STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

(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 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective	F 156		1/11/17

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

Electronically Signed | 01/06/2017

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services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans

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Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not

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limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for

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F 156	Continued From page 4 Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	F 156		

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F 156	Continued From page 5 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to keep residents informed of the location of the contact information for the State Agency and the local Regional Long Term Care Ombudsman. Findings included: During an interview with the Resident Council President, Resident # 24, on 12/13/16 at 11:35 AM, she stated that she was not aware of who the ombudsman was for the facility nor did she know that she was able to contact the state agency or the location of the contact information for the state agency or the ombudsman in the facility. Between 2:30 PM and 3:15 PM on 12/14/16 three additional resident council members who attended resident council meetings on a regular basis were interviewed and all stated that they did not know that they were able to contact the State Agency or Regional Long Term Care Ombudsman or where the State Agency or Regional Long Term Care Ombudsman contact	F 156	Resident # 24 was informed of the availability to contact the local Regional Long Term Care Ombudsman, the name of the local Regional Long Term Care Ombudsman, and the location of the contact information for the State Agency and the local Regional Long Term Care Ombudsman and on 1/5/17 by the Social Worker and Activities Director. A Resident Council meeting was held on 1/5/17 by the Social Worker and Actvities Director to inform residents to include resident # 24 of the availability to contact the local Regional Long Term Care Ombudsman, the name of the local Regional Long Term Care Ombudsman, location of the contact information for the State Agency and the local Regional Long Term Care Ombudsman. The Social Worker informed all other residents that	

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F 156	Continued From page 6 information was located in the facility, and that they had not been informed of this information during resident council meetings. In an interview with the social worker on 12/14/16 at 5:00 PM, she stated that the State Agency and Regional Long Term Care Ombudsman information was posted in the facility and residents and/or their representatives were informed of the information upon admission and sometimes during care plan meetings, if necessary, but it was not discussed on a monthly basis during resident council meetings. In an interview at 5:45 PM on 12/14/16, the facility administrator stated that he would expect all residents to be informed of their right to contact the State Agency and Regional Long Term Care Ombudsman, where the necessary contact information for the State Agency and Regional Long Term Care Ombudsman was located, and to be reminded of this information monthly during the resident council meeting.	F 156	did not attend the resident council meeting of the availability to contact the local Regional Long Term Care Ombudsman, the name of the local Regional Long Term Care Ombudsman, location of the contact information for the State Agency and the local Regional Long Term Care Ombudsman on 1/5/17. The social worker was in-serviced on informing the residents on a monthly basis during resident council meetings of their right to contact the State Agency and Regional Long Term Care Ombudsman and the names and locations of the State Agency and Regional Long Term Care Ombudsman on 1/5/17 by the Administrator. The administrator will monitor the monthly resident council minutes monthly x 3 months to ensure residents were informed of the availability to contact the local Regional Long Term Care Ombudsman, the name of the local Regional Long Term Care Ombudsman, location of the contact information for the State Agency and the local Regional Long Term Care Ombudsman during the resident council meeting utilizing a Resident Council Meeting QI Audit Tool. The social worker will be re-trained and a resident council meeting will be rescheduled prior to the next monthly meeting to discuss the information if any issues or concerns are noted during the audit. The Executive QI committee will meet monthly and review audits of Resident Council Meeting QI Audit Tool and	

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F 156	Continued From page 7	F 156	address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to keep residents informed of the	F 167	Resident # 24 was informed of the availability and location of the survey	1/11/17

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F 167	Continued From page 8 location of the annual recertification survey results in the facility. Findings included: During an interview with the Resident Council President, Resident # 24, on 12/13/16 at 11:35 AM, she stated that she was not aware of where to find the results of the survey in the facility. Between 2:30 PM and 3:15 PM on 12/14/16 three additional resident council members who attended resident council meetings on a regular basis were interviewed and all stated that they did not know that they were able to review the results of the survey or where in the facility the results of the survey were located. In an interview with the social worker on 12/14/16 at 5:00 PM, she stated that the staff shared survey results with the residents in the Resident Council meeting directly following the annual recertification survey, but the location and availability of the survey results for residents to review was not discussed on a monthly basis during resident council meetings. In an interview at 5:45 PM on 12/14/16, the facility administrator stated that he would expect all residents to be informed of their right to know the results of the annual recertification survey and the location of the survey results on a regular basis.	F 167	results on 1/5/17 by the Social Worker and Activities Director. A Resident Council meeting was held on 1/5/17 by the Social Worker and Activities Director to inform residents to include resident # 24 of the availability and location of the survey results. The Social Worker informed all other residents that did not attend the resident council meeting of the availability and location of the survey results on 1/5/17. The social worker was in-serviced on informing the residents on a monthly basis during resident council meetings of the availability and location of the survey results on 1/6/17 by the Administrator. The administrator will monitor the monthly resident council minutes monthly x 3 months to ensure residents were informed of the availability and location of the survey results during the resident council meeting utilizing a Resident Council Meeting QI Audit Tool. The social worker will be re-trained and a resident council meeting will be rescheduled prior to the next monthly meeting to discuss the information if any issues or concerns are noted during the audit. The Executive QI committee will meet monthly and review audits of Resident Council Meeting QI Audit Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 278	Continued From page 9	F 278		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) 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	F 278	Resident # 22, 55, 119, 126 and 183	1/11/17

