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	345228	A. BUILDING _____ B. WING _____	11/02/2016

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F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 interviews with staff and residents the facility failed to provide a dignified dining experience by allowing residents seated in the dining room to eat food items which were not removed from the service trays for 2 (Residents #60 & #23) of 7 residents observed during the initial dining observations and failed to remove the food items form the service trays during 3 additional meal observations on 10/31/16 at the dinner meal, on 11/1/16 at the breakfast meal and the dinner meal. The findings included: During the initial dining observation on 10/30/16 at the dinner meal 7 residents were seated in the dining room. All of the residents were served by staff members. The food items were not removed from the service trays. An additional observation of the dinner meal on 10/31/16 revealed the residents seated in the main dining room were served by staff members and the food items were not removed from the service trays. Resident # 23 was present. On 11/1/16 during an observation of the breakfast meal service in the main dining room all the residents were served by staff members and the food items were not removed from the service trays. During an observation on 11/1/16 at 5:19 PM	F 241	1. Residents having meals in the dining room have been provided a homelike dining experience. Residents are no longer served their meals on trays. 2. Residents throughout the facility will be provided a homelike dining experience in dining areas by removing trays while serving meals. 3. Nursing staff/staff serving meals will be in-serviced on how to provide a homelike dining experience. In-service will include removing plates from trays, placing silverware next to plate and having beverages within reach. In-service will be completed by 11-30-16. 4. Audits will be conducted weekly by DON/Designee of Dining experience weekly x 4 weeks then bi-monthly x 4 weeks. Progressive discipline will be initiated for failure to comply. 5. Results will be reported to the QA committee by the DON for review. If negative trends are identified the action plan will be revised by the QA committee. Completion date: 11-30-16.	11/30/16

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

Electronically Signed | 11/27/2016

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F 241	Continued From page 1 there were 8 residents seated in the main dining room. Six of the residents had received their food. Those 6 residents ' food items were still on the service trays. Resident #23 was present. On 11/2/16 at 1:45 PM Resident #60 was observed sitting the dining room. He stated he ate his meals in the dining room and his food items were not removed from the service tray. He stated he would rather have his foods items removed from the service tray. On 11/2/16 at 3:17 PM Resident #23 stated the food items were only removed from the service tray when there were 4 people seated at the same table. He added that he preferred the food items not be left on the service tray because it would look better and be more appetizing. On 11/2/16 at 3:48 PM the Administrator stated during the week, at the lunch meal service, the administrative staff passed trays to the residents who ate in the dining room and the food items were removed from the service trays. He stated he was not aware that the food items were not removed from service trays during the other meal times. He added the food items should be served the same way at all meals and should be removed from the service tray.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and facility record review the facility failed to maintain a clean	F 253	The bathrooms in rooms numbered 215, 224, 220, 222, 218, and 326 have been	11/30/16

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F 253	Continued From page 2 environment in resident bathrooms for 5 of 35 areas (Room numbers 224, 220, 222, 218, and 326). An observation on 10/31/16 at 8:46 am of room #224 revealed there were unlabeled wash basins on the floor under the bathroom sink and one unlabeled, uncovered dirty bed pan placed on top of a bedside commode in the shower area. This was also observed on 11/2/16 during a tour of the 200 hall at 11:00 am. An observation on 10/31/16 at 9:30 am of room #220 revealed there were wash basins on the floor under the bathroom sink and dirt rings around the sink basin and commode bowl. This was observed again on 11/2/16 during a tour of the 200 hall at 11:00 am. An observation on 10/31 16 at 2:28 pm and 11/2/16 at 11:00 am room #222 revealed the vanity door beneath the sink in the bathroom was missing and two unlabeled wash basins were under the sink on the floor. The floor around the commode was urine stained yellow with a thick layer of black dirt on the floor around the base of the commode. There was a dead roach on the bathroom floor on 10/31/16 and not on 11/2/16. An observation on 10/30/16 at 5:11pm of room #218 revealed there were unlabeled wash basins on the bathroom floor. The closet door in the room was open and a thick layer of dust was observed on the closet floor on both 10/30/16 and 11/2/16 at 11:10 am. On 11/2/16 at 11:10 am a dirty raised toilet seat was observed in the bathroom. An observation on 10/31/16 at 9:38 am and on 11/2/16 at 11:20 am of room #326 revealed there was a hole in the bathroom door near the bottom. An observation on 11/2/16 at 11:25 am of room #219 revealed there was an unlabeled bed pan on the floor in the bathroom and four unlabeled	F 253	cleaned. The floor tiles have been stripped and fresh wax applied and any necessary repairs will be completed. Bathrooms in the building will be inspected and necessary stripping, re-waxing, and repairs will be completed as indicated. Housekeeping staff will be in-serviced by the Housekeeping supervisor on proper way to clean resident bathrooms. Nursing will be in-serviced to label and bag basins and pans. In-service will be by the Nursing Administration. Bathrooms will be inspected by housekeeping manager 5 x week for one month to ensure ongoing compliance and weekly for two months. Any negative trends will be brought to the Quality Assurance Committee for review and further action. Completion Date: 11-30-16.	

