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	345013	A. BUILDING _____ B. WING _____	C 12/08/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		12/31/16

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

Electronically Signed | 12/30/2016

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

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observations, interviews with a physician, nurse practitioners and staff, the facility failed to notify the physician when Resident #164 developed a discolored hard scab/lesion to the right lateral side of the right foot, for 1 of 4 sampled residents reviewed for physician notification. The findings included: Resident #164 was re-admitted to the facility on 08/09/16. Diagnoses included diabetes mellitus type II, peripheral vascular disease, heart disease, hyperlipidemia and dementia. A Resident Skin Integrity Review (RSIR), dated 08/11/16 was completed by Nurse #1 (wound care nurse). The RSIR documented that Resident #164 was assessed with multiple bruises and bilateral reddened heels. The RSIR did not identify a reddened skin area to the lateral side of the right foot. Resident #164 had a physician's order dated 08/16/16 to apply skin prep to his bilateral heels each shift and to conduct weekly skin assessments on the 3 - 11 shift. Review of treatment administration records August 2016 to December 2016 revealed documentation of skin prep to his bilateral heels. The quarterly Minimum Data Set (MDS)	F 157	POC 157 Resident #164 was evaluated by the Nurse Practitioner on 12/8/16 and scheduled to see the wound MD on 12/13/16 Those with potential: a) 100% of resident had a head to toe skin audit/observation completed by a licensed nurses, these audits was completed on 12/23/16. b) Each audit was reviewed by the wound nurse to ensure treatment orders were in place for residents with skin related issues. c) Nursing staff were educated by the Director of Nursing and other supervisory RN staff regarding notification of changes in condition based on the facility policy i.e.: Change in Residents Condition or Status, the policy includes but is not limited to: 1. Notifying the MD/Family of an incident/accident; discovery of an injury, reaction to medication; need to alter medical treatment; refusal of treatment and significant change in the resident condition. Systemic changes:	

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F 157	Continued From page 2 assessment dated 08/16/16, assessed Resident #164 with no ulcers, wounds or skin problems to his feet. The annual MDS assessment and Care Area Assessment dated 09/21/16, assessed Resident #164 at risk for developing pressure ulcers and other skin problems regarding impaired mobility and incontinence, with skin tears, but no other ulcers, wounds or skin problems to his feet. The quarterly MDS assessment dated 11/03/16 and a November 2016 care plan, assessed Resident #164 with severely impaired cognition, required extensive staff assistance with bed mobility, transfers, dressing, hygiene, and no unstageable/unhealed pressure ulcers. Care plan interventions included to conduct a systemic skin inspection, monitor for skin breakdown and to report any signs of skin breakdown (sore, tender, red, or broken areas). Continued medical record review revealed a Skin Audit dated 11/30/16, completed by Nurse #3 which documented "black heels" to the right lateral side of his heel. Resident #164 was observed on 12/08/16 at 10:01 AM with Nurse #2 (wound care nurse). At the time of the interview, Nurse #2 stated Resident #164 had a "dark scab/calloused area" to the right lateral side of the right foot. Nurse #2 stated that the area was currently intact, without drainage, or redness. Nurse #2 stated that she began treating the dark scab/calloused area with skin prep in October 2016 and that the only change was that the "scab appeared to be pulling away from skin." Nurse #2 stated that Resident #164 was not being followed by a wound physician and that the area had remained a dark scab/calloused area since she started treatment	F 157	a) The facility policy titled Change in Residents Condition or Status was reviewed, no revisions were necessary. b) The facility skin audit schedule was reviewed, each resident will have a skin audit/observation done by a licensed nurse weekly. c) The wound nurses were met with and educated regarding notifying the attending physician and the wound physician (as ordered by the attending MD/NP) when a change in the resident skin condition is detected as well as notifying the resident representative this was completed on 12/9/16. d) An Event is to be initiated in the electronic medical record when there is a skin condition change. Monitoring: a) During the morning Stand-up meeting all events are reviewed by the clinical team at which time appropriate follow up will be determined ie: notification of physician and resident representative of any skin related issues. b) The Event report will be reviewed weekly to establish if the physician and the resident representative have been notified of the residents change in condition. c) The Event report will be reviewed weekly for 8 weeks, then monthly for 4 months. 12/23/16 QAPI: a) Results of the Event report compliance will be discussed and analyzed at the monthly QAPI committee meeting.	

