STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and resident and staff interviews, the facility failed to assess and obtain a physician's order for the self-administration of Renvela (a medication used to control high levels of phosphorus levels in dialysis patients) for 1 of 1 sampled resident receiving dialysis treatment. Resident #166. Findings included: Review of the facility's policy "Medications: Self-Administration" (revised 01/02/14) included: "1. When a patient requests medication self-administration, complete the Self-Administration of Medications Evaluation. 2. If evaluation indicates patient is capable of medication self-administration, notify physician/mid-level provider to obtain order. 2.1 When transcribing order, indicate self-administration for the medication on the Physician Order Sheet and Medication Administration Record (MAR). 3. Address medication self-administration in patient's care plan. Include plans for: 3.1 Storage and location of medications; 3.2 Education for patient/family; and 3.3 Ongoing monitoring and re-evaluation of	F 176	Resident #166 was assessed for self-administration of medication by Unit Managers (UM) on 7/12/17. The resident was assessed as not being able to safely administrate his medication secondary to could not identify the medication or understand the side effects. Residents that have a BIMS of 9 and above were assessed for self-administration of medication on 7/11/17-7/12/17 by UM. Newly admitted residents will be assessed. Residents that are assessed that are safe to administer and wish to self-administer their medications will have a physician order written to reflect self-administration of medication, educated on self-administration and a locked drawer will be provided. One resident requested to self-administer nasal spray and eye drops. Licensed nurses were educated on the completion of self-administration of medication assessment on 7/17/17, 7/18/17 and 7/19/17 by Center Nurse Executive (CNE), Assistant Center Nurse Executive (ACNE) and UM. Unit Mangers will maintain a log of residents that request to self-administer their medication	7/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/14/2017

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F 176	Continued From page 1 patient's capability. 4. Secure medications in a locked drawer at patient's bedside. Assure that patient and nursing both have a key. 5. Instruct patient in medication self-administration procedure. Include: 5.1 Obtaining medication; 5.2 Administering medication according to order; 5.2 Drug information related to effectiveness and side effects. 6. Monitor patient to assure effectiveness and/or side effects of medication. 6.1 Notify physician/mid-level provider of any side effects or changes in condition that may require medication adjustment. 6.2 Notify physician/mid-level provider and care plan team if patient demonstrates decrease in capability for medication self-administration. 7. Adjust plan for medication self-administration as indicated. 8. Document: 8.1 Patient's request and evaluation of capability in Nurses' Notes or progress notes; 8.2 Plan for storage, location, education, and monitoring on patient's care plan. 8.3 Notification of physician/mid-level provider if indicated." Resident #166 was admitted to the facility on 3/4/15 with diagnosis which included: end-stage	F 176	that includes the medication that resident is self-administering, if assessment is complete, physician order is present and a locked drawer is available for use. UM will monitor newly admitted residents to determine if self-administration of medication assessment is needed and monitor for any significant change in residents that may have changes that may need an updated self-administration of medication assessment weekly for one month then monthly times 2 months. The Center Nurse Executive (CNE) will present the data collected regarding resident that can safely self-administer medication to the Quality Assurance Committee (QAC) monthly for three months.	

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F 176	Continued From page 2	F 176		

renal disease (ESRD).

Review of the Grievance/Concern Form dated 4/5/17 revealed Resident #166 complained that a tube of numbing cream was removed from his room. During the investigation, the Assistant Director of Nursing (ADON) met with the resident to explain about having medictions at his bedside assessable to other residents. The corrective action was to keep medications locked in the cart. The grievance was resolved as the ADON documented the resident understood why he could not keep the medication at his bedside.

Review of the quarterly Minimum Data Set (MDS) dated 5/8/17 indicated Resident #166 was cognitively intact, had no behaviors, and received dialysis treatment. The Care Plan completed 5/22/17 revealed the resident was transported to the dialysis center on Mondays, Wednesdays, and Fridays.

During an observation and interview on 6/20/17 at 1:53 p.m., a large white, oval shaped pill was noted in a small medicine cup on the bedside table next to Resident #166's bed. The resident identified the white pill as Renvela. The resident removed the pill from the medicine cup and presented the wording on the pill, which read Renvela. The resident revealed he received this medication four times each day from the nursing staff at the facility.

A review of the clinical record indicated Resident #166 was not assessed for and did not have a physician's order for the self-administration of Renvela or any medications.

Review of the Medication Administration Record

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F 176	Continued From page 3 (MAR) for June 2017 indicated Resident #166 received 800 mg (milligram) of Renvela as scheduled at 1:00 p.m. on 6/20/17 from N#1 (Nurse #1). During an interview on 6/21/17 at 4:15 p.m., Resident #166 stated that some of the nurses (no names given) allowed him to keep the Renvela medication in his possession and ingest it when he consumed a meal. During an interview on 6/21/17 at 5:00 p.m., N#1 stated on days in which he went to dialysis Resident #166 was administered his 8:00 a.m. to 9:00 a.m. medications with his breakfast, before leaving the facility. NA#1 revealed occasionally the resident requested and was allowed to take his scheduled 1:00 p.m. Renvela medication with him to dialysis. During an interview on 6/22/17 at 9:01 a.m., the DON (Director of Nursing) acknowledged Resident #166 was not assessed for self-administration of any of his medications. She stated that the Physician would be notified that the resident had been self-administering his Renvela medication. The DON revealed that an in-service would be conducted with all licensed staff on each shift concerning medications left at bedside without a nurse present and any resident requesting self-administration required a self-administration assessment. The DON stated her expectation is when a nurse administered medication to a resident, the nurse was not to leave the resident's room without observing the resident swallowing the medication.	F 176		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		7/20/17

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F 278	Continued From page 4 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code on the comprehensive Minimum Date Set (MDS)	F 278	Resident #69 with a Level 11 PASSAR had their MDS modified to reflect the Level 11 by the MDS Coordinator on	

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F 278	Continued From page 5 assessment a level two PASRR (Preadmission Screening and Resident Review) for 1 of 1 resident (Resident #69) reviewed for PASRR. Findings included: 1. Resident #69 was admitted to the facility on 9/22/14 with diagnoses that included major depressive disorder, anxiety disorder and schizophrenia. A review of the North Carolina Medicaid Uniform Screening Tool (NC MUST) PASRR history revealed that Resident #69 was determined to be a PASRR level two (The purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services). A review of the comprehensive MDS assessment dated 5/8/17 indicated Resident #69 was not coded as a level two PASRR. An interview was completed with MDS Nurse #1 on 6/22/17 at 9:48 AM. She stated she didn't know how the information was incorrectly coded. She stated she typically called the business office to check if a resident was a level two PASRR and didn't know how the information about Resident #69's PASRR was missed. An interview was completed with the Admissions Director on 6/22/17 at 10:23 AM. She said she printed off PASRR information from the MUST system. If the PASRR was a level two she made a note on the admission notification notice and gave it to the business office. An interview was completed with Business Office	F 278	6/22/17. Residents with a one year limitation Level 11 PASSAR had their MDS reviewed by the MDS coordinator on 6/22/17. Nine residents were found with a Level 11 PASSAR that were not reflected on the MDS. Modifications were completed to reflect Level 11 PASSR by the MDS Coordinator on 6/22/17. Social Workers were educated on the PASSAR process and documentation on the MDS to reflect the correct Level of PASSAR by the Administrator on 7/13/17. Upon admission of the new resident, the PASSAR will be verified through the NC MUST system. A copy of the PASSAR will be printed, placed in a notebook in the admission office and scanned in PCC as part of the medical record by the Health Information Manager (HIM). Social Workers will maintain a log of all PASSARs and update as changes occurs. An audit of the coding of Section A 1500 and A1510 A, B and C will be completed by the Social Workers monthly for 3 months. The Social Workers will present the results of audits to the QA committee monthly for three months.	

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F 278	Continued From page 6 Employee #1 on 6/22/17 at 10:30 AM. She reported she received all PASRR information from Admissions and stated one of the MDS nurses typically called and asked if a resident was a level 2 PASRR. An interview with the Director of Nursing on 6/22/17 at 2:44 PM revealed her expectation that the PASRR be correctly coded on the MDS assessment.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280		7/20/17

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right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident

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F 280	Continued From page 8 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to update the Care Plans for 1 of 1 sampled resident receiving dialysis who was self-administering medication, and was no longer on fluid restrictions (Resident #166); and for 1 of 1 sampled resident who was noncompliant with requesting assistance with ADL (activities of daily living) care (Resident #251). The facility also failed to invite a resident to participate in their care plan meetings for 1 of 2 (Resident # 205) who were reviewed for notification of participation in care plan meetings. Findings included: 1. Review of the facility's policy "Medications: Self-Administration" (revised 01/02/14) included: "Address medication self-administration in patient's care plan. Include plans for: 3.1 Storage and location of medications; 3.2 Education for patient/family; and 3.3 Ongoing monitoring and re-evaluation of patient's capability."	F 280	Resident #166 care plan was updated to reflect that the resident was no longer on fluid restrictions and not able to self-administer medications by MDS on 6/21/17. A self-administration assessment of medications was completed on 7/12/17 by UM. The assessment reflected that the resident was not capable of self-administering medication. Resident #251 was discharged on 7/3/17. Resident #205 care plan was reviewed with resident on 6/30/17 by social worker and Interdisciplinary Team (IDT). Residents with BIMS of 9 and above will have a self-administration of medication assessment to determine if they are capable of self-administering medication. One resident was assessed as capable and requesting to self-administer medication, nasal spray and eye drops. Physician orders were obtained 7/14/17. Resident also has locked drawer to keep	

