

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345267</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>POPLAR HEIGHTS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>804 SOUTH POPLAR STREET ELIZABETHTOWN, NC 28337</b>		
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F 253 SS=E	<p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to provide maintenance services necessary to maintain a safe and homelike environment, by not repairing a sink, not repairing call bell cords, not keeping rooms painted and walls in good repair, and not storing personal items labeled, covered and stored properly for 8 of 30 resident rooms observed.</p> <p>Findings included:</p> <p>1. An observation was made of the shared bathroom between rooms #7 and #9 on 9/13/2016 at 4:20 PM. The bathroom sink was observed to be loose from the wall and a broom stick was wedged between the floor and the bottom of the sink.</p> <p>An interview with the Maintenance Director (MD) was conducted on 9/13/2016 at 4:20 PM. The MD stated he had been aware of the loose sink in the bathroom between rooms #7 and #9 since last week.</p> <p>An interview with the Assistant Director of Nursing (ADON) was conducted on 9/14/2016 at 8:30 AM. The ADON stated she had only become aware of the sink issue in room #7 and #9 's bathroom last week. The ADON stated she</p>	F 253	<p>1. The bathroom sink between rooms 7 and 9 was repaired 9/14/2016 by Maintenance Director. The identified areas needing repair in rooms 304,210,205,218, bathroom for 305 and 307, bathroom for 7and 9 will be completed by Maintenance Director before 10/12/2016.</p> <p>2. Residents in the facility have the potential to be effected. Staff in-service will be conducted by Facility Educator and completed by 10/12/2016 on procedures for reporting malfunctioning equipment. Re-education of staff by Facility Educator will be completed by 10/12/2016 on proper labeling, bagging of graduated cylinders, covering of bedside commodes and storage of these items. Re-education will also include proper procedure to report repairs needed in resident rooms.</p> <p>3. The bathroom sinks will be monitored using an audit tool on Resident Rounds by department head staff 3x per week for 3 weeks, 2x per week for 2 weeks and 1x per week ongoing. Monitoring will continue with an audit tool on Resident Rounds conducted by department head staff 3x per week for 3 weeks, 2x per</p>	10/12/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/03/2016

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 253	<p>Continued From page 1 expected staff to report any problems.</p> <p>An interview with Nurse Aide (NA) #4 was conducted on 9/14/2016 at 9:10 AM. The NA stated the sink between rooms #7 and #9 had fallen off of the wall twice. The NA stated she had alerted maintenance and the sink had been repaired after the first time earlier this year. The NA stated she had cautioned Resident #44 not to use the sink to support his weight since it was loose.</p> <p>An interview with Housekeeper (HK) #1 was conducted on 9/14/2016 at 9:20 AM. The HK stated about two weeks ago while cleaning the bathroom between rooms #7 and #9 she had bumped the sink and it had come loose from the wall, she lowered it down and notified the housekeeping manager. The HK stated the housekeeping manager had wedged a stick under the sink to support it.</p> <p>An interview with the Housekeeping Manager (HM) was conducted on 9/14/2016 at 9:30 AM. The HM stated about 2 weeks ago he had been alerted the sink between rooms #7 and #9 had come part way off of the wall. He stated he propped the sink so it would not fall and told the interim administrator about the sink problem.</p> <p>An interview with Resident #44 was conducted on 9/14/2016 at 11:00 AM. The resident stated the sink had come loose from the wall about 4 weeks earlier. He stated the sink never fell on him and he did not feel unsafe using the bathroom.</p> <p>An interview with the Administrator (AD) was conducted on 9/14/2016 at 11:30 AM. The AD stated he had not been made aware of the sink</p>	F 253	<p>week for 2 weeks and 1x per week ongoing.</p> <p>4. The audits will ne reviewed by QAPI committee x3 months to ensure continued compliance.</p>		

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F 253	<p>Continued From page 2</p> <p>problem in the bathroom between rooms #7 and #9.</p> <p>An interview with the Director of Nursing (DON) was conducted on 9/14/2016 at 12:15 PM. The DON stated is was her expectation of staff to report any maintenance problems to a supervisor.</p> <p>2. a. An observation was made of room #304 on 9/11/2016 at 12:18 PM. The wall behind the resident ' s bed had paint scratched off and several small dents in the wall. A bed pan and a bedside commode bucket were observed uncovered on the bathroom floor.</p> <p>b. An observation of the shared bathroom between rooms #305 and #307 was made on 9/11/2016 at 12:26 PM. An uncovered bedside commode bucket was observed on the bathroom floor. The baseboard in the bathroom was observed peeling away from the wall. The white emergency call bell cord had brown dirt on it.</p> <p>c. An observation was made of the shared bathroom located between rooms #7 and #9 on 9/11/2016 at 3:32 PM. The wall paper at the top left corner of the sink was observed to be torn. Two wash basins and two bed pans were stacked together, one inside the other on the floor under the sink. An unlabeled graduated cylinder was on the back of the toilet.</p> <p>d. An observation of the bathroom in room #4 was conducted on 9/11/2016 at 4:04 PM. A wash basin was observed on the bathroom floor under the sink and a graduated cylinder used for measuring urine was uncovered and unlabeled.</p> <p>e. An observation of room #210 was made on</p>	F 253			