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in October 2016. She further stated that she could not say when the area developed. Nurse #2 stated that she had not reported the dark scab/calloused area to the right lateral side of Resident #164's right foot to the physician or nurse practitioner (NP).

Nurse #1 stated on 12/08/16 at 10:53 AM during an observation of Resident #164 that he completed the RSIR for Resident #164 dated 08/11/16. Nurse #1 observed the right foot of Resident #164 during the interview and stated that the dark scab on the lateral side of the right foot was an intact reddened blanchable area when the Resident was readmitted on 08/09/16. Nurse #1 stated that he did not document the area on the RSIR. Nurse #1 stated he treated the area until October 2016 by applying skin prep, but could not recall when the reddened area darkened and became a calloused/scab. Nurse #1 stated that he did not refer Resident #164 for a wound consult and did not notify the physician or NP that Resident #164 had a dark calloused scab to his right foot.

An interview with the Director of Nursing (DON) occurred on 12/08/16 at 12:56 PM. The DON stated that she observed Resident #164's right foot that morning (12/08/16) with a calloused/scabbed area, but she was not sure when the area developed since she had only been the DON in the facility for the past 2 months. The DON stated that she expected nursing staff to assess any changes in skin integrity and to notify herself or the physician/NP or refer the resident for a wound consult.

A telephone interview with Resident #164's physician on 12/08/16 at 1:05 PM revealed that

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he was not made aware of a change in a reddened area to a scabbed area to this Resident's right foot. The physician stated that he expected notification of this change to have been brought to his attention or to the attention of the NP.

An interview with NP #1 occurred on 12/08/16 at 1:20 PM. NP #1 stated that she was the NP for Resident #164 when he returned from the hospital in August 2016 until the end of November 2016. NP #1 stated that she was asked to assess the right foot of Resident #164 for the first time that day (12/08/16) since his re-admission and that she was not advised of a reddened area to his right foot on re-admission or any changes to his feet prior to that day (12/08/16). NP #1 further stated that she assessed Resident #164 on 12/08/16 with a calloused/scabbed area to the lateral aspect of his right foot and that a wound consult referral would be a good idea.

An interview with NP #2 occurred on 12/08/16 at 2:35 PM. NP #2 stated that she was the NP for Resident #164 as of 12/01/16, but assessed him for the first time on 12/08/16. NP #2 stated she assessed Resident #164 on 12/08/16 with a discolored hard scab/lesion as a result of poor circulation and peripheral vascular disease and that she was not previously aware of the lesion before that day. NP #2 further stated that she would expect nursing to assess and document any changes in skin integrity and notify the physician or NP when the area changed to this discolored hard scab/lesion.

Nurse #3 was interviewed on 12/08/16 at 3:10 PM. Nurse #3 stated that she completed the skin audit for Resident #164 dated 11/30/16 and

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F 157	Continued From page 5 assessed the resident with a black scabbed area to the right lateral aspect of the right foot. Nurse #3 stated that she was not aware of when the black scab developed to the resident's foot and that she did not notify the physician or NP.	F 157		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of medical records, the facility failed to provide thickened liquids with a nutritional supplement, as ordered by a physician, to a	F 309	POC 309 483.24 Quality of Life 1. Resident # 134 was clinically assessed by a licensed nurse post	1/5/17