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F 280	Continued From page 9 Resident #166 was admitted to the facility on 3/4/15 with diagnosis which included: end-stage renal disease (ESRD). Review of the Grievance/Concern Form dated 4/5/17 revealed Resident #166 complained that a tube of numbing cream was removed from his room. During the investigation, the Assistant Director of Nursing (ADON) met with the resident to explain about having medictions at his bedside assessable to other residents. The corrective action was to keep medications locked in the cart. The grievance was resolved as the ADON documented the resident understood why he could not keep the medication at his bedside. Review of the quarterly Minimum Data Set (MDS) dated 5/8/17 indicated Resident #166 was cognitively intact, had no behaviors, and received dialysis treatment. The Care Plan completed 5/22/17 revealed the resident was transported to the dialysis center on Mondays, Wednesdays, and Fridays. During an observation and interview on 6/20/17 at 1:53 p.m., a large white, oval shaped pill was noted in a small medicine cup on the bedside table next to Resident #166's bed. The resident identified the white pill as Renvela (a medication used to control high levels of phosphorus levels in dialysis patients). The resident removed the pill from the medicine cup and presented the wording on the pill, which read Renvela. The resident revealed he received this medication four times each day from the nursing staff at the facility. There was no documentation in the Care Plan	F 280	medications. Care plans that were completed in June were reviewed and updated to reflect the resident status by the IDT on 7/13/17 and 7/14/17. Residents that had a care plan completed in June and July, an invitation was extended to resident and family for care plan review by the Social Workers by 7/20/17. The IDT was educated on updating and revising of care plans on 7/11/17 by the Regional Resource Nurse Manager. Social workers will complete a calendar for care plan meetings and present to team monthly. Care Plan calendar was completed on 7/14/17. Care plans will be reviewed and updated per MDS calendar and with changes in care by the UM and IDT. ACNE will audit care plans weekly as they are completed x 4 weekly for 3 months. Social workers will send out invitations to the resident and family and place a copy of the invitation in the medical record. Social workers will have the resident and/or family member attending the care plan meeting along with the IDT signature that care plan meeting was attended. The social workers will present the results of the audits to the QA committee monthly for three months.	

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concerning Resident #166 self-administering medication.

During an interview on 6/21/17 at 4:15 p.m., Resident #166 stated that some of the nurses (no names given) allowed him to keep the Renvela medication in his possession and ingest it when he consumed a meal.

During an interview on 6/21/17 at 5:00 p.m., N#1 stated on days in which he went to dialysis Resident #166 was administered his 8:00 a.m. to 9:00 a.m. medications with his breakfast, before leaving the facility. NA#1 revealed occasionally the resident requested and was allowed to take his scheduled 1:00 p.m. Renvela medication with him to dialysis.

1a. Resident #166 was admitted to the facility on 3/4/15 with diagnosis which included: end-stage renal disease (ESRD).

Review of the quarterly Minimum Data Set (MDS) dated 5/8/17 indicated Resident #166 was cognitively intact, had no behaviors, and received dialysis treatment.

The Care Plan completed on 5/22/17 revealed Resident #166 exhibited or was at risk for dehydration and or fluid excess as evidence by recent Infection, fever, ESRD with fluid restriction on dialysis. Interventions included: a 1500ml (milliliter) fluid restriction/day- 720ml from Dietary, 540ml from Nursing, 240ml from Activities; monitor for signs and symptoms of fluid excess.

During an interview on 6/20/17 at 1:53 p.m., Resident #166 revealed he was on fluid

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restrictions and he limited himself to 24 ounces of fluids and water he received with his medications for a total of 32 ounces per day.

During an interview on 6/21/17 at 9:30 a.m., the RD (Registered Dietitian) stated Resident #166 was not on fluid restrictions. The RD revealed the resident was on fluid restrictions prior to his hospitalization for pneumonia in January 2017. She stated upon the resident's return to the facility, the fluid restriction was discontinued, but the resident continued to monitor his fluids.

During an interview on 6/21/17 at 4:44 p.m., the MDS Coordinator indicated fluid restrictions should not have been included in Resident #166's Care Plan. She stated the resident's Care Plan should have been updated in March 2017 and May 2017 to reflect the discontinuation of the fluid restriction.

2. Resident #251 was admitted to the facility on 5/9/17 with diagnoses which included: diabetes mellitus, congestive heart failure, and respiratory failure.

Review of the clinical records indicated Resident #251 had a fall on 5/12/17. The resident was discovered sitting on the floor at the foot of his bed. Neurological checks were initiated. The Nurse Practitioner was notified and ordered continued monitoring. The resident's Responsible Party was also notified. Summary of investigation: unsteady gait and poor safety awareness. Close monitoring of the resident was initiated.

The facility's Nursing Assessment dated 5/14/17

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revealed Resident #251 was a high risk for falls.

The Admission Minimum Data Set (MDS) dated 5/16/17 indicated Resident #251 was cognitively intact, required extensive assistance of one staff for transfers, walking, toileting, had unsteady balance, and had one fall without injury.

The Care Plan completed 5/22/17 revealed Resident #251 was at risk for falls due to cognitive loss, lack of safety awareness, impaired mobility. Fall on 5/12/17 at 10:30 p.m.-resident noted lying on floor at foot of bed. Interventions included: encourage resident to call for assistance before attempting to transfer; monitor for and assist with toileting needs; provide resident/caregiver education for safe techniques; physical therapy evaluation.

The 30-Day MDS dated 6/4/17 indicated Resident #251 was cognitively intact, required limited assistance of one staff with transfers, walking in room and toileting, had an unsteady balance, had no falls, and received physical and occupational therapy.

Review of the Nurse's Note dated 6/4/17 revealed Resident #251 was noncompliant with requesting assistance with transfers to and from his wheelchair and requesting assistance with his toileting needs.

The Care Plan was not updated to include Resident #251's noncompliance with requesting assistance with ADL care.

On 6/19/17 at 12:17 p.m., Resident #251 was observed ambulating with a rolling walker in the hallway, unassisted.

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During an observation and interview on 6/22/17 at 10:25 a.m. Resident #251 was noted with a scabbed area to back of his left hand (below thumb and forefinger). The resident revealed that he "skinned" the back of his hand against the toilet when he lost his balance in the bathroom one night during the prior week. He insisted he did not fall, but slid himself against wall. The resident stated that he revealed the skin tear to the nurse at the nurse's station who cleaned, applied medicine, and placed a bandaid on the area.

During an interview on 6/22/17 at 10:43 a.m., NA#1 (nursing assistant) revealed Resident #251 required supervision to limited assistance with his ADL care. NA#1 stated the resident preferred providing his own ADLs, such as bathing, with setup help, only. She stated that the resident was capable but rarely used the call light. NA#1 also revealed that with the use of his rolling walker, the resident toileted himself.

During an interview on 6/22/17 at 5:20 p.m., the MDS Coordinator revealed Resident #251's Care Plan was not updated due to the Medicare Assessment (30-day MDS) did not require a Care Plan and the resident was still in therapy with anticipation to continue to improve. The MDS Coordinator stated it was the responsibility of the Nursing Department to update a resident's Care Plan when the resident was noncompliant with care, skin tears, falls, wounds, and such.
3. An interview on 6/19/17 at 4:04 pm with Resident #205 revealed that she had never been invited to her care plan meeting.

Resident #205 was admitted to the facility on

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10/3/16 and her diagnoses included end stage renal failure, diabetes and chronic obstructive pulmonary disease.

A quarterly minimum data set (MDS) dated 4/4/17 for Resident #205 revealed she was alert and oriented.

The facility Social Services policy with a revision date of 11/28/16 was provided by the Social Services Director. The section titled care plan included practice standards stating "Patient / HCDM (health care decision maker) will be invited to care plan conference. Provide update to patient / HCDM if he/she is unable to attend and document in progress notes."

A review of the most recent care plan for Resident #205 dated 4/4/17 did not identify if the resident had been invited or attended the care plan meeting.

A review of the progress notes for Resident #205 for the past 6 months did not reveal any documentation that she had been invited to her care plan meeting or that her care plan had been reviewed with her.

An interview on 6/22/17 at 4:17 pm with the MDS Nurse revealed the Social Worker was responsible for inviting residents and their families to care plan meetings. She stated she did not know if Resident #205 had ever been invited or attended any care plan meetings.

An interview on 6/22/17 at 4:40 pm with the Social Services Director revealed that she is responsible for inviting the residents and their responsible parties to the care plan meetings.