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F 278	Continued From page 10 facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 5 of 11 residents (Residents #22, #55, #119, #126, and #183) identified as a Level II PASRR resident. Findings included: 1. Resident #22 was admitted to the facility with diagnoses including Delusional Disorder and Major Depressive Disorder. Review of Resident #22's PASRR level II revealed that the resident had a permanent number. Review of the Annual MDS, completed on 07/19/16, 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 MDS Coordinator on 12/14/16 at 4:10 PM, she stated that it was an oversight that the PASRR information for Resident #22 was incorrectly coded on the MDS and that if the MDS was not coded or was coded incorrectly it meant that the MDS coordinator did not receive the Level II PASRR information for that resident. She reported that if the information was not available in the admission packet or in the resident ' s electronic medical record, then	F 278	MDS was modified to reflect the level II PASSAR on 12/14/2016 by MDS Nurse. 100% audit of all current residents with level II PASSAR to include resident # 22, 55, 119, 126 and 183 most current MDS was reviewed by the Facility Nurse Consultant to ensure the level II PASSAR are coded accurately on the MDS on 12-30-2016. The MDS will be corrected by MDS Nurse with modification on 12-30-2016 for any identified areas of concerns. 100% in-service was completed with the social worker and MDS Nurses to ensure all areas of the MDS are coded accurately to include level II PASSAR on 1/9/17 by the Administrator. 10% of completed MDS assessments to include resident # 22, 55, 119, 126, and 183 will be reviewed to ensure that PASSAR level II are coded correctly by the Admissions Coordinator utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the Administrator by retraining with the social worker and/or MDS nurse and modifications to the MDS with oversite by the Director of Nursing. The DON will review and initial the MDS Accuracy QI tool weekly X 8 weeks then monthly X1 month to ensure any areas of concern have been addressed. The Executive QI committee will meet monthly and review audits of MDS Accuracy QI tool and address any issues, concerns and\or trends and to make	

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MDS would assume that the resident was not a Level II PASRR resident.

During an interview with the Director of Nursing (DON) on 12/14/16 at 4:43 PM, he stated that it was his expectation that all MDS information for each resident should have been 100% accurate.

2. Resident #55 was admitted to the facility with a diagnosis history that included Paranoid Personality Disorder, Psychosis, Anxiety Disorder, and Major Depressive Disorder.

Review of Resident #55's PASRR Level II revealed that the resident's number was permanent.

A review of Resident #55's Annual MDS, completed on 07/24/16, revealed 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 MDS Coordinator on 12/14/16 at 4:10 PM, she stated that it was an oversight that the PASRR information for Resident #22 was incorrectly coded on the MDS and that if the MDS was not coded or was coded incorrectly it meant that the MDS coordinator did not receive the Level II PASRR information for that resident. She reported that if the information was not available in the admission packet or in the resident ' s electronic medical record, then

changes as needed, to include continued frequency of monitoring x 3months.

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F 278	Continued From page 12	F 278		

MDS would assume that the resident was not a Level II PASRR resident.

During an interview with the Director of Nursing (DON) on 12/14/16 at 4:43 PM, he stated that it was his expectation that all MDS information for each resident should have been 100% accurate.

3. Resident #119 was admitted to the facility with diagnoses including Major Depressive Disorder, Anxiety Disorder, and Post Traumatic Stress Disorder.

Review of Resident #119's Annual MDS, Completed on 09/07/16, 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.
Review of the PASRR Level II number for Resident #119 revealed that it was a permanently assigned number.

During an interview with the MDS Coordinator on 12/14/16 at 4:10 PM, she stated that it was an oversight that the PASRR information for Resident #22 was incorrectly coded on the MDS and that if the MDS was not coded or was coded incorrectly it meant that the MDS coordinator did not receive the Level II PASRR information for that resident. She reported that if the information was not available in the admission packet or in the resident's electronic medical record, then

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MDS would assume that the resident was not a Level II PASRR resident.

During an interview with the Director of Nursing (DON) on 12/14/16 at 4:43 PM, he stated that it was his expectation that all MDS information for each resident should have been 100% accurate.

4. Resident # 126 was admitted to the facility with a diagnosis history that included Schizophrenia.

Review of the PASRR Level II number for Resident # 126 revealed that the resident had a permanent number.

Review of Resident # 126's most recent Annual MDS, completed on 05/26/16, 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 recommendations for servicing to help develop an individual's plan of care.

During an interview with the MDS Coordinator on 12/14/16 at 4:10 PM, she stated that it was an oversight that the PASRR information for Resident #22 was incorrectly coded on the MDS and that if the MDS was not coded or was coded incorrectly it meant that the MDS coordinator did not receive the Level II PASRR information for that resident. She reported that if the information was not available in the admission packet or in the resident's electronic medical record, then MDS would assume that the resident was not a Level II PASRR resident.

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During an interview with the Director of Nursing (DON) on 12/14/16 at 4:43 PM, he stated that it was his expectation that all MDS information for each resident should have been 100% accurate.

5. Resident # 183 was admitted to the facility with a diagnosis history that included Bipolar Disorder.

Review of the resident's PASRR Level II number showed the resident had a Level II PASRR number upon admission to the facility and had a current number with a 60 day limitation.

Review of Resident # 183's Admission MDS, completed on 08/08/16, revealed 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 MDS Coordinator on 12/14/16 at 4:10 PM, she stated that it was an oversight that the PASRR information for Resident #22 was incorrectly coded on the MDS and that if the MDS was not coded or was coded incorrectly it meant that the MDS coordinator did not receive the Level II PASRR information for that resident. She reported that if the information was not available in the admission packet or in the resident's electronic medical record, then MDS would assume that the resident was not a Level II PASRR resident.
During an interview with the Director of Nursing (DON) on 12/14/16 at 4:43 PM, he stated that it was his expectation that all MDS information for

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F 278	Continued From page 15 each resident should have been 100% accurate.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 279		1/11/17