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F 253	<p>Continued From page 3</p> <p>9/11/2016 at 4:20 PM. Black marks were observed on the wall next to bed " A ". The privacy curtain which separated bed " A " from bed " B " was torn at the top. The bathroom emergency call bell was a standard light switch which had been broken off to a nub and the pull cord was missing. No sharp edges were observed. The call bell was difficult to activate because of the shortness of the switch and lack of a pull cord, but was functional and alarmed when activated. A pull cord enables the user to activate but not touch the switch because their hands may be wet, it may be handed to the resident with impaired vision or range of motion who may not be able to see or reach the switch.</p> <p>f. An observation of room #205 was made on 9/11/2016 at 3:17 PM. The bathroom emergency call bell was a standard light switch next to the commode and was functional, but the pull cord was missing. A pull cord enables the user to activate but not touch the switch because their hands may be wet, it may be handed to the resident with impaired vision or range of motion who may not be able to see or reach the switch.</p> <p>g. An observation of room #218 was made on 9/12/2016 at 9:43 AM. The bathroom emergency call bell was a standard light switch with a standard switch plate over it and was located next to the commode. Both the switch and the plate were loose from the wall, no wires were exposed. When activated, the emergency call bell light outside of the room was observed to not light up.</p> <p>h. An observation of room #214 was made on 9/13/2016 at 4:12 PM. Two unmarked urinals were hanging from the raised toilet seat in the bathroom.</p>	F 253			

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F 253	Continued From page 4  An interview with the Assistant Director of Nursing (ADON) was conducted on 9/14/2016 at 8:30 AM. The ADON stated she expected staff to report any maintenance problems. The ADON stated bedside commode buckets that were not in use should be not be stored in residents ' bathrooms. The ADON stated bed pans, urinals and measuring cylinders should be marked with resident names and stored in plastic bags in the bathroom.  An interview with NA #3 was conducted on 9/14/2016 at 10:20 AM. The NA stated when something was not working, a work order would be filled out and place into the maintenance box. The NA stated bed pans, wash basins, urinals and measuring cylinders should be marked with the resident name and should be stored in a plastic bags in the bathroom to keep them separated.  An observation was made on 9/14/2016 at 11:30 AM with the Administrator (AD) of the bathroom between rooms #7 and #9. The AD stated wash basins and bed pans should not be stacked together on the bathroom floor.  An interview with the Director of Nursing (DON) was conducted on 9/14/2016 at 12:15 PM. The DON stated it was her expectation that resident care equipment be labeled with the resident name and be stored properly. The DON stated is was her expectation of staff to report any maintenance problems to a supervisor.	F 253			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		10/12/16	

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F 278	<p>Continued From page 5</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 3 of 15 residents who required antianxiety and antipsychotic medications (Resident #4), reviewed for dental status (Resident #2), and reviewed for a resident receiving an antidepressant medication (Resident #84).</p>	F 278	<p>1. MDS modifications were completed for residents #4 on 9/13/16 and #84 on 9/14/16 to accurately reflect antianxiety, antipsychotic, and antidepressant use. MDS significant correction was completed for resident #2 on 9/14/16 to accurately reflect her dental status as edentulous.</p>		

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F 278	<p>Continued From page 6</p> <p>Findings included:</p> <p>1. a. Resident #4 had been admitted on 11/21/2012. Admission diagnoses included schizophrenia, depression, hypertension and diabetes.</p> <p>Review of the March 2016 Medication Administration Record (MAR) indicated Resident #4 had diagnoses including anxiety, depression and schizophrenia. Resident #4 had received two doses of Ativan (an antianxiety medication to treat anxiety) 1 milligram (mg), one dose on 3/23/2016 and another dose on 3/24/2016.</p> <p>Review of Resident #4's Quarterly MDS dated 3/29/2016 indicated Resident #4 had received one dose of antianxiety medication.</p> <p>An interview with MDS nurse #2 was conducted on 9/13/2016 at 12:05 PM. The MDS nurse stated she was unsure how the correct number of medication doses had been missed being marked on the MDS assessment.</p> <p>An interview with the Director of Nursing (DON) was conducted on 9/14/2016 at 12:15 PM. The DON stated it was her expectation that the MDS assessments be accurate.</p> <p>b. Resident #4 had been admitted on 11/21/2012. Diagnoses included schizophrenia, depression, hypertension and diabetes.</p> <p>Review of the June 2016 Medication Administration Record (MAR) indicated Resident #4 had received one injection of Risperidone (an antipsychotic medication used to treat</p>	F 278	<p>2. Residents residing in the facility have the potential to be affected. Residents receiving antianxiety, antipsychotic, and antidepressant medications were identified through medical record review. Most recent MDS assessments for identified residents will be reviewed by the MDS nurse to validate accurate coding of these medications. Modifications will be completed as necessary to reflect accurate medication usage. Dental status for residents residing in the facility will be reviewed and compared to the most recent MDS assessment to validate accuracy. Significant corrections will be completed as necessary to reflect accurate dental status. Licensed staff will be educated by the Nurse Practice Educator on accurate documentation and MDS coding of resident dental status and use of antianxiety, antipsychotic, and antidepressant medications. Education sessions are scheduled for 10/3/16-10/10/16.</p> <p>3. MDS assessments will be reviewed by the DNS or designee prior to transmission weekly x 4, then 2 x month x 1 month, then monthly x 1 month to ensure accurate coding of dental status and antianxiety, antipsychotic, and antidepressant use. The DNS or designee will maintain a log of assessments reviewed with any necessary corrections/modifications noted with date corrected.</p> <p>4. Results of the MDS reviews will be reported to the facility's Quality Assurance</p>		

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F 278	<p>Continued From page 7</p> <p>schizophrenia) 37.5 milligrams (mg) on 6/27/2016.</p> <p>Review of Resident #4's Quarterly MDS dated 6/29/2016 did not indicate Resident #4 had received an injection or an antipsychotic medication.</p> <p>An interview with MDS nurse #2 was conducted on 9/13/2016 at 12:05 PM. The MDS nurse stated she was unsure how the injection and medication had been missed being marked on the MDS assessment.</p> <p>An interview with the Director of Nursing (DON) was conducted on 9/14/2016 at 12:15 PM. The DON stated it was her expectation that the MDS assessments be accurate.</p> <p>2. Resident #2 was admitted to the facility 8/27/2010 with diagnoses which included anemia, hemiplegia, and weight loss. Her annual Minimum Data Set (MDS) of 3/28/16 indicated she was cognitively intact and independent with all activities of daily living except bed mobility, toilet use and personal hygiene which required extensive assistance. The dental assessment for no natural teeth or tooth fragments (endentulous) was answered no. A review of the Care Plan initiated 5/26/15 and last reviewed 3/31/16 indicated a focus of "Resident exhibits or is at risk for oral health or dental care problems as evidenced by resident is endentulous and reuses dentures." An interview was conducted 9/11/16 at 2:49 PM with Resident #2. She denied any dental problems. She further stated that she didn ' t have any natural teeth and she had dentures but</p>	F 278	Committee monthly x 3 months for review and further recommendation for continued compliance.		