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F 280	Continued From page 15 She stated that she either called them or sent a letter, but that she did not document this anywhere. She stated that only the people that attend the care plan meetings sign-in that they attended. She stated that she does not document if a resident was invited and declined to attend. She stated that she really hadn ' t been inviting residents to their care plan meetings, but now with the new regulations she is trying to make sure and invite them. An interview on 6/22/17 at 6:40 pm with the Administrator revealed she expected residents to be invited to their care plan meetings and that there should be a system to track who was invited and if they accepted or declined the invitation.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews and pharmacy interview the facility failed to administer doses of Morphine to one of 2 sampled residents using a method to dose the Morphine to ensure the physician ordered dosage was administered. Resident # 111. The findings included: Resident #111 was admitted to the facility on	F 281	Resident #111 has received the correct dose of Morphine. The nurse called the pharmacy on 6/21/17 and obtained syringes that could measure the morphine. Residents' physicians orders were reviewed by the UM on 6/21/17 for liquid morphine orders and if a syringe was available to give the correct dose. Five	7/20/17

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F 281	Continued From page 16 5/4/17 with diagnoses of pain in unspecified joint, seizures, osteoporosis, and degenerative joint disc. Resident #111 was currently on Hospice Services. Review of the physician orders dated 5/11/17 included Morphine 20 milligrams (mg) per milliliter (ml). The ordered dose was to give .25ml via Gastrostomy tube every 2 hours as needed for pain or shortness of breath. Review of the Medication Administration Record (MAR) revealed the Morphine was given on 5/26, 6/5, 6/11. 6/13 and 6/14. The documented pain level on the MAR for those times of administration were from 5 to 8, in a scale from 0 to 10. There was no documentation that the pain was not relieved. Interviews with nurse #2 on 6/22/17 at 2:30 PM revealed she had given Morphine to Resident #111. She explained she used the syringe in the packaged medication. The syringe was calibrated in increments of 0.1 ml, 0.2 ml, 0.3 ml etc. Nurse #2 explained she drew up 0.2 ml plus half way between the 0.2 ml and the 0.3ml. She explained there were no lines to indicate where the halfway mark was for the correct dose. The nurse had not informed anyone of the problem with the syringe dosing system. Interview with the pharmacist on 6/22/17 at 9:36 AM revealed the Morphine came prepackaged with the syringe inside the box. She was not aware the dosing could not accommodate the ordered doses. The pharmacist explained the pharmacy had syringes that could be sent to the facility for that amount of Morphine dose.	F 281	residents were found with orders for liquid morphine and appropriate syringe was available. Licensed nurses on all shifts including weekends were educated on the use of the appropriate equipment to measure medication accurately on 7/15/17, 7/17/17, 7/18/17 and 7/19/17 by the CNE, ACNE and UM. Unit Managers, CNE and ACNE observed licensed nurses on all shifts including weekends, drawing up liquid medication using a syringe for accuracy on 7/15/17, 7/17/17, 7/18/17 and 7/19/17. Newly hired licensed nurses will be educated and perform return demonstration to CNE, ACNE or UM for administration of liquid morphine. Two licensed nurses will perform return demonstration once initial observation is complete weekly for 3 months. Physician orders will be monitored 5x weekly for the next 3 months for any new liquid morphine orders in clinical morning meeting along with syringe being used by nurses by CNE, ACNE and UM. Unit Managers will complete audit on residents that have orders for liquid morphine weekly for the presence of correct dispensing syringe weekly for one month, then monthly for 2 months. CNE will present the finding from the return demonstration to the QA committee meeting for three months.	

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F 281	Continued From page 17 Interview on 6/22/17 at 3:00 PM with Nurse #3 revealed he gave the medication by measuring with the syringe in the packaged Morphine. He drew up to the 0.2 ml and then halfway between the 0.2 and 0.3 ml. Nurse #3 had not informed anyone of the problem with the syringe dosing system. Interview with Nurse #5 on 6/22/17 at 3:05 PM revealed she had given the Morphine and measured the dose for administration in the same manner as Nurse #3. Interview with the Director of Nursing on 6/22/17 at 5:17 PM revealed she would expect the nurse to question how to administer the medication. She would expect the nurse to notify her, the ADON, unit manager or someone and not give the medication without the correct means of administrating the correct dose. She further explained she had not been made aware there was a problem with the dosing syringes.	F 281		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		7/20/17

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F 323	Continued From page 18 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and resident interview the facility failed to maintain the hot water in residents' room at or below 116 degrees. This affected rooms on the second floor of a two story building. (2 North, 2 South and Homestead unit.) The findings included: During tour of rooms on the Homestead unit, on 6/19/17 at 11: 43 AM the hot water was checked in rooms 231, 230 and 229. The hot was too hot to hold a hand under the water. The Maintenance Director was asked to check the water temperatures for those rooms. Rooms on 2 North and 2 South were checked randomly on 6/19/17 at 11:45 AM in rooms 129, 130 and 131. The hot water in these rooms was too hot to hold a hand under the water. On 6/19/17 at 11:50 AM the Maintenance Director arrived to check the water temperatures on the Homestead unit. The temperatures were	F 323	CED was notified of water temperatures out of range on 6/19/17. CED notified CNE who notified all nursing units to inservice staff on water temperature issues and to test water prior to using water for patient care. Disposable use products were purchased to continue care. Maintenance Director replaced the mixing valve on 6/19/17 at 2:15pm. Maintenance Director continues to monitor water temperatures after mixing valve was replaced for the next four hours with no issue. On 6/20/17 temperatures were checked from 7am to 330pm with no temperature issues. All staff were educated on 6/19/17 on what to do if the water seems too hot/cold to notify the Maintenance Department. Regional Maintenance Director will educate the Maintenance Director and Maintenance Assistant on 7/14/17 on the procedure of what to do if the water is too	

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F 323	Continued From page 19 checked with a laser thermometer and were as follows: room 229 registered at 122 degrees Fahrenheit (F), room 230 registered at 120 degrees F and room 231 registered at 121 degrees F. Interview with the Maintenance Director immediately after checking the temperatures revealed there had been a problem with the mixing valve and he had rebuilt the valve in May 2017. The Maintenance Director left Homestead floor to adjust the mixing valve. Water temperatures were checked again on 6/19/17 at the following times: Room 240 was 120 degrees F at 12:20 PM, room 237 was 120 degrees F at 12:25 PM, room 209 was 122.1 degrees F at 12:30 PM and room 212 was 117.5 degrees F at 12:31 PM. Interview with the Maintenance Director on 6/19/17 at 12:33 PM revealed he would continue checking the water temperatures every hour. He explained there was one water line in the residential area of the building, and it made a loop beginning on the first floor. A separate valve was checked and was set at 119 degrees F. Further interview revealed he usually checks the temperature setting every morning, but had not done so that morning. The area was kept locked and he did not know how the temperature setting was changed. During the interview, he explained the temperature setting was to be at 113 degrees F at that particular valve. The Maintenance Director indicated he had checked the temperatures of the water on the first floor prior to coming to the second floor. In room 103 the water temperature was 110 degrees when checked after turning down the water	F 323	hot/cold. Maintenance Director/designee checks the temperature daily Monday through Friday at risers (points of entry) for temperatures within range for 2 months. Three rooms on each unit are checked twice daily Monday through Friday by the Maintenance Director/designee and by the weekend Manager on Duty on the weekends for 4 weeks then once daily for 4 weeks then weekly for 4 weeks. Maintenance Director will present the data collected regarding water temperatures to the QA committee meeting monthly for three months.	

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temperature.

Interview conducted on 6/19/17 at 12:15 PM with the nurse #4 revealed she was not aware the water temperatures were too hot.

Interview with Unit Manager #2 on 6/19/17 at 12:17 PM revealed she was not aware the water temperatures were too hot.

Interviews were conducted with aide # 2 on the Homestead Unit and she explained she had used the hot water that morning and it did not seem too hot. If the water would be too hot, she would mix cold water with the hot. She further explained the water is usually too cool and not hot enough.

Interview with the Administrator on 6/19/17 at 1:00 PM revealed she was informed by the Maintenance Director of the water temps. Further interview revealed she thought the nurses had informed regarding the water temperatures. The Administrator informed the Director of Nursing, who called the units to alert them the water temps were too high.

Interview with the Maintenance Director on 6/19/17 at 2:51 PM revealed he had replaced the mixing valve with a new mixing valve. Review of the water temperatures after the mixing valve was repaired revealed the highest water temperature was 112 degrees F. Further interview revealed it would take a while to totally mix the water. He would check temperatures every hour to ensure it was down and stayed down.

Review of the water temperature log for June 2017 revealed the water temps were checked on a random basis until every room was checked.

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F 323	Continued From page 21 The log review revealed on 6/2/17 one temperature at the following: 117 degrees, 118 degrees and 119 degrees. There were no other dates or water temperatures that were elevated above 113 degrees. Interview on 6/19/17 at 2:54 PM with the Maintenance Director revealed the elevated water temperatures checked on 6/2/17 were corrected with the mixing valve being adjusted. During the interview he explained the temperatures were rechecked to ensure the temperatures had come down. Rechecks of the water temperatures on 6/20/17 at 10:42 AM with the Maintenance Director revealed the water temperatures ranged from 100 degrees F to 112 degrees F.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329		7/20/17

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F 329	Continued From page 22 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff and pharmacist interviews and record review, the facility failed to address a request for Gradual Dose Reduction (GDR) by the pharmacy or document the continued need for three antidepressants (bupropion HCL XL, fluoxetine HCL, trazodone) and an antipsychotic (risperidone) medication ordered for 1 of 5 sampled residents reviewed for unnecessary drugs (Resident #26). Findings included: 1. Resident #26 was admitted to the facility on 12/30/14 with diagnoses that included anxiety disorder, bipolar disorder, insomnia and major depressive disorder. A review of Resident #26's comprehensive	F 329	Resident's #26 psychotherapist was contacted by CNE on 7/12/17 and voicemail was left. Call was returned to CNE on 7/13/17 stating that resident was being seen by a psychotherapist, not a psychiatrist. The psychotherapist retired 6/30/17. Facility Nurse Practitioner (NP) was contacted by CNE on 7/14/17 regarding Gradual Dose Reduction (GDR). Facility NP recommendation is to start GDR with one psychotropic medication at a time and monitor for any behavior changes. Pharmacy consultant reports from May 2017 to July 2017 were reviewed for residents on psychotropic drugs for	