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F 279	Continued From page 16 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop antipsychotic care plans for 2 of 5 residents (Resident #125 and #164) reviewed for unnecessary medications who were receiving antipsychotics. Findings included: 1. Resident #164 was admitted to the facility on 11/16/16. The resident's documented diagnoses included dementia with lewy bodies, cognitive communication deficit, gait and mobility problems, hypertension, and atrial fibrillation. Review of the resident's November 2016 medication administration record (MAR) revealed	F 279	Care plans were updated for resident #125 and #164 by MDS Nurse on 12/14/16 to include antipsychotics. 100% audit of all residents' Care Plans to include resident #125 and #164 was initiated on 1/03/17 by Director of Nursing to ensure all residents receiving antipsychotics are addressed on the care plan. Care plans will be immediately revised during the audit for any concerns identified by Director of Nursing. An in-service on updating residents' care	

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F 279	Continued From page 17 the resident was admitted to the facility on 11/16/16 with an order for Abilify (antipsychotic medication) 5 milligram (mg) daily (QD). The resident's 11/23/16 admission minimum data set (MDS) documented his cognition was severely impaired, he exhibited no psychosis or behaviors, he required extensive assistance from the staff with his activities of daily living (ADLs) except for eating, and during a 7 day look-back period the resident received antipsychotic medication all seven of those days. At 3:36 PM on 12/14/16 Nurse #9 (a MDS nurse) reviewed Resident #164's care plan. She stated she did not see a care plan for the resident's antipsychotic (Abilify), and there should be one. She reported care plans were supposed to comprehensively address the needs and care issues for residents, and they should be updated immediately as needs emerged and on admission and quarterly thereafter as MDS assessments were completed. Nurse #9 explained the MDS staff was made aware of emerging problems in the morning meetings when the pink copies of physician orders were reviewed. According to Nurse #9, she thought Resident #164's antipsychotic care plan was missed due to oversite because November 2016 was a busy month for new admits. She stated care plans for antipsychotic medications were important to remind staff that they should be monitoring the toleration and effectiveness of the high-risk medications. At 4:55 PM on 12/14/16 the Director of Nursing (DON) stated all residents receiving antipsychotic medications should have a care plan for them. He reported the antipsychotic care plans were	F 279	plans to reflect antipsychotic use was conducted by Director of Nursing on 1/5/17 with Nurse #9 and MDS nurses. Any newly hired staff to the Care Planning Team will be in-serviced regarding updating residents' care plans to reflect antipsychotic use by the Staff Development Coordinator during orientation. The Staff Development Coordinator will audit 10% of all resident's to include resident # 125 and # 164 with antipsychotics to ensure antipsychotic use are addressed on the care plan weekly x 8 weeks then monthly x 1 month utilizing the QI Tool: Care Plan Monitoring. The Staff Development Coordinator will retrain the MDS nurse and ensure the care plan is revised during the audit for any identified areas of concern. The Director of Nursing will review and initial the QI Tool for care plan monitoring for completion and to ensure all areas of concern have been addressed weekly x 8 weeks then monthly x 1 month. The Executive QI committee will meet monthly and review audits of Care Plan Monitoring QI Audit Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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important because they specified the behaviors the residents were being treated for. He also commented these care plans gave direction on the monitoring and management of the behaviors. According to the DON, the MDS staff should be immediately aware when antipsychotics were started or restarted since pink slips (the pink copies of physician orders) were reviewed in morning meetings daily, and the MDS staff had access to psychiatric consults on their computers.

2. Resident #125 was admitted to the facility on 08/25/16. Her documented diagnoses included depression, dementia without behavioral disturbances, repeat urinary tract infections, and acute respiratory distress syndrome.

Review of the resident's August 2016 medication administration record (MAR) revealed she was admitted on 08/25/16 with an order for Zyprexa (antipsychotic medication) 5 milligrams (mg) nightly (Q HS).

The resident's 09/01/16 admission minimum data set (MDS) documented her cognition was severely impaired, she exhibited no psychosis or behaviors, she required supervision to extensive assistance from staff in order to complete her activities of daily living (ADLs), and during a 7 day look-back period the resident received antipsychotic medication six of those days.

A 10/24/16 physician ordered decreased Resident #125's Zyprexa to 2.5 mg Q HS.

A 11/07/16 physician order discontinued Resident #125's Zyprexa.

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A 11/17/16 progress note documented Resident #125 was experiencing severe outbursts of crying.

A 11/28/16 physician order for Resident #125 documented, "Restart Zyprexa 5 mg QD (daily) for psychotic depression.

At 3:36 PM on 12/14/16 Nurse #9 (a MDS nurse) reviewed Resident #125's care plan. She stated she did not see a care plan for the resident's antipsychotic (Zyprexa), and there should be one. She reported care plans were supposed to comprehensively address the needs and care issues for residents, and they should be updated immediately as needs emerged and on admission and quarterly thereafter as MDS assessments were completed. Nurse #9 explained the MDS staff was made aware of emerging problems in the morning meetings when the pink copies of physician orders were reviewed. According to Nurse #9, she thought Resident #125's antipsychotic care plan was missed due to oversite because November 2016 was a busy month for new admits. She added that the resident had a gradual dose reduction and then a discontinuation of her Zyprexa, and she thought the MDS staff had not picked up on the re-initiation of the Zyprexa on 11/28/16. She stated care plans for antipsychotic medications were important to remind staff that they should be monitoring the toleration and effectiveness of the high-risk medications.

