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	345264	A. BUILDING _____ B. WING _____	C 07/13/2017

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STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation Event ID: PPKW11. 8/8/17 NH provided evidence that Resident # 167 in F 241 was not a skilled nursing home bed and was deleted from F 241. BW IDR 9/1/17 resulted in deletion of F 241 cited for another resident and F 329 was upheld. BW	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F 278		8/10/17

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

Electronically Signed | 08/04/2017

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F 278	Continued From page 1 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 medical record review, the facility failed to accurately code an annual Minimum Data Set (MDS) to include all active diagnoses (Resident #107) and an admission MDS regarding incontinence (Resident #47) for 2 of 19 sampled MDS reviewed. The findings included: 1. Resident #107 was admitted to the facility on 4/25/14. Diagnoses include age-related osteoporosis. An annual MDS assessment dated 12/8/16 did not include the diagnoses of age-related osteoporosis. Review of Resident #107's cumulative physician's orders for December 2016, signed by the physician, revealed a physician's order dated 8/26/16 for Calcium 500 plus Vitamin D 200, 1 tablet by mouth once daily with food. Review of the December 2016 Medication Administration Record (MAR) revealed Resident #107 received Calcium 500 plus Vitamin D 200 daily during the assessment review period of 12/1/16 through 12/8/16. An interview on 7/13/17 at 11:50 AM with MDS Coordinator #1 revealed she reviewed the medical record (hospital records, physician's	F 278	Bladder documentation for Resident #47 was reviewed and properly coded on the most recent MDS assessment—it was resubmitted to CMS by the MDS Coordinator on 7/14/17. Osteoporosis was added as a diagnosis for Resident #107--it was resubmitted to CMS by the MDS Coordinator on 7/14/17. The most recent MDS assessments for all current residents will be audited by the MDS Coordinators for accurate documentation of bladder and diagnosis—this audit will be complete and any inaccuracies in these areas will be corrected, properly coded, and resubmitted to CMS by the MDS Coordinator by 8/7/17. The MDS Coordinators will attend a Myers & Stauffer MDS documentation training seminar on 8/8/17 and will also be re-educated on proper coding in Section H and Section I of the MDS through the use of online CMS videos specifically for “Section H training” and “MDS 3.0 Provider Updates for Section I” by 8/10/17. There are (2) MDS Coordinators	

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F 278	Continued From page 2 progress notes, nurse's notes and MAR) when completing the active diagnoses section of the MDS. MDS coordinator #1 further stated that when she completed Resident #107's annual MDS, she did not refer to the MAR, but that she had been recently reminded to refer to the MAR when completing this section of the MDS. She stated, "If the MAR includes the diagnoses, signed by the physician and the diagnoses is actively being treated, I would include it on the MDS, but I did not do that when I completed this MDS." MDS Coordinator #1 stated that the diagnoses of osteoporosis should have been included on the annual MDS for Resident #107. An interview on 7/13/17 at 2:20 PM with the director of nursing (DON) revealed she expected MDS staff to refer to the signed physician's orders/progress notes related to diagnoses when completing the active diagnoses section of the MDS. The DON verified that osteoporosis was an active diagnoses that should have been included for Resident #107 when the annual MDS was completed. 2. Resident #47 was admitted to the facility on 3/1/17. Diagnoses included hip fracture, congestive heart failure, chronic kidney disease, and chronic pulmonary edema. An admission MDS assessment dated 3/8/17 assessed Resident #47 with occasional bladder incontinence, or less than 7 occurrences of bladder incontinence during the assessment period of 3/2/17 through 3/8/17. Review of a Voiding Pattern record (nurse aide documentation of continence) dated 3/2/17 through 3/8/17 revealed 21 documented	F 278	employed full-time. Each MDS Coordinator will randomly audit the other MDS Coordinator's completed assessments for accuracy of bladder and diagnosis beginning on 8/7/17 with 3 comprehensive assessments from the weekly MDS calendar/schedule weekly X 4 weeks, followed by 3 comprehensive assessments from the weekly MDS calendar/schedules every other week X 4 weeks, and finally 5 comprehensive assessments from the weekly MDS calendar/schedules monthly X 4 months. Any concerns identified from any of these audits will be immediately corrected by the MDS Coordinator who completed the assessment. The Director of Nursing will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning with the August 2017 QA&A Committee meeting.	