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F 329	Continued From page 23 minimum data set (MDS) assessment dated 1/4/17 revealed she was cognitively intact. The same assessment revealed there were no negative behaviors or psychosis and was cooperative with care. A review of Resident #26's current medications for the month of June 2017 revealed she received fluoxetine HCL, 40 milligrams (mg) daily (started 12/2/15), risperidone, 1mg at night (started 4/26/16), trazodone 100mg at night (started 12/2/16) and buproprion HCL XL, 300mg daily (started 12/2/15). A review of Resident #26's medical record revealed there was no documentation of GDRs having been addressed for the bupropion HCL XL, fluoxetine HCL, trazodone and risperidone. On 6/22/17 an interview was attempted with the facility's Consultant Pharmacist; however, he was out of the office all week and unavailable. An interview was completed on 6/22/17 at 6:40 PM with the Consultant Pharmacist's supervisor. He reviewed the pharmacy record and stated a GDR was requested on 2/22/17 for fluoxetine HCL, bupropion HCL XL and trazodone. Additionally, he stated a GDR was requested on 3/21/17 for the risperidone. The Director of Nursing (DON) provided a copy of the pharmacist's consultation report for February and March 2017. The report dated 2/22/17 revealed that Resident #26 was taking three antidepressants and recommended that the physician (MD) "re-evaluate the need for three agents, perhaps giving consideration to a GDR." There was no documented response from the MD	F 329	recommendations for gradual drug reduction (GDR) by CNE, ACNE and UM on 7/12/17. Twenty-six pharmacy consultant reports for GDRs were identified. The residents' physician was notified by UMs on 7/12/17 for orders for GDR or reasons why recommendations were not advised. A copy of the pharmacy consultant recommendation report will be maintained in the CNE office. UMs will present the original to the MD. Once the MD addresses the recommendation the UM will ensure that the recommendation is completed by the nurse if applicable. The completed recommendation along with a copy of order will be returned to the CNE office, copy made, attached to original copy with the original then placed on the medical record. CNE will audit the copy of pharmacy consultant recommendations weekly to ensure that MD has addressed all recommendation for 3months. The CNE will present the results of audits to the PI committee monthly for 3 months.	

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F 329	Continued From page 24 related to the recommendation, and there were no physician orders present to reduce the dosages of the fluoxetine, trazodone, or buproprion. The pharmacist's consultation report dated 3/21/17 revealed that Resident #26 was taking risperidone and recommended that the physician (MD) "consider GDR while monitoring for re-emergence of target and/or withdrawal symptoms." There was no documented response from the MD related to the recommendation. On 6/22/17 at 6:51 PM an interview was completed with the DON. She stated after the pharmacist reviewed charts he emailed the reports to her. She printed them off and stated she usually made a copy for her office file. She gave reports to her unit managers and they would be placed in the MD book. The DON said the MD typically reviewed the recommendations, "sometimes in a day or two, sometimes a week." She reported she looked for the signed reports for 2/22/17 and 3/21/17 but was unable to locate them. She further stated the MD who would have reviewed the reports was no longer at the facility and a new MD started in either March or April 2017. The DON said she would expect that the pharmacist's recommendations would be addressed by the physician.	F 329		
F 363 SS=E	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in	F 363		7/20/17

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F 363	Continued From page 25 accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide the residents that received puree diets (5 of 5 residents) who were served from the 200 hall dining room (1 of 3 service areas), the meat and starch portions of their meal. The facility failed to identify and serve the correct portion size for a menu substitution for 1 of 2 meals that were observed. Findings Included: A review of the planned menu and production sheets for the lunch meal on 6/21/17, provided by the Dietary Manager (DM), revealed the menu had been changed from pepperoni pizza to pasta. This change was made for both the regular and	F 363	Residents receiving a pureed diet order have received proper portion sizes as outlined by dietary spreadsheet since 6/21/17. Substitution log was reviewed by Registered Dietitian (RD) on 6/21/17 and compared substituted items to the spreadsheet to determine if portions sizes were correct for substitutions to provide nutritional adequacy. Director of Dining Services (DDS) updated spreadsheets on 7/14/17 to reflect food items on the current menu, to include proper portion sizes.	

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F 363	Continued From page 26 puree diets. The portion size on the production sheet stated 1 slice. The production sheet also indicated the puree diets were to receive 1 serving of pureed tossed salad, a #12 scoop of puree bread and a ½ cup of pureed pears. A continual observation was made of the 200 hall dining room where the serving line was located, on 6/21/17 from 12:20 pm until 1:40 pm. The following observations and interviews were conducted during this observation. The tray line contained the pureed beef cheese pasta bake with a #12 portion scoop, the pureed tossed salad with a #8 portion scoop, the pureed bread with a #12 portion scoop and pre-portioned bowls of pureed pears. The portion scoop for the regular beef cheese pasta bake was a 6 ounce ladle. During observation on 6/21/17 at 12:20 pm of the meal the pureed beef cheese pasta bake was removed from the steam table to be re-heated. Two residents that were present in the dining room were served a #8 scoop of pureed salad, a #12 scoop of pureed bread and a bowl of pureed pears. Observation on 6/21/17 at 12:50 pm of the two residents who received the partial plates of pureed foods were assisted with their meal by the Assistant Activity Director (AAD) and the Assistant Director of Nursing (ADON). When they finished eating both residents were removed from the dining room. An interview on 6/21/17 at 12:55 pm with the Assistant Activity Director revealed that she had taken the residents back to their room as they	F 363	The dietary staff were inserviced on the week of 7/10/17 on portion sizes with return demonstration with the Director of Dining Services (DDS) and Executive Chef (EC). DDS/EC will complete audit on scoops/ladles used during meal service (portion size) three times daily for 6 days per week to include one weekend day for 4 weeks, twice daily for 4 weeks then once daily for 4 weeks. RD will present and discuss any issues or trends discovered during monitoring to QA committee meeting for three months.	

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F 363	Continued From page 27	F 363		

had finished eating their lunch. When AAD was informed that the residents on puree diets had not received their main entrées, the pureed beef cheese pasta bake she bought the two residents back to the dining room to eat the rest of their meal.

Observation on 6/21/17 at 1:00 pm of the tray line revealed 3 additional residents that received puree diets were served a #8 scoop of pureed salad, a #12 scoop of pureed bread and a bowl of pureed pears. These trays were delivered to the residents rooms.

Observation 6/21/17 at 1:20 pm of the tray line revealed the pureed beef cheese pasta bake had been returned to the steam table after it had been reheated. A #12 portion scoop was being used to serve the pasta bake. Dietary Aide #2 served the two residents that had been returned to the dining room one #12 scoop of the pureed pasta bake.

An interview on 6/21/17 at 1:20 with Dietary Aide #2 stated that a #12 scoop was equivalent to a 3 ounce portion and the puree diets received one #12 scoop of the pasta bake

An interview on 6/21/17 at 1:30 with the DM revealed that the puree diets were supposed to receive 2 #12 scoops of the pureed casserole because this was both their protein and starch serving for the meal.

An interview on 6/21/17 at 1:40 with Dietary Aide #2 revealed that they were finished serving the lunch meal to all of the residents. The surveyor intervened to inform Dietary Aide #2 that 3 residents that had been served in their rooms had not received the pureed pasta bake. She stated

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F 363	Continued From page 28 "oh, that ' s right we didn ' t have the re-heated pureed pasta bake then." Interview and observation on 6/21/17 at 1:40 pm with the DM revealed she had the staff prepare 3 - 6 ounce servings of the pureed pasta bake and these were taken to the 3 residents that were served in their rooms. The DM stated that the puree trays should not have been made until all of the foods were ready to be served. An interview on 6/22/17 at 4:03 pm with the Registered Dietitian (RD) and the DM revealed that the pizza had been taken off of the menu because the residents had a hard time eating it. The RD stated the beef cheese pasta bake had been substituted and residents should have been served a 6 ounce serving. She additionally stated that the correct portion size should have been reflected on the menu and the production sheets. An interview on 6/22/17 at 6:41 pm with the Administrator revealed it was her expectation that residents would be served the correct food portions to ensure their nutritional needs were met.	F 363		
F 364 SS=D	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive,	F 364		7/20/17

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F 364	Continued From page 29 and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews the facility failed to serve hot foods at an acceptable temperature for 1 of 1 resident (Resident #42) that was reviewed for food palatability. Findings Included: An interview on 6/19/17 at 4:59 pm with Resident #42 revealed that his meals were frequently cold when they were served to him. He stated that he had reported his concerns to the nurses and other staff but nothing had changed. Resident #42 was admitted to the facility on 1/10/17 and his diagnoses included diabetes and coronary artery disease. A review of the annual minimum data set (MDS) dated 4/17/17 for Resident #42 revealed he was alert and oriented, required tray -set up and supervision with eating. An observation was made of the steam table in the main kitchen on 6/22/17 at 12:15 pm. The temperatures were taken, using a calibrated thermometer, by Dietary Aide #3 and revealed the temperature of the chicken tenders was 142 degrees F, the waffles were 146 degrees F and the fried okra was 147 degrees F. A test tray was prepared at 1:04 pm from the kitchen steam table and contained the chicken and waffles (2 thick cut waffles with 3 breaded chicken tenders and maple syrup) and a serving of fried okra. The test tray was delivered to the	F 364	Resident #42 was interviewed on 7/11/17 for food preferences and food palatability, to include cold food. Resident #42 has not mentioned any food related concerns for additional interviews on 7/12/17, 7/13/17 and 7/14/17. DDS/EC completed Food Preference Questionnaire, which includes concerns about cold food, for all alert and oriented residents (for BIMS over 9) in the facility the week of 7/10/17. DDS/EC completes meal assessment audit (includes temperature and palatability) once daily for 6 days per week including 1 weekend day for 4 weeks, three times per week for 4 weeks then once weekly for 4 weeks. RD completes Food Service Quality Indicators audit from all findings from the meal assessment audits completed by DDS/EC weekly for 3 months. RD will present and discuss any issues or trends discovered during monitoring to QA committee meeting for review at monthly QA meeting for three months.	