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F 309	Continued From page 6 resident (Resident #134) with a history of and at high risk for aspiration for 1 of 2 sampled residents reviewed and assess a change in skin integrity for 1 of 3 sampled residents observed for changes in skin integrity (Resident #164). Findings included: 1. Resident #134 was re-admitted to the facility on 12/05/2016 with multiple diagnoses including Vitamin B-12 deficiency anemia, pneumonia, non-Alzheimer's dementia, anxiety, and depression. The most recent Minimum Data Set dated 11/29/16 coded Resident #134 with severely impaired cognition, requiring extensive to total assistance with 1-2 person physical assist for most of her activities of daily living. Resident #134 was on therapeutic and mechanically altered diet. Review of care plan dated 09/01/16 revealed that Resident #134 was at risk of pneumonia. The goal was for Resident #134 to remain free from pneumonia-related complications. Interventions included administration of antibiotics, evaluate, record, and report effectiveness/adverse side effects, avoid any unnecessary diagnostic/therapeutic procedures and devices, encourage fluids, and report fever or signs of pneumonia. Review of the medical record revealed Resident #134 had a physician's order dated 12/05/16 for Juven (arginine-glutamine-calcium) powder packet, 7-7-1.5 gram; one packet by mouth twice daily at 8 AM and 4 PM for Vitamin B 12 deficiency anemia. The instructions on electronic medication administration records (EMAR)	F 309	administration of a thin liquid, there were no adverse effects to the resident. Staff education (i.e.: need for thickened liquids) regarding resident #134 was completed. 2. Resident #164 was evaluated by the nurse practitioner on 12/8/16 and scheduled to see the wound MD on 12/13/16. Those with potential: 1. 100% of residents with physician orders for thickened liquids had a medication administration record (MAR) review, this included ensuring a documented note on the MAR which identified the residents that require thickened liquids during the medication pass. 2. The policy regarding Thickened Liquids was reviewed and in-serviced with the licensed nurses this policy included but was not limited to the rationale for thickened liquids and the consistency types of thickened liquids. The in-service was instructed by the Director of Nurses, Regional nurse consultant and other RN supervisory nurses. 12/31/16 Systemic changes: 1. The policy regarding Thickened Liquids was reviewed by the Clinical Dietary Manager and Regional nurse□s consultant, no changes in the policy were necessary. 2. The contracted Clinical Dietary Manager will review the resident record to determine all resident who have thickened liquids ordered, this report will be forward to Director of Nurses/Assistant Director of Nurses weekly.	

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F 309	Continued From page 7 specified this nutritional supplement to be administered via nectar thickened liquids (NTL). Review of the Diet Requisition Form dated 12/05/16 revealed Resident #134 received NTL. During a medication pass observation conducted on 12/06/16 at 4:22 PM, Nurse #4 was observed mixing Juven packet powder with thin consistency water. The powder turned into a clear red liquid after mixing with thin consistency water and it did not thickened. Nurse #4 stirred the liquid for about 3-4 minutes, the liquid remained thin consistency. Then, when Nurse #4 started to give Juven as a thin/clear liquid, Resident #134 coughed twice after receiving the first sip. Nurse #4 stopped the administration of Juven and called the Nurse Practitioner (NP) immediately. The NP ordered Nurse #4 to discontinue the Juven. Resident #134 remained calm with no signs and symptoms of distress, pain, or further coughing. An interview conducted on 12/07/16 at 2:39 PM with Nurse #4 revealed she was aware that Resident #134 was supposed to receive NTL. Nurse #4 stated that the Juven administration on 12/06/16 evening was the first time she ever administered medication to Resident #134. She stated that when she mixed the Juven with thin consistency water, she stirred the mixture for a while, expecting the supplement to thicken the water, but the mixture remained clear/thin after she had stirred for 3-4 minutes. Nurse #4 stated that she decided to give the clear, thin consistency liquid to Resident #134 as she did not know that Resident #134 would cough. In an interview conducted on 12/07/16 at 3:10 PM, Nurse #5 stated that Juven could be	F 309	3. The DON/ADON will then check this report against the medication administration record (MAR) to determine if all residents on thickened liquids have this specifically noted on the MAR under Administrative Notes, any corrections/updates to the MAR will be done immediately. Monitoring: 1. The Weekly report regarding residents on thickened liquids will be forwarded to the DON/ADON and reviewed to determine whether the Thickened liquids information is noted on the MAR. 2. The thickened liquids report will be reviewed weekly for 8 weeks, every other week for 8 weeks and then monthly x 4 months. 3. Staff will be observed for administration of thickened liquids to 20% of residents who have thickened liquids ordered. This will be completed weekly for 4 weeks, then monthly for 3 months. These observations will be done by Administrative nurses and RN Supervisors. Ongoing observations will continue based on the prior 4 months of monitoring. These observation audits will be forwarded to the Director of Nursing/Assistant Director of Nursing for review and follow up as necessary. QAPI: 1. Results of the weekly report regarding thickened liquids being addressed on the MAR will be reviewed analyzed and discussed by the QAPI committee monthly. The committee will give input and recommendations as necessary.	