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wash basins on the bathroom floor under the sink.
In an interview on 10/31/16 at 9:46 am resident (#26) revealed that housekeeping does not do a good job. He stated they do not sweep the floors well. He reported there was a dead roach on the floor in his room for three days once before it was swept up.
In an interview on 10/31/16 at 10:02 am resident (#7) revealed that the bathroom floor, sink and toilet in her room are not cleaned very often.
In an interview on 11/2/16 at 1:10 pm with housekeeper #1 it was revealed that the usual housekeeping routine when cleaning a room was to empty the trash, pick up the floor and sweep and mop. She also said she cleans the toilet and tub with Clorox. The mirror is cleansed with a window cleaner. A special cleaner is used to pick up stains off sinks and toilets. If a housekeeper has a problem it is reported to the onsite supervisor. She said that if there is a spill or something else that needs cleaned up right away the nurses let the housekeepers know about it.
In an interview on 11/2/16 at 1:30pm with the Housekeeping Manager she revealed that she expects the resident areas to be clean. She stated that the housekeeping staff is contracted and that she oversees the housekeepers at this facility. There was a system in place that included a deep cleaning schedule and a project work schedule. She said the housekeeping staff did a morning walk through to check the bathrooms, empty trash, dust and mop the rooms on each assignment. Certain rooms where called " hot rooms " and checked frequently for urine on the floors. She stated that staff was trained to use the 5 and 7 Step cleaning methods and were to check the walls and pull furniture to dust.
In an interview on 11/2/16 at 2:00 pm with the

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F 253	Continued From page 4 Housekeeping Staff Supervisor he revealed that he expected the resident rooms to be clean including the bathrooms. He stated that it was not the responsibility of housekeeping to pick up wash basins or bed pans off the floors. He used a pocket knife to scrape the floor around the base of the commode in room #222 and removed a thick layer of dirt. He stated that maintenance had been working on this bathroom but that the worker had left 2 months ago to return to Florida and repairs had stopped. He summoned a housekeeper to come and clean the bathroom. In an interview on 11/2/16 at 2:30 pm with the Director of Nursing she said that she expected the resident rooms to be clean.	F 253		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: The facility failed to complete MDS assessments by the regulatory deadline for 3 of 26 residents (Residents #8, #27, and #169) whose MDS assessments were reviewed. Findings included: 1. Resident #8's most recent quarterly Minimum Data Set (MDS) assessment, dated 10/07/2016, was incomplete and the electronic medical record indicated that it was still in progress. The sections that had been completed indicated that the	F 276	1. The assessments for residents #8, #27, and #169 have been completed. 2. An audit of residents' MDS assessment schedule will be done by printing the in-progress list on 11-29-16 and any MDS assessments found to be out of compliance will be completed. 3. MDS coordinators will be in-serviced on the appropriate time frames for completion of the MDS by the MDS consultant. A new MDS nurse has been hired and is in training.	11/30/16