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F 364	Continued From page 30 100 hall where Resident #42 resided and ate his meals. There were 4 trays, including the test tray that were delivered on the cart. The resident trays were delivered at 1:06 pm and the temperature of the foods on the test tray were checked by the DM using the same calibrated thermometer that had been used in the kitchen. The internal temperature of the chicken and waffles registered 108 degrees F and the fried okra registered 116 degrees F. The food items were tasted by the surveyor and the DM. The chicken and waffles were cool to taste and the fried okra tasted barely warm. An interview on 6/22/17 at 3:57 pm with the DM revealed that all foods should be held and served at the required temperatures. She stated that she wanted all residents to be satisfied with the temperature of their meals when they were served. An interview on 6/22/17 at 6:45 pm with the Administrator revealed it was her expectation that foods are cooked, held and served at the required temperatures.	F 364		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly 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	F 371		7/20/17

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F 371	Continued From page 31 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 observations, record review and staff interviews the facility failed to maintain the temperature of foods stored in the walk-in cooler at / below 41 degrees F, failed to ensure dishes were sanitized and in good repair, failed to store foods in sealed, labeled and dated containers, failed to maintain clean kitchen equipment, failed to maintain the holding temperature of a cold salad at / below 41 degrees F and failed to reheat a casserole to a minimum of 165 degrees F. Findings Included: 1. An observation of the kitchen on 6/19/17 at 9:50 am with the Dietary Manager (DM) and Registered Dietitian (RD) revealed: A. The thermometer inside the walk-in refrigerator registered 54 degrees F. A calibrated thermometer was used to check the temperature of a 4 inch deep, full size steam table pan of coleslaw and it registered 47 degrees F. A calibrated thermometer was used to check the	F 371	Maintenance contacted a refrigeration company to evaluate the temperature of the walk-in on 6/19/17. The refrigeration company evaluated the walk-in to ensure all systems were working properly. The refrigeration company found that the loading dock was not circulating air properly, causing the air to be hot. The refrigeration company replaced a fan on the loading dock in order to circulate air. The coleslaw, sliced bologna, ricotta cheese, case of dough, breaded okra, quiche, parmesan cheese and bowl of tartar sauce were discarded on 6/19/17 by the DDS. The bag of rotini pasta and spaghetti were discarded on 6/19/17 by the DDS. The convection ovens were deep cleaned on the night of on 6/19/17 by a dietary aide.	

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F 371	Continued From page 32 temperature of a bag of sliced bologna and it registered 47 degrees F. The walk-in refrigerator had a container of ricotta cheese that had expired 6/10/17. B. The walk-in freezer had a case of roll dough that was open and exposed to the air, 2 bags of roll dough that were not labeled or dated, a case of breaded okra that was open and exposed to the air with no label or date and 3 pre-cooked quiche that were partially wrapped in plastic wrap with no labels or dates. C. The dry storage room had a case of rotini pasta that was not sealed, labeled or dated and an open case of spaghetti that was not labeled or dated. D. The reach-in refrigerator had a container of parmesan cheese that was open and exposed to the air and a bowl of tartar sauce dated 6/11/17. E. The convection ovens (2) had a heavy build-up of black burnt on food particles. The ceiling and light fixture of the walk-in cooler had blackened areas and food particles. A shelving unit in the walk-in cooler had a food substance dripping off of the shelf. 3 ingredient bins located in the dry storage room had a build-up of dried food on the lids. An interview with the DM on 6/19/17 at 10:15 am revealed she thought the walk-in refrigerator temperature was up because the door had been open. She stated the temperature was checked that morning and it was 40 degrees F; she would have maintenance look at the refrigerator. She stated that all opened food products should be stored in sealed containers, labeled and dated	F 371	The ceiling and light cover in the walk-in were cleaned on 6/19/17 by the DDS. The shelving units in the walk-in were cleaned on 6/19/17 by the DDS. All three ingredient bins in dry storage were cleaned on 6/19/17 by the DDS. The cobb salad, ranch dressing and pureed beef pasta bake were removed from lunch meal service on 6/21/17 by RD. The pureed beef pasta bake was reheated in the kitchen by the DDS and returned to meal service, only to register at 147 degress Fahrenheit. The pureed beef pasta bake was removed from meal service immediately by DDS and a new batch was returned to meal service by DDS. The five residents who were on a pureed diet received the correct portion size of the pureed beef pasta bake on 6/21/17. Ecolab was contacted by the Corporate Dining Services Director and sanitizer for the dish machine was brought into the facility on 6/21/17. Disposable dishes were used for lunch and dinner meal services on 6/21/17. All milk/protein based food items in the walk-in were discarded on 6/19/17 at 6:20pm by the RD, Center Executive Director (CED) and the Maintenance Director.	

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F 371	Continued From page 33 and that foods should be discarded by the expiration date. She stated that all kitchen equipment and storage areas should be clean and will be added to the cleaning list. An observation on 6/19/17 at 10:20 am of the temperature log for the walk-in refrigerator revealed that the temperature of the walk-on refrigerator had been recorded at 40 degrees the morning of 6/19/17 (no time documented). The log revealed that the temperatures of the walk-in refrigerator were recorded in the morning and the evening (no times documented) June 1st through June 18th. The documented temperatures were 41 degrees F or below. An observation of the kitchen on 6/19/17 at 6:00 pm with the RD revealed the thermometer inside the walk-in refrigerator registered 50 degrees F. The RD, using a calibrated thermometer, took the temperature of an 8 ounce carton of milk and it registered 56 degrees F. The Corporate Chef, using a calibrated thermometer, took the temperature of a 4 ounce nutritional shake and it registered 54 degrees F. An interview with the RD on 6/19/17 at 6:10 pm revealed milk that had been stored in the walk-in refrigerator had been sent to 2 dining rooms for service at the supper meal. The RD stated that maintenance had a refrigeration company look at the unit earlier in the day and she thought the temperature had come down to 40 degrees F. She stated that she would discard all of the items from the walk-in refrigerator. An interview on 6/20/17 at 8:15 am with the maintenance director revealed that the walk-in refrigerator temperature was down to the correct	F 371	Hourly checks during operating hours were conducted on the walk-in beginning 6/20/17 and completed until 6/30/17; all completed by the RD and DDS. All temperatures recorded for the walk-in were maintained below 41 degrees Fahrenheit. RD completed kitchen sanitation audit on 6/19/17 and issues identified were corrected on 6/19/17 by a dietary aide. The DDS/EC inserviced the dietary staff the week of 7/10/17 on the kitchen cleaning schedule which includes a detailed list of all kitchen appliances and utensils to be cleaned. The schedule contains a completion sheet to be signed by dietary staff after cleaning assignment is completed daily. The DDS/EC inserviced the dietary staff the week of 7/10/17 on recording temperatures of refrigeration/freezer units during each shift, the temperature ranges each unit should be within and who/when to contact if the temperature is above the proper temperature range. The DDS/EC inserviced the dietary staff the week of 7/10/17 on proper procedures for storing, labeling and dating food items. The DDS/EC inserviced the dietary staff the week of 7/10/17 on proper procedures for dish machine service, including taking temperatures and sanitation levels three times per day.	

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F 371	Continued From page 34 temperature. He stated that a corporate representative was coming to look at it today. He stated that they were not storing any food in the walk-in refrigerator. An interview on 6/20/17 at 10:00 am with the RD revealed that she was monitoring the temperature of the walk-in refrigerator every 2 hours to ensure that the temperature was correct before using it for any cold food storage. She stated that refrigeration temperatures should be maintained at 41 degrees F or below to ensure that food was stored at the appropriate temperature. A review of the every 2 hour temperature checks, provided by the RD, revealed the temperature was being maintained below 41 degrees F. 2. An observation of the 200 hall dining room on 6/20/17 at 12:30 pm revealed the following: A. A steam table was present in the 200 hall dining room and contained a pan of Cobb salad (a salad that included meat, eggs and cheese), a pan of ranch dressing and a pan of pureed beef cheese pasta bake. Dietary Aide #2 was observed to calibrate a thermometer and take the temperature of the Cobb salad. The temperature registered 45.3 degrees F. Dietary Aide #2, using the same calibrated thermometer, took the temperature of the ranch dressing and it registered 45 degrees F. Dietary Aide #2 proceeded to prepare 2 residents plates with the Cobb salad and ranch dressing. Dietary Aide #2, using the same calibrated thermometer, took the temperature of the pureed beef cheese pasta bake and it registered 127 degrees F. The RD then proceeded to remove the Cobb salad, ranch dressing and pureed beef cheese pasta bake	F 371	The DDS/EC inserviced the dietary staff the week of 7/10/17 on appropriate temperatures for food and the process if food is not at appropriate temperatures. The DDS/EC inserviced the dietary staff the week of 7/10/17 on portions sizes with return demonstration with the DDS and EC. DDS/EC completes cleaning log audit two times per day for 6 days to include 1 weekend day for 4 weeks, once daily for 4 weeks then twice weekly for 4 weeks. Any issues from cleaning log audit will be corrected immediately and attached to the audit. DDS/EC completes audit of dish machine temperature log three times daily for 6 days to include 1 weekend day for 4 weeks, twice daily for 4 weeks then once daily for 4 weeks. Any issues for dish machine temperature audit will be corrected immediately and attached to audit. DDS and EC completes dish machine sanitizer audit, with test strips, three times daily for 6 days to include 1 weekend day for 4 weeks, twice daily for 4 weeks then once daily for 4 weeks. Any issues for dish machine sanitizer audit will be corrected immediately and attached to audit. DDS/EC completes sanitation audit, to include: foods sealed/labeled/dated, temperatures recorded of walk-in, temperature of foods in walk-in, cleanliness of equipment, daily for 6 days to include 1 weekend day for 4 weeks, twice weekly for 4 weeks then weekly for 4 weeks. Any issues from sanitation audit	