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F 309	Continued From page 8 thickened by mixing the powder with the thickened water before administration. If a Resident received NTL the order would be stated clearly could be seen easily in the electric medication administration record. In a phone interview on 12/07/16 at 4:03 PM, the physician stated that it was his expectation for all nursing staff to administer medications or supplements as ordered. Due to Resident #134's high risk for aspiration, the physician expected all the medications or supplements to be administered with thickened liquids and the nursing staff had the knowledge to thicken a medication or supplement as needed. He stated that the coughing reactions could indicate liquids were accidentally sent to the airway and it could trigger another round of pneumonia. In an interview conducted on 12/08/16 at 12:49 PM, the Director of Nursing (DON) stated that it was her expectation for all the nurses to follow physician's orders 100% at all time. When the order stated to administer thickened liquid for a specified Resident, she expected the nurse to thicken all liquids before administration of medications. The DON expected all the nurses to review the order carefully before administering medications/supplements to a Resident, especially when they were not familiar with the Resident. It was her expectation for all the nurses to have the knowledge to thicken a medication/supplement as needed.	F 309	Resident #164 was evaluated by the Nurse Practitioner on 12/8/16 and scheduled to see the wound MD on 12/13/16 Those with potential: a) 100% of resident had a head to toe skin audit/observation completed by a licensed nurses, these audits was completed on 12/23/16. b) Each audit was reviewed by the wound nurse to ensure treatment orders were in place for residents with skin related issues. c) Nursing staff were educated by the Director of Nursing and other supervisory RN staff regarding notification of changes in condition based on the facility policy i.e.: Change in Residents Condition or Status, the policy includes but is not limited to: 1. Notifying the MD/Family of an incident/accident; discovery of an injury, reaction to medication; need to alter medical treatment; refusal of treatment and significant change in the resident condition. Systemic changes: a) The facility policy titled Change in Residents Condition or Status was reviewed, no revisions were necessary. b) The facility skin audit schedule was reviewed, each resident will have a skin audit/observation done by a licensed nurse weekly.	

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F 309	Continued From page 9 2. Resident #164 was re-admitted to the facility on 08/09/16. Diagnoses included diabetes mellitus 2, peripheral vascular disease, heart disease, hyperlipidemia and dementia. A Resident Skin Integrity Review (RSIR), dated 08/11/16 was completed by Nurse #1 (wound care nurse). The RSIR documented that Resident #164 was assessed with multiple bruises and bilateral reddened heels. The RSIR did not identify a reddened skin area to the lateral side of the right foot. Resident #164 had a physician's order dated 08/16/16 to apply skin prep to his bilateral heels each shift and to conduct weekly skin assessments on the 3 - 11 shift. Review of treatment administration records August 2016 to December 2016 revealed documentation of skin prep to his bilateral heels. The quarterly Minimum Data Set (MDS) assessment dated 08/16/16, assessed Resident #164 with no ulcers, wounds or skin problems to his feet. The annual MDS assessment and Care Area Assessment dated 09/21/16, assessed Resident #164 at risk for developing pressure ulcers and other skin problems regarding impaired mobility and incontinence, with skin tears, but no other ulcers, wounds or skin problems to his feet. Medical record review of nursing progress notes revealed the following documentation regarding Resident #164's skin, but did not record an assessment regarding a change from a reddened area to a calloused/scab lesion to the right foot: · 08/09/16, resident noted with redness and	F 309	c) The wound nurses were met with and educated regarding notifying the attending physician and the wound physician (as ordered by the attending MD/NP) when a change in the resident skin condition is detected as well as notifying the resident representative this was completed on 12/9/16. d) An Event is to be initiated in the electronic medical record when there is a skin condition change. Monitoring: a) During the morning Stand-up meeting all events are reviewed by the clinical team at which time appropriate follow up will be determined ie: notification of physician and resident representative of any skin related issues. b) The Event report will be reviewed weekly to establish if the physician and the resident representative have been notified of the residents change in condition. c) The Event report will be reviewed weekly for 8 weeks, then monthly for 4 months. 12/23/16 QAPI: a) Results of the Event report compliance will be discussed and analyzed at the monthly QAPI committee meeting.	