At 4:55 PM on 12/14/16 the Director of Nursing (DON) stated all residents receiving antipsychotic medications should have a care plan for them. He reported the antipsychotic care plans were important because they specified the behaviors

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F 279	Continued From page 20 the residents were being treated for. He also commented these care plans gave direction on the monitoring and management of the behaviors. According to the DON, the MDS staff should be immediately aware when antipsychotics were started or restarted since pink slips (the pink copies of physician orders) were reviewed in morning meetings daily, and the MDS staff had access to psychiatric consults on their computers.	F 279		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide nutrition interventions to promote wound healing for 1 of 3 residents (Resident #167) who were reviewed for pressure ulcers. Findings included:	F 314	Resident # 167 was provided yogurt on her tray on 12/14/16 by the Dietary Manager. A 100% audit of all residents with pressure sores to include #167 meal trays	1/11/17

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F 314	Continued From page 21 Resident #167 was admitted to the facility on 01/13/16. Her diagnoses included pressure ulcers to the heels and sacrum/coccyx, protein calorie malnutrition, diabetes, and edema. A 02/19/16 Wound Ulcer Flowsheet documented the resident had a stage IV pressure ulcer on the right buttock and stage II pressure ulcers on her bilateral heels. A 02/29/16 physician order initiated Magic Cups at lunch and supper for Resident #167. Resident #167's 04/11/16 physician order documented, "Enriched meals, mechanical soft diet." A 07/01/16 Wound Ulcer Flowsheet documented the resident had a stage IV pressure ulcer on the right buttock and stage III pressure ulcers on her bilateral heels. Resident #167's 07/18/16 physician order documented, "Increase Prostat (protein supplement) to 90 cc TID (cubic centimeters three times daily), increase remeron (appetite stimulant) to 15 mg Q HS (milligrams nightly), add zinc sulfate 220 mg x 14 days, add yogurt to all trays." A 07/28/16 physician order documented, "Clarify diet to mechanical soft, ground meats, EMP (enriched meal program)." A 08/09/16 physician order reduced Resident #167's vitamin C from 500 mg twice daily (BID) to vitamin C 500 mg daily (QD). On 08/29/16 "Ulceration or interference with	F 314	were observed and diet slips were audited on 1/6/17 by the MDS nurse nutritional interventions were provided to promote wound healing per MD order. Any concerns or issues found during the audit were immediately corrected by updating the diet slip and ensuring the resident received the nutritional intervention per MD order by MDS Nurse. A 100% in-service to all licensed nurses to include Nurse #10 on completion of diet slips on any diet changes and nutritional interventions to promote wound healing provided by dietary on 1/11/17 by the Staff Development Coordinator. All newly hired staff will be in-serviced in completion of diet slips on any diet changes and nutritional interventions to promote wound healing provided by dietary during orientation by the Staff Development Coordinator. Pink copies of the physician orders will be reviewed to identify any new orders for nutritional interventions to promote wound healing and will be compared to diet slips and resident meals of 10% of residents with pressure ulcers to include resident #167 trays to ensure that newly ordered nutritional interventions to promote wound healing provided by dietary were written on diet slips and provided on residents' meal trays weekly X 8 weeks and monthly X 1 month utilizing a Nutritional Intervention QI Tool by the Director of Nursing, Quality Improvement Nurse, MDS Nurses and Staff Development Coordinator. Any concerns or issues noted during the audit will be immediately	

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F 314	Continued From page 22 structural integrity of layers of skin caused by prolonged pressure r/t (in regard to) decreased mobility resulting in pressure areas to stage II left heel/stage III coccyx" was identified as a problem in Resident #167's care plan. Interventions to this problem included, "Supplement as ordered by the physician." Resident #167's 10/13/16 quarterly minimum data set (MDS) documented the resident's cognition was moderately impaired, she sometimes rejected care, she ranged from being independent to being totally dependent on staff for her activities of daily living (ADLs), she was always incontinent of bowel and bladder, and she had a stage III and an unstageable pressure ulcer. A 12/01/16 RD (registered dietitian) progress note documented the resident's weight had been stable for six months, her meal intake ranged from 50 - 100%, and she had Prostat, Remeron, EMP meals, vitamin C, Magic Cups, and yogurt with meals in place to promote wound healing and stabilize weight. The resident's 12/09/16 Wound Ulcer Flowsheet documented she had a stage IV pressure ulcer on her sacrum and a stage III pressure ulcer on her left heel. At 8:28 AM on 12/14/16 Resident #167 was eating breakfast in her room. She received whole milk, cranberry juice, ground bacon, scrambled eggs, a waffle, and cold cereal. There was no yogurt on the resident's meal tray. Her tray slip documented she was on an EMP mechanical soft diet.	F 314	corrected by updating the diet slips and meals to match the new physician orders by the Director of Nursing and retraining will be provided to the nurse. The Administrator will review and initial the Nutritional Intervention QI Tool for completion weekly X 8 weeks and monthly X 1 month. The Executive QI committee will meet monthly and review audits and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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At 12:42 PM on 12/14/16 Resident#167 was eating lunch in her room. She received whole milk, tea, water, ground sausage, dried beans, greens, cornbread, and a Magic Cup. There was no yogurt on the resident's meal tray. Her tray slip documented she was on an EMP mechanical soft diet.

At 12:55 PM on 12/14/16 the dietary manager (DM) stated when orders were taken from the physician concerning nutrition supplements/interventions, the nurse who took the phone order was also supposed to complete a diet order slip with dietary services receiving the white copy of the slip. She reported a diet order slip should have been written up on 07/18/16 for Resident #167 to receive yogurt on all meal trays. According to the DM, the EMP food for the 12/14/16 breakfast meal was either oatmeal or cheese grits, and the EMP food for the 12/14/16 lunch meal was cream soup. She explained the EMP food products provided extra calories and protein. The DM commented there was a "checker" position on the trayline that checked the accuracy of the trays, and the "checker" should have noticed the lack of an EMP product on Resident #167's 12/14/16 breakfast and lunch trays. The DM reported the trayline was running a little behind during the 12/14/16 breakfast and lunch meals, and everyone was moving fast so there was the possibility when the "caller" called out the diet, by the time the person at the steam table put the food on the plate, the complete diet order may have been forgotten.

