STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345297	A. BUILDING _____ B. WING _____	01/20/2017

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SCOTIA VILLAGE-SNF	2200 ELM DRIVE LAURINBURG, NC 28352

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F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data.	F 356		2/10/17

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

Electronically Signed | 02/09/2017

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 356	Continued From page 1 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post nurse staffing information and also failed to maintain the daily nurse staffing data. Findings included: An initial tour of the facility was begun on 01/17/17 at 10:58 AM. No current or previous nurse staffing information was observed in the facility during the initial tour. In an interview on 01/17/17 at 11:14 AM the staff member responsible for posting the staffing stated she usually placed the nurse staffing on the bulletin boards inside the nursing stations. She indicated she had not posted the staffing for that day. In an observation on 01/17/17 at 12:25 PM nurse staffing had been posted on each unit. In an interview on 01/17/17 at 4:20 PM the Administrator indicated the facility had recently undergone construction and this had caused some issues with the postings. He stated he was unable to discover exactly when the nurse staffing had last been posted as the documentation had been disposed of and not maintained. The Administrator indicated it was his expectation that nurse staffing be posted and updated daily and that the records be maintained. In an interview on 01/20/17 at 11:10 AM the Director of Nursing (DON) stated she expected	F 356	F356- Scotia Village was given a deficiency for 483.35- Posted Nurse Staffing Information during the annual QIS survey on 1/20/2017. The following has are the steps taken to remedy the area of concern. On 1/17/2017, Survey Consultant, Sharon Neusen-RN informed this administrator that the Staff Posting could not be located. Shortly after being informed of the observation, nursing administration noticed that the information was not posted and immediately placed the information in the four common spaces at each household. the scheduler has continued to place the Staff Posting Information everyday since it was brought to her attention. Common spaces for each household/residential areas have been identified to place the staffing information for residents, family members, and visitors to review. a place holder was mounted on the wall for the information sheet and the nursing staff educated of the location.	

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F 356	Continued From page 2 the nurse staffing information to be posted daily.	F 356	The Scheduler has restarted printing out Staff Posting Information for each day including weekends. The nursing staff have been educated that the information must be posted at the beginning of each shift with the census #'s and the total number & amount of hours worked by each direct care staff- RN, LPN, and C.N.A. Because there are four residential areas, one area, Urban House, has been identified for the charge nurse of each shift to be responsible in communicating and revising the staff posting form as needed. the scheduler will communicate with the Urban House Nurse on a daily basis to determine if there are any changes in the staffing pattern. The Scheduler will also verify that the forms were completed as well. Also, in case, the scheduler is not present at work, there are two employee designees - Medical Records Director and Administrative Assistant to distribute The Staff Postings and verify form completion per day. the documentation will be stored for 18 months in the nursing administrative office. The forms will be reviewed weekly by Director of Nursing and The Administrator every week for 3 months to assure that The Staffing Information is posted and completed. Also, the Staff Posting Information and the storage of the records will be reviewed during the Quality Assurance Performance Improvement meetings X's 3.	
F 371	483.60(i)(1)-(3) FOOD PROCURE,	F 371		2/10/17

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F 371 SS=F	Continued From page 3 STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to clean wall fans blowing into the dish machine and kitchenware storage areas, failed to air dry kitchenware prior to stacking it in storage, and failed to discard/replace kitchenware with abraded/scratched interior preparation/serving surfaces. Findings included: 1. During initial tour of the kitchen, beginning at 11:19 AM on 01/17/17, the blades, front, and back of two wall fans were coated with dust and	F 371	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. • Wall Fans-All wall fans in dish area were disassembled and each part (blades, front, and back) cleaned with all-purpose cleaner or degreaser. Also, wall fan cleaning was added to policy on 1/20/2017. • Wet Pans-An extra drying rack was	