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F 278	Continued From page 3 occurrences of bladder incontinence for Resident #47. An interview on 7/13/17 at 11:41 AM with MDS Coordinator #1 revealed she used the Voiding Pattern record and interviewed staff to assess bladder continence when she completed the MDS. MDS coordinator #1 verified 21 documented occurrences of bladder incontinence from 3/2/17 to 3/8/17 by review of the Voiding Pattern record for Resident #47 and stated that a data entry error occurred when she completed the MDS. She stated that she should have assessed Resident #47 as having frequent occurrences of bladder incontinence. An interview on 7/13/17 at 2:20 PM with the director of nursing revealed she expected MDS staff to review nurse aide documentation when assessing bladder continence for the MDS and that a coding error occurred for the admission MDS for Resident #47 regarding bladder continence.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279		8/8/17

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F 279	Continued From page 4	F 279		

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to

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F 279	Continued From page 5 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to develop a care plan that accurately reflected visual information for 1 of 3 residents sampled for vision (Resident #102). The findings included: Resident #102 was admitted to the facility on 12/21/13. The quarterly Minimum Data Set (MDS) dated 07/03/17 indicated Resident #102 had impaired vision (sees large print, but not regular print in newspapers/books) with no corrective lenses used. The MDS also indicated Resident #102 had moderate cognitive impairment and had diagnoses which included anxiety and dementia. The MDS further indicated Resident #102 needed extensive assistance with most activities of daily living. The most recent care plan update that was dated 07/07/17 indicated the "resident has impaired vision with glasses" with approaches that included "ensure that eyeglasses are in place/being worn by resident" and "provide assistance to resident with maintaining cleanliness of glasses." A review of Social Services department notes for 2017 indicated the comment "he has impaired vision with no glasses" was included in information written about Resident #102 on	F 279	Resident #102 was re-assessed on 7/14/17 to have impaired vision with no use of glasses. The note written by the Social Services Assistant on 7/3/17 and the Get To Know Me form completed on 7/7/17 were accurate based on this current assessment. The Social Services Assistant contacted the Representative for Resident #102 on 7/14/17 regarding visual status in which it was noted the resident has impaired vision but does not wear glasses. The Care Plan for vision was revised by the Social Services Assistant on 7/14/17 based on this re-assessment to match both the social note and the Get To Know Me form noting impaired vision without any glasses. An audit will be completed by Social Services staff on all residents with current care plans for visual status to compare with current Get To Know Me forms, social notes, and actual devices in use to the care plan to ensure all are accurate as to the resident's current visual status-- this audit will be complete and any inaccuracies in these areas were corrected by 8/3/17. Social Services staff who complete the	

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F 279	Continued From page 6 01/23/17, 04/07/17, and 07/03/17. During an observation on 07/12/17 at 9:56 AM, Resident #102 was observed in his room and he was not wearing glasses. During an observation on 07/12/17 at 11:15 AM, Resident #102 was observed in his room and he was not wearing glasses. During an observation on 07/13/17 at 10:02 AM, Resident #102 was observed in his room and he was not wearing glasses. During an interview conducted on 07/13/17 with the Nurse Assistant (NA) #1 at 10:14 AM, NA #1 stated she was very familiar with Resident #102 and the care he required. NA #1 also stated that Resident #102 had dentures and hearing aids, but did not have glasses. NA #1 further stated she had never put glasses on Resident #102 and she had never seen Resident #102 wearing glasses. During an interview conducted on 07/13/17 with the Minimum Data Set Coordinator (MDSC) #1 at 12:38 PM, MDSC #1 stated the section on the MDS for vision is completed by Social Services and they are also responsible for writing the care plans for their areas that triggered. During an interview conducted on 07/13/17 with the Social Services Assistant (SSA) at 12:53 PM, SSA stated he created a care plan for the resident if they had vision issues that triggered and he had just recently updated the care plan for Resident #102. The SSA reviewed the care plan dated for 07/07/17 and acknowledged it was incorrect and should have stated Resident #102	F 279	visual assessment on the MDS and any care plans related to vision status/visual needs were educated on properly identifying the needs of each resident through care planning, the use of the Get To Know Me forms, clinical documentation, and actual devices in place for use to ensure all are accurate an in place as needed by the Administrator on 7/31/17. The Social Services staff will also attend a Myers & Stauffer MDS documentation training seminar on 8/8/17. There are (2) Social Services staff employed full-time. Each will randomly audit the others' completed care plans for visual status and visual needs and will compare to the written social note, the Get To Know Me form, and the actual item(s) in place beginning on 8/7/17 with 3 residents from the weekly MDS calendar/schedule weekly X 4 weeks, followed by 3 residents from the weekly MDS calendar/schedules every other week X 4 weeks, and finally 5 residents from the weekly MDS calendar/schedules monthly X 4 months. Any concerns identified from any of these audits will be immediately corrected. The MDS Coordinators will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning in August.	