At 1:03 PM on 12/14/16 Nurse #10 stated when she took a nutrition related physician order she completed a diet order slip for the resident to which it applied. She reported the white copy of

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F 314	Continued From page 24 the slip went to dietary, and the yellow copy was kept in a file box at the nursing station. When she checked the file box she commented there was no yellow copy of a slip documenting yogurt on all meal trays for Resident #167. At 1:10 PM on 12/14/16 the DM reported she had no while copy of a diet order slip to provide Resident #167 with yogurt at all meals. At 2:35 PM on 12/14/16 the Treatment Nurses changed the dressings to Resident #167's pressure ulcers. The resident had a wound on the sacrum which was nearly closed with a small amount of brown eschar present. There was no drainage or odor. The resident also had a reddened area which was not open on her left heel. At 4:55 PM on 12/14/16 the Director of Nursing (DON) stated the dietary department provided nourishments/nutrition interventions such as yogurt, Magic Cups, EMP, and shakes. He reported the RD notified the dietary department when the physician ordered nutritional supplements or special food products. He commented nutrition interventions were very important in wound healing. He explained they frequently provided extra protein and calories which were important in the healing process.	F 314		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 371		1/11/17

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F 371	Continued From page 25 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to monitor food storage areas which resulted in opened and repackaged food items not being labeled and dated and left overs and dairy products/dried fruit past their use-by dates not being discarded or separated out where they would not be used by the dietary staff. The facility also failed to maintain sanitizing solutions at the strength recommended by the manufacturer. Findings included: 1. During initial tour of the kitchen, beginning at 5:04 PM on 12/11/16, food items in the dry storage room which were opened or repackaged had not been labeled and dated. These included a 80-ounce bag of quick grits, a 2-pound bag of confectioner's sugar, a 16-ounce box of cornstarch, 1 15-ounce box of raisins, a 24-ounce	F 371	All food items in the dry storage room which were opened or repackaged and not labeled to include grits, confectioner's sugar, cornstarch, raisins, lemonade drink mix, lasagna noodles, rotini noodles, spaghetti noodles, and elbow macaroni were immediately removed and discarded on 12/11/16 by the Dietary Manager. The eleven 15 ounce boxes of raisins were discarded on 12/11/16 by the Dietary Manager. The leftovers in the walk-in refrigerator to include lemon pudding, spaghetti sauce, unidentified pureed food, chocolate pudding, raw hamburger, bologna, 32 ounce package of smoked ham, a 5 lb bag of shredded cheddar cheese, a cucumber, a bag of broccoli, and a storage container of raw chicken	

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F 371	Continued From page 26 package of lemonade drink mix, a 3.35-ounce packet of dry ranch dressing mix, a plastic bag of lasagna noodles, a plastic bag of rotini noodles, a plastic bag of spaghetti noodles, and a bag of elbow macaroni. In addition, there were eleven 15-ounce boxes of raisins with a best-by date of 12/10/16 mixed in with other food stock on shelving in the dry storage room. In the walk-in refrigerator there were leftovers which were past their discard dates mixed in with other leftovers which were still within date range. These included lemon pudding placed in storage on 12/02/16 and to be discarded on 12/09/16, spaghetti sauce placed in storage on 11/27/16 and to be discarded on 12/02/16, an unidentified pureed food which was purple in color placed in storage on 12/01/16 and to be discarded on 12/05/16, chocolate pudding placed in storage on 11/27/16 and to be discarded on 12/02/16, raw hamburger which was turning brown placed in storage on 11/30/16 and to be discarded on 12/03/16. There were also food items found in the walk-in refrigerator which were in storage containers, had been opened, or had been used without labels and dates on them. They included a pack of bologna, a 32-ounce package of smoked ham, a 5-pound bag of shredded cheddar cheese, a cucumber, a bag of broccoli, and a storage container of raw chicken legs. In addition, mixed in with other milk stock stored in the walk-in refrigerator there were 50 half-pints of whole milk with a use-by date of 12/10/16. In the walk-in freezer a brown bag of steak fries which had been opened had no label and date on it. During a follow-up tour of the kitchen, beginning at 9:45 AM on 12/13/16, a brown bag of steak fries which was opened was without a label and date in the walk-in freezer.	F 371	legs, and 50 half- pints of whole milk were discarded on 12/11/16 by the Dietary Manager. The brown bag of steak fries were discarded on 12/13/16 by the Dietary Manager. The sanitizing solution in the red bucket was discarded and replaced with sanitizing solution at the strength recommended by the manufacturers and the meal carts were re-wiped down on 12/13/16 by the dietary aide. 100% audit of the dry storage area, walk-in refrigerator, and walk-in freezer was completed on 1/5/17 by the Administrator to ensure opened and repackaged food items were labeled and dated and there were no leftover foods to include dairy products/dried fruit past their use date. The Dietary Manager immediately removed any opened or repackaged food items that were not labeled, not dated, or expired during the audit. All buckets and sinks containing sanitizing solution were audited on 1/6/17 by the Administrator to ensure the sanitizing solutions were maintained at the strength recommended by the manufacturer. Any sanitizing solutions found not to be at the manufacturer's recommended strength during the audit were discarded by 1/6/17. A 100% In-service was completed for all Dietary Aides, Cooks, Dietary Manager Assistant and the Dietary Manager by the Administrator regarding ensuring that any opened or re-packaged items must be labeled and dated when opened, to discard and separate out leftovers and	