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F 371	Continued From page 4 dirt with the coating as thick as a quarter inch on the back of the fans. One fan was blowing directly into the dish machine area, and the other blew across a storage unit of kitchenware into the dish machine area. During a follow-up inspection of the kitchen, beginning at 9:30 AM on 01/19/17, the blades, front, and back of two wall fans were coated with dust and dirt with the coating as thick as a quarter inch on the back of the fans. One fan was blowing directly into the dish machine area, and the other blew across a storage unit of kitchenware into the dish machine area. At 10:55 AM on 01/20/17 the food service director (FSD) stated the dietary department was responsible for cleaning fans used in the kitchen. He reported currently the fans were not on a cleaning schedule, but were cleaned when the dietary employees noticed dust and dirt were collecting on the fans. According to the FSD, the two fans blowing into the dish machine area should have already been cleaned to avoid contaminating sanitized kitchenware exiting the dish machine and stacked on a storage rack. He commented every three or four weeks the fans should be disassembled with the blades, fronts, and backs of the fans being wiped down with a cloth and degreasing solution. At 11:10 AM on 01/20/17 dietary employee #1 stated the dietary department was supposed to clean wall fans in the kitchen monthly to prevent dust, dirt, and grease build-up on the fan blades and covers from contaminating sanitized kitchenware. He reported the dietary department had been short staffed so some cleaning duties had been overlooked or postponed. The	F 371	added to allow more space for air drying pots and pans. Staff was in-serviced on February 7th on proper drying and storage procedures for pots and pans. • Pots/Dishes-Scarred pans and bowls have been discarded and new ones placed in inventory. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. • Wall Fans- the wall fans were immediately cleaned and all employee's in-serviced on 1/20/17. The dietitian will also assess the deficient concerns and evaluate area during her inspection on 2/22/2017; policy revised to check for wall fans. Employees to review policy and signoff on by 2/20/2017. • Wet Pans-an audit was completed on all pots and pans and an extra drying rack was added on 1/20/2017 to create better storage to air dry. An in-service began and will be completed on 2/10/2017. Dish drying policy has been updated in our policy book. • Pans/Dishes- an In-service was held on 1/20/2017 with regards to checking for compromised dishes and pots. All items that appeared compromised were discarded and new items used.-2/10/2017. All employees instructed to report damaged dishes and utensils to manager.-2/10/2017 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. • Wall Fans- A bi-monthly inspection will be completed by the dining managers.	

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F 371	Continued From page 5 employee commented in order to prevent kitchenware contamination the fans were supposed to be disassembled so dirt and dust from the blades as well as the front and rear grills could be removed using a degreaser. 2. At 9:20 AM on 01/19/17 15 of 21 tray pans were stacked on top of one another with water/moisture trapped between them. The employee operating the three-compartment sink system stated most of these tray pans were washed that morning. At 10:55 AM on 01/20/17 the food service director (FSD) stated within the last month in-servicing was held during which the dietary staff was instructed to air dry kitchenware before stacking it in storage. He reported the employee operating the three-compartment sink on the morning of 01/19/17 had attended this in-service. According to the FSD, the damp, dark, wet environment formed by stacking wet pieces of kitchenware on top of one another created the perfect breeding ground for germs and bacteria. At 11:10 AM on 01/20/17 dietary employee #1 stated during in-services the dietary staff was trained kitchenware should be free of dried food particles and dry before stacking it in storage. He reported the facility had drying racks where tray pans could be air-dried before stacking them on top of one another. The employee commented the geriatric population was very susceptible to the harmful bacteria that grew when moisture was trapped between pieces of wet kitchenware that were stacked on top of one another. 3. At 9:23 AM on 01/19/17 the non-stick coating on 2 of 3 fry/saute pans being utilized by the	F 371	Any items that need to be cleaned will be done within 24 hours' time. Information will be recorded in an audit tool and maintained on file in the dietary administrative office. • Wet Pans-. The dietary managers will conduct a spot check weekly of pots and pans making sure they are clean and dry. All information recorded in an audit tool will be held in the dietary administrative office • Pans/Dishes-Inspection of all plate ware and cooking utensils will be conducted quarterly. Results will be documented and maintained on file in the administrative office. A bi-monthly inspection by managers will also be added to the policy. Employees will be instructed to report damaged dishes and utensils to a manager. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system and will include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. • Wall Fans-All forms will be completed 2/12/2017. Results will be recorded on a bi-monthly basis and reported to the director of Dining Services. This information will also be presented to Quality Assurance x's 3. • Wet Pans- Dishes will be checked	