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F 279	Continued From page 7 did not have glasses. The SSA also acknowledged approaches for Resident #102 would be incorrect as staff did not need to assist him to do something with an appliance that he didn't have. During an interview conducted on 07/13/17 with the Director of Nursing (DON) at 1:29 PM, DON stated she expected care plans to accurately reflect information about the resident.	F 279		
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 (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--	F 329		8/7/17

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F 329	Continued From page 8 (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 record review, staff interview, and physician interview the facility failed to follow the physician/practitioner signed note titled Consultant Pharmacist Communication to Physician from the pharmacist regarding a Gradual Dose Reduction (GDR) of an antidepressant medication for 1 of 5 residents (Resident #111) reviewed for unnecessary medication use. The findings included: Resident #111 was admitted to the facility on 04/04/16. The annual Minimum Data Set (MDS) dated 03/02/17 indicated Resident #111 had diagnoses including non-Alzheimer's dementia and depression among others. The MDS also indicated Resident #111 had short and long term memory problems with severe impairment for daily decision making. The MDS further indicated Resident #111 required extensive to total assistance for all activities of daily living. The MDS specified Resident #111 was taking an antidepressant medication daily.	F 329	An order was obtained and fully processed for Resident #111 on 7/12/17 to decrease Remeron from 15mg to 7.5mg daily per pharmacy recommendations. All pharmacy recommendations for the previous 4 months (March – June) were audited by the Director of Nursing on 8/1/17 to ensure all recommendations had corresponding physician's orders—concerns were immediately corrected. A new policy for Pharmacy Consultant Medication Review & Recommendations will be implemented on 8/7/17, which includes: • The consultant Pharmacist will provide (2) separate reports following each review to the Director of Nursing. • Once the reports are provided to the Director of Nursing, he/she will maintain an original set and then distribute copies of the reports to the physician/physician extender review upon his/her next visit who will note his/her response to each	

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F 329	Continued From page 9 Record review for the medication of Resident #111 indicated a pharmacy review of current medications is completed monthly. Record review indicated on 05/25/17 a GDR of an antidepressant taken by Resident #111 was suggested by the pharmacist. The reduction recommendation was to decrease the dose from 15 milligrams (mg) every night to 7.5 mg every night in an effort to use the lowest effective dose for Resident #111. The Consultant Pharmacist Communication to Physician indicated the physician/practitioner was in agreement to reduce the medication as indicated by the pharmacist and a note is written on the form stating "order written 6/2/17." Also noted on the form is another signature of a nurse with the date 06/16/17 with no other detail. Record review of nurses' notes on 06/16/17 indicated Nurse #1 (N) wrote the following statement at 4:58 AM "Consultant Pharmacist Communication to Physician reviewed by ECP with order written to reduce Remeron 15 mg to 7.5 mg. Order written on 6/2/17." Review of Physician's orders for the month of June 2017 indicated no order had been written to reduce the antidepressant dosage of Resident #111. Review of the Medication Administration Record for the months of June and July 2017 indicated Resident #111 continued to be given 15 milligrams of the antidepressant medication at night. During a phone interview on 07/12/17 with N #1	F 329	directly on the request form and then also write any orders as needed. Any orders written will be properly flagged for the licensed nurse to process. He/She will then return all completed recommendations to the Director of Nursing. • The licensed nurse on each unit will fully process all orders written from pharmacy recommendations. A nursing note will be written regarding the processing of a pharmacy order only after actually visualizing the order—not simply based on a note saying “order written”. • The Director of Nursing will cross-compare all forms returned by the Physician/physician extender with the original forms to ensure completion of all pharmacy recommendations made for that specific period of time. Anything missing will be addressed at that time. Completed forms will then be given to the 1st shift Nursing Supervisor for follow-up. • The 1st shift Nursing Supervisor will check each clinical record in which there was a pharmacy recommendation made with noted order changes to ensure there is in fact a written order to correspond. Once verified, these forms will be filed on the clinical record. • During the next visit, the Consultant Pharmacist will review all recommendations made during the previous visit and will compare to written physician’s orders and the medication record to ensure each was fully processed as recommended. All nurses will be in-serviced on this new	