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F 371	Continued From page 27 At 10:38 AM on 12/13/16 the dietary manager (DM) stated the PM cooks were to monitor the storage areas nightly. She reported it was their responsibility to make sure opened and repackaged foods were labeled and dated, leftovers were disposed of on their discard dates, and food items past their use-by or best-by dates were thrown away or separated from the other stock so that the dietary staff would not accidentally pick them up and use them in feeding residents. She commented these responsibilities were important to provide residents with the best quality food and to avoid accidentally making residents sick due to spoiled food. According to the DM, the facility did not use food items past their use-by or best-by dates, even though they might still be without spoilage, because it was not worth the risk of making compromised residents sick. The DM stated cooked foods stored as leftovers were supposed to be disposed of in three days and more shelf stable foods such as pudding disposed of after being in storage for 3 - 5 days. At 3:20 PM on 12/13/16 a dietary employee stated it was the responsibility of all staff to check storage areas when they entered them, removed food items from them, or placed food items into them. She reported the staff that opened food items, which were not completely used and returned to storage, or the staff who placed leftovers into storage was supposed to label and date these items to assure freshness and avoid spoilage. She commented the facility did not use food items past their use-by and best-by dates. She explained these items were supposed to be thrown away or pulled out of stock and stored separately so that they would not accidentally be	F 371	dairy products/dried fruit when past their use-by dates, and maintaining the strength of the sanitizing solutions per the manufacturer's recommendations on 12/15/16. All newly hired dietary employees to include dietary aides and dietary cooks will be in-serviced regarding ensuring that any opened or re-package items must be labeled and dated when opened, to discard and separate out leftovers and dairy products/dried fruit when past their use-by dates, and maintaining the strength of the sanitizing solutions per the manufacturer's recommendations during orientation by the Dietary Manager. The Dietary Manager and/or the Dietary Assistant will audit the dry storage area department, the walk-in refrigerator, and the walk-in freezer to ensure that any opened or repackaged items are labeled and dated and that all food items to include leftovers, dairy products and dried fruit are not past their use-by date by utilizing a QI Outdated Food Tool 3 x per week for 4 weeks, then weekly x 4 weeks then monthly x 1 month.. The Dietary Manager and/or Dietary Assistant will audit the sanitizing solution strength to ensure it registers at the manufacturer's recommendations by utilizing the Sanitizing Solution QI Audit tool 3x per week for 4 weeks, then weekly x 4 weeks then monthly x 1 month. The administrator will review and initial the QI Outdated Food Audit Tool and the Sanitizing Solution QI Audit tool weekly for 3 months for completion and to ensure all areas of	

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F 371	Continued From page 28 given to residents to eat. The employee reported the staff could get credit for dairy products which could not be used up before they reached their use-by dates. 2. On 12/13/16 a dietary aide was observed washing and spraying down emptied meal carts at 9:08 AM, 9:20 AM, 9:33 AM, and 9:42 AM. The aide was using cloths from green and red buckets to wipe down the carts. At 9:43 AM on 12/13/16 a strip used to check the quaternary sanitizing solution in the red bucket only registered 50 parts per million (PPM) of sanitizer. At this time the dietary aide using the buckets stated the green bucket contained a dishwashing solution, and the red bucket contained quaternary sanitizing solution dispensed from the three-compartment sink. She reported the red bucket was last filled with fresh sanitizing solution at about 8:30 AM on 12/13/16. The dietary manager (DM) stated the manufacturer required the strips register at least 150 PPM, preferably 200 PPM, for effective sanitization. At 10:38 AM on 12/13/16 the DM stated the red sanitizer buckets should be changed out before the breakfast, lunch, and supper dishes were run through the dish machine. She reported it was important to make sure sanitizing solutions remained strong enough because meal carts had been out on the halls and in the dining rooms, and it was necessary to kills any germs or bacteria which may have been collected along the way. The DM explained there could be cross contamination between the carts and the food they carried if proper sanitizing did not occur.	F 371	concern that were identified were addressed. The Executive QI committee will meet monthly and review the QI Outdated Food Audit Tool and the Sanitizing Solution QI Audit Tool to address any issues, concerns and/or trends and to make changes as needed to include continued frequency of monitoring x 3 months.	

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F 371	Continued From page 29 At 3:20 PM on 12/13/16 a dietary employee stated red buckets were to be changed at each meal so that when kitchenware came back off the halls to run through the dish machine the sanitizing solutions would be strong enough to kill germs. She reported sanitizing solutions should be checked with strips frequently, and if they did not register 200 PPM of sanitizer, they were to be emptied out, and fresh solutions were to be run from the three-compartment sink.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		1/11/17

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F 431	Continued From page 30 (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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, record review and staff interviews the facility failed to store medications at recommended temperatures for 1 of 2 medication refrigerators. Findings included: Review of the Cardinal refrigerator Medication Room Record for December 2016 showed 12 of 12 recorded temperatures below 34 degrees Fahrenheit (F.). Review of the United States Food and Drug Administration literature revealed "According to	F 431	All medications to include Glatopa injectable pens, Risperdal injectable pens, insulin vials, hepatitis B vaccines, and Ativan vials requiring refrigeration were removed, immediately discarded, and reordered by the Director of Nursing on 12/12/16. Medication refrigerator removed and new one placed in medication room with temperature checked and within range by the Director of Nursing on 12/13/16.	