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F 371	Continued From page 6 facility was scratched and flaking. At 11:16 AM on 01/19/17 16 of 18 plastic soup/cereal bowls were abraded inside. At 10:55 AM on 01/20/17 the food service director (FSD) stated when kitchenware became compromised with chips, cracks, and abrasions dietary employees were instructed to pull it out of circulation, take it to a supervisor for evaluation, and almost always it would be counted, replacements would be ordered, and the compromised pieces would be disposed of. According to the FSD, he thought the use of scouring pads had contributed to the breakdown of the non-stick coating and the interior serving surfaces. He reported pieces of the coating and plastic could contaminate the food, and the compromised surfaces made it more difficult to keep the kitchenware free of dried food particles. At 11:10 AM on 01/20/17 dietary employee #1 stated compromised kitchenware was supposed to be taken to a supervisor who could count and reorder it before disposing of it. He reported bits of non-stick coating and abraded plastic could get ingested by residents and make them sick or create a choking hazard.	F 371	weekly or as needed and monitored by the dining supervisors. All information will be presented to Quality Assurance x's 3. • Pans/Dishes-Director of Dining Services will review all audit forms and make any necessary corrections needed. Also He will present audit tools and findings to Quality Assurance Performance Improvement x's 3.	
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.	F 431		2/3/17

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F 431	Continued From page 7 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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	F 431		

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F 431	Continued From page 8 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and Registered Pharmacist interviews, the facility failed to store medications inside a locked medication cart for 1 of 4 medication carts, failed to dispose of expired and/or undated medications for 2 of 4 medication storage refrigerators, failed to follow special storage instructions placed by the pharmacy on a medication stored in a medication refrigerator for 1 of 4 medication refrigerators, and failed to store medications at recommended temperatures for 1 of 4 medication refrigerators. Findings included: 1. In an observation on 01/17/17 at 10:58 AM a medication storage card containing 30 capsules of Gabapentin 100mg (milligrams) was seen on top of an unattended medication cart. A continuous observation of the medication and the medication cart was continued until 11:03 AM when Nurse #2 returned to the medication cart. In an interview on 01/17/17 at 11:03 AM Nurse #2 indicated there were two cards of Gabapentin in the drawer of the medication cart so she had removed one and placed it on top of the medication cart with the intention of placing the card in the medication storage room. She indicated she had left her cart unattended with the medication on top to answer a call light. Nurse #2 stated she knew she was not supposed to leave medications unattended on top of the medication cart and should have taken them to the medication storage room. In an interview on 01/20/17 at 11:10 AM the DON	F 431	F43I The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Example #1: Facility failed to store medications inside a locked medication cart for 1 of 4 medication cart. o On 1/17/17, Nurse#2 who left a Gabapentin card on the cart and walked away was verbally in-serviced by the Lighthouse RN nurse mentor on 1/17/17 regarding the facility policy and procedures on proper storage of medications with a formal in-service on 1/23/17. No residents were found to have been affected by the deficient practice as all medications unsecured on the med cart were accounted for by the charge	