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F 329	Continued From page 10 at 4:41 PM, N #1 stated she could not remember where the information had been written about the medication reduction for Resident #111, but she was sure she saw it somewhere since she had written a note about it. N #1 thought it was a doctor's order but was not sure. During a phone interview on 07/12/17 with the pharmacist at 7:48 PM, he stated that sometimes the way diagnoses are written can be confusing, especially if they list a reason for the medication as depression and appetite. He also stated that he looks at dementia and weight loss issues and if the weight appeared stable to him, he looks at how long it has been since the last GDR and then writes a consult communication note to the physician with his recommendations. The pharmacist further stated Resident #111 had been on this medication for a while and in his clinical judgment had no negative side effects. During a phone interview of 07/13/17 with the Medical Doctor (MD) at 12:28 PM, the MD stated the delay in decreasing the antidepressant for Resident #111 would cause no harm to the resident. During an interview on 07/13/17 with the Director of Nursing (DON) at 2:07 PM, the DON stated her expectation was for the order to have been written so it could have been implemented. The DON also stated the nurse needed to physically look at the physician's order to verify it had been written.	F 329	policy/procedure by the Administrator between 8/3/17 – 8/7/17. The Consultant Pharmacist will document all physician recommendations in the consultant regimen review note. Each routine review notation will include documentation of the status of the previous month's request(s). All signed physician recommendations will be verified for completion by direct observation by the Consultant Pharmacist in both the paper and electronic records. Any physician recommendations pending from the previous month will result in a duplicate physician recommendation for the current month and the Director of Nursing will be notified of such duplicate requests. The Assistant Director of Nursing will randomly audit the monthly pharmacy recommendations for completion of all orders beginning in August 2017 with 10 recommendations monthly X 6 months. Any concerns identified from any of these audits will be immediately corrected including disciplinary actions as necessary. The Director of Nursing will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning in August 2017.	

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F 371 SS=E	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 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, staff interviews and review of facility records, the facility failed to store bananas per vendor recommendations to prevent the growth of bacteria (60 - 65 degrees Fahrenheit), discard expired produce (sweet potatoes and bananas) and store frozen biscuits in a secured container with a date of opening for 3 of 5 storage units observed. The findings included:	F 371	All items of concern (sweet potatoes, bananas, and frozen biscuits) were immediately discarded by the Food Service Director on 7/10/17. The remaining bananas were placed in refrigerated storage for the appropriate temperature. On 7/10/17. An audit was conducted by both the Kitchen Manager and Food Service Director together of the dry storage area	8/9/17