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F 431	Continued From page 31 the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36°F to 46°F. Avoid freezing the insulin. Do not use insulin that has been frozen. Review of the Vaccine Storage Temperatures showed Hepatitis B vaccine should be, "stored at 35-46 degrees. Irreversible loss of potency occurs with exposure to freezing temperatures." Review of the undated Storage of Refrigerated Medications Policy revealed, " Medications requiring refrigeration shall be stored in a refrigerator in the medication room specifically designed for that purpose. Medications stored in refrigerators containing non-medication items or food shall be stored in a locked box. The temperature of all refrigerators containing medications shall be maintained between 36 degree F. to 46 degree F." In an observation on 12/13/15 at 9:30 AM the thermometer in the Cardinal medication refrigerator read 52 degrees F. The medication refrigerator contained multiple Glatopa injectable pens (a medication for Multiple Sclerosis (MS)), multiple Risperdal injectable pens (a medication for Bipolar disorder), multiple vials of different insulins, multiple vials of hepatitis B vaccine, and multiple vials of Ativan. In an interview and observation on 12/13/16 at 9:35 AM with the Director of Nursing (DON) revealed the Cardinal medication refrigerator temperature was 52 degree F. The DON confirmed the refrigerator temperature should have been between 36 degrees F. and 46 degrees F., and was not. The DON also stated the Cardinal medication refrigerator temperatures from December 1 through December 12 were all reading between 31 degree F. and 33 degrees F. The DON stated it was the responsibility of the	F 431	A 100% audit of all medication refrigerators was completed on 1/6/17 by the Director of Nursing to ensure all refrigerated medications were stored at recommended temperatures. For any identified areas of concern during the audit, the medication was immediately removed, discarded and reordered from pharmacy by the Director of Nursing. 100% of licensed nurses to include the QI nurse were in-serviced on 1/11/17 by the Pharmacy Consultant and the DON regarding monitoring and recording medication refrigerator temperatures and proper storage of medications and if any temperatures are out of range, adjust the temperature and re-check in 1 hour. If any concerns remain after an hour, notify the DON and maintenance immediately. All newly hired licensed nurses to receive training during orientation by the Staff Facilitator regarding monitoring and recording medication refrigerator temperatures and proper storage of medications and if any temperatures are out of range, adjust the temperature and re-check in 1 hour. If any concerns remain after an hour, notify the DON and maintenance immediately. The Assistant Administrator will monitor refrigerator temperatures for medication refrigerators utilizing the QI Temperature Audit Tool to ensure medications to include Glatopa injectable pens, Risperdal injectable pens, insulin vials, hepatitis B vaccines, and Ativan vials are stored at the recommended temperatures, temperatures are documented and	

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F 431	Continued From page 32 11-7 nurses to record the medication refrigerator temperatures. The DON stated if temperature registered below 36 degree F. or above 46 degree F., for staff to immediately notify maintenance department, notify manager, and to retake temperature in 1 hour. And if temperature (after 1 hour) registers below 36 degree F. or above 46 degree F., to initiate product removal/relocation procedure, which was not done. In an interview on 12/13/16 at 2:04 PM the Quality Improvement (QI) nurse stated the December/2006 Cardinal medication refrigerator temperatures should have been kept between 36 degrees F. and 46 degrees F., and was not. The QI nurse stated it was the responsibility of the 11-7 nurses to record the medication refrigerator temperatures. The QI nurse said she was the nurse who signed off on the December 1, 2016 Cardinal refrigerator temperature log of 32 degrees F. and failed to follow the facility ' s policy to immediately notify maintenance department, notify her manager, and to retake the temperature in 1 hour. The QI nurse and DON, could not identify the nurse who initialed the Cardinal medication refrigerator temperature log from December 2, 2006 through December 12, 2016. The QI nurse and DON, were not able to produce the Cardinal medication refrigerator temperature logs from October/2016 and November/2016. In an interview on 12/13/16 at 2:30 PM the Director of Nursing (DON) stated the December/2016 Cardinal medication refrigerator temperatures should have been kept between 36 degrees F. and 46 degrees F., and was not. In a telephone interview on 12/13/16 at 4:30 PM the Consultant Pharmacist stated the December/2016 Cardinal medication refrigerator	F 431	temperatures were adjusted if out of range, rechecked in 1 hour, and if remained out of range for an hour to notify the DON and maintenance immediately weekly x 8 weeks and monthly x 1 month. The licensed nurses will be re-educated by the ADON, treatment nurses and weekend supervisor for any identified areas of concern during the audit. The DON will review and initial the proper medication storage audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the QI Temperature Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 431	Continued From page 33	F 431		

temperatures should have been kept between 36 degrees F. and 46 degrees F., and if it was not, the medications stored in it needed to be replaced.
In a telephone interview on 12/14/16 at 10:05 AM the Consultant Pharmacist stated she had been in contact with the DON today and reviewed with him the Cardinal medication refrigerator December 2016 temperatures as well as reviewed the medications that were stored in the refrigerator. She indicated she told the DON that 32 degrees was considered freezing. She indicated medications should be kept between 36-46 degrees. The Consultant Pharmacist stated medications that had been frozen should not be used. The Consultant Pharmacist stated: that all medications stored in the Cardinal medication refrigerator were discarded and replaced, that the facility was in the process of purchasing a new refrigerator, that the nursing staff were in-serviced on refrigerator temperatures and what to do if temperatures were out of range, and that the facility purchased 2 new thermometers for each of the two refrigerators to insure temperature accuracy. The Consultant Pharmacist stated she was not aware of any Adverse Drug Reactions (ADRs) as a result of the Cardinal refrigerator temperatures for December 2016 not being within 36 degrees F. and 46 degrees F.
In an observation on 12/14/15 at 2:00 PM the Cardinal medication refrigerator was removed and the facility was waiting for the new refrigerator to arrive.
In an interview on 12/14/16 at 3:00 PM the Director of Nursing (DON) stated on 12/13/16 the nursing staff completed an in-service training on need to look at the bottom of temperature chart on the medication refrigerators, to ensure

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F 431	Continued From page 34 temperature was in the correct range of 36-46 degrees F., and if not to follow corrective action to notify maintenance and to fill out a work order.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		1/11/17

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F 441	Continued From page 35 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to post an isolation sign outside resident door for 2 of 2 residents who were placed on isolation precautions (Resident #205 and #214). Findings included: A review of the facility's infection control manual	F 441	Contact isolation precaution sign and PPE equipment was placed for resident # 205 and 214 in a visible place on the door on2/11/16 by the Treatment Nurse. A 100% audit of residents to include resident # 205 and 214 on isolation	

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	345119	A. BUILDING _____ B. WING _____	12/14/2016