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F 371	Continued From page 35 from the steam table. The re-heated pureed pasta bake was returned to the steam table. Dietary Aide #2, using the same calibrated thermometer, took the temperature of the pureed beef cheese pasta bake and it registered 147 degrees F. Dietary Aide #2 prepared 1 plate of the pureed beef cheese pasta bake for service. An interview with Dietary Aide # 2 revealed that re-heated foods are required to be at 165 degrees F or higher. The DM removed the pureed beef cheese pasta bake from service. B. An observation on 6/20/17 at 12:45 pm with the DM revealed 27 plate covers that had deep scratches and layers of the plastic peeling off. The DM stated that the plate covers and bases were in bad shape and they needed to be replaced. She stated that she would need to obtain pricing to replace these and discuss with the facility Administrator. 3. An observation of the kitchen on 6/22/17 at 12:15 pm revealed the dish machine was in use. There were 2 racks of dishes that had just been run through the dish machine on the clean end table and 1 rack of dishes that were getting ready to enter the machine. The wash temperature registered 160 degrees and the rinse temperature registered between 120 to 140 degrees. The sanitizer level was checked using a test strip and the strip remained white; no evidence of any sanitizer. An interview with the DM on 6/22/17 at 12:20 pm revealed she was not sure if the dish machine used hot water or chemicals for sanitizing the dishes. The corporate chef joined the conversation and he stated that it was a low temperature machine and used a chemical	F 371	will be corrected immediately and attached to audit. RD completes audit of all findings from audits completed by DDS/EC weekly. All findings from audits will be brought to monthly QA. RD completes sanitation audit twice weekly for 4 weeks, weekly for 4 weeks then twice per month for 4 weeks. Any issues from sanitation audit will be corrected immediately and attached to the audit. RD will present and discuss any issues or trends discovered during audits and monitoring to QA committee for review at monthly QA meeting for three months.	

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sanitizer.

A continuous observation was made from 12:20 pm to 12:30 pm while the corporate chef checked the machine and sanitizer. He was unable to get the sanitizer to register on the test strips. He stated that they would have to use the dishes for lunch service because they didn ' t have anything else to serve on. He additionally stated that he would contact the chemical company.

A review of the dish machine temperature and sanitizer log for June 2017 revealed that the last time the temperature or sanitizer level had been recorded was on 6/20/17 at the breakfast meal.

An interview on 6/22/17 at 12:40 pm with Dietary Aide #1 revealed she wasn ' t sure if the sanitizer was checked when they washed the breakfast dishes. She stated that it should have been. She additionally stated that lunch service had already started in the 100 and 200 hall dining rooms and on the Homestead Unit.

An interview with the RD on 6/22/17 at 12:50 pm revealed that they were going to change to disposable dishes because the dish machine was not sanitizing correctly.

An interview with the DM on 6/22/17 at 3:20 pm revealed they determined that the facility was out of sanitizer for the dish machine and they were waiting on the representative from the chemical company to bring them some. She stated that they were not using the dish machine until the sanitizer was working correctly.

An interview on 6/22/17 at 3:48 pm with the DM and RD revealed that they expected the dish

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F 371	Continued From page 37 machine to be working and sanitizing according to the manufacturers recommendations and that the sanitizer level should be checked and documented 3 times a day. An interview on 6/22/17 at 5:00 pm with the Corporate Chef revealed that the facility had been out of sanitizer for several days. He stated that the facility had changed to a new management company for dietary services and the procedure for ordering chemicals had changed which is why they ran out of sanitizer. He provided a copy of the last chemical order the facility had placed which was dated 5/31/17 and indicated that no dish machine sanitizer was ordered. He stated the facility had received a chemical shipment on 6/7/17 from the new management company but they had not shipped them enough sanitizer to last the entire month. The chemical company had brought them a container of sanitizer and the test strip revealed that the dish machine was now sanitizing correctly. An interview on 6/22/17 at 6:43 pm with the Administrator revealed that the dish machine should be operating correctly to ensure that all dishware were properly sanitized.	F 371		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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	F 425		7/20/17

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F 425	Continued From page 38 pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and pharmacy interview the pharmacy failed to provide a method of dispensing accurate doses of liquid Morphine to 3 of 5 sampled residents with liquid Morphine ordered for pain. This included Residents # 111, 191 and 19. The findings included: 1. Observations on medication administration with Nurse # 4 on 6/21/17 at 3:31 PM revealed liquid Morphine with a concentration of 100 milligrams per 5 milliliter (ml) was drawn up in a syringe to be administered to Resident #191. Nurse # 4 asked the unit manager #2 to check the dose for accuracy. During the observation, the medication dose to be administered was 0.25 ml. Observations of the syringe calibrations revealed the marked increments were 0.1 ml, 0.2ml, 0.3ml, 0.4 cc and 0.5cc. There were no markings to indicate a dose of 0.25cc. The unit manager #2 stopped the nurse, and called the physician for a one time order of 0.2ml. Interview with Nurse # 4 on 6/21/17 at 3:45 PM revealed she did not have any other syringe or method of administering the physician ordered dose of 0.25ml. Review of the Medication Administration Record for Resident #19 revealed he had not received any doses of the Morphine before 6/21/17.	F 425	Resident #111, #191 and #19 have received an accurate dose of morphine with a syringe that dispenses the accurate dose. UM called the pharmacy on 6/21/17 to request that different dispensing syringes be sent to the center for residents #111, #191 and #19. Syringes were received on 6/21/17. Physician orders for residents were received for orders for liquid morphine and medication carts checked to ensure that correct dispensing syringe was available on 6/21/17 by UM. No resident receiving liquid morphine was found not to have correct dispensing syringe. Licensed nurses on all shifts including weekends were educated on the use of the appropriate equipment to measure medication accurately on 7/17/17, 7/18/17 and 7/19/17 by CNE, ACNE and UM. Unit managers, CNE and ACNE observed licensed nurses on all shifts including weekends drawing up liquid medication using a syringe for accuracy on 7/17/17, 7/18/17 and 7/19/17. Newly hired licensed nurses' will be educated and perform return demonstration for administration of liquid morphine. Two licensed nurses will perform return demonstration once initial observation is complete weekly for 3 months. Physician orders will be	

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F 425	Continued From page 39 Interview with the pharmacist on 6/22/17 at 9:36 AM revealed the morphine came prepackaged with the syringe inside the box. She was not aware the dosing could not accommodate the ordered doses. The pharmacist explained the pharmacy had syringes that could be sent to the facility for that amount of Morphine dose. 2. Observations of the medication cart on 1 North revealed Resident # 111 had liquid Morphine of 20 milligrams (mg) per 1 milliliter (ml). Instructions on the label were to administer 0.25 ml via gastrostomy tube. The syringe in the package was calibrated at 0.1 ml, 0.2 ml, 0.3 ml, 0.4 ml and 0.5ml. The syringe did not have a calibration to measure 0.25 ml. Review of the Medication Administration Record (MAR) revealed the Morphine was given on 5/26, 6/5, 6/11. 6/13 and 6/14. The documented pain level on the MAR for those times of administration were from 5 to 8, in a scale from 0 to 10. There was no documentation that the pain was not relieved. Interviews with nurse #2 on 6/22/17 at 2:30 PM revealed she used the syringe in the packaged medication and drew up 0.2 ml plus half way between the 0.2 ml and the 0.3ml. She explained there were no lines to indicate where the halfway mark was for the correct dose. The nurse had not informed anyone of the problem with the syringe dosing system. Interview with the pharmacist on 6/22/17 at 9:36 AM revealed the morphine came prepackaged with the syringe inside the box. She was not aware the dosing could not accommodate the ordered doses. The pharmacist explained the	F 425	monitored 5x weekly for the next 3 months any new liquid morphine orders in clinical morning meeting along with syringe being used by nurses by CNE, ACNE and UM. CNE will present the results of the return demonstration to the QA committee monthly for three months.	

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pharmacy had syringes that could be sent to the facility for that amount of Morphine dose.

Interview with the pharmacist on 6/22/17 at 9:36 AM revealed the morphine came prepackaged with the syringe inside the box. She was not aware the dosing could not accommodate the ordered doses. The pharmacist explained the pharmacy had syringes that could be sent to the facility for that amount of Morphine dose.

3. Observations on 2 South on 06/22/2017 at 8:48 AM revealed Resident #19 had liquid Morphine of 20 milligrams (mg) per 1 milliliter (ml). Instructions on the label were to administer 0.125 ml. The syringe in the package was calibrated at 0.1 ml up to 0.5 ml. There were no calibrations indicating a dose of 0.125 ml could be administered. The bottle was sealed and had not been opened.

Review of the Medication Administration Record revealed no doses of the Morphine had been administered. The resident had been assessed for pain and had not complained of pain.

Interview with the pharmacist on 6/22/17 at 9:36 AM revealed the morphine came prepackaged with the syringe inside the box. She was not aware the dosing could not accommodate the ordered doses. The pharmacist explained the pharmacy had syringes that could be sent to the facility for that amount of Morphine dose. Further interview with the pharmacist revealed the pharmacy did not have syringes or other methods of administration for a low dose at 0.125 ml. She further explained she would need to speak with the pharmacy director to special order something to accommodate that dose.

