STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	POST OFFICE BOX 8495 ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to keep the call light in reach for 1 of 27 sampled residents (Resident #29). The findings include: Resident #29 was admitted to the facility on 11/11/15 and re-admitted on 6/21/16 with diagnoses including End stage renal disease, Hypertension, Pain and Heart Failure. Review of the most recent quarterly Minimum Data Set Assessment, dated 11/3/16, identified Resident #29 as cognitively intact with a Brief Interview for Mental Status score of 14. Resident #29 required extensive, two person assistance with bed mobility and was totally dependent on two persons for transferring. Walking in the room or corridor did not occur. An observation on 11/29/16 at 5:05PM revealed the resident sitting in her geri-chair near the foot of the bed. The call bell was observed to be wrapped around the side rail approximately 3 feet away from Resident #29. An observations on 11/29/16 at 6:00PM revealed the resident sitting in her geri-chair near the foot of the bed. The call bell was observed to be wrapped around the side rail approximately 3 feet away from Resident #29.	F 246	The call light for resident # 29 was placed within resident reach by the assigned CNA and rechecked by the nurse manager on 12/01/2016. 100% audit was completed for all residents to include resident #29 to ensure call lights are within reach by the treatment nurses on 12/13/2016. Call lights were immediately placed within reach during the audit for any identified areas of concern. 100% in-service was initiated on 11/30/2016 with all license nurses, nursing assistants, and therapy department regarding ensuring resident call lights are within reach at all times to include when up in chair by the RN Assistant Director of Nursing on 12/29/2016. All newly hired employees license nurses, nursing assistants, and therapy employees will be in- serviced during orientation by the RN ADON regarding ensuring call lights are within resident reach to include when up in chair. A Call light Audit Tool will be completed by the East Wing treatment Nurse, West Wing Treatment Nurse, LPN QI Nurse,	12/29/16

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

Electronically Signed | 12/22/2016

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F 246	Continued From page 1 During an interview with Resident #29 on 11/30/2016 1:53PM she stated the evening before she returned from dialysis around 5PM and stayed in her geri-chair until 7PM when the aides were finished feeding residents. She stated the call bell was wrapped around the bed rail because that ' s where it always stays. She stated she could not reach the call bell, while in the geri chair, and did not know what she would do if she needed anyone. During an interview on 11/30/2016 9:58AM with the Director of Nursing she stated it was her expectation that a call light should remain in reach of a resident.	F 246	RN ADON and Nurse Supervisor to audit 10% of residents to include resident # 29 call light to include nights and weekend to ensure call lights are within reach, 5 times per week for 4 weeks, then weekly for 8 weeks. The CNA□s and /or Licensed Nurse will be reeducated by the RN ADON, RN DON, or Administrator for any identified areas of concern during the audit. The Administrator will review and initial the Call light Audit Tool weekly x 12 weeks for completion and to ensure all areas of concern have been addressed. The Executive QI committee will meet monthly and review the Call light 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.	
F 278 SS=D	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. 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	F 278		12/29/16

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F 278	Continued From page 2 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 interview the facility failed to accurately assess 4 of 27 sampled residents (Resident #61, Resident #151, Resident #29 and Resident #102) for active diagnoses under Section I of the Minimum Data Set Assessment. The findings included: 1. Resident #61 was admitted to the facility on 1/20/16 with a diagnosis of Depression. Review of the Admission Minimum Data Set (MDS) assessment dated 1/28/16, Section I, documented the following diagnoses: Depression. Review of the quarterly MDS dated 7/22/16 and the most recent quarterly MDS assessment dated 10/20/16 documented the resident received an anti-depressant 7 days per week. Section I - Active Diagnoses did not assess Resident #61 as having Depression. Review of the Physician ' s orders for November	F 278	A modification of resident #61 MDS for section I was completed on 12/13/2016 by RN MDS Coordinator to reflect Diagnosis of Depression. A modification of resident #151 MDS for section I was completed on 12/14/2016 by the MDS Coordinator to reflect hyperlipidemia and Glaucoma. A modification of resident #29 MDS for section I was completed on 12/13/2016 by the RN MDS Coordinator to reflect hyperlipidemia and depression. A modification of resident #102 MDS for section I was completed on 12/8/2016 by the RN MDS Coordinator to reflect Insomnia. 100% audit was completed of all resident□s current MDS□s for section I comparing the MDS to the resident□s diagnosis sheet and current physician medication orders to ensure active diagnosis are appropriately coded on the MDS on 12/27/2016 by the QI Nurse, East Wing Treatment Nurse, West Wing treatment Nurse and the ADON. MDS	

