the potential to be affected:In-services started with staff on 03-21-16 at 3 PM by Director of Nursing and Staff Development Coordinator related to acceptable water temperature range (100-116 degrees Fahrenheit). In the event the water feels too hot to touch, staff will turn water off under the sink and notify nursing supervisor who will then notify Maintenance Supervisor, Director of Nursing and Administrator. No baths or showers will be given until Director of	3/25/16

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F 323	Continued From page 6 need to let him know to turn it down again." At 12:50 P.M. on 3/21/16, the Head of Maintenance returned to C Hallway and calibrated thermometer. He took the temperature in the bathroom serving Room 606 and Room 608. It read 115.4 F while being placed under running hot water. He stated, "I adjusted the mixing valve this morning at 7:00 A.M." He also said he rechecked it at 8:00 AM and the temp was 111.0 F for C Hall. He could not explain why the temperature was back to 122.5 F at 12:30 P.M. He continued, "I may need to clean the mixing valves." He explained, C Hallway was a new addition and used a different pump than A & B Hallways. On 3/21/16 at 1:10 PM during observations of A Hall = 101.9 F, and at 1:20 PM B Hall = 113.5 F. In an interview with the Head of Maintenance, he stated, " I check the water daily - Monday through Friday. I record it on my log sheets. If I turn it down, I make a note and come back and check it again later. I check different rooms or the shower rooms each day. " When asked if he informed the staff of the water being too hot he said " No, I just make adjustments. " When asked about the temperature this morning, he reported he records the temperature after the adjustment in the log. When asked for a policy for service, record of cleaning of mixing vales, or copies of invoices for any repairs, he did not have any to provide. He responded, he had not policy, he cleaned around October but did not document it, and there had been no invoices of repairs since the system had been installed. During an interview with the Administrator at 12:55 P.M. she stated, she had not heard about any problem related to water temperature since she was hired in January. She was made aware of the elevated temperature in the locked unit (C	F 323	Maintenance has checked water temps and given clearance that water temperature is within correct range and safe to use.Administrator reviewed procedure of water surveillance with Maintenance Supervisor on 03-21-16. Measures put into place: The Maintenance Supervisor and/or designee will check water temperatures in random resident rooms and shower rooms on a daily basis to ensure temperatures are within 100-116 degrees Fahrenheit. If water temperatures fall out of appropriate range, Administrator, Director of Nursing and direct care staff are to be notified immediately to prevent accidents and/or injuries. Hot water valve will be turned off until temperatures are corrected. Staff will be advised not to use hot water until otherwise directed by Maintenance Supervisor that water temperature is safe to use. Maintenance Supervisor and/or designee will complete Daily Surveillance Log daily. If temperatures fall out of appropriate range, comments section on log is to be completed with action taken to get temperature back within range. On 03-21-16 at approximately 7 PM Hot water was turned off to patient care areas in facility with only dietary and laundry having hot water. Staff notified that hot water will remain off until further notice. Corporate Life Safety notified and to be at facility on 03-22-16 AM. Staff notified to inform patients and/or families related to reason not giving showers/baths. On 03-22-16 Maintenance Supervisor and Corporate	

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F 323	Continued From page 7 Hall - Alzheimer ' s Unit). She verified the Head of Maintenance routine was to check it daily Monday through Friday. She explained, staff checks the water by hand contact. She also said she depends on the maintenance person to tell her if there is a problem. She said the facility has in-services regarding the need to check water temperatures routinely before showering residents. She provided copies of the temperature log. She also could not find any record of repair maintenance on the units in the past year. No maintenance was in progress and no parts were on order. During an interview with Nurse #4 on 3/21/16 at 1:36 PM, she explained Residents in Rooms 601D, d04D, 702W and 708D are independent residents. All other residents on the 600 and 700 hallways are dependent on staff for care. She also stated the staff checks the water temperature prior to giving showers or baths to the residents during morning care. She continued with " no nursing staff or maintenance staff has informed me of any hot water problems " . During an interview with Nurse Assistant #2 on 3/21/16 at 5:30 PM, he responded when asked have you had problems with the water temperature during care of the residents being too cold or too hot, he explained he had not had any problems. He said he reports problems to his Charge Nurse on duty. He explained he turns on the hot first then the cold prior to giving any residents their evening care. On review of the temperature logs, there were seventeen days recorded with temperatures on the C Hall that exceeded 116 F from the last service date of October, 2015 to the 3/21/16. These included the following for C Hall: November 16, 2015 - 118	F 323	Life Safety made adjustments/repairs to correct water temperature. The circulator pump was taken apart on C-Hall and cleaned with checking the impeller for wear. The pump was found to be with in good condition. Pump was put back together and reinstalled. The temperatures were reset and the system was tested to maintain temperatures between 102 and 112 degrees. On 3-23-16 at approximately 8:15am, temperatures were checked on each unit for temperature compliance. A and B Hall in compliance. C-Hall temperature read 116.5 degrees. Hot water was immediately turned off by Maintenance Supervisor. Maintenance Supervisor and Administrator informed nursing staff of hot water being turned off to patient care areas on C-Hall until further notice. Corporate Life Safety notified and electric digital valves were ordered. Maintenance Supervisor and/or designee initiated hourly temperature checks on A and B Hall for monitoring until electric digital valves installed. On 3-25-16, electric digital valves were installed. Water temperatures returned back to compliant temperatures. Daily temperature checks to continue ongoing in random resident rooms and shower rooms with no discrepancies. Monitoring: Administrator will audit temperature logs weekly x 3 then monthly x 3 to ensure logs completed daily and if any variance of temperature out of acceptable ranges that appropriate action taken and	