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F 441	Continued From page 36 (version date: 09/2014) revealed residents with methicillin-resistant staphylococcus aureus (MRSA) infection or colonization should not be placed in a room with another resident that has vancomycin-resistant enterococci (VRE) infection or colonization. Contact precaution recommendations include: utilize clean gloves when entering resident's room and during care, wear a gown when entering room and caring for the resident, and remove and dispose of gown before leaving the resident's room. An observation on 12/11/16 at 5:00 PM showed a Personal Protection Equipment (PPE) box hanging on the outside of Resident #205's door. No Contact Isolation sign was observed on the resident's door or in the resident's room. An observation on 12/11/16 at 5:05 PM showed no PPE box hanging on the outside of Resident #214's door or in the resident's room; however, there was an 8.5" x 11" inch white piece of paper taped to the resident ' s door with "Isolation Precautions" written in colored marker attached to the resident's door. No facility approved printed contact isolation sign was observed on the resident's door or in the resident's room, and no PPE was hanging or laying near the resident's door. In an interview on 12/11/16 at 5:07 PM Nurse #1 stated Resident #214 was on Contact Isolation Precautions. The nurse explained, she was a new agency nurse and did not know where the facility's isolation signs or the PPE were kept; so, she hand wrote an "Isolation Precautions" sign and taped it to Resident #214's door. The nurse said there should have been a printed Contact Isolation precaution sign posted on Resident #214's door with PPE, and there was not. In an interview on 12/11/16 at 5:11 PM Nurse #2 stated there should have been a Contact Isolation	F 441	precautions was initiated on 1/6/17 by the Director of Nursing to assure isolation precaution sign to include contact sign and PPE equipment are in a visible location on the door. All identified areas of concerns will be immediately addressed by posting appropriate precaution sign and PPE equipment by the Director of Nursing during the audit. A 100 % of all licensed nurses to include Agency, Nurse #1, Nurse #2, Nurse #3, and Nurse #4 will be in-serviced by the Staff Development regarding posting of appropriate PPE equipment and isolation sign are in a visible location on the resident’s door when isolation precaution signs are initiated per policy by 1/11/17. All newly hired license nurses will be in-serviced by the Staff Facilitator during orientation regarding posting of appropriate PPE equipment and isolation sign are in a visible location on the resident’s door when isolation precautions are initiated per policy. The Quality Improvement Nurse will perform room rounds for all residents to include resident #205 and 214 requiring isolation precautions to ensure that PPE equipment and isolation precaution sign are in a visible location on the door utilizing Isolation Precaution tool weekly X 8 weeks and monthly X 1 month. The DON will review and initial the Isolation Precaution audit tool to include resident # for completion, and to ensure all areas of concern were addressed weekly x eight weeks then monthly x 1 month.	

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F 441	Continued From page 37 precaution sign posted on Resident #205's door, and there was not. She, also stated Resident #214 should have had a facility printed Contact Isolation precaution sign and door hanging PPE, and there was not. Nurse #2 confirmed Resident #214 and #205 were the only resident's in the facility on Contact Isolation precautions, and both were for MRSA in wounds. In an interview on 12/11/16 at 7:11 PM with Nurse #3 and Nurse #4 revealed that it was their expectation that a printed contact isolation sign and PPE should have been up on Resident #214's room, and was not. In an interview on 12/14/16 at 9:00 AM with the Director of Nursing, the DON stated that it was his expectation that a printed Contact Isolation sign should have been posted on Resident #205 and #214 rooms on 12/11/16, and there were not. He also stated that PPE should have been posted outside Resident #214's room on 12/11/16, and was not. Nurse #7, the Quality Improvement Nurse, was not available for interview.	F 441	The Executive QI committee will meet monthly and review Isolation Precaution audit tool to address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		1/11/17

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F 520	Continued From page 38 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to kitchen sanitation which resulted in a repeat deficiency at F371. The re-citing of F371 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings	F 520	The Administrator, DON, QI Nurse, and Dietary Manager were educated by the Corporate consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include monitoring	

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F 520	Continued From page 39 included: This tag is cross-referenced to: F371: Kitchen Sanitation: Based on observation and staff interview the facility failed to monitor food storage areas which resulted in opened and repackaged food items not being labeled and dated and left overs and dairy products/dried fruit past their use-by dates not being discarded or separated out where they would not be used by the dietary staff. The facility also failed to maintain sanitizing solutions at the strength recommended by the manufacturer. Review of the facility's survey history revealed F371 was cited during the facility's 02/19/16 annual recertification survey, and was re-cited during the current 12/14/16 annual recertification survey. On 12/14/2016 at 6:09 PM in an interview conducted with the Director of Nursing he stated that it was his opinion that the reason the deficiency reappeared was because someone basically dropped the ball and didn't follow the plan. He stated there had been less than 25% retention in staff and the new staff was not following through. He reported they had a good plan, but because of a high turnover rate with new employees not everyone was aware of the plan.	F 520	kitchen sanitation practices and maintaining clean storage areas on 1/5/17. The Administrator, DON, QI Nurse, and Dietary Manager were educated by corporate consultant on the QA process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on 1/5/17. The Administrator completed 100% audit of previously citation and action plans within the past year to include monitoring kitchen sanitation practices ie, labeling and dating opened and repackaged foods, discarding or separating out food items past their use by date and maintaining sanitizing solutions to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QI Committee by Quality Improvement Nurse on 1/19/17 for any concerns identified. All data collected for identified areas of concerns to include monitoring kitchen sanitation practices ie, labeling and dating opened and repackaged foods, discarding or separating out food items past their use by date and maintaining sanitizing solutions will be taken to the Quality Assurance committee for review monthly x 4 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan	

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F 520	Continued From page 40	F 520	of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by Quality Improvement Nurse. The Corporate Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions to include monitoring kitchen sanitation practices ie, labeling and dating opened and repackaged foods, discarding or separating out food items past their use by date and maintaining sanitizing solutions and all current citations and QI plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON, QI nurse, and Dietary Manager for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	