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F 278	Continued From page 3 2016 documented Resident #61 was receiving Zoloft 50 milligrams daily for Depression. During an interview with the MDS Nurse #1 on 11/30/2016 at 3:14PM she stated if the Physician Order was signed and the resident was being actively treated for the diagnosis then that diagnosis should have been checked on the MDS Section I - Active Diagnoses. 2. Resident #151 was admitted to the facility on 8/10/16 with diagnoses including Hyperlipidemia and Glaucoma. Review of the Admission MDS, dated 8/17/16 and the 60 day MDS, Section I - Active Diagnoses, did not assess Resident #151 as having Hyperlipidemia or Glaucoma. Review of the Physician ' s orders for November 2016 documented Resident #151 was receiving Atorvastatin 10milligrams every night at bedtime for Hyperlipidemia and Xalantan 0.005% Solution one drop to each eye every evening for Glaucoma. Resident #151 ' s start date for the medications was his admission dated of 8/10/16. During an interview with the MDS Nurse #1 on 11/30/2016 at 3:14PM she stated if the Physician Order was signed and the resident was being actively treated for the diagnosis then that diagnosis should have been checked on the MDS Section I - Active Diagnoses. 3. Resident #29 was admitted to the facility on 11/11/15 and re-admitted on 2/11/16 with diagnoses including Hyperlipidemia and Depression. Review of the Annual MDS, dated 2/11/16,	F 278	modifications will be completed for section I for any identified areas of concern during the audit by 12/29/2016 by the RN MDS Coordinator. The MDS Coordinator was in-serviced re: accurate coding to include accurately assessing for active diagnosis under section I of the MDS on 12/19/2016 by the RN MDS Consultant. The RN ADON and the QI Nurse will audit 10% of all residents MDS to include resident #61, #151, #29, and #102 to ensure accurate coding for active diagnosis under section I of the MDS utilizing the MDS audit tool weekly x 8 weeks then monthly x 1 month. The MDS nurses will be reeducated by the MDS Consultant and/or RN DON and a modification will be completed for any identified areas of concern during the audit. The DON will review and initial the MDS 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 MDS 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 4	F 278		

documented Hyperlipidemia and Depression as active diagnoses under Section I.
Review of the most recent quarterly MDS, dated 11/3/16, Section I - Active Diagnoses, did not assess Resident #29 as having Depression or Hyperlipidemia.
Review of the Physician ' s order for November 2016 documented Resident #29 receiving Atorvastatin 40milligrams every night at bedtime for Hyperlipidemia and Lexapro 5 milligrams every day for Depression.
During an interview with the MDS Nurse #1 on 11/30/2016 at 3:14PM she stated if the Physician Order was signed and the resident was being actively treated for the diagnosis then that diagnosis should have been checked on the MDS Section I - Active Diagnoses.

4. Resident #102 was originally admitted to the facility on 12/11/15 with diagnoses including Altered Mental Status, Dementia and Insomnia.
Review of the most recent Significant Change in Status Minimum Data Set (MDS) Assessment dated 9/16/16 did not assess Resident #102 as having insomnia under Section I Active Diagnoses.

Review of the Physician's telephone orders dated 7/28/16, read in part, "Start Trazodone 50mgs (milligrams) q h.s. (bedtime) for insomnia."
Review of Physician Orders for the month of November 2016 revealed an order for Desyrel (Trazodone) 50mgs. by mouth at bedtime.