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F 323	Continued From page 8 November 17, 2015 - 118 November 18, 2015 - 118 November 23, 2015 - 118 November 24, 2015 - 118 November 25, 2015 - 118 November 26, 2015 - 118 November 27, 2015 - 118 December 17, 2015 - 116.6 December 18, 2015 - 116.6 February 3, 2016 - 117.1 February 4, 2016 - 117.1 February 15, 2016 - 117 February 29, 2016 - 117.7 March 1, 2015 - 117.7 March 2, 2015 - 117.7 March 21, 2015 - 111.7 recorded in log but during observation it was noted at 122.5. During observation of temperature checked on the Shower Room/500 section (C Hall) temperature 118 F at 7:03 PM on 3/21/16, the Administrator made decision to cut hot water off on C Hall until Corporate Maintenance Team arrival on 3/22/16. Residents and staff on C Hall were notified of plan by Administration until repairs could be made. On 3/22/16 at 6:00 PM an interview with Corporate Maintenance offered an explanation of the problem being a " probable mixing valve issue " . He reported there was no monitoring log available for maintenance for cleaning and there was no policy regarding cleaning. He explained there should be log of daily temperatures, with also an explanation of any interventions performed when temperatures are out of range. He said it was his expectation that the problem with the temperature fluctuations will be serviced by the plumbers and a policy, monitoring of service and daily checks will be implemented. He	F 323	documented in comments section. Results of audit findings will be reviewed during monthly QA meetings. Any areas of concern will be discussed immediately and the plan of correction will be adjusted if the need occurs.	

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F 323	Continued From page 9 reported his immediate response was to keep C Hallway hot water off and to monitor A and B Hallways hourly until repair is complete.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 26 opportunities resulting in a medication error rate of 7.69% for 2 or 6 residents (Resident 47 and Resident #58) observed during a medication pass. Findings included: 1. Resident #47 was admitted to the facility on 2/21/14 with a diagnosis of heart failure and hypertension. On 3/24/16 at 8:50 AM, Medication Aide (MA) #1 was observed preparing to administer medications to Resident #47. The medications pulled for administration included Vitamin D3 1000 units one tablet. The actual physician orders for March 2016 indicated Resident #47 was to receive Vitamin D3 2000 units daily. In an interview on 3/24/16 at 9:10 AM, MA #1 stated he understood that the order read 2000 units, but the facility only stocked 1000 unit Vitamin D3 tablets. He did not think to give two tablets. In an interview on 3/24/16 at 9:15 AM, the	F 332	F332: Failure to ensure medication error rate less than five percent For the residents affected: Medication Aide was immediately pulled from medication cart. For the residents with the potential to be affected: All 200 Hall residents have the potential to be affected due to medication aide gives medications to 200 Hall residents. Medication Aide is not administering medications until he completes re-education, in-servicing, and re-training. Measures put in place: Medication Aide was re-educated and in-serviced by DON on administering transdermal medicated patch/disc, topical medication, sublingual medication, rectal suppository and enema, nasal medication, nose drops and nasal spray medication, inhalant medication, infection control, general medication administration, eye	4/20/16