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bruising to bilateral upper extremities, sacrum blanchable to pressure
· 08/15/16, head to toe skin assessment completed, noted with red skin area to bilateral heels, red skin areas to sacrum, bruises to right upper extremities and abdomen
· 09/02/16, an old skin tear to left elbow reopened
· 09/05/16, resident noted with skin tear to left elbow
· 09/14/16, resident noted with skin tear on inner aspect of right arm
· 10/18/16, resident's skin assessed after a fall, no injury noted
· 10/30/16, resident's skin assessed after a fall, no injury noted
The quarterly MDS assessment dated 11/03/16 and a November 2016 care plan, assessed Resident #164 with severely impaired cognition, required extensive staff assistance with bed mobility, transfers, dressing, hygiene, and no unstageable/unhealed pressure ulcers. Care plan interventions included to conduct a systemic skin inspection, monitor for skin breakdown and to report any signs of skin breakdown (sore, tender, red, or broken areas).

Continued medical record review revealed a Skin Audit dated 11/30/16, completed by Nurse #3 which documented "black heels" to the right lateral side of his heel.
Resident #164 was observed on 12/08/16 at 10:01 AM with Nurse #2 (wound care nurse). At the time of the interview, Nurse #2 stated Resident #164 had a "dark scab/calloused area" to the right lateral side of the right foot. Nurse #2 stated that the area was currently intact, without drainage, or redness. Nurse #2 stated that she began treating the dark scab/calloused area with

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skin prep in October 2016 and that the only change was that the "scab appeared to be pulling away from skin. Nurse #2 stated that Resident #164 was not being followed by a wound physician and that the area had remained a dark scab/calloused area since she started treatment in October 2016.

Nurse #1 stated on 12/08/16 at 10:53 AM during an observation of Resident #164 that he completed the re-admission skin assessment dated 08/11/16. Nurse #1 observed the right foot of Resident #164 during the interview and stated that the dark scab on the lateral side of the right foot was an intact reddened blanchable area when the Resident was readmitted on 08/09/16. Nurse #1 stated that he did not document the area on the RSIR. Nurse #1 stated he treated the area until October 2016 by applying skin prep, but could not recall when the reddened area darkened and became a calloused/scab. Nurse #1 stated that he did not refer Resident #164 for a wound consult.

An interview with the Director of Nursing (DON) occurred on 12/08/16 at 12:56 PM. The DON stated that she observed Resident #164's right foot that morning (12/08/16) with a calloused/scabbed area, but she was not sure when the area developed since she had only been the DON in the facility for the past 2 months. The DON stated that she expected nursing staff to assess any changes in skin integrity and to notify herself or the physician/nurse practitioner (NP) or refer the resident for a wound consult.

An interview with NP #1 occurred on 12/08/16 at 1:20 PM. NP #1 stated that she was the NP for

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F 309	Continued From page 12 Resident #164 when he returned from the hospital in August 2016 until the end of November 2016. NP #1 stated that she was asked to assess the right foot of Resident #164 for the first time that day (12/08/16) since his re-admission and that she was not advised of a reddened area to his right foot on re-admission or any changes to his feet. NP #1 further stated that she assessed Resident #164 on 12/08/16 with a calloused/scabbed area to the lateral aspect of his right foot and that a wound consult referral would be a good idea. An interview with NP #2 occurred on 12/08/16 at 2:35 PM. NP #2 stated that she was the NP for Resident #164 as of 12/01/16, but assessed him for the first time on 12/08/16. NP #2 stated she assessed Resident #164 on 12/08/16 with a discolored hard scab/lesion as a result of poor circulation and peripheral vascular disease and that she was not previously aware of the lesion before that day. NP #2 further stated that she would expect nursing to assess and document any changes in skin integrity and notify the physician or NP when the area changed to this discolored hard scab/lesion.	F 309		
F 431 SS=E	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	F 431		1/5/17

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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.