During an interview on 11/30/16 at 4:13 PM with MDS Nurse Coordinator #1 and MDS Nurse Coordinator #2, MDS Nurse Coordinator #1 revealed insomnia was not listed on the Significant Change in Status MDS list of

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F 278	Continued From page 5 diagnoses. MDS Nurse Coordinator #2 stated there was not a signed doctor's order for insomnia within the last sixty days. She stated Resident #102 went to the hospital and returned to the facility and insomnia was not on the return diagnosis on the MAR which said give at bedtime. During an interview on 11/30/16 at 4:27 PM, the Director of Nursing, (DON) revealed during the MDS Nurse's assessment, they review the medications and should have seen the order for the medication for insomnia. During an interview on 12/1/16 at 10:55 AM, the Administrator stated the MDS should be coded correctly.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to follow a care plan for a resident who was identified with weight loss, by failing to document refusals to participate in the restorative dining program and failing to offer a substitute for 1 of 1 resident reviewed for weight loss (Resident #151). The findings included:	F 282	Resident #151 Care Plan was reviewed to ensure that interventions to prevent weight loss to include documentation of restorative refusal is being completed and that meal substitutes are being offered completed on 12/13/2016 by the LPN QI Nurse. 100% audit of all residents to include resident # 151 with a 5 % weight loss in 30 days and 10% weight loss in 180 days	12/29/16

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F 282	Continued From page 6 Resident #151 was admitted to the facility on 8/10/16 with diagnoses including Alzheimer's disease, Chronic Kidney disease, Hypertension, Dysphagia and cognitive communication deficit. Review of the Admission Minimum Data Set Assessment dated 8/17/16 identified Resident #151 as severely impaired cognitively. Resident #151 had no behaviors and did not reject care. Section D identified him as having a poor appetite or overeating with symptoms present 2-6 days of the assessment. Resident #151 was assessed as needing extensive, one person assistance with eating, had no swallowing problems and was on a mechanically altered diet. His admission height was 64 inches and his weight was 197 pounds. Review of the Care Area Assessment (CAAs) summary, dated 8/17/16 triggered in the area of Nutrition related to Resident #151 having a body mass (BMI) that was too high or too low and receiving a mechanically altered diet. Review of Care plan dated 11/16/16, titled: required assistance/potential to restore or maintain maximum function of self-sufficiency for eating related to: cognitive deficit included the intervention restorative dining: Breakfast/lunch/dinner: Resident #151 was to self-feed himself 50% of two meals per day, 7 days per week and assist when needed and if resident did not participate in restorative dining program, document reason. Review of Care Plan - State of Nourishment, dated 8/22/16 listed potential for weight loss to due being on mechanically altered diet, adjusted BMI. Interventions included, in part, monitor and record percentage of meal intake and offer	F 282	will be reviewed to ensure care plan interventions are followed to include documentation for refusals to participate in restorative dining program and offering a substitute on Rn ADON, RN DON by 12/27/2016. Retraining will be conducted during the audit by RN DON or RN ADON_ with assigned nursing assistant and licensed nurse for any identified areas of concern. 100% nursing assistants to include nursing assistant # 1 and restorative aide and licensed nurses to include treatment nurse will be in-serviced regarding following the care plan to include documenting refusals for meals and documenting refusals to participate in restorative dining program and offering a substitute if refused meals on 12/23/2016 by the RN ADON. All newly hired licensed nurses and nursing assistants will be in-serviced during orientation by RN ADON regarding following the care plan to include documenting refusals for meals and documenting refusals to participate in restorative dining program and offering a substitute if refused meals. 10% of residents to include resident # 151 with a 5 % weight loss in 30 days and a 10% in 180 days will be monitored to ensure interventions to prevent weight loss on the care plan are followed to include documentation for refusals to participate in restorative dining program and offering a substitute utilizing a care plan audit tool by the LPN QI nurse and RN ADON weekly times 8 weeks then monthly times 1 month. The nursing assistant and licensed nurse will be reeducated by the RN ADON and LPN QI	