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F 278	<p>Continued From page 8</p> <p>did not like to wear them.</p> <p>An interview was conducted on 9/14/16 at 9:33 AM with MDS Nurse #1. She stated if a resident was endentulous, the dental assessment for no natural teeth should be answered yes. She stated the assessment for Resident #2 was incorrect.</p> <p>An interview was conducted on 9/14/16 at 9:51 AM with the Director of Nursing. She stated if a resident had no natural teeth the dental assessment question should be answered yes for endentulous.</p> <p>3. Resident #84 was admitted to the facility 10/27/15 with diagnoses which included diabetes, hypertension, dementia, stroke and depression. A review of his Admission Minimum Data Set (MDS) of 12/2/15 indicated he was moderately cognitively impaired. A staff assessment of resident mood indicated Resident #84 was down or depressed 2-6 days out of a 14 day look back period. The MDS diagnosis section did not include depression, however, the medication section indicated the resident took an antidepressant 7 out of 7 days.</p> <p>A review of the quarterly MDS from 1/30/16, 4/14/16 and 7/14/16 revealed no diagnosis of depression. The medication assessment indicated Resident #84 was receiving an antidepressant 7 out of 7 days on each of those assessments. The resident assessment for mood revealed Resident #84 indicated he felt down or depressed.</p> <p>A review of the quarterly MDS from 9/2/16 revealed no diagnosis of depression. The medication assessment indicated Resident #84 was not receiving antidepressant medication. Resident #84 reported feeling down or depressed 2 to 6 days of the look back period.</p>	F 278			

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F 278	Continued From page 9 A review of the August and September 2016 electronic medical record (eMAR) indicated Resident #84 had received Lexapro daily during the MDS look back period. An interview was conducted on 9/14/16 at 9:14 AM with MDS Nurse #2. She stated she obtained diagnosis from the resident's chart, consolidated orders, progress notes, History and Physical, discharge summary, and consult notes. She further stated she reviews the eMAR for verification of medications. She stated she would have expected the diagnosis of depression to be coded on the MDS assessment. She stated the diagnosis of depression was missed. An interview was conducted on 9/14/16 at 9:51 PM with the Director of Nursing. She stated the MDS nurses have several sources they could use to obtain diagnoses such as discharge summaries, history and physicals, consult notes and psych notes. She stated it was her expectation the MDS be coded correctly.	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	F 279		10/12/16	

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F 279	<p>Continued From page 10</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to develop comprehensive care plans for 2 of 15 residents (Resident #5 and Resident #61) whose care plans were reviewed for range of motion and urinary incontinence.</p> <p>Findings included:</p> <p>1. Resident #5's most recent re-admission to the facility was on 8/22/16. Diagnoses included loss of motor function due to an accident and contractures.</p> <p>A 7/19/16 Quarterly Minimum Data Set (MDS) indicated Resident #5 was cognitively intact and required total assistance of staff for completion of activities of daily living. The resident was coded on the MDS with functional limitation in his range of motion (ROM) for bilateral upper and lower extremities. Contractures was identified as an active diagnosis. There was no indication the resident received restorative therapy for ROM or splinting for contracture management and to prevent the loss of existing function.</p> <p>Review of the care plan revised on 7/11/16 indicated Resident #5 was at risk for pain due to contractures. The goal of maintaining an acceptable pain level was to be achieved by</p>	F 279	<p>1. Care plan for resident #5 was updated on 9/27/16 to include ROM for contracture management as well as refusal of care for his bilateral upper and lower extremity contractures. Care plan for resident #61 was updated on 9/27/16 for improved bowel/bladder control with goal of less than 3 incontinent episodes per day with prompted toileting scheduled upon rising, before meals, and at HS. Resident is alert and care plan intervention added to encourage her to use call light for assistance at first urge to void or defecate.</p> <p>2. Residents with contractures or with decline in continence status have the potential to be affected. Residents with contractures will be identified through observation and medical record review. Care plans will be reviewed for those identified to ensure range of motion was addressed on the care plan for contracture management as appropriate. Bowel and bladder assessments will be completed on residents who were continent upon admission, but became incontinent post admission. Residents with potential for improved continence</p>		