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F 276	Continued From page 5 resident was cognitively intact, but required extensive assistance with activities of daily living (ADLs). Resident# 8's diagnosis history included hemiplegia, cerebral infarct, heart failure, cognitive communication deficit, and schizoaffective disorder. An interview with MDS Nurse #1 was conducted on 11/02/2016 at 3:04 PM. The nurse stated she had gotten behind on several assessments including Resident #8's. An interview with the Director of Nursing (DON) was conducted on 11/02/2016 at 4:09 PM. The DON stated MDS assessments should be completed on time. 2. Resident #169 was readmitted to the facility on 9/29/16 with a Medicare 5 day MDS due date of 10/12/16. The Medicare 5 day MDS assessment, dated 10/06/16, was incomplete and the electronic medical record indicated that it was still in progress. Resident#169's diagnosis history included coagulation deficit, cognitive communication deficits, disorder of the pituitary gland, chronic peripheral venous insufficiency, type 2 diabetes mellitus, congestive heart failure and muscle weakness. An interview with MDS Nurse #1 was conducted on 11/02/2016 at 3:04 PM. The nurse stated she had gotten behind on several assessments including Resident #8's. An interview with the Director of Nursing (DON)	F 276	4. The administrator will audit the PCC in MDS in-progress list weekly and the MDS consultant report monthly x 3 months. 5. Audit results will be reported to the QA committee for review. If negative trends are identified the action plan will be revised by the QA committee. Progressive discipline for non-compliance. Completion Date: 11-30-16.	

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F 276	Continued From page 6 was conducted on 11/02/2016 at 4:09 PM. The DON stated MDS assessments should be completed on time. 3. Resident #27's most recent quarterly Minimum Data Set (MDS) assessment dated 7/09/2016 and indicated Resident #27 had severe cognitive impairment and had required extensive assistance with Activities of Daily Living (ADLs). Resident #27's diagnoses included hypertension and anxiety. An interview with MDS Nurse #1 was conducted on 11/02/2016 at 3:04 PM. The nurse stated she had gotten behind on several assessments including Resident #27. An interview with the Director of Nursing (DON) was conducted on 11/02/2016 at 4:09 PM. The DON stated MDS assessments should be completed on time.	F 276		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		11/30/16

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F 278	Continued From page 7 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 6 of 15 residents (Residents #4, #8, #51, #64, #162 and #178) identified as a Level II PASRR resident. Findings included: 1. Resident #4 was admitted to the facility on 07/01/11 with a diagnosis history that included unspecified intellectual disabilities. Review of Resident #4's PASRR level II	F 278	1. MDS corrections have been made for residents #4, #8, #51, #64, #162, and #178 to reflect an accurate Assessment of the PASSAR information in section A. 2. All MDS assessments of residents with level II PASSARs have been audited to ensure the MDS is coded accurately. 3. The MDS team has been in-serviced on which member of the Team completes each section of the MDS. It has been determined that the MDS coordinator will complete the PASSAR information in Section A by reviewing the resident's chart. 4. MDS Audits of Section A will be done	

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F 278	Continued From page 8 documentation revealed that the resident had a permanent number. Review of the Annual MDS, dated on 04/04/16, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. During an interview with the social worker, on 11/01/16 at 2:45 PM, she stated that the MDS coordinators were responsible for entering PASRR information in section A of the MDS for PASRR residents. During an interview with Nurses # 9 and 10, the MDS coordinators, on 11/02/16 at 2:30 PM, they stated that the social worker was supposed to enter PASRR information, but they were responsible for looking over the entire MDS for completion and accuracy. During an interview with Nurse #9, on 11/02/16 at 2:30 PM, she stated that she has had to do some coding of the PASRRs for newer resident recently, but she was not sure why because she was not aware of who was or was not a level II PASRR resident and it was always her understanding that the social worker was responsible for completing that part of the MDS. During an interview with the social worker, on 11/02/16 at 3:55 PM, she stated that there had been some confusion about who was responsible for completing the PASRR information on the MDS and that she used to do them and at some	F 278	weekly by the Administrator/designee x 4 weeks then monthly x 4 months. 5. Results of the audits will be reported to the QA committee for review. If negative trends are identified the action plan will be revised by the QA committee. Completion Date: 11-30-16.	

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point she stopped, but was not sure if she was told that she no longer had to do them or not. She reported that she had cleared it up with the MDS coordinators and would definitely be doing them moving forward.