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F 282	Continued From page 7 substitutions for uneaten food. Review of the Registered Dietician ' s (RD) progress note of 11/7/16 documented a current body weight of 172.4 pounds, with a 4 pound significant weight loss of 12% (23.4#) x 30 days. The note documented Resident #151 had 2+ edema during the last RD review of 9/7/16 and had no current edema noted. The note further documented he had variable intake ranging approximately from 25%-100%, 2 meals refused x 7 days. There was some significant weight loss likely from recent edema and some weight loss possibly related to erratic intake. Supplements were added and were documented as given. Review of the weight summary documented Resident #151 weighed 172.4 pounds on 10/28/16 and he weighed 179.4 pounds on 11/13/16. Review of the Quality Improvement weight management note dated 11/16/16 documented, in part, Resident #151 ' s current weight was 179.4 pounds with a 3% change. He was receiving a pureed diet with EMP (extra protein) added and Boost with lunch. His intake varied with documented refusals. The listed action read: resident to begin restorative dining for all meals to encourage intake. Review of restorative history note documented restorative dining began on 11/17/16. Documentation showed Resident #151 participated 8 times out of 36 potential restorative dining times. There was no documentation as to why he refused or did not participate in restorative dining for 28 potential dining times.	F 282	nurse for any identified areas of concern during the audit. The DON will review and initial the Care plan 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 Care plan 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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During a meal observation on 11/29/16 at 8:30AM Resident #151 was in bed. His tray was in front of him. The oatmeal, sausage, eggs and orange juice had not been touched. Resident #151 was sleeping sitting up in bed. The treatment nurse entered the room and asked the resident if he wanted to try his oatmeal and he stated he did not like oatmeal. The treatment nurse then asked if he would like his orange juice and he stated he did not like orange juice it was too sweet. The treatment nurse did offer apple juice, which he drank. There were no observations of any further attempts to assist the resident with breakfast.

Meal observations on 11/29/16 at 5:10PM showed Resident #151 in his room with his meal tray beside him. Documentation showed a family member brought dinner and he did not eat the facility meal.

Meal observations on 11/30/16 at 7:36AM showed Resident #151 in his bed when breakfast trays were delivered. At 8:13AM Resident #151 ' s breakfast tray was brought from restorative to his room.

During an interview with Nursing Assistant #1 on 11/30/2016 at 8:13AM she stated that Resident #151 sometimes did not want to get out of bed and therefore did not go to restorative dining.

During an interview on 11/30/2016 at 12:05:47 PM, the treatment nurse stated she did not offer resident #151 anything different to eat at breakfast on 11/29/16 because he had his mind made up he wasn't going to eat. She stated sometimes he has bad days. She stated sometimes it's just better to leave the tray and try again later.

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F 282	Continued From page 9 During an interview with the Restorative Aide on 11/30/2016 10:10AM she stated Resident #151 was added to restorative on 11/17/16. She stated he did not come to the restorative dining area often. She stated he doesn't want to get up out of bed and then sometimes refuses to eat. She stated if he doesn't come to restorative dining then the nursing assistants on the hall should be feeding him. She stated she expected the nursing assistants would sit and encourage him to eat and if he refused to go back and try again to encourage him to eat, assisting when needed. She further stated he had had a weight loss of 3% and she wanted to try restorative dining to put something in place so he would not have a 5% weight loss or more. She stated supplements were already in place. She stated he did refuse at times to get out of bed. She stated there should have been documentation stating why he did not come to restorative for dining. She stated she would need to update the care plan to reflect that he does not come to restorative three times per day and also communicate with the weight committee about documenting refusals. During an interview with the Administrator on 11/30/16 at 11:46AM she stated she expected for restorative to document refusals to come to restorative as the care plan reads and for substitutes to be offered.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		12/29/16