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F 431	Continued From page 9 stated it was her expectation that nurses not store medications on top of the medication carts and to never leave medications unattended. 2. An observation of the medication storage refrigerator on the Lighthouse nursing unit was conducted on 01/19/17 at 11:10 AM with Nurse #3. The medication storage refrigerator contained one opened and accessed vial of fluvirin vaccine with a handwritten opened date of 11/30/16. The refrigerator also contained an opened and accessed vial of Tuberculin purified protein derivative (PPD) which was in a box with a handwritten opened date of 12/17/16. The instructions on the box read, "Once entered, vial should be discarded after 30 days." In an interview on 01/19/17 at 11:15 AM Nurse #3 stated opened vials of medications were to be discarded 30 days after opening. She indicated the medications were no longer effective after 30 days. In an interview on 01/19/17 at 4:00 PM Registered Pharmacist (RPh) #1 stated that after opening, fluvirin was good for 28 days and then should be discarded. She indicated that after 28 days the vaccine may not be effective. She indicated Tuberculin PPD should be discarded 30 days after opening as per the instructions on the box. An observation of the medication storage refrigerator on the Farmhouse nursing unit was conducted on 01/19/17 at 11:22 AM with Nurse #3. The medication storage refrigerator contained one opened and accessed vial of fluvirin vaccine with no opened date. In an interview on 01/19/17 at 11:25 AM Nurse #3 stated it was standard practice for nurses to write the date on the box or vial of a medication when it was opened. She indicated writing the opened date was important because these medications	F 431	nurse. b. Example #2: Facility failed to dispose of expired and/or undated medications for 2 of 4 medication storage refrigerators. o (Lighthouse refrigerator) On 1/19/17, the opened and accessed vial of fluvirin vaccine with a handwritten opened date of 11/30/16 was returned to the pharmacy upon discovery. All nightshift nurses responsible for checking the Lighthouse refrigerator daily for expired medications were verbally educated on 1/19/17 by a RN nurse mentor with a formal in-service completed on 1/23/17. On 1/19/17, the Lighthouse RN nurse mentor completed a 100% audit on the residents to see if any Lighthouse resident was given the fluvirin vaccine on the day of the discovery (1/19/17). The audit revealed that no Lighthouse resident received the fluvirin vaccine on (1/19/17). o (Lighthouse refrigerator) On 1/19/17, the opened and accessed vial of Tuberculin purified protein derivative (PPD) which was in a box with a handwritten opened date of 12/17/16 was returned to the pharmacy upon discovery. All nightshift nurses responsible for checking the Lighthouse refrigerator daily for expired medications were verbally educated on 1/19/17 by a RN nurse mentor with a formal training completed on 1/23/17. On 1/19/17, the Lighthouse RN nurse mentor completed a 100% audit on the residents to see if any resident was given the Tuberculin purified protein (PPD) on the date of discovery (1/19/17). The audit revealed that no Lighthouse	

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F 431	Continued From page 10 expired 30 days after opening and would not be effective if used after that date. In a telephone interview on 01/19/17 at 4:00 PM RPh #1 stated that after opening, fluvirin was good for 28 days and then should be discarded. She indicated that after 28 days the vaccine may not be effective. RPh #1 stated if there was no opened date on the vial the medication could not be used and should be discarded. She indicated there would be no way to tell if the medication had expired if the dated opened was not on it. In an interview on 01/20/17 at 11:10 AM the DON stated she expected expired medications to be returned to the pharmacy and that the date a medication was opened should be written on the medications. She indicated if the date was not written on the medication the nurse would not know if the medication had expired. 3. An observation of the medication storage refrigerator on the Clubhouse nursing unit was conducted on 01/19/17 at 11:30 AM with Nurse #1. The medication refrigerator contained 1 unopened Humalog (insulin) flex pen, 2 unopened vials of Levemir (insulin), and a storage box containing 2 Levemir (insulin) Flex Touch pens one of which was opened and partially empty. The handwritten opened date on the Levemir flex touch pen read 01/14/17. A yellow label with special instructions placed by the facility pharmacy was noted on the Levemir Flex Touch storage box. The label showed a picture of a refrigerator with an X over it with the instruction, "Do not refrigerate this product after opening for use. Store at room temperature." In an interview on 01/19/17 at 11:40 AM Nurse #1 stated special instructions provided by the pharmacy on medications needed to be followed. She indicated the Levemir Flex Touch pen should not have been placed back into the medication	F 431	resident received the Tuberculin purified protein (PPD) on 1/19/17. o (Farmhouse refrigerator) On 1/19/17, the opened and accessed vial of fluvirin vaccine with no open date was returned to the pharmacy upon discovery. The household data shows that the Farmhouse resident flu vaccinations began on 10/28/16. The date of open label on the vial found should have reflected 10/28/16. The expiration/discard date should have been 11/26/16. Nurse #3 who opened the vial was verbally in-serviced by a RN nurse mentor on 1/19/17 regarding the facility policy and procedures on proper storage of medications with a formal in-service on 1/24/17. All nightshift nurses responsible for checking the Farmhouse refrigerator daily for proper medication storage in the Farmhouse were verbally educated on 1/19/17 by a RN nurse mentor with a formal in-service completed on 1/23/17. On 1/19/17, the Farmhouse nurse mentor completed a 100% audit on the residents to see if any residents received the flu vaccination on the date of discovery (1/19/17). The audit revealed that no Farmhouse residents received the fluvirin vaccine on (1/19/17). c. Example #3: Facility failed to follow special storage instructions placed by the pharmacy on a medication stored in a medication refrigerator for 1 of 4 medication refrigerators. o (Clubhouse refrigerator) On 1/19/17, one Levemir (insulin) Flex Touch pen with open date of 1/14/17 found in the refrigerator was returned to the pharmacy	