(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

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F 431	Continued From page 14 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to remove from use expired medications on 4 of 9 medication carts and 2 of 2 medication storage rooms. Findings included: An observation of the 400 hall medication cart on 12/07/2016 at 10:01 AM revealed a bottle of multivitamins. The bottle expired 11/16. Interview on 12/07/2016 at 10:01 AM with Nurse #6 revealed she looked before giving medications for the expiration date. She stated if we have extra time we look at the cart for expired medications. An observation of the 100 hall medicaton storage room refrigerator on 12/07/2016 at 6:00 PM revealed venofer 200 milligrams (mg) diluted with normal saline (ns) 100 milliliters (ml) (an iron preparation that is chemically stable for 7 days after diluting with ns). A label on the medication indicated to discard after 12/02/2016. Interview on 12/07/2016 at 6:00 PM with Nurse #7 revealed it was everyone's responsibility to pull expired medications. The nurse added the nurse on the cart checked medications for expired dates and they got sent back to the pharmacy. An observation of the 500 hall medication storage room on 12/07/2016 at 6:09 PM revealed budesonide 0.5 mg/2 ml suspension ampules	F 431	Charlotte POC F431 Medication Storage 1. All expired medications were removed from the medication carts, medication storage room and the medication refrigerators immediately. No resident was effected by any expired medications. 12/8/16 2. Those with potential A) All medication carts, medication rooms and medication including central supply and medications refrigerators were audited for any other expired medications. 12/9/16 B) Any medications found were removed and sent back to the pharmacy For destruction. 12/9/16 3. Systems Review: A) The medication storage policy was reviewed by the DON/Regional Nurses Consultant no changes were necessary 12/27/16 B) In-service education was provided starting on 12/13/16 to licensed nurses by the Interim Director of Nurses	

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F 431	Continued From page 15 expired 07/23/2016, and a bottle of multivitamins with minerals expired 10/16. Interview on 12/07/2016 at 6:09 PM with Nurse #5 revealed that every nurse looked for expired medications. The pharmacy audited and pulled medications from the carts. An observation on 12/08/2016 at 9:10 AM of the 700 hall medication cart revealed a bottle of multivitamins with minerals expired 10/16. Interview on 12/08/2016 at 9:10 AM with Nurse #8 revealed nurses checked for expired medications. Expired medications were discarded. There was no system for checking expired medications. An observation on 12/08/2016 at 9:48 AM of the 900 hall medication cart revealed cranberry supplement 450 mg expired 10/16, magnesium 250 mg expired 11/16, bacid probiotic expired 11/16, vitamin B12 100 micrograms expired 11/16, and a bottle of multivitamins with minerals expired 11/16. Interview 12/08/2016 10:25 AM with the Director of Nursing revealed her expectation was that all medications on the medication carts and in the medication storage areas would be in date. Expired medication should be removed and returned to pharmacy.	F 431	and other supervisory RN□s, regarding medication storage I.e.: Medication Storage Policy was reviewed with a focus on observing routinely for expired medications. 12/31/16 4. Monitoring: a) An audit tool was developed which includes: 1. Are over the counter medications within the expiration date 2. Insulin/insulin pens are within the expiration date 3. Liquid medications are within expiration date 4. Blister pack medications are within the expiration date 5. Any/all other medications are within the expiration date These audits will be completed by the hall nurses weekly. 12/23/16 b) An audit tool was developed for the medication rooms, central supply and refrigerators. These audits will be completed by the clinical care coordinators weekly. Central supply will be audited by the Central Supply Manager , the audit was initiated on 12/9/16. c) The pharmacy consultant will inspect medication carts, refrigerators, and medication rooms for expired medication monthly and the Pharmacy Technician will inspect those same areas twice monthly. the contracted pharmacy will continue to inspect for any/all expired medications in the medication carts, medication storage areas and refrigerators monthly. d) Audits will be completed weekly for 4 weeks then every 2 weeks for 2 months.	