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F 309	Continued From page 10 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews the facility failed to assess a resident upon return from dialysis for 1 of 2 residents reviewed for dialysis (Resident #29). The findings include: Resident #29 was admitted to the facility on 11/11/15 and re-admitted on 6/21/16 with diagnoses including End stage renal disease, Dialysis state, Anemia, Hypertension and Heart Failure. Review of the most recent quarterly Minimum Data Set Assessment, dated 11/3/16, identified Resident #29 as cognitively intact with a Brief Interview for Mental Status score of 14. Resident #29 required extensive, two person assistance with bed mobility and was totally dependent on two persons for transferring. Walking in the room or corridor did not occur. Resident #29 received dialysis while a resident. Review of the Care Plan for End Stage Renal Disease: at risk for complication due to hemodialysis documented the following intervention, in part: assess resident upon return from dialysis treatment and notify physician of any significant changes. Review of the Nursing note dated 11/29/16 documented Resident #29 returned to the facility from dialysis at 5:05PM. During an interview with Resident #29 on 11/29/16 at 5:10PM she stated she had just returned from dialysis. She stated the nurse had not come in yet to the room to check her shunt	F 309	Resident #29 was assessed by the charge nurse to include dialysis shunt site, bandage and vital signs and documented the assessment in the electronic medical records on 12/01/2016. 100% audit of all residents to include resident #29, receiving dialysis, shunt site, dressing, and vital signs were assessed with documentation in the electronic medical records by the charge nurse on 12/20/2016. 100% of licensed nurses will be in-serviced regarding assessing residents immediately upon return from dialysis to include dialysis shunt site, dressing, and vital signs and documenting the assessment in the electronic medical record by the ADON to be completed by 12/27/2016. All newly hired licensed nurses will be trained regarding assessing residents immediately upon return from dialysis to include dialysis shunt site, dressing, and vital signs and documenting the assessment in the electronic medical record by the ADON during orientation. The RN ADON, LPN QI nurse, and LPN treatment nurses will review progress notes 3 X per week for 4 weeks, then weekly X 8 weeks to ensure that all residents receiving dialysis to include resident #29 have been immediately assessed to include dialysis shunt site, dressing, and vital signs upon return to	

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F 309	Continued From page 11 site and bandage. She stated no one had taken any vital signs including blood pressure or temperature. During an interview with Nurse #3 on 11/29/16 at 6:06PM she stated when dialysis residents return to the facility they have a communication book that comes and goes with them. The nurse pulled out the communication book and there was no communication sheet from 11/29/16. Nurse #3 stated the dialysis center must have not sent one. Nurse #3 pulled another dialysis resident ' s communication book and showed the surveyor the form that normally comes back with the resident and stated this is what the form looks like. She stated the bottom portion is completed by the center and the nurse receiving the resident completes the top portion upon return to the facility. Nurse #3 stated when she finished her medication pass and the meal trays were completed she would assess the resident and complete the form. She stated she would also document in the computer. Review of the Nursing note dated 11/29/16 at 11:58PM documented Resident #29s vital signs and assessment of the shunt site. During an interview with the Director of Nursing on 11/30/2016 at 9:58AM she stated it was her expectation when a dialysis resident returns to the facility an assessment be done as soon as possible to include return time to the facility, vital signs, condition of the shunt site and bruit and thrill.	F 309	facility from dialysis with documentation in the electronic medical record utilizing a dialysis Assessment QI Audit Tool. The licensed nurse will be retrained by the RN DON or RN ADON for any identified areas of concern during the audit. The DON will review and initial the dialysis assessment QI audit tool weekly x 12 weeks for completion and to ensure that all areas of concern were addressed. The Executive QI committee will meet monthly and review the Dialysis assessment 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.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		12/29/16