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F 279	<p>Continued From page 11</p> <p>monitoring pain, positioning pillows for comfort. There were no measurable goals related to contracture management and interventions were not listed for use in maintaining the resident's current functional level.</p> <p>During an interview with Resident #5 on 9/13/16 at 9:13 AM, he stated he had used splints in the past, but at this point, it was his choice not to use splints. He stated at times he allowed ROM if the staff offered and at times, he just did not wanted to be bothered.</p> <p>On 9/14/16 at 8:49 AM, Unit Manager (UM) #1 was interviewed. She stated care planning started on admission and was updated as needed by either the assigned nurse or the UM. The UM added she would have expected to see a care plan for Resident #5's contracture management that included measurable goals and interventions used to maintain his ROM at the current level. The UM reviewed the resident's care plan and confirmed there was not a care plan for contracture management.</p> <p>MDS Nurse #1 was interviewed on 9/14/16 at 9:57 AM. The nurse stated the MDS nurses were responsible for developing care plans. She added she would expect to see a care plan for contracture management that included goals and interventions to be used to maintain a resident's current level of functioning. The MDS nurse reviewed the care plan for Resident #5 and stated she saw no care plan for contracture management. There was no reason given for the absence of a care plan.</p> <p>2. Resident #61 was admitted on 5/24/16 and re-admitted to the facility on 8/22/16 with</p>	F 279	<p>management will be identified and placed on bladder/bowel retraining programs and care plans updated to reflect specific goals and interventions. Licensed staff will be educated by the Nurse Practice Educator on contracture management, assessment of bowel/bladder status, and implementation of appropriate individualized toileting programs to improve continence status for appropriate residents. Education sessions are scheduled for 10/3/16-10/10/16.</p> <p>3. Care plans for residents with contractures will be reviewed quarterly with interventions updated as indicated. Newly admitted residents with contractures will be reviewed upon admission and a care plan initiated for contracture management. The DNS or designee will maintain a log of residents identified with contractures with documentation of care plan initiation/updates and review dates. Residents with a decline in continence status will be identified through medical record review and MDS review, assessed for bowel/bladder status, and an appropriate individualized toileting plan implemented to improve continence status. Those identified with potential for improvement in continence status will be care planned for improvement in continence status with appropriate individualized interventions implemented. The DNS or designee will maintain a log of residents identified with a decline in continence status with documentation of care plan update and review dates.</p>		

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F 279	<p>Continued From page 12</p> <p>diagnoses that included a fracture.</p> <p>The 5/24/16 Nursing Admission Assessment documented Resident #61 as continent of bowel and bladder.</p> <p>The 5/31/16 Admission Minimum Data Set (MDS) indicated Resident #61 was cognitively intact and required extensive assistance with toilet use. The resident was coded as always continent of bowel and bladder.</p> <p>Review of the 7/13/16 quarterly MDS indicated Resident #61 was frequently incontinent of urine and occasionally incontinent of bowel. There was no documentation a bladder or bowel retraining program had been attempted for Resident #61.</p> <p>An 8/29/16 quarterly MDS indicated Resident #61 was cognitively intact. The MDS indicated the resident required extensive assistance with toilet use and indicated Resident #61 was now frequently incontinent of bowel and bladder with no bladder or bowel retraining program identified.</p> <p>The care plan, last reviewed on 8/23/16, indicated the resident was at risk for urinary incontinence, but did not address the resident's actual urinary continence decline or decline in bowel continence.</p> <p>At 4:10 PM on 9/12/16 Resident #61 was interviewed. Resident #61 stated on admission to the facility she was continent of bowel and bladder, but was now incontinent. The resident stated instead of assisting her to the bathroom, staff would tell her to wet and /or soil her brief and they would clean her up. The resident stated she</p>	F 279	<p>4. The logs for residents with contractures and with decline in continence status will be reviewed by the facility's Quality Assurance Committee monthly x 3 months for further recommendation and to ensure continued compliance.</p>		

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F 279	<p>Continued From page 13</p> <p>knew when she had to void and preferred going to the bathroom instead of incontinence. Resident #61 denied the facility had attempted a toileting plan or retraining program.</p> <p>Unit Manager (UM) #1 was interviewed on 9/14/16 at 8:57 AM. The UM reviewed Resident #61's MDS for July and August and acknowledged she was no longer continent of bowel or bladder. She added she had been unaware of the decline in the resident's continence level and stated to the best of her knowledge there had been no program/investigation to determine why the resident had increased bowel and bladder incontinence. The UM stated she attended Resident #61's care plan meetings and there had been no discussion of placing Resident #61 on a toileting program or a scheduled toileting plan. The UM acknowledged there had not been a care plan developed to address the resident's loss of bowel and bladder control or interventions placed to help her achieve continence.</p> <p>On 9/14/16 at 10:12 AM, MDS nurse #1 was interviewed. She stated the MDS nurses were responsible for coding the bowel and bladder continence section of the MDS using information recorded on the activities of daily living sheets by the NAs. She added the information on the MDS was accurate and acknowledged Resident #61's continence level had declined and there had been no toileting program developed. The MDS nurse reviewed the resident's care plan and added there was no care plan addressing Resident #61's incontinence of bowel and bladder with interventions to return to her previous level of bowel and bladder continence.</p>	F 279			

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F 312 F 312 SS=D	Continued From page 14 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide nail care for 1 of 3 residents (Resident #17) reviewed for nail care.  Findings included:  Resident #17 was admitted to the facility on 12/1/11 with diagnoses that included hemiparesis due to a stroke.  The 7/1/16 Quarterly Minimum Data Set (MDS) indicated Resident #17 was sometimes understood and rarely was able to understand others. He was assessed as having severely impaired cognitive skills for daily decision making. The MDS identified Resident #17 as requiring extensive assistance for completion of personal hygiene tasks.  The care plan for Resident #17, last reviewed on 7/11/16, indicated the resident required assistance with activities of daily living secondary to a stroke and cognitive loss. Interventions included bath/shower per the bath schedule to include nail care and to assist with grooming needs.	F 312 F 312	1. Nail care was provided for resident #17 on 9/14/16 to include cleaning and trimming of nails.  2. Residents residing in the facility have the potential to be affected. Resident's needing nail care will be identified through staff observation and nail care provided as indicated. Nursing staff will be educated by the Nurse Practice Educator on ADL care, including daily nail care with return demonstration completed. Education sessions are scheduled for 10/3/16-10/10/16.  3. Residents needing nail care will be identified during resident round completed by department head staff 3 x week x 2 weeks, 2 x week x 2 weeks, then weekly. The DNS or designee will compile a list of residents needing nail care from the completed rounds and validate that nail care is completed by follow-up observation of identified residents. The DNS will maintain the nail care lists once nail care has been validated.	10/12/16	