In an interview with the Director of Nursing (DON) at 4:15 PM on 11/02/16, she stated that the expectation was for all sections of the MDS to be coded correctly and completed before the submission deadline.

2. Resident #8 was admitted to the facility on 04/23/15 with a diagnosis of schizoaffective disorder.

Review of Resident #8's PASSAR level II documentation revealed that the number was permanent.

Review of Resident #8's most recent comprehensive assessment requiring PASRR coding, the annual MDS, dated 4/18/16, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.

During an interview with the social worker, on 11/01/16 at 2:45 PM, she stated that the MDS coordinators were responsible for entering PASRR information in section A of the MDS for PASRR residents.

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During an interview with Nurses # 9 and 10, the MDS coordinators, on 11/02/16 at 2:30 PM, they stated that the social worker was supposed to enter PASRR information, but they were responsible for looking over the entire MDS for completion and accuracy.
During an interview with Nurse #9, on 11/02/16 at 2:30 PM, she stated that she has had to do some coding of the PASRRs for newer resident recently, but she was not sure why because she was not aware of who was or was not a level II PASRR resident and it was always her understanding that the social worker was responsible for completing that part of the MDS.
During an interview with the social worker, on 11/02/16 at 3:55 PM, she stated that there had been some confusion about who was responsible for completing the PASRR information on the MDS and that she used to do them and at some point she stopped, but was not sure if she was told that she no longer had to do them or not. She reported that she had cleared it up with the MDS coordinators and would definitely be doing them moving forward.

In an interview with the Director of Nursing (DON) at 4:15 PM on 11/02/16, she stated that the expectation was for all sections of the MDS to be coded correctly and completed before the submission deadline.

3. Resident #51 was admitted to the facility on 11/13/15 with diagnoses including bipolar disorder and paranoid schizophrenia.

Review of Resident #51's annual MDS, dated on 05/12/16, indicated the resident was not

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considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.
Review of the PASRR Level II number for Resident #51 revealed that it was a permanent number.

During an interview with the social worker, on 11/01/16 at 2:45 PM, she stated that the MDS coordinators were responsible for entering PASRR information in section A of the MDS for PASRR residents.

During an interview with Nurses #9 and 10, the MDS coordinators, on 11/02/16 at 2:30 PM, they stated that the social worker was supposed to enter PASRR information, but they were responsible for looking over the entire MDS for completion and accuracy.
During an interview with Nurse #9, on 11/02/16 at 2:30 PM, she stated that she has had to do some coding of the PASRRs for newer resident recently, but she was not sure why because she was not aware of who was or was not a level II PASRR resident and it was always her understanding that the social worker was responsible for completing that part of the MDS.
During an interview with the social worker, on 11/02/16 at 3:55 PM, she stated that there had been some confusion about who was responsible for completing the PASRR information on the MDS and that she used to do them and at some point she stopped, but was not sure if she was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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told that she no longer had to do them or not. She reported that she had cleared it up with the MDS coordinators and would definitely be doing them moving forward.

In an interview with the Director of Nursing (DON) at 4:15 PM on 11/02/16, she stated that the expectation was for all sections of the MDS to be coded correctly and completed before the submission deadline.

4. Resident # 64 was admitted to the facility on 02/04/10 with a diagnosis history that included major depressive disorder and schizoaffective disorder.

Review of the PASRR Level II number for Resident # 64 revealed that the resident had a permanent number.

Review of Resident # 64's most recent comprehensive MDS requiring PASRR coding, a significant change/Medicare 5 day MDS, dated 12/30/15, indicated the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for servicing to help develop an individual's plan of care.

During an interview with the social worker, on 11/01/16 at 2:45 PM, she stated that the MDS coordinators were responsible for entering PASRR information in section A of the MDS for PASRR residents.