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F 371	Continued From page 12 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and policy review the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean one of one wall mounted fans free of dust and failed to clean the tray steam table under shelf for one of one steam tables observed. The findings included: Review of the facility Dietary Policy Manual (last revised 9/2009) under Housekeeping and Sanitation Maintenance of Sanitary Conditions, reads as: " It is the responsibility of the Food Service Manager to ensure that sanitary conditions are maintained in the storage, preparation and serving areas, as well as in the distribution of food, dish washing, pot and pan washing, etc. " The undated daily assignment sheet read as " 1. Clean under the eyes of the stove, 2. Under the steam table, 3. Check the cook ' s refer. Wipe it down. " During an observation on 11/30/16 at 3:27 PM the dish machine and hand sink area were observed. Above the hand sink the wall mounted fan was observed. The cage of the wall mounted fan was observed covered with a volume of grey dust and blowing onto a clean rack of insulated dome lids. During an interview on 11/30/16 at 3:34 PM the assistant Dietary Manager stated that the	F 371	The wall mounted fan in dietary was immediately cleaned on 12/1/2016 by the Maintenance Assistant. The tray steam table under shelf was cleaned on 12/1/2016 by the Dietary Manager. 100% audit of all kitchen equipment to include wall mounted fans and tray steam table under shelves were completed on 12/13/2016 by the Dietary Manager. The Dietary Manager immediately cleaned any kitchen equipment with areas of concern during the audit. 100% In-service was completed for all Dietary Aides, Cooks and Dietary Manager Assistant by the Dietary Manager regarding ensuring kitchen equipment is cleaned and kept in a sanitary condition and the procedure and schedule for checking and cleaning kitchen equipment, and completion of maintenance work orders on 12/13/2016. All newly hired dietary employees to include dietary aides and dietary cooks will be inserviced regarding ensuring kitchen equipment is cleaned and kept in a sanitary condition and the procedure and schedule for checking and cleaning kitchen equipment, and completion of maintenance work orders during orientation by the dietary manager.	

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F 371	Continued From page 13 maintenance man usually took the cover off and cleaned the fan or sometimes staff would report the fan as dirty to maintenance. During an observation on 11/30/16 at 3:36 PM the 5 well steam table was observed. The 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried substance or stain. In an interview on 11/30/16 at 3:37 PM the assistant Dietary Manager stated that staff do clean the steam table. She indicated that it looked like rust on the underside of the steam shelf and staff would clean it up with a scrubbie. In an interview on 11/30/16 at 3:50 PM the Certified Dietary Manager (CDM) stated that the fan had been scheduled to be cleaned and staff would clean it that day. The CDM stated the steam table was on the cleaning schedule and she would rewrite the cleaning schedule to include the steam table shelves.	F 371	The dietary aide and cook will check kitchen equipment for cleanliness and ensure in a sanitary condition daily, to prevent cross contamination to include wall mounted fans and tray steam table under shelves and complete a work order for any kitchen equipment required to be cleaned by the Maintenance department. The Dietary manager will audit kitchen equipment to include wall mounted fans and tray steam table under shelves for cleanliness and sanitation and to ensure work orders have been completed when required utilizing a Kitchen Equipment Sanitation Tool 3 x per week for 4 weeks, then weekly x 4 weeks then monthly x 1 month. The Administrator will review and initial the Kitchen Equipment Sanitation audit tool weekly for 3 months for completion and to ensure all areas of concern that were identified were addressed to include work orders. The Executive QI committee will meet monthly and review the Kitchen Equipment Sanitation Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
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	F 431		12/29/16

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F 431	Continued From page 14 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to store unopened insulin in the refrigerator per manufacturer specifications for 2 of 4 medication carts observed. The findings included: 1a. An observation of the medication cart on the 400 Hall was made on 12/01/16 at 9:40 AM with Nurse #1. Nurse #1 stated insulin for the cart was kept in a plastic container and in the refrigerator	F 431	Medication requiring refrigeration that was removed was immediately discarded and reordered by the charge nurse on 12/01/2016. 100% audit of all medication carts was completed on 12/1/2016 by Treatment Nurse to assure that all new unopened medication requiring refrigeration to include insulin vials and insulin pens was	