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F 312	<p>Continued From page 15</p> <p>Observations of Resident #17 were made on 9/11/16 at approximately 10:15 AM during the initial tour of the facility. The resident was sitting in a chair in the hall. His fingernails extended 1/4 inch to 1/2 inch beyond the tip of his finger with black matter seen underneath the fingernails.</p> <p>On 9/12/16 at 4:00 PM, Resident #17 was observed. His nails remained long and the black matter remained underneath his fingernails.</p> <p>Resident #17 was again observed on 9/13/16 at 9:20 AM. He was lying in bed. His fingernails extended 1/4 inch to 1/2 inch beyond the tip of his nails with black matter underneath. At 11:20 AM, Resident #17's incontinent care was observed. The nursing assistants (NAs) did not address the resident's fingernails.</p> <p>NA #5 was interviewed on 9/13/16 at 11:15 AM. She stated she had been assigned to care for Resident #17 during the 7:00 AM to 3:00 PM shift. The NA stated residents received nail care or shower days and as needed. She reported Resident #17 received his showers on Monday, Wednesday and Friday. The NA acknowledged she had been assigned to care for Resident #17 on Sunday, Monday, Tuesday and Wednesday of this week. She stated she had tried to clean his nails once, which was earlier that day, but he refused. The NA acknowledged she had not tried cleaning the resident's nails on any other day she had cared for him and had not tried to clip the resident's nails on any day she had been assigned to care for him. She gave no reason for lack of fingernail care.</p> <p>On 9/13/16 at 11:24 AM, Nurse #3 was</p>	F 312	<p>4. The facility's Quality Assurance Committee will review the nail care lists monthly x 3 months for further recommendation and validation of continued compliance.</p>		



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F 312	Continued From page 16 interviewed. She stated NAs were responsible for cleaning and clipping nails. The nurse added NA #5 had not reported any refusal of care to her. Nurse #3 observed Resident #17's fingernails and confirmed his fingernails had black matter underneath the nails and confirmed all fingernails extended from 1/4 to 1/2 inch beyond the end of his fingers. The nurse stated the NA had not reported Resident #17 refused care and had not reported Resident #17's nails were as long and dirty as what she had observed.  The Director of Nursing (DON) was interviewed on 9/13/16 at 11:42 AM. She stated she had a NA to clean and clip Resident #17's fingernails that morning and was surprised her instructions had not been followed.	F 312			
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 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 observations, interviews with Resident #61 and facility staff and record review, the facility failed to implement a program to improve the level of bowel and urinary continence for 1 of 1	F 315	1. Resident #61 was placed on a prompted voiding/scheduled toileting program on 9/28/16. Her care plan was updated to reflect this with a new goal of	10/12/16	

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F 315	<p>Continued From page 17</p> <p>resident (Resident #61) reviewed for a decline in bowel and bladder continence.</p> <p>Findings included:</p> <p>Resident #61 was admitted on 5/24/16 and re-admitted to the facility on 8/22/16 with diagnoses that included a fracture.</p> <p>The 5/24/16 Nursing Admission Assessment documented Resident #61 as continent of bowel and bladder.</p> <p>The 5/31/16 Admission Minimum Data Set (MDS) indicated Resident #61 was cognitively intact and required extensive assistance with toilet use. The resident was coded as always continent of bowel and bladder.</p> <p>Review of the 7/13/16 quarterly MDS indicated Resident #61 was frequently incontinent of urine and occasionally incontinent of bowel. There was no documentation a bladder or bowel retraining program had been attempted for Resident #61.</p> <p>An 8/29/16 quarterly MDS indicated Resident #61 was cognitively intact. The MDS indicated the resident required extensive assistance toilet use. The MDS indicated Resident #61 was now frequently incontinent of bowel and bladder with no bladder or bowel retraining program identified.</p> <p>The care plan, last reviewed on 8/23/16, indicated the resident was at risk for urinary incontinence, but did not address the resident's actual urinary continence decline or decline in bowel continence. There was no indication a plan had been initiated to improve the Resident #61's level</p>	F 315	<p>less than 3 incontinent episodes per day.</p> <p>2. Residents with a decline in continence status have the potential to be affected. Bowel and bladder assessments will be completed on residents who were continent upon admission, but became incontinent post admission. Residents with potential for improved continence status will be identified and placed on bladder/bowel retraining programs and care plans updated to reflect specific goals and interventions. Licensed staff will be educated by the Nurse Practice Educator on assessment of bowel/bladder status and implementation of individualized toileting programs to improve continence status for appropriate residents. Education sessions are scheduled for 10/3/16-10/10/16.</p> <p>3. Residents with a decline in continence status will be identified through medical record and MDS assessment review, assessed for bowel/bladder, and an appropriate individualized toileting plan implemented to improve continence status. The DNS or designee will maintain a log of residents identified with a decline in continence status with documentation of care plan initiation/update and review dates.</p> <p>4. The facility's Quality Assurance Committee will review the log of residents identified with a decline in continence status monthly x 3 months for further recommendation and validation of continued compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315	<p>Continued From page 18 of continence.</p> <p>At 4:10 PM on 9/12/16 Resident #61 was interviewed. Resident #61 stated on admission to the facility she was continent of bowel and bladder, but was now incontinent. The resident stated since her fall and fracture that required surgery, instead of assisting her to the bathroom, staff would tell her to wet and /or soil her brief and they would clean her up. The resident stated she knew when she had to void and preferred going to the bathroom instead of incontinence, and added she had fallen trying to get to the bathroom, rather than soiling herself. Resident #61 denied the facility had attempted a toileting plan or retraining program.</p> <p>Nursing Assistant (NA) #1 was interviewed on 9/13/16 at 1:18 PM. The NA stated the resident had been continent on admission, but since her surgery to repair her fracture, she wet and soiled her brief because she could not toilet independently. The NA stated the only reason the resident was incontinent was because she required more assistance with toilet use. The NA stated Resident #61 was alert, oriented and reliable in the information given. The NA was unaware of any bowel and bladder retraining program.</p> <p>On 9/14/16 at 8:34 AM, NA #2 was interviewed. The NA stated when Resident #61 was admitted to the facility she had been continent of bowel and bladder. The NA added the resident's urinary and bowel continence had declined after her last fall. The NA described the resident as alert and oriented, able to use the call bell, but confused at times. The NA stated she was unable to determine if the resident was aware if she had to</p>	F 315			