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F 332	Continued From page 10 Director of Nursing (DON) stated MA #1 should have pulled two of the 1000 unit Vitamin D3 tablets for administration. In an interview on 3.24.16 at 3:10 PM, the Staff Development Coordinator (SDC) stated the facility had a medication administration in-service on 3/9/16 but MA #1 was not in attendance. 2. Resident # 58 was admitted to the facility on 1/21/10 with a diagnosis of osteoporosis and seizures. On 3/24/16 at 9:20 AM, MA #1 was observed preparing to administer medications to Resident # 58. The medication pulled was Vitamin D3 four 1000 unit tablets for administration. The actual March 2016 physician orders was for Vitamin D3 5000 units daily. In an interview on 3/24/16 at 9:20 AM, MA #1 stated he just did not pour out enough tablets for administration and should have given 5 tablets. In an interview on 3/24/16 at 10:00 AM, the Director of Nursing (DON) stated MA #1 should have pulled given 5 1000 unit tablets to Resident #58. In an interview on 3.24.16 at 3:10 PM, the Staff Development Coordinator (SDC) stated the facility had a medication administration in-service on 3/9/16 but MA #1 was not in attendance.	F 332	medications, eardrops, buccal medication and administering medications by mouth beginning on 4-6-2016 with completion date set for 4-20-2016. Medication Aide watched a video by Legacy Consultant Pharmacy titled Medication-Pass Techniques on 4-7-2016. Reviewed Medication Aide Job Description with Medication Aide on 4-6-2016. Re-training/skills check with medication pass with an RN for 3-5 days, beginning on 4-7-16 with completion date of 4-20-2016. Please note that original completion date was set for 4/15/16, but due to unforeseen medical issue, Medication Aide on 3/28/16 and 4/4/16 was excused from work per doctor's order. On 4/12/16 facility received from Medication Aide a medical note to be excused from work until 4/19/16 due to injury. Medication Aide was to return on 4/20/16, but called out on 4/20/16. Due to unable to complete training efficiently within appropriate timeframe, medication aide will no longer be eligible to practice as medication aide within the facility. Monitoring: Medication Aide will no longer be eligible to practice as medication aide within the facility. Will discuss any issues or concerns in the QAPI Meeting.	
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	F 431		4/6/16

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	345280	A. BUILDING _____ B. WING _____	03/24/2016

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F 431	Continued From page 11 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure a house stock medication capsule was not left lying out on top of a laptop sitting on a medication cart (200 hall) and failed to lock an unattended medication cart (200 hall) for 1 of 5 medication Carts (200 hall) reviewed for medication storage.	F 431	F431: Drug Records, Label/Store Drugs & Biologicals For the residents affected: Medication Aide was immediately pulled from medication cart.	

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F 431	Continued From page 12 Findings included: A review of the facility policy titled Medication Storage in the Facility dated June 2012 reads in part: Medication cart are to be locked when not attended by person with authorized access. On 3/24/16 at 8:50 AM, Medication Aide (MA) #1 was observed preparing to administer medications to a resident. Observed lying on the left lower corner of the medication laptop was a pink capsule. When MA #1 was questioned why a capsule was lying out on top of his cart, he replied, " It ' s just a cranberry capsule. I ' ll just throw it away. " MA #1 confirmed there should be no medications lying out on top of a medication cart not secured in its original container until ready to be administered. On 3/24/16 at 8:50 AM, MA #1 unlocked his medication cart and retrieved a pulse oximetry device to assess a resident prior to a medication administration. He left his cart unlocked in the hallway outside the doorway of the resident lounge where the resident was sitting. Upon return, MA #1 verified he should have locked his medication cart prior to leaving it unattended in the hall. In an interview on 3/24/16 at 10:00 AM, the Director of Nursing stated it was her expectation that no loose medications be left anywhere on top of a medication cart and that anytime nursing staff had to leave their medication cart unattended, it should be locked to secure the contents for safety.	F 431	For the residents with the potential to be affected: All 200 Hall residents have the potential to be affected due to medication aide gives medications to 200 Hall residents. Medication Aide is not administering medications until he completes re-education and in-servicing. Measures put in place: All Nurses\medication aides re-educated by SDC/DON on Medications Storage in the facility (On Medication Cart, Controlled Substance Storage, and Bedside Medication Storage). In-service start date: 3-25-16. Completion date: 4-6-16. Monitoring: Medication storage/securing medication care will be audited. The DON, ADON, or Designee will audit 5 medication carts to ensure compliance with medication storage. Will audit weekly X 4 weeks. If substantial compliance noted, will decrease audit to bi-weekly X 4 weeks then monthly X 2 months. Any issues or violations of compliance will be discussed in the QAPI meeting.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		4/7/16