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F 431	Continued From page 15 and when time for the medication pass, she would take the basket out of the refrigerator and put on the medication cart. The Nurse stated at the completion of the medication pass she would return the basket of insulin to the refrigerator. There was one unopened vial of Humulog Insulin on the medication cart. The Nurse stated she removed the insulin from the refrigerator that morning in case the resident required insulin per sliding scale. The Nurse stated she did not know if the resident would require insulin that day but would put the date on the vial if and when she opened the vial. Humalog Insulin is a rapid acting insulin frequently used to treat elevated blood glucose levels at meal time based on a scale ordered by the physician. The manufacturer ' s package insert contained directions to keep all unopened Humalog Insulin in the refrigerator at 36-46 degrees Fahrenheit and throw away an opened vial after 28 days even if there is insulin still in the vial. The package insert said that unopened vials could be used until the expiration date on the vial if the medication had been stored in the refrigerator. On 12/01/16 at 10:34 AM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated that unopened vials should remain in the refrigerator until opened and dated when opened. 1b. During the observation of the medication cart on the 400 Hall with Nurse #1, there was a plastic bag containing 2 Victoza Pens. One pen was opened and dated with the date it was opened. The other pen had not been opened. The label on the bag revealed the Victoza pens were dispensed by the pharmacy on 11/10/16. A label on the pen read: " Refrigerate before first use. " The Nurse stated it was a facility practice to	F 431	appropriately stored in the refrigerator. For any identified areas of concern during the audit, the medication was immediately removed, discarded and reordered from pharmacy by 12/1/2016. 100% of licensed nurses to include Nurse #1 and Nurse #2 to be in-serviced by pharmacy consultant and/or ADON regarding storage of unopened refrigerated medications per manufacturer specification on 12/6/2016. All newly hired licensed nurses to receive training regarding storage of unopened refrigerated medications per manufacturer specification during orientation by the RN ADON. The ADON, QI nurse, treatment nurses and weekend supervisor will audit all med carts to ensure new unopened medications to include insulin vials and insulin pens requiring refrigeration are stored per manufacturer specifications utilizing proper medication storage audit tool weekly x 8 weeks and monthly x 1 month. The licensed nurses will be reeducated by the ADON, QI nurse, 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 proper medication storage 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 16	F 431		

remove the basket of insulin that also contained the Victoza pens prior to the medication pass and return the basket to the refrigerator after the medication pass. The Nurse stated she did not know how long the unopened Victoza pen had been in the bag with the opened pen of Victoza or in the basket removed from the refrigerator during medication passes.
Victoza is a medication used to improve glucose control in adults with type 2 diabetes. The manufacturer ' s package insert revealed that prior to first use, Victoza pens should be stored in a refrigerator at 36-46 degrees Fahrenheit and after initial use of the pen, the pen could be stored for 30 days at room temperature.
On 12/01/16 at 10:34 AM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated that unopened vials of insulin should remain in the refrigerator until opened and dated when opened. The DON was not familiar with the storage of Victoza pens.
2a. 12/2/16 at 10:00 AM an observation of the medication cart for the 500 Hall was made with Nurse #2. There was an unopened vial of Novolog Insulin dispensed from the pharmacy on 11/6/16. Nurse #2 stated she removed the basket of insulin from the refrigerator between 7:30 and 8:00 that morning for her medication pass and did not know how long the Novolog Insulin had been in the basket. The Nurse stated if she opened the vial of insulin, she would date the vial with the date she opened the vial.
The manufacturer ' s package insert revealed that unopened Novolog Insulin vials should be stored in the refrigerator at 36-46 degrees Fahrenheit and that opened Insulin should be discarded in 28 days.
On 12/01/16 at 10:34 AM an interview was