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F 315	<p>Continued From page 19</p> <p>void or not and for the last several weeks, Resident #61 had used the call bell after she voided to get staff to provide incontinent care. The NA added she had tried to get the resident on the toilet, but because of the back brace she was unable to do that and stated Resident #61 refused to use a bed pan because she, the resident, found the bedpan too uncomfortable. NA #2 stated she had mentioned her dilemma in toileting Resident #61 to a nurse, but was unable to remember which nurse. NA #2 stated she had not received any help with her dilemma in toileting Resident #61.</p> <p>Nurse #1 was interviewed on 9/13/16 at 1:45 PM. She stated bowel and bladder assessments were completed by nurses on the halls to determine if residents were appropriate for toileting programs. Nurse #1 stated if a resident had been assessed as appropriate, she would have to ask the Unit Manager (UM) or another nurse what to do to begin the toileting program. The nurse added to the best of her knowledge, Resident #61 had not participated in a bowel or bladder retraining program.</p> <p>UM #1 was interviewed on 9/14/16 at 8:57 AM. She stated the residents' assigned nurses were responsible for admission and quarterly bowel and bladder assessments. The UM added if a resident was continent on admission and then became incontinent of bowel and bladder, an investigation would be held to determine why the resident's continence had declined. The UM reviewed the medical record for Resident #61 and stated she had been found continent during the 5/24/16 assessment. The UM then reviewed Resident #61's MDS for July and August and acknowledged she was no longer continent of</p>	F 315			

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F 315	Continued From page 20 bowel or bladder. She added she had been unaware of the decline in Resident #61's continence level and stated to the best of her knowledge there had been no program/investigation to determine why the resident had increased bowel and bladder incontinence. The UM added she had realized Resident #61 had more incontinent episodes since her fracture and surgery that had occurred in August. The UM stated she attended care meetings for Resident #61 and there had been no discussion of placing Resident #61 on a toileting program or a scheduled toileting plan.  On 9/14/16 at 10:12 AM, MDS Nurse #1 was interviewed. She stated the MDS nurses were responsible for coding the bowel and bladder continence section of the MDS using information recorded on the activities of daily living sheets by the NAs. She added the information on the MDS was accurate and acknowledged Resident #61's continence level had declined and there had been no toileting program developed. The MDS nurse reviewed the resident's care plan and added there was no care plan addressing Resident #61's incontinence of bowel and bladder with interventions to return the resident to her prior level of continence.	F 315			
F 371 SS=E	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		10/12/16	

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F 371	Continued From page 21  This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and date opened corn and cookies in the walk in freezer and opened rice in the dry storage area, failed to cover prepared pureed green beans and potatoes on top of the steamer and chopped ham in the food preparation area, failed to date premeasured cereal, failed to properly date thawing chicken, and failed to cover pork shoulder roast thawing in the walk in refrigerator. The findings included: On 9/11/16 at 10:15 AM, an observation was made of the food prep area beside the hand washing sink. A pan ¾ full of chopped ham was uncovered on the right end of the table and a 1 inch thick piece of ham was observed on a cutting board on the left end of the table. There were no employees in the food prep area. A pan of white potatoes and a pan of pureed green vegetables were observed sitting uncovered on top of the steamer. In the dry food storage room, 13 premeasured bowls of cereal were observed without dates on the plastic covers. A box of rice marked 8/30 was exposed to air on the bottom rack of the dry goods storage. Observation of the walk in refrigerator revealed a box on the bottom shelf labeled chicken sitting on a sheet pan with a piece of tape marked " thaw 9/6 ". There was a reddish liquid covering ½ of the pan around the box. A pan with three individually bagged pork shoulder roast was observed with red liquid covering the bottom of	F 371	1. The items of concern that were improperly labeled, dated and stored were disposed by 9/14/2016: opened corn, cookies in the walk-in freezer, opened rice in dry storage, uncovered pureed green beans and potatoes, chopped ham left uncovered in food preparation area, premeasured cereal uncovered, thawing chicken undated, thawing pork roast uncovered in walk-in refrigerator.  2. Current residents and newly admitted residents have the potential to be affected. Re-education of Dietary Staff will be completed by 10/12/2016 on proper dating, labeling, food thawing and food handling protocol. The re-education will be conducted by Interim Dietary Manager or Registered Dietitian.  3. Monitoring of kitchen procedures will be conducted by Administrator or designee using an audit tool 3x per week for 3 weeks, 2x per week for 2 weeks and 1x per week ongoing.  4. The audits will be reviewed by QAPI committee x 3 months for continued compliance.		

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F 371	<p>Continued From page 22</p> <p>the pan, the bag on top was open to air. A label had a hand written date of 9/7, no use by date was recorded.</p> <p>An open bag of grapes was observed on the top shelf with no opened or use by date label.</p> <p>Observation of the walk in freezer revealed a box dated 8/29/16 with a bag of exposed corn. A box dated 7/5/16 contained an open bag of chocolate chip cookies.</p> <p>An interview was conducted with Cook #1 on 9/11/16 at 10:35 AM. She stated foods like the corn and cookies should be tied up to close. She stated she was not aware of when the chicken and pork shoulder roast were moved from the freezer to the refrigerator because she had been off work a few days.</p> <p>An observation was made on 9/12/16 at 8:20 AM with the Interim Dietary Manager (IDM). She observed the open bag of rice in the dry storage area and stated it should be closed and labeled with a opened date. She stated the pre-measured cereal should have been dated when it was put in the bowls.</p> <p>The IDM stated the chicken in the refrigerator was delivered 9/6 but she was unsure of when it was moved from the freezer to the refrigerator. She stated grapes should not be left opened and should be labeled. A pan of biscuits partially covered with parchment paper was observed on a shelf in the refrigerator. She stated it should have been wrapped in plastic. A pan was observed with three bagged pork shoulder roast standing in a reddish liquid with the top bag open. The IDM stated the meat should have been put in another container and covered with plastic.</p> <p>An observation was made on 9/13/16 at 4:25 PM, all foods in the freezer, refrigerator and dry storage were properly labeled and covered.</p> <p>On 9/14/16 at 11:01 AM an interview was</p>	F 371			