During an interview with Nurses # 9 and 10, the

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	345228	A. BUILDING _____ B. WING _____	11/02/2016

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MDS coordinators, on 11/02/16 at 2:30 PM, they stated that the social worker was supposed to enter PASRR information, but they were responsible for looking over the entire MDS for completion and accuracy.
During an interview with Nurse #9, on 11/02/16 at 2:30 PM, she stated that she has had to do some coding of the PASRRs for newer resident recently, but she was not sure why because she was not aware of who was or was not a level II PASRR resident and it was always her understanding that the social worker was responsible for completing that part of the MDS.
During an interview with the social worker, on 11/02/16 at 3:55 PM, she stated that there had been some confusion about who was responsible for completing the PASRR information on the MDS and that she used to do them and at some point she stopped, but was not sure if she was told that she no longer had to do them or not. She reported that she had cleared it up with the MDS coordinators and would definitely be doing them moving forward.

In an interview with the Director of Nursing (DON) at 4:15 PM on 11/02/16, she stated that the expectation was for all sections of the MDS to be coded correctly and completed before the submission deadline.

5. Resident #162 was admitted to the facility 8/15/16 and had a diagnosis history that included alcohol dependence with withdrawal delirium, and psychoactive substance use with psychoactive substance induced mood disorder.

A review of the resident's PASRR Level II number revealed the resident had a permanent Level II PASRR.

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Review of Resident #162's admission/Medicare 5 day MDS, dated 08/22/16, indicated the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendation for servicing to help develop an individual's plan of care.

During an interview with the social worker, on 11/01/16 at 2:45 PM, she stated that the MDS coordinators were responsible for entering PASRR information in section A of the MDS for PASRR residents.

During an interview with Nurses # 9 and 10, the MDS coordinators, on 11/02/16 at 2:30 PM, they stated that the social worker was supposed to enter PASRR information, but they were responsible for looking over the entire MDS for completion and accuracy.
During an interview with Nurse #9, on 11/02/16 at 2:30 PM, she stated that she has had to do some coding of the PASRRs for newer resident recently, but she was not sure why because she was not aware of who was or was not a level II PASRR resident and it was always her understanding that the social worker was responsible for completing that part of the MDS.
During an interview with the social worker, on 11/02/16 at 3:55 PM, she stated that there had been some confusion about who was responsible for completing the PASRR information on the MDS and that she used to do them and at some point she stopped, but was not sure if she was told that she no longer had to do them or not. She

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reported that she had cleared it up with the MDS coordinators and would definitely be doing them moving forward.

In an interview with the Director of Nursing (DON) at 4:15 PM on 11/02/16, she stated that the expectation was for all sections of the MDS to be coded correctly and completed before the submission deadline.

6. Resident #178 was admitted to the facility on 07/20/16 with a diagnosis history that included paranoid schizophrenia and bipolar disorder.

Review of the resident's PASRR Level II documentation showed the resident had an active Level II PASRR with a 90 day limitation.

Review of Resident # 178's Admission MDS, dated 07/27/16, indicated the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendation for servicing to help develop an individual's plan of care.

During an interview with the social worker, on 11/01/16 at 2:45 PM, she stated that the MDS coordinators were responsible for entering PASRR information in section A of the MDS for PASRR residents.

During an interview with Nurses # 9 and 10, the MDS coordinators, on 11/02/16 at 2:30 PM, they stated that the social worker was supposed to enter PASRR information, but they were responsible for looking over the entire MDS for

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F 278	Continued From page 16 completion and accuracy. During an interview with Nurse #9, on 11/02/16 at 2:30 PM, she stated that she has had to do some coding of the PASRRs for newer resident recently, but she was not sure why because she was not aware of who was or was not a level II PASRR resident and it was always her understanding that the social worker was responsible for completing that part of the MDS. During an interview with the social worker, on 11/02/16 at 3:55 PM, she stated that there had been some confusion about who was responsible for completing the PASRR information on the MDS and that she used to do them and at some point she stopped, but was not sure if she was told that she no longer had to do them or not. She reported that she had cleared it up with the MDS coordinators and would definitely be doing them moving forward. In an interview with the Director of Nursing (DON) at 4:15 PM on 11/02/16, she stated that the expectation was for all sections of the MDS to be coded correctly and completed before the submission deadline.	F 278		
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	F 431		11/30/16

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F 431	Continued From page 17 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 observation, facility policy and staff interviews the facility failed to remove from stock outdated medications from 1 of 3 (Central Medication Storage) medication storage areas and failed to secure 2 of 5 medication carts (B1 and B2) and 2 of 5 treatment carts (B2 and B3) during 4 separate observations. Findings included: 1. A review of the facility Medication Storage policy (dated 9/10) on 11/1/16 stated that outdated, contaminated, discontinued or	F 431	1. The expired vitamins found in the stock room were removed and discarded. Education on locking medication/treatment carts was initiated immediately. 2. No residents were affected by the deficient practice. 3. Licensed nurses will be in-serviced on Medication and labeling. licensed nurses will also be in-serviced on locking all medication and treatment carts when unattended by 11-30-16. In-service by Nursing Administration.	