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F 431	Continued From page 17 conducted with the Administrator and the Director of Nursing (DON). The DON stated that unopened vials should remain in the refrigerator until opened and dated when opened. 2b. During an observation of the medication cart for the 500 Hall with Nurse #2 on 12/2/16 at 10:00 AM there was one vial of unopened Lantus Insulin on the medication cart. The label revealed the insulin was dispensed from the pharmacy on 11/20/16. Nurse #2 stated she removed the basket of insulin from the refrigerator between 7:30 and 8:00 that morning for her medication pass and did not know how long the Novolog Insulin had been in the basket. The Nurse stated if she opened the vial of insulin, she would date the vial with the date she opened the vial. The manufacturer ' s package insert for Lantus Insulin revealed that unused, unopened Lantus Insulin vials should be kept in the refrigerator and discarded 28 days after opening. On 12/01/16 at 10:34 AM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated that unopened vials should remain in the refrigerator until opened and dated when opened.	F 431		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		12/29/16

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F 520	Continued From page 18 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to have an effective Quality Assurance program to monitor kitchen sanitation practices and systems and failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean one of one wall mounted fans free of dust and failed to clean the tray steam table under shelf for one of one steam tables observed. The findings included: 1. An observation in the kitchen on 11/30/16 at 3:27 PM revealed a wall mounted fan above the hand sink. The cage of the wall mounted fan was observed to be covered with a volume of grey dust and blowing onto a clean rack of insulated dome lids. The Assistant Dietary Manager stated in an interview on 11/30/16 at 3:34 PM that maintenance staff usually took the cover off and cleaned the fan or sometimes the staff would report to maintenance that the fan was dirty and	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 kitchen sanitation practices and maintaining clean kitchen equipment on 12/22/2016. 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 12/22/2016. The Administrator completed 100% audit of previous citations and action plans	

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F 520	Continued From page 19 needed cleaning. On 12/01/16 at 11:12 AM an interview was conducted with the facility ' s Administrator. The Administrator stated that during the facility ' s previous recertification survey completed on 1/14/16 the facility was cited for sanitation problems in the kitchen. The Administrator stated their plan of correction included an audit tool the dietary manager or her assistant used for weekly audits of the kitchen. The Administrator stated if there was a maintenance issue the dietary manager would fill out a work order for maintenance to take care of the problem. The Administrator stated maintenance had cleaned the fan in the kitchen not long ago. 2. An observation was made of the 5 well steam table on 11/30/16 at 3:36 PM. The 5.5 foot underside of the steam table shelf was observed to be covered with dark dried substance or stain. The Assistant Dietary Manager stated that staff clean the steam table. She stated it looked like rust on the underside of the steam shelf and staff would clean it up with a scrubbie. The Certified Dietary Manager (CDM) stated in an interview on 11/30/16 at 3:50 PM that the fan had been scheduled to be cleaned and staff would clean it that day. The CDM stated the steam table was on the cleaning schedule and she would rewrite the cleaning schedule to include the steam table shelves. On 12/01/16 at 11:12 AM an interview was conducted with the facility ' s Administrator. The Administrator stated that during the facility ' s previous recertification survey completed on 1/14/16 the facility was cited for sanitation problems in the kitchen. The Administrator stated their plan of correction included an audit tool the dietary manager or her assistant used for weekly audits of the kitchen. The Administrator stated the	F 520	within the past year to include monitoring kitchen sanitation practices (F 371) and maintaining clean kitchen equipment 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 the Administrator on 12/29/2016 for any concerns identified. All data collected for identified areas of concerns to include monitoring kitchen sanitation practices and maintaining clean kitchen equipment 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 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 Medical Records and/or the Administrator. 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 and maintaining clean kitchen equipment 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	

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F 520	Continued From page 20 steam table being dirty and rusty had not been identified by the dietary manager or staff and had not been brought up in their Quality Assurance meetings. The Administrator stated they did random rounds in the kitchen and had a consultant come in last month to see if there were any issues in the kitchen related to sanitation problems and this problem had not been identified.	F 520	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.	