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F 371	Continued From page 23 conducted with Cook #2. She stated all kitchen staff are responsible for checking the freezer, refrigerator and dry storage areas. She stated it should be done at least once a week but there was no specific schedule. She stated the staff was responsible for making sure all opened foods were labeled and dated, throwing out outdated foods and making sure all drinks were covered and cleaning up spills.	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 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	F 431		10/12/16	



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F 431	<p>Continued From page 24</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label 4 bottles of ophthalmic solution with an opened date on 1 of 4 medication carts observed. Findings included: An observation of the Intermediate Care Facility (ICF) medication cart was made on 9/13/2016 at 2:11 PM. Four bottles of Latanoprost 0.005% ophthalmic solution were observed. Each of the 4 bottles were missing the cap safety seal indicating they had been opened. The pharmacy label indicated "discard 6 weeks after opening". The bottles did not have an opened date or a discard date noted.</p> <p>An interview with Nurse #3 was conducted on 9/13/2016 at 2:11 PM. The nurse stated the eye drops had been opened and she was unable to tell when the eye drops should be discarded. The nurse stated the bottles should have been marked when they were opened.</p> <p>An interview with Unit Manager #2 (UM#2) was conducted on 9/13/2016 at 2:41 PM. The UM#2 stated eye drops should be marked with an opened date when they are opened.</p> <p>An interview with the Director of Nursing (DON) was conducted on 9/14/2016 at 12:15 PM. The</p>	F 431	<ol style="list-style-type: none"> <li>1. The four bottles of Latanoprost 0.005% identified without an opened date were dated as opened on the date dispensed from the pharmacy as this was the earliest date the medication could have been opened. All four bottles were within their use by date.</li> <li>2. Residents receiving medication in the facility have the potential to be affected. Medication carts will be audited by the Unit Managers on 10/7/16 to identify opened medications without an opened date documented on the bottle/container. Bottles/containers will be labeled with the pharmacy fill date if no date opened is available. Expired medications will be removed and discarded. Licensed staff will be educated by the Nurse Practice Educator on proper labeling of multi dose medications and use of Recommended Minimum Medication Storage Parameters (Omnicare Guide) for determining expiration dates of medications. A copy of the Recommended Minimum Medication Storage Parameters will be placed in the front of each Medication Administration Record book and each Medication Storage room for easy reference.</li> </ol>		

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F 431	Continued From page 25 DON stated it was her expectation that medications be labeled with a date when opened.	F 431	Education sessions are scheduled for 10/3/16-10/10/16.  3. Unit Managers will audit medication carts weekly x 2 months, then monthly x 1 month to validate multi dose medications are labeled when opened. The unit managers will note on the audit any medications found not labeled and either remove the medication if expired or label the medication with the pharmacy fill date if medication is still within recommended use by date. The DNS or designee will maintain these audits and address non-compliance with individual nurses as needed.  4. Results of the medication cart audits will be reviewed by the facility's Quality Assurance Committee monthly x 3 months for further recommendation and validation of continued compliance.		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to maintain 1 of 35 call bells in working order (Resident #72).  Findings included:	F 463	1. The call bell system was repaired on 9/14/2016 by Mehlich Electronics Company and the Maintenance Director.  2. Residents of the facility have the	10/12/16	

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F 463	<p>Continued From page 26</p> <p>Resident #72 had been admitted on 4/22/2015. Diagnoses included hypertension, peripheral vascular disease, diabetes and dementia.</p> <p>Resident #72's most recent Quarterly Minimum Data Set (MDS) was dated 7/15/2016. The MDS indicated Resident #72 had moderately impaired cognition, required extensive assistance with toileting and was independent with transfers to and from her wheelchair.</p> <p>On 9/12/2016 at 9:43 AM an observation was made of the bathroom call bell for Resident #72. The call bell switch was loose and the call light remained unlit when activated.</p> <p>On 9/13/2016 at 4:03 PM an observation was made of the bathroom call bell for Resident #72. The call bell switch and plate were loose on the wall. Neither the call light nor the alarm bell were observed to be on when activated.</p> <p>An interview with Unit Manager #2 (UM#2) was conducted on 9/13/2016 at 4:04 PM. The UM#2 stated she had been unaware the call bell for Resident #72's bathroom was not working properly.</p> <p>An interview was conducted on 9/13/2016 at 4:12 PM with the Maintenance Director (MD). The MD stated he had not been aware the call bell in Resident #72's bathroom was not working.</p> <p>An interview with Nurse #2 was conducted on 9/14/2016 at 8:45 AM. The nurse stated she had not been aware of Resident #72's call bell not working. The nurse stated a maintenance work order needed to be filled out and placed in the</p>	F 463	<p>potential to be affected. The staff will be in-serviced by Facility Educator on procedures for reporting malfunctioning equipment by 10/12/2016.</p> <p>3. The call bell system will be monitored 3x per week for 3 weeks, 2x per week for 2weeks, 1x per week ongoing with an audit tool used on Resident Rounds by department head staff.</p> <p>4. The audits will be reviewed by QAPI committee x 3 months to ensure continued compliance.</p>		