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F 431	Continued From page 18 deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. An observation was made on 11/1/16 at 9:15am of two expired medications stored in the Central Supply medication storage cabinet: 1. Centravites 50 plus expired 3/16/16 2. Zinc Sulfate expired 6/16/16 In an interview on 11/1/16 at 9:15 am with Nurse #8, stated that expired medications should be discarded immediately. She said that expired medication should not be in the medication storage cabinet and she removed the two named expired medications from the storage cabinet. Nursing staff is responsible for disposing of expired medications. In an interview on 11/1/16 at 10:03 am with the Director of Nursing (DON) she stated that expired medications should never be brought to the medication cart. She agreed that expired medications should be disposed of per the facility policy. 2. An observation was made of treatment cart B3 on 10/30/2016 at 2:40 PM. The cart had been	F 431	4. Audits of medication/treatment carts and storage room will be conduced by nursing administration weekly x 4 weeks and bi-monthly x 4 months. 5. Results of audits will be reported to the QA committee. If negative trends are identified the action plan will be revised by the QA committee. Progressive discipline will be initiated for non-compliance. Completion date: 11-30-16.	

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parked midway on the 300 hall and was observed to be unlocked. No medications or treatments were observed on the top of the cart. No nursing staff or residents were observed in the hallway.

An interview with Nurse #7 was conducted on 10/30/2016 at 2:45 PM. The nurse stated she had left the wound treatment cart unlocked and indicated she had just walked away from the cart. The nurse stated she had been instructed to always lock the cart.

An interview with the Director of Nursing (DON) was conducted on 11/02/2016 at 4:08 PM. The DON stated medication and treatments carts need to be locked when they are out of the sight line of the nurse.

3. An observation was made of medication cart B2 on 10/30/2016 at 2:45 PM. The cart was parked in the hall across from nursing station B, and was unlocked. Treatment cart B2 was parked on the other side of the hall from medication cart B2 and was also observed to be unlocked. No medications or treatments were observed on the top of the carts and no nursing staff were observed in the hallway. The nurse was observed coming out of room 312.

An interview with Nurse #4 was conducted on 10/30/2016 at 2:50 PM. The nurse stated she had left the medication and the treatment carts unlocked and should have locked both of them.

An interview with the Director of Nursing (DON) was conducted on 11/02/2016 at 4:08 PM. The DON stated medication and treatments carts need to be locked when they are out of the sight line of the nurse.

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4. An observation was made on 11/01/2016 at 8:00 AM. The nurse had been observed at medication cart B1, and then was observed walking into room 226. The cart was observed in the hall parked across from room 226. The cart was observed unlocked. No medications were observed on top of the cart and no residents were observed in the hallway.

An interview with Nurse #2 was conducted at 11/01/2016 at 8:05 AM. The nurse stated the cart should have been locked when she went into the residents ' room.

An interview with the Director of Nursing (DON) was conducted on 11/02/2016 at 4:08 PM. The DON stated medication and treatments carts need to be locked when they are out of the sight line of the nurse.

5. An observation of medication cart B2 was made on 11/02/2016 at 7:56 AM. The cart was observed parked in the hall across from nursing station B, and was unlocked. No medications were observed on the top of the cart. No residents were observed in the hallway. The nurse was observed coming out of room 312.

An interview with Nurse #6 was conducted on 11/02/2016 at 8:00 AM. The nurse stated she thought she had locked the medication cart.

An interview with the Director of Nursing (DON) was conducted on 11/02/2016 at 4:08 PM. The DON stated medication and treatments carts need to be locked when they are out of the sight line of the nurse.