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F 425	Continued From page 41 Interview on 6/22/17 with unit manager #1 at 12:30 PM revealed the dose could not have been administered using the syringe in the package. There were no other methods available to administer the medication. The physician had been contacted on 6/22/17 to change the dose should the resident experience complaints of pain.	F 425		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 428		7/20/17

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F 428	Continued From page 42 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff and pharmacist interviews and record review, the facility failed to follow up on pharmacy consultation reports to address a request for Gradual Dose Reduction (GDR) for three antidepressants (bupropion HCL XL, fluoxetine HCL, trazodone) and an antipsychotic (risperidone) medication ordered for 1 of 5 sampled residents reviewed for unnecessary drugs (Resident #26). Findings included: Resident #26 was admitted to the facility on 12/30/14 with diagnoses that included anxiety disorder, bipolar disorder, insomnia and major	F 428	Resident's #26 psychotherapist was contacted by CNE on 7/12/17 and voicemail was left. Call was returned to CNE on 7/13/17 stating that resident was being seen by a psychotherapist, not a psychiatrist. The psychotherapist retired 6/30/17. Facility Nurse Practitioner (NP) was contacted by CNE on 7/14/17 regarding Gradual Dose Reduction (GDR). Facility NP recommendation is to start GDR with one psychotropic medication at a time and monitor for any behavior changes. Pharmacy consultant reports from May	

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F 428	Continued From page 43 depressive disorder. A review of Resident #26's comprehensive minimum data set (MDS) assessment dated 1/4/17 revealed she was cognitively intact. The same assessment revealed there were no negative behaviors or psychosis and was cooperative with care. A review of Resident #26's current medications for the month of June 2017 revealed she received fluoxetine HCL, 40 milligrams (mg) daily (started 12/2/15), risperidone, 1mg at night (started 4/26/16), trazodone 100mg at night (started 12/2/16) and buproprion HCL XL, 300mg daily (started 12/2/15). A review of Resident #26's medical record revealed there was no documentation of GDRs having been addressed for the bupropion HCL XL, fluoxetine HCL, trazodone and risperidone. On 6/22/17 an interview was attempted with the facility's Consultant Pharmacist; however, he was out of the office all week and unavailable. An interview was completed on 6/22/17 at 6:40 PM with the Consultant Pharmacist's supervisor. He reviewed the pharmacy record and stated a GDR was requested on 2/22/17 for fluoxetine HCL, bupropion HCL XL and trazodone. He further stated a GDR was requested on 3/21/17 for the risperidone. He said that most pharmacists waited about two months before another GDR notice was issued. No other notices were issued after 2/22/17 or 3/21/17. The Director of Nursing (DON) provided a copy of the pharmacist's consultation report for February and March 2017. The report dated 2/22/17 revealed	F 428	2017 to July 2017 were reviewed for residents on psychotropic drugs for recommendations for gradual drug reduction (GDR) by CNE, ACNE and UM on 7/12/17. Twenty-six pharmacy consultant reports for GDRs were identified. The residents' physician was notified by UMs on 7/12/17 for orders for GDR or reasons why recommendations were not advised. A copy of the pharmacy consultant recommendation report will be maintained in the CNE office. UMs will present the original to the MD. Once the MD addresses the recommendation the UM will ensure that the recommendation is completed by the nurse if applicable. The completed recommendation along with a copy of the order will be returned to the CNE office, copy made, attached to original copy with the original then placed on medical record. CNE will audit the copy of pharmacy consultant recommendations weekly to ensure that MD has addressed all recommendation for 3 months. The CNE will present the results of the audits to the PI monthly for 3 months.	

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F 428	Continued From page 44 that Resident #26 was taking three antidepressants and recommended that the physician (MD) "re-evaluate the need for three agents, perhaps giving consideration to a GDR." There was no documented response from the MD related to the recommendation, and there were no physician orders present to reduce the dosages of the fluoxetine, trazodone, or buproprion. The pharmacist's consultation report dated 3/21/17 revealed that Resident #26 was taking risperidone and recommended that the physician (MD) "consider GDR while monitoring for re-emergence of target and/or withdrawal symptoms." There was no documented response from the MD related to the recommendation. On 6/22/17 at 6:51 PM an interview was completed with the DON. She stated after the pharmacist reviewed charts he emailed the reports to her. She printed them off and stated she usually made a copy for her office file. She gave reports to her unit managers and they would be placed in the MD book. The DON said the MD typically reviewed the recommendations, "sometimes in a day or two, sometimes a week." She reported she looked for the signed reports for 2/22/17 and 3/21/17 but was unable to locate them. She was unable to provide any notices that were re-issued from the pharmacist regarding GDR.	F 428		
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	F 431		7/20/17

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§483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(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.

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F 431	Continued From page 46 (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications from 3 of 3 medication rooms, failed to remove undated multidose vials and expired medications from 4 of 4 medication carts and failed to maintain cleanliness of 3 of the 4 medication carts. The findings included: 1. a In an observation on 6/21/17 at 5:18 PM, of medication cart #1, on 1 north hall, revealed there were 17 loose pills in the drawers. An opened bottle of Fiber Caps (laxative) had expired 10/16 and Poly Iron (iron supplement) expired 4/17. The drawers were soiled with black substance and a powdery substance. b. In an observation on 6/21/17 at 5:18 PM of the medication refrigerator on 1 north hall revealed the following expired medications: Tubersol (for TB skin test) solution multi-dose vial was opened and not dated opened; 3 bags of Cefepime (antibiotic) injection intravenous solution with one thawed and two frozen; Augmentin (antibiotic) suspension liquid was opened 4/4/17 and expired; one Trulicity single	F 431	Medication cart #1 on north hall was cleaned on 6/22/17 by charge nurse (CN), removing loose pills and expired fiber caps and poly iron. The expired Tubersol solution that was not dated, 3 bags of Cefepime injection intravenous, Augmentin suspension and one Trulicity dose pen found in the medication refrigerator on 1 north hall was removed and sent back to the pharmacy on 6/22/17 by CN. The 2 vials of Lidocaine not dated, the insulin pens not dated and the bottle of Bisacodyl outdated were moved from the medication chart on 1 south and sent back to the pharmacy on 6/22/17 by CN. The medication cart was cleaned on 6/22/17 by CN. The outdated vitamin B complex with C on cart 3 was removed and sent back to pharmacy by CN on 6/22/17. The medication cart was cleaned on 6/22/17 by CN. The Risperdal powder, Pneumovax,	

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F 431	Continued From page 47 dose pen and not discarded. Interview with Unit Manager #1 on 6/21/17 at 5:18 PM revealed the medications in the medication refrigerator should have been removed. Each nurse on the medication cart would be responsible to keep the cart clean and check for expired medications. 2. a. In an observation on 6/21/17 at 5:25 PM, of medication cart #2, on 1 south hall, revealed 2 Lidocaine (local anesthetic) multi-dose vials opened and not dated; Insulin pens of one Lantus and one Toujeo opened and not dated; one bottle of Bisacodyl (laxative) expired on 2/17. The cart had liquid sticky spills, and a build-up of a white substance. b. In an observation on 6/21/17 at 5:30 PM of medication cart #3, on 1 south with one bottle of Vitamin B complex with C that expired on 4/17. Cart #3 had drawers with spills that were sticky and loose pills inside. c. In an observation on 56/21/17 at 5:27 PM of the medication refrigerator on 1 south revealed a vial of Risperdal powder (antipsychotic) not labeled for a resident with instructions for use and the cap seal was broken at one edge; house stock Pneumovac (immunization) opened and not dated; (3) prefilled syringes Influenza vaccination that expired 5/17/17 and one prefilled single use syringe of Risperdal Consta (antipsychotic) not labeled for a resident with instructions for use. 3. a. In an observation on 6/21/17 at 5:43 PM of medication cart #4, on homestead unit with one Insulin pen Levemir opened and not dated.	F 431	influenza and Risperdal consta was removed and sent back to pharmacy that was found in the medication refrigerator on 1 south on 6/22/17 by CN. Insulin pen Levemir not dated on Homestead Unit was removed and sent back to pharmacy by CN on 6/22/17. The Aplisol vial opened and not dated found in the Homestead Unit medication refrigerator was removed and sent back to pharmacy on 6/22/17 by CN. The 9 medication carts were checked for out of date or open undated medications on 6/22/17 by CN. No outdated or open undated medication was found. The 4 medication refrigerators were checked on 6/22/17 by CN and no outdated or open undated medication was found. Licensed nurses were reeducated on dating specific medication when opened and to monitor expiration dates prior to giving medication and keeping a clean cart on 6/22/17 and 7/17/17, 7/18/17 and 7/19/17 by CNE, ACNE and UM. UMs will audit each medication cart and medication refrigerators for out dated, open undated medication and cleanliness of medication carts weekly. 11-7 medication nurse will be responsible for cleaning the medication cart weekly. The results of the audits for the medication carts and medication refrigerators will be presented to the QA committee for 3 months by CNE.	