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	345297	A. BUILDING _____ B. WING _____	01/20/2017

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F 431	Continued From page 11 refrigerator after it was opened. In a telephone interview on 01/19/17 at 5:30 PM RPh #2 stated once an insulin pen was opened it should be placed in the medication cart and not put back in the refrigerator. In a telephone interview on 01/19/17 at 5:44 PM RPh #3 stated the facility should have followed the special instructions for storage of the Levemir that the pharmacy had placed on the box. In an interview on 01/20/17 at 11:10 AM the DON stated she expected the nurses to follow any special instruction labeling that the pharmacy placed on medications. 4. Review of the December 2016 Clubhouse nursing unit medication refrigerator Temperature Chart revealed: "Refrigerators: 36 to 40 degrees. Abnormal temperatures: Please report to Maintenance and Southern Pharmacy immediately". According to the Temperature Chart the medication storage refrigerator in the Clubhouse medication room was installed on 12/14/16. The Temperature Chart revealed 9 out of 18 days where the temperature was below 36 degrees. 17 of the 18 recorded temperatures had staff initials next to them. Review of the January 2017 Clubhouse nursing unit medication refrigerator Temperature Chart revealed: "Refrigerators: 36 to 40 degrees. Abnormal temperatures: Please report to Maintenance and Southern Pharmacy immediately". The Temperature Chart revealed 15 out of 19 days where the temperature was below 36 degrees. 19 of the 19 recorded temperatures had staff initials next to them. Review of the United Stated Food and Drug Administration literature revealed, "According to the product labels from all three U. S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36	F 431	upon discovery due to improper storage. One (1) resident who owned this Levemir (insulin) Flex Touch pen was affected by this deficient practice. This resident was immediately assessed. No adverse reactions were found within the (5) days of the improper storage of the insulin pen. All blood sugar levels for the resident during the month were stable and consistent with her historical levels. The resident□s doctor was notified and no new orders were given. d. Example #4: Facility failed to store medications at recommended temperatures for 1 of 4 medication refrigerators. o (Clubhouse refrigerator) On 1/19/17, all the medications found in this refrigerator were returned to the pharmacy upon discovery of improper storage temperatures according to the December 2016 and January 2017 refrigerator logs. Two (2) residents were found to be affected by this deficient practice. Both residents owned either Humalog insulin flex pens, a vial of Levemir insulin, and/or a Levemir flex pen that was stored within the refrigerator on the day of discovery. Both residents were immediately assessed. No adverse reactions were found. All blood sugar levels for the residents during the period of December 2016 and January 2017 were stable and consistent with their historical levels. The residents□ doctors were notified and no new orders were given. A new refrigerator for this household was purchased on 1/19/17.	