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F 441	Continued From page 13 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to disinfect a nebulizer mask prior to storage for 1 of 6	F 441	F441: Failure to prevent the spread of infections (disinfect a nebulizer mask prior to storage)	

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F 441	Continued From page 14 residents (Resident #97) observed during a medication pass. The facility also failed to follow infection control procedures for hand washing/hand hygiene between residents for 2 of 6 residents (Resident #47 and Resident #58) observed during a medication pass. Findings included: 1. A review of the facility policy titled Oral Inhalation Administration dated June 2012 read in part: Rinse and disinfect the nebulizer equipment per facility policy and when equipment was completely dry, store in a plastic bag with the residents name and date on it. On 3/23/16 at 9:20 AM, Nurse #2 was observed during a medication pass on Resident #97. Upon completion of the ordered nebulizer treatment, Nurse #2 removed the nebulizer mask from Resident #97 ' s face and proceeded to dry the inside of the mask with a tissue. Once the mask was dry, Nurse #2 placed the nebulizer mask inside a zip-lock plastic bag for storage. In an interview on 3/23/16 at 9:20 AM, Nurse #2 stated she should have used a disinfectant wipe to clean Resident #97 ' s nebulizer mask before returning it to the zip-lock bag for storage. In an interview on 3/24/16 at 10:00 AM, the Director of Nursing (DON) stated it was her expectation that Nurse #2 wear gloves when handling a dirty nebulizer mask and disinfect it prior to storage for reuse for Resident #97. 2. On 3/24/16 at 9:10 AM, Medication Aide (MA) #1 completed his medication pass on Resident #47. He then proceeded to pull medications to administer to Resident #58. He did not wash his hands or use hand sanitizer then took the medications into Resident #58 ' s room and assisted Resident #58 ' s with taking her medications.	F 441	For the resident affected: Old nebulizer mask was discarded and resident was given a new nebulizer mask and new zip-lock plastic bag on 3-24-2016. For the residents with the potential to be affected: All residents that receive nebulizer treatments with a nebulizer mask were given a new nebulizer mask and new zip-lock plastic bag to place the mask in on 3-25-2016. Measures put in place: All nurses/medication aides in-serviced by SDC/DON, beginning 3-25-16 and completed on 4-7-16, on cleaning nebulizer mask/storage of nebulizer mask after completion of nebulizer treatment. Monitoring: Cleaning and storage of nebulizer mask will be audited. DON, ADON, or Designee will audit 2 nurses/medication aides during medication pass on cleaning and storage of nebulizer mask weekly X 4 weeks. If substantial compliance is noted, will decrease audit to bi-weekly X 4 weeks then monthly X 2 months. Will discuss any issues or violations of compliance in the QAPI meeting. F441: Failure to prevent the spread of infections (handwashing during medication pass) For the residents affected: Medication Aide was immediately pulled from	

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F 441	Continued From page 15 In an interview on 3/24/16 at 9:20 AM, MA #1 stated he should have washed his hands in between the administration of Resident #47 ' s medications and the preparation and administration of Resident #58 ' s medications. In an interview on 3/24/16 at 10:00 AM, the DON stated it was her expectation that MA #1 wash his hands in between residents during medication administration to prevent possible cross contamination.	F 441	medication cart. For the residents with the potential to be affected: All 200 Hall residents have the potential to be affected due to medication aide gives medications to 200 Hall residents. Medication Aide is not administering medications until he completes re-education and in-servicing. Measures put into place: All nurses/medication aides re-educated and in-serviced by SDC/DON, beginning 3-25-16 and completed on 4-7-16, on washing hands during medication pass. All nurses/medication aides re-educated and in-serviced by SDC/DON, beginning 3-25-16 and completed on 4-7-16, on policy on handwashing. Monitoring: Hand hygiene during medication pass will be audited. DON, ADON, or Designee will audit 2 nurses/medication aides during medication pass to ensure using proper hand hygiene. Will audit weekly X 4 weeks. If substantial compliance note, will decrease audit to bi-weekly X 4 weeks then monthly X 2 months. Will discuss any issues or compliance violations in the QAPI meeting.	