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F 431	Continued From page 16	F 431	Completed audits will be forwarded to the Director of Nursing/Assistant Director of Nursing for review. 5. All audit results will be reviewed, discussed and analyzed at the monthly QAPI meeting, recommendations will be made a necessary.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 514		1/5/17

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F 514	Continued From page 17 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, review of skin assessments and interviews with staff, the facility failed to document a re-admission skin assessment and skin audit to include a reddened area to the right lateral foot and failed to accurately document a wound consult referral for 1 of 4 sampled residents reviewed for accuracy of skin assessments (Resident #164). The findings included: Resident #164 was re-admitted to the facility on 08/09/16. Diagnoses included diabetes mellitus 2 and dementia. A Resident Skin Integrity Review (RSIR), dated 08/11/16 was completed by Nurse #1 (wound care nurse). The RSIR documented that Resident #164 was assessed with multiple bruises and bilateral reddened heels. The RSIR did not identify a reddened skin area to the lateral side of the right foot. Continued medical record review revealed a Skin Audit dated 11/30/16, completed by Nurse #3 which documented "black heels" to the right lateral side of the left heel and that Resident #164 was being followed by a wound physician. Resident #164 was observed on 12/08/2016 at 10:01 AM with Nurse #2 (wound care nurse). Nurse #2 assessed Resident #164 with a "dark scab/calloused area to the right lateral side of the right foot. Nurse #2 stated that the area was intact, without drainage, or redness. Nurse #2 stated that she began treating the dark	F 514	POC 514 Resident records 1. Resident #164 was evaluated by the nurse practitioner and scheduled to see the wound physician on 12/13/16. 2. Those with potential: a) The facility policy regarding resident records complete, accurate and accessible was reviewed by the Medical Record (Health Information Manager), the Director of Nurses and the Administrator. No changes to the policy were required. b) The Skin Audit form was reviewed by the Director of Nursing and the HIM Manager, no changes to the form were required. c) 100% of residents were observed for skin related changes by licensed nurses, utilizing the Skin Audit form. 12/23/16 3. Systemic changes: a) The facility policy regarding medical record documentation was reviewed by the Administrator, Regional Nurse Consultant and the Health Information Manager, no changes were necessary. b) An audit tool was developed which addresses the accuracy of the clinical record.	

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F 514	Continued From page 18 scab/calloused area with skin prep in October 2016 and that the only change was that the "scab appeared to be pulling away from skin." Nurse #2 stated that Resident #164 was not being followed by a wound physician. Nurse #1 stated on 12/08/16 at 10:53 AM during an observation of Resident #164 that he completed the re-admission skin assessment dated 08/11/16. Nurse #1 observed the right foot of Resident #164 during the interview and stated that the dark scab on the right lateral side of the right foot was an intact reddened blanchable area when the Resident was re-admitted on 08/09/16. Nurse #1 stated that he did not document the area on the re-admission assessment and that he could not say when the reddened area changed to a dark scab. Nurse #1 stated he treated the area until October 2016 and that he did not refer Resident #164 for a wound consult. Nurse #3 was interviewed on 12/08/16 at 3:10 PM. Nurse #3 stated that she completed the skin audit for Resident #164 dated 11/30/16 and assessed the Resident with a black scabbed area to the right lateral aspect of the right foot. Nurse #3 stated that the skin audit documented that the dark scab was on the left foot, but should have indicated the right foot and the indication that Resident #164 was being followed by the wound physician was an error. The Director of Nursing (DON) was interviewed on 12/08/16 at 12:56 PM. The DON stated that she expected skin audits to be completed accurately and that Resident #164 had not been followed by the wound physician.	F 514	4. Monitoring: a) The admission process regarding residents skin condition was reviewed with licensed nurses, this included, use of the Resident Skin Integrity Review, and the Skin Audit form. b) An audit tool was developed for the medical record department, this tool included the following: " Does the record have all identifying information in place? " Is the information accurate & readily accessible? " Are medical records systematically organized? " Is the Skin integrity review form signed as accurately being completed by the licensed nurse? " Is there a Skin Tab noted in the EHR (Electronic Health Record) under Documents? An audit will be completed on a randomly selected sample of residents i.e.: 15% of the facility census every week for 4 weeks, then 10% of the facility census for 4 weeks, then 10% every other week for 4 weeks. All completed audits will be forwarded to the Director of Nursing/Assistant Director of Nursing for review. 5. The results of the medical record audits will be discussed, analyzed by the QA committee and recommendations made as needed.	
F 520	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA	F 520		12/31/16