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F 431	Continued From page 12 degrees Fahrenheit to 46 degrees Fahrenheit. Avoid freezing the insulin. Do not use insulin that has been frozen." In an observation on 01/19/17 at 11:30 AM the medication refrigerator temperature was 36 degrees. The medication refrigerator contained 1 unopened Humalog (insulin) flex pen, 2 unopened vials of Levemir (insulin), and a storage box containing 2 Levemir (insulin) Flex Touch pens one of which was opened and partially empty. In an interview on 01/19/17 at 11:40 AM Nurse #1 stated that storing medications outside of the parameters set by the manufacturer would impact how the medication worked. She stated if a medication was given that was stored outside the parameters it could hurt someone and the medication would not be effective. She stated medications that had been frozen should not be used and noted that the refrigerator medication storage temperatures had been as low as 28 degrees. In an interview on 01/19/17 at 12:02 PM the Maintenance Manager, who had been employed by the facility for two weeks, stated it was the Maintenance Department's responsibility to respond to nurse requests to check the medication storage refrigerators. He indicated the instructions on the refrigerator temperature charts (to notify maintenance for abnormal temperatures) should have been followed. He indicated he was not aware of any reports from staff that the medication storage refrigerator temperatures were not being maintained at the correct setting but he would check his records. In a telephone interview on 01/19/17 at 4:00 PM RPh #1 indicated medications that had been frozen should not be used. The medication could cause pain if injected.	F 431	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. a. Example #1: Facility failed to store medications inside a locked medication cart for 1 of 4 medication cart. o On 1/17/17, Nurse#2 who left a Gabapentin card on the cart and walked away was verbally in-serviced on 1/17/17 by a RN nurse mentor regarding the facility policy and procedures on proper storage of medications with a formal in-service on 1/23/17. No residents were found to have the potential of having been affected by the deficient practice as all medications unsecured on the med cart were accounted for by the charge nurse. b. Example #2: Facility failed to dispose of expired and/or undated medications for 2 of 4 medication storage refrigerators. o (Lighthouse refrigerator) On 1/19/17, the opened and accessed vial of fluvirin vaccine with a handwritten opened date of 11/30/16 was returned to the pharmacy upon discovery. On 1/19/17, the Lighthouse RN nurse mentor completed a 100% audit on the Lighthouse residents to see if any resident had the potential to be affected by this deficient practice. No Lighthouse resident was given the fluvirin vaccine after the 12/30/16 expiration. o (Lighthouse refrigerator) On 1/19/17, the opened and accessed vial of Tuberculin purified protein derivative (PPD) which was in a box with a handwritten opened date of 12/17/16 was immediately returned to the pharmacy upon discovery. On 1/19/17, the	

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	345297	A. BUILDING _____ B. WING _____	01/20/2017

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F 431	Continued From page 13 In an interview on 01/19/17 at 4:32 PM the Administrator stated there were no records that staff had notified the Maintenance Department or the Pharmacy that medication storage refrigerator temperatures were out of range. In a telephone interview on 01/19/17 at 4:46 PM Nurse #4, who had initialed 6 out of 9 of the out of parameter temperatures in December 2016 and 12 out of 15 out of parameter temperatures in January 2017, stated she had not notified the Maintenance Department or the Pharmacy when she recorded the out of parameter refrigerator temperatures. She indicated she had adjusted the temperature once but had not recorded that the temperature was okay when she rechecked it. She stated she had not notified the DON or the Administrator that maintaining the medication storage refrigerator temperatures was an issue. In a telephone interview on 01/19/17 at 5:30 PM RPh #2 stated the acceptable practice was to store medications that required refrigeration between 36 degrees Fahrenheit and 46 degrees Fahrenheit. She indicated the nurse who checked the temperature should have called the pharmacy for instructions when the medication storage refrigerator temperature fell below or rose above the acceptable parameters. In a telephone interview on 01/19/17 at 5:44 PM RPh #3 stated medications that were stored in a refrigerator where the temperature had dropped under 32 degrees may have become frozen and should not be used. In an interview on 01/19/17 at 5:50 PM the DON stated she had been made aware of the medication storage refrigerator temperature problem on the Clubhouse nursing unit on 12/26/16. She stated nurses had monitored the temperature for 24 hours and no other follow-up was done. The DON indicated she had not been	F 431	Lighthouse RN nurse mentor completed a 100% audit on the residents to see if any resident had the potential to be affected by this deficient practice. No Lighthouse resident was given the Tuberculin purified protein (PPD) after the 1/16/17 expiration. o (Farmhouse refrigerator) On 1/19/17, the opened and accessed vial of fluvirin vaccine with no open date was returned to the pharmacy upon discovery. The household data shows that the Farmhouse resident flu vaccinations began on 10/28/16. The date of open label should have reflected 10/28/16. The expiration/discard date should have been 11/26/16. On 1/19/17, the Farmhouse RN nurse mentor completed a 100% audit on the residents to see if any resident had the potential to be affected by this deficient practice. The audit revealed (1) resident received a flu vaccination after 11/26/17. The resident□s doctor was notified and ordered a revaccination. The order was completed on 1/31/17. c. Example #3: Facility failed to follow special storage instructions placed by the pharmacy on a medication stored in a medication refrigerator for 1 of 4 medication refrigerators. o (Clubhouse refrigerator) On 1/19/17, one Levemir (insulin) Flex Touch pen with open date of 1/14/17 found in the refrigerator was returned to the pharmacy upon discovery due to improper storage. On 1/19/17, the Clubhouse RN nurse mentor completed a 100% audit on the insulin pens found in the refrigerator to determine if any resident other had the potential to be affected by this deficient	