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F 431	Continued From page 48 b. In an observation of the medication room on homestead unit on 6/21/17 at 5:45 PM revealed one multi-dose vial of Aplisol (for TB skin test) opened with no date. Interview with Unit Manager #1 on 6/21/17 at 5:18 PM revealed the medications in the medication refrigerator should have been removed. Each nurse on the medication cart would be responsible to keep the cart clean and check for expired medications.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		7/20/17

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(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 441	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to clean a glucometer between residents for one of two nurses observed obtaining fingerstick blood sugars. Nurse #1. The findings included: Review of the policy and procedure for glucometer usage dated 3/16/17 included 1. Gather equipment: 1.3 Environmental Protection Agency (EPA) approved disinfectant against Hepatitis B, Hepatitis C, and HIV (do NOT use alcohol). #2. Disinfect meter before and after each patient use. Observations during a medication pass on 6/21/17 at 4:10 PM Nurse #1 on the 1 north hall returned to the medication cart with the glucometer in her hand. She explained she had checked a resident's blood sugar. Nurse #1 was observed to place the glucometer on top of the cart. Nurse #1 proceeded to prepare medications for the next resident. After returning to the cart, the glucometer was not cleaned and remained on top of the cart. Observations of the glucometer revealed no obvious blood was on the glucometer. The next resident to receive medications was in contact isolation. After administration of medications to the resident in isolation, Nurse #1 returned to the cart, sanitized her hands and placed the glucometer insider the medication cart. Interview on 06/21/2017 at 4:42 PM with Nurse #1 revealed she had not cleaned the glucometer. She explained the glucometer was used for	F 441	No resident was identified. Residents receiving finger stick blood sugar (FSBS) have the potential to be affected. Licensed nurses were educated on cleaning of the glucometers with an Environmental Protection Agency (EPA) approved disinfectant against Hepatitis B, Hepatitis C and HIV before and after each use on 6/22/17 and 7/17/17, 7/18/17 and 7/19/17. Each resident, starting 7/19/17 will receive a personal glucometer and maintained on the medication cart in a plastic bag labeled with resident's name, on discharge the glucometer will be sent home with resident or discarded. UM will maintain a log for residents requiring FSBS and the presence of glucometer on medication cart, bagged and labeled. UM will audit the medication carts weekly x 4 then every 2 week for 2 months. The CNE will present the results of the audit to the QA meeting monthly for three months.	

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F 441	Continued From page 51 multiple residents. Nurse #1 said she "should clean it after each use." She did not explain why she had not cleaned the glucometer. Nurse #1 left the medication cart, did not open and clean glucometer and proceeded to the next cart to give medications. Interview on 06/22/2017 at 11:50 AM with the Director of Nursing revealed she would expect the glucometer to be cleaned after each use.	F 441		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (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	F 520		7/20/17

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F 520	Continued From page 52 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to implement, monitor and revise as needed the action plan developed for the complaint surveys dated 1/19/17 and 3/10/17, in order to achieve and sustain compliance. This was for four recited deficiencies on a recertification and complaint survey on 6/22/17. The deficiencies were in the areas of assessments, food and nutrition services and infection control. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: 1. F281: Based on record review and staff interviews and pharmacy interview the facility failed to administer doses of Morphine to one of 2	F 520	F 363 Director of Dining Services updated spreadsheets on 7/18/17 to reflect food items on the current menu, to include proper portion sizes. The dietary staff were inserviced on the week of 7/10/17 on portion sizes with return demonstration with the Director of Dining Services (DDS) and Executive Chef (EC). DDS/EC will complete audit on scoops/ladles used during meal service (portion size) three times daily for 6 days per week to include one weekend day for 4 weeks, twice daily for 4 weeks then once daily for 4 weeks. F 371 All milk/protein based food items in the walk-in were discarded on 6/19/17 at	

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F 520	Continued From page 53 sampled residents using a method to dose the Morphine to ensure the physician ordered dosage was administered. Resident # 111. 2.a. F363: Based on observations, record review and staff interviews the facility failed to provide the residents that received puree diets (5 of 5 residents) who were served from the 200 hall dining room (1 of 3 service areas), the meat and starch portions of their meal. The facility failed to identify and serve the correct portion size for a menu substitution for 1 of 2 meals that were observed. 2.b. F371: Based on observations, record review and staff interviews the facility failed to maintain the temperature of foods stored in the walk-in cooler at / below 41 degrees F, failed to ensure dishes were sanitized and in good repair, failed to store foods in sealed, labeled and dated containers, failed to maintain clean kitchen equipment, failed to maintain the holding temperature of a cold salad at / below 41 degrees F and failed to reheat a casserole to a minimum of 165 degrees F. 3. F441: Based on observations, staff interviews and record review the facility failed to clean a glucometer between residents for one of two nurses observed obtaining finger-stick blood sugars. Nurse #1.	F 520	6:20pm by the RD, Center Executive Director (CED) and the Maintenance Director. Hourly checks during operating hours were conducted on the walk-in beginning 6/20/17 and completed until 6/30/17; all completed by the RD and DDS. All temperatures recorded for the walk-in were maintained below 41 degrees Fahrenheit. RD completed kitchen sanitation audit on 6/19/17 and issues identified were corrected 6/19/17 by a dietary aide. The DDS/EC inserviced the dietary staff the week of 7/10/17 on the kitchen cleaning schedule which includes a detailed list of all kitchen appliances and utensils to be cleaned. The schedule contains a completion sheet to be signed by dietary staff after cleaning assignment is completed daily. The DDS/EC inserviced the dietary staff the week of 7/10/17 on recording temperatures of refrigeration/freezer units during each shift, the temperature ranges each unit should be within and who/when to contact if the temperature is above the proper temperature range. The DDS/EC inserviced the dietary staff the week of 7/10/17 on proper procedures for storing, labeling and dating food items. The DDS/EC inserviced the dietary staff the week of 7/10/17 on proper procedures	

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F 520	Continued From page 54	F 520	for dish machine service, including taking temperatures and sanitation levels three times per day. The DDS/EC inserviced the dietary staff the week of 7/10/17 on appropriate temperatures for food and the process if food is not at appropriate temperatures. The DDS/EC inserviced the dietary staff the week of 7/10/17 on portions sizes with return demonstration with the DDS and EC. DDS/EC completes cleaning log audit two times per day for 6 days to include 1 weekend day for 4 weeks, once daily for 4 weeks then twice weekly for 4 weeks. Any issues from cleaning log audit will be corrected immediately and attached to the audit. DDS/EC completes audit of dish machine temperature log three times daily for 6 days to include 1 weekend day for 4 weeks, twice daily for 4 weeks then once daily for 4 weeks. Any issues for dish machine temperature audit will be corrected immediately and attached to audit. DDS and EC completes dish machine sanitizer audit, with test strips, three times daily for 6 days to include 1 weekend day for 4 weeks, twice daily for 4 weeks then once daily for 4 weeks. Any issues for dish machine sanitizer audit will be corrected immediately and attached to audit. DDS/EC completes sanitation audit, to include: foods sealed/labeled/dated, temperatures recorded of walk-in, temperature of foods in walk-in, cleanliness of equipment, daily for 6 days	

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F 520	Continued From page 55	F 520	to include 1 weekend day for 4 weeks, twice weekly for 4 weeks then weekly for 4 weeks. Any issues from sanitation audit will be corrected immediately and attached to audit. RD completes audit of all findings from audits completed by DDS/EC weekly. All findings from audits will be brought to monthly QA. RD completes sanitation audit twice weekly for 4 weeks, weekly for 4 weeks then twice per month for 4 weeks. Any issues from sanitation audit will be corrected immediately and attached to the audit. F 281 Residents' physicians orders were reviewed by the UM on 6/21/17 for liquid morphine orders and if a syringe was available to give the correct dose. Five residents were found with orders for liquid morphine and appropriate syringe was available. Licensed nurses on all shifts including weekends were educated on the use of the appropriate equipment to measure medication accurately on 7/17/17, 7/18/17 and 7/19/17 by the CNE, ACNE and UM. Unit Managers, CNE and ACNE observed licensed nurses on all shifts including weekends, drawing up liquid medication using a syringe for accuracy on 7/17/17, 7/18/17 and 7/19/17. Newly hired licensed nurses will be educated and perform return demonstration for administration of liquid morphine. Two licensed nurses will perform return demonstration once initial observation is complete weekly for 3	

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F 520	Continued From page 56	F 520	months. Physician orders will be monitored 5x weekly for the next 3 months for any new liquid morphine orders in clinical morning meeting along with syringe being used by nurses by CNE, ACNE and UM. Unit Managers will complete audit on residents that have orders for liquid morphine weekly for the presence of correct dispensing syringe weekly for one month, then monthly for 2 months. F 441 Residents receiving finger stick blood sugar (FSBS) have the potential to be affected. Licensed nurses were educated on cleaning of the glucometers with an Environmental Protection Agency (EPA) approved disinfectant against Hepatitis B, Hepatitis C and HIV before and after each use on 6/22/17 and 7/17/17, 7/18/17 and 7/19/17. Each resident, starting 7/19/17 will receive a personal glucometer and maintained on the medication cart in a plastic bag labeled with resident's name, on discharge the glucometer will be sent home with resident or discarded. UM will maintain a log for residents requiring FSBS and the presence of glucometer on medication cart, bagged and labeled. UM will audit the medication carts weekly x 4 then every 2 week for 2 months. F 363 RD will present and discuss any issues or	

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F 520	Continued From page 57	F 520	trends discovered during monitoring of portion sizes to QA committee meeting for three months. F 371 RD will present and discuss any issues or trends discovered during audits and monitoring of kitchen cleaning schedule, recording temperatures of refrigeration/freezer units, proper procedures for storing/labeling/dating food items, appropriate temperatures of food and portion sizes to QA committee for review at monthly QA meeting for three months. F 281 CNE will present the finding from the return demonstration of liquid morphine to the QA committee meeting for three months. F 441 The CNE will present the results of the finger stick audit to the QA meeting monthly for three months.	