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F 463	Continued From page 27 maintenance box when something was not working.  An interview with Nurse Aide (NA) #3 was conducted on 9/14/2016 at 10:20 AM. The NA stated Resident #72 had been independent with transferring herself on and off of the toilet and asked for assistance as needed. The NA stated she had not been aware the call bell in her bathroom was not working. The NA stated when she became aware of broken equipment, she filled out a maintenance repair form and alerted the maintenance staff of the problem.  An interview with Resident #72 was conducted on 9/14/2016 at 10:30 AM. Resident #72 stated she was able to independently transfer herself on and off of her bed, wheelchair and toilet. Resident #72 stated on Monday 9/12/2016 she was going to transfer herself off of the toilet and back onto her wheelchair but the wheelchair rolled out of her reach. She stated she had flipped the emergency call bell in the bathroom but no one came. The Resident stated she did not fall but had to yell for help and a nurse aide came and helped her into her wheelchair.  The NA who assisted Resident #72 on Monday when Resident #72 had called out for assistance was unavailable for an interview on 9/14/2015.  An interview with the Director of Nursing (DON) was conducted on 9/14/2016 at 12:15 PM. The DON stated it was her expectation that all equipment problems should be reported for repair.	F 463			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		10/12/16	

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F 520	<p>Continued From page 28 QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews the facility's Quality Assurance and Assessment (QAA) Committee failed to maintain implemented procedures and monitoring practices to address the interventions put into place after the 10/9/15 recertification survey, the complaint investigation dated 4/21/16 and the recertification survey of 9/14/16 in order to achieve and sustain compliance. This was for 3 recited deficiencies, which were originally cited</p>	F 520	<p>1. The goal of the Quality Assurance Process Improvement Committee is to make a good faith attempt to identify areas of deficiency, develop and implement plans of action. The QAPI committee will revise protocols by 10/12/2016 in order to meet the standards set forth by SS483.75(o) involving F253, F371, F463 and F520.</p>		

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F 520	<p>Continued From page 29</p> <p>during a 10/9/15 recertification investigation and on the current recertification survey of 9/14/16. The pattern of repeat deficiencies were in the areas of housekeeping and maintenance services, kitchen sanitation and medication labeling and storage. The continued failure of the facility during two federal surveys of record and a complaint investigation show a pattern of the facilities inability to sustain an effective Quality Assurance and Assessment Program. The findings included: This tag is cross referenced to</p> <p>1. F253 on the current survey of 9/14/16 - Based on observations, resident and staff interviews, the facility failed to provide maintenance services necessary to maintain a safe and homelike environment, by not repairing a sink, not repairing call bell cords, not keeping rooms painted and walls in good repair, and not storing personal items labeled, covered and stored properly for 8 of 30 resident rooms observed. During a previous complaint survey on 2/23/15 the facility was cited for not thoroughly investigating an injury of unknown origin for 1 of 1 sampled resident (Resident #30). During the complaint investigation survey of 4/21/16, the facility was cited for failing to maintain housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior for 8 of 17 resident room window screens observed with holes. During the recertification survey of 10/9/15, the facility was cited for failing to maintain housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior on 3 out of 4 halls observed</p> <p>2. F371 on the current survey of 9/14/16- Based on observations and staff interviews, the facility failed to label and date opened corn and cookies</p>	F 520	<p>2. Residents in the facility have the potential to be affected. Education will be provided by the Administrator to the Maintenance Director, House Keeping Director, Dietary Director and/or designees about the importance of continued compliance with weekly and monthly facility rounds. Documentation of identified concerns, development of action plans and monitoring of interventions will be implemented for ongoing quality assurance.</p> <p>3. House Keeping/ Maintenance Services, Dietary Services operating procedures will be added to the standing agenda in monthly QAPI meetings.</p> <p>4. Results of the monitoring rounds will be reviewed by the facility's Quality Assurance Committee monthly along with newly identified concerns. The Committee will ascribe a plan of action and review monthly or PRN.</p>		

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F 520	<p>Continued From page 30</p> <p>in the walk in freezer and opened rice in the dry storage area, failed to cover prepared pureed green beans and potatoes on top of the steamer and chopped ham in the food preparation area, failed to date premeasured cereal, failed to properly date thawing chicken, and failed to cover pork shoulder roast thawing in the walk in refrigerator.</p> <p>During the recertification survey of 10/9/15, the facility was cited failing to maintain sanitary conditions in one of two ice machines used for residents and one of two nourishment room refrigerators used for residents.</p> <p>3. F431 on the current survey of 9/14/16- Based on observations and staff interviews, the facility failed to label 4 bottles of ophthalmic solution with an opened date on 1 of 4 medication carts observed.</p> <p>During the recertification survey of 10/9/15 the facility failed to remove expired medications in one of four medication carts.</p> <p>On 9/14/16 at 1:14 PM an interview was conducted with the facility ' s Administrator who identified he was the coordinator of the facility ' s QAA Committee. He stated the facility ' s QAA met monthly and consisted of the Medical Director, the Director of Nursing and all other department managers. The Administrator stated after the 10/9/15 survey, the QAA committee had discussed housekeeping and maintenance issues in November and December 2015. He added the issue cited in the October 2015 had been resolved. He stated he had recently been made aware of the broken sink. The Administrator stated administrative rounds were made daily, but he had been unaware of the other issues that were being cited this year. He added after the 10/9/15 survey, kitchen sanitation issues were discussed in November and December 2015 and</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER  <b>POPLAR HEIGHTS CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>804 SOUTH POPLAR STREET ELIZABETH TOWN, NC 28337</b>		
(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 520	Continued From page 31 January 2016. He stated there had been no further problems with dirty ice machines. The Administrator added weekly rounds were being made in the kitchen until the last dietary manager started. She had worked from May 2016 through September 9, 2016 and had told the facility dietary rounds were not needed and she would take care of monitoring the kitchen. The Administrator stated he had been unaware of any dating or labeling of food issues in the kitchen. The Administrator added after the 10/9/15 survey, the QAA committee discussed expired medications in November and December 2015 and deemed the problem had been resolved. He stated all nurses should have been checking medications for dating when they were opened.	F 520		