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F 431	Continued From page 14 informed the temperatures continued to be a problem. She indicated she expected the nurses to follow the directions on the Temperature Chart and notify the Maintenance Department and the Pharmacy immediately if the temperatures were not within the parameters on the Temperature Chart. The DON indicated the facility would be replacing the medication storage refrigerator on the Clubhouse nursing unit.	F 431	practice. No other insulin pens were found to be opened and stored incorrectly in the refrigerator as witnessed by a state surveyor. d. Example #4: Facility failed to store medications at recommended temperatures for 1 of 4 medication refrigerators. o (Clubhouse refrigerator) On 1/19/17, all the medications found in this refrigerator were returned to the pharmacy upon discovery of improper storage temperatures according to the December 2016 and January 2017 refrigerator logs. Two (2) residents were found to be affected by this deficient practice. Both residents owned either Humalog insulin flex pens, a vial of Levemir insulin, and/or a Levemir flex pen that was stored within the refrigerator on the day of discovery. Both residents were immediately assessed. No adverse reactions were found. All blood sugar levels for the residents during the period of December 2016 and January 2017 were stable and consistent with their historical levels. The residents□ doctors were notified and no new orders were given. The Clubhouse RN nurse mentor completed a 100% audit on residents who may have the potential to be affected by this deficient practice. One (1) more Clubhouse resident was identified as having stored refrigerated medicated mouthwash during December 2016 and January 2017. This resident was assessed. No adverse reactions were found. The resident□s doctor was notified and no new orders were given.	

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F 431	Continued From page 15	F 431	3. Address what measures will be put in place or system changes needed to ensure that the deficient practice will recur. a. Example #1: Facility failed to store medications inside a locked medication cart for 1 of 4 medication cart. b. Example #2: Facility failed to dispose of expired and/or undated medications for 2 of 4 medication storage refrigerators. c. Example #3: Facility failed to follow special storage instructions placed by the pharmacy on a medication stored in a medication refrigerator for 1 of 4 medication refrigerators. d. Example #4: Facility failed to store medications at recommended temperatures for 1 of 4 medication refrigerators. e. After consulting with the facility pharmacy and Maintenance Director, the temperature chart was changed to include: (1) CDC recommended temperature reference range; (2) 1st shift quality assurance compliance check of the night shift temperature; (3) new procedures of notifying the Nurse Mentor and placing a work order in the computer for maintenance if the temperature is not in compliance; (4) Directions to discard and reorder all medications if the temperature is not in compliance; (5) placing an Out of Order sign on the refrigerator if the temperature is not in compliance; (6) a bold notification on the bottom of the form which states, Per maintenance, do not attempt to adjust temperature settings; (7) Submission of	

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F 431	Continued From page 16	F 431		

the form to the household RN nurse mentor for quality assurance review at the end of each month. Implementation of the new form began 2/1/17.
o 100% of facility nurses were in-serviced on proper medication storage (Facility policies on Security of Medication Cart, Storage of Medication, Labeling of Medication Containers, and Southern Pharmacy□s policy on Medication Storage in the facility). All education was completed by 1/25/17.
o 100% of facility nurses were in-serviced on the proper procedure and use of the medication storage refrigerator temperature chart, as well as the new Quality Assurance changes to the form. All education was completed by 1/27/16.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
o The RN nurse mentor of the households will audit the Night Shift Checklist weekly to ensure audits on Medication Storage and Temperature Charts are completed by the night shift nurses. This will be done weekly for one month or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator/whoever is to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing. The auditing program will be reviewed at a weekly QA meeting. The weekly QA Meeting will be attended by the DON, RN Nurse Mentors, Nursing Administrative Assistants, and the

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F 431	Continued From page 17	F 431	Administrator. Results of the Medication Storage and Temperature Chart monitoring will be brought and discussed by the DON in a monthly QA report at each meeting. The monthly QA report will review the Night Shift Checklist with RN Nurse Mentor audits as well as the Temperature Charts of each household. This will be done by the DON x 3 months, to include quarterly QA review and will continue until compliance is ensured.	