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F 520 SS=D	Continued From page 19 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; (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	F 520		

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F 520	Continued From page 20 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, staff interviews, and review of medical records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March 2016. This was for a recited deficiency that was originally cited in March 2016 on a Complaint Survey and subsequently recited on the facility's current Recertification/Complaint survey. The deficiency was in the area of physician notification of a significant change. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 157 Notify Physician of a Change: Based on observations, interviews with a physician, nurse practitioners and staff, the facility failed to notify the physician when Resident #164 developed a discolored hard scab/lesion to the right lateral side of the right foot, for 1 of 4 sampled residents reviewed for physician notification. During a Complaint survey of March 14, 2016 the facility was cited for failure to notify the nurse practitioner of an attempt to insert a urinary catheter after balloon inflation which resulted in bleeding, pain and hospitalization and notify the family of the need for IV fluids and a urinary catheter. On the current Recertification/Complaint	F 520	POC F520 QA&A Committee 1. Resident #164 was assessed by the Nurse Practitioner on 12/8/16 and scheduled to see the wound physician on 12/13/16. 2. Resident with potential: a) Facility QAPI committee members were in-serviced by the Administrator and the Director of Nurses about the Quality Assurance Performance Improvement Committee and program: The in-service objective is: " Identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan as needed. " The facility committee members will understand the purpose of the QA program i.e.: to provide a means for a resident(s) care and safety issues to be resolved. " Committee members will understand how the QA committee monitors issues and follows up with unresolved issues that have been identified. 3. Measures/systemic changes: a) The QA policy was reviewed by the Administrator, the policy states the facility shall develop, implement and maintain an	

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F 520	Continued From page 21 survey of December 08, 2016, the facility failed to notify the physician of a change in skin integrity. The Administrator and Director of Nursing were both interviewed on 12/0816 at 5:04 PM. They stated that the facility's QA committee meetings included discussion from previous surveys. The Administrator said that the facility discussed daily notification as a part of the facility's review when a resident sustained a change. The Administrator further stated that the facility reviewed action reports daily, but since the change in skin integrity for Resident #164 was not documented, that could answer how the facility missed the follow-up for this Resident.	F 520	ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care and to resolve identified problems. No changes to the policy were necessary. b) A tool was developed titled Self-Evaluation the tool included the following: " Does the QA Committee have a current plan in place? " Does the committee identify who is responsible to oversee the plan/project? " Is the plan working? " If the plan is not working have changes been put in place to improve? " Is the outcome measurable? " Has the project been successful? " Can the plan be considered resolved? This tool was developed for a QA sub-committee to establish the successfulness of the QAPI project(s) and make recommendations as necessary. 4. Monitoring: a) The Self-Evaluation tool will be completed by the sub-committee at scheduled meetings twice a month prior to the next scheduled QAPI monthly meeting (all participants of the QAPI Committee). b) The sub-committee is made up of 4 members of the QAPI general committee. c) Findings of the sub-committee will be addressed at the monthly QAPI meeting when all participants attend. d) The Self-Evaluation tool will be utilized for 6 months; ongoing use of the tool will be determined by the prior 6 months of Self-Evaluating the QAPI process.	

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F 520	Continued From page 22	F 520	5. QAPI: The results of the Self-Evaluation tool will be reviewed at the monthly QAPI meeting and changes or recommendations will be discussed as necessary.	