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F 371	Continued From page 12 1a. An observation of the walk-in refrigerator occurred on 7/10/17 at 11:06 AM. A long 2 inch stainless steel pan was observed covered with aluminum foil and contained 18 sweet potatoes. The label on the pan recorded a use by date of 7/6/17. Further observation revealed 8 of the 18 sweet potatoes had white fuzzy growth on the exterior of the sweet potatoes. An interview on 7/10/17 at 11:06 AM with the food service director (FSD) revealed dietary staff received produce on Tuesdays/Fridays and should remove any expired foods when new stock was received. The FSD stated the sweet potatoes should have been discarded on Friday, 7/7/17 when new produce was received. 1b. A review of vendor recommendations for storage of bananas included instructions to store them at a room temperature 60 - 65 degrees Fahrenheit (F). An observation of the dry storage room occurred on 7/10/17 at 11:25 AM. A case of ripe bananas was observed stored with 12 of the bananas observed dark brown and soft to touch. The temperature of the dry storage room was observed at 74 degrees F. An interview on 7/10/17 at 11:25 AM with the FSD revealed that the dark brown bananas should be discarded and that it was the facility's routine practice to store bananas in the dry storage room. During the interview, the FSD provided written vendor recommendations to store bananas at room temperature (60 - 65 degrees F). The FSD stated that it was not their practice to monitor the temperature of the dry storage room to ensure a temperature range of 60 - 65 degrees F. She	F 371	and all freezers/coolers on 7/18/17—areas of concern were immediately addressed and/or discarded at that time. The Food Storage policy for dietary services will be revised on 8/7/17 to include the proper storage of bananas following the NC Food Code requirements as well as a review of specifically assigned dietary staff to check for proper storage and appropriate labeling/dating and use of food items: •The 1st shift Cook will check all food storage areas (refrigerators/coolers, freezers, and dry storage) daily at the beginning of the shift to ensure all food items are properly stored, labeled/dated, and discarded as necessary. •The 2nd shift Cook will check all food storage areas (refrigerators/coolers, freezers, and dry storage) daily at the end of the shift to ensure all food items are properly stored, labeled/dated, and discarded as necessary. •The Dietary Aide assigned to check in all groceries upon delivery will check all food storage areas (refrigerators/coolers, freezers, and dry storage) at the time groceries are being put away to ensure all food items are properly stored, labeled/dated, and discarded as necessary—this will occur at least once weekly. All dietary staff will be in-service by the Food Services Director on this policy	

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F 371	Continued From page 13 further stated that the dry storage room could be kept as cool as 67 degrees F, but that was the coolest the room would get. 1c. An observation of the freezer occurred on 7/10/17 at 11:18 AM. The freezer was observed with a plastic bag secured by being tied into a knot. The FSD identified the bag contained frozen biscuits. The bag was observed with a hole in it, there were 10 biscuits observed with ice crystals and there was no label to include a date of storage. An interview on 7/10/17 at 11:18 AM with the FSD revealed that anytime any items were opened, a label should be placed to include the name of item, the date of storage and the date of expiration.	F 371	revision and expectations between 8/4/17 – 8/9/17. The Kitchen Manager will conduct an audit of the dry storage and all coolers/freezers to ensure all food items are properly labeled/dated for use and no items are expired, beginning on 8/7/17 weekly X 4 weeks, followed every other week X 4 weeks, and finally monthly X 4 months. Any concerns identified from any of these audits will be immediately corrected including disciplinary action as necessary. The Food Service Director will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning in August 2017.	
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:	F 428		8/10/17

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F 428	Continued From page 14 (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 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:	F 428		

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F 428	Continued From page 15 Based on record review, staff, pharmacist, and physician interviews the consultant pharmacist failed to identify 1 of 5 residents reviewed that did not have a recommended medication gradual dose reduction (GDR) (Resident #111). The findings included: Resident #111 was admitted to the facility on 04/04/16. The annual Minimum Data Set (MDS) dated 03/02/17 indicated Resident #111 had diagnoses including non-Alzheimer's dementia and depression among others. The MDS also indicated Resident #111 had short and long term memory problems with severe impairment for daily decision making. The MDS further indicated Resident #111 required extensive to total assistance for all activities of daily living. The MDS specified Resident #111 was taking an antidepressant medication daily. Record review for the medication of Resident #111 indicated a pharmacy review of current medications is completed monthly. Record review indicated on 05/25/17 a GDR of an antidepressant taken by Resident #111 was suggested by the pharmacist. The reduction recommendation was to decrease the dose from 15 milligrams (mg) every night to 7.5 mg every night in an effort to use the lowest effective dose for Resident #111. The Consultant Pharmacist Communication to Physician indicated the physician/practitioner was in agreement to reduce the medication as indicated by the pharmacist and a note is written on the form stating "order written 6/2/17."	F 428	An order was obtained and fully processed for Resident #111 on 7/12/17 to decrease Remeron from 15mg to 7.5mg daily per pharmacy recommendations. All pharmacy recommendations for the previous 4 months (March – June) were audited by the Director of Nursing on 8/1/17 to ensure all recommendations had corresponding physician's orders-- concerns were immediately corrected The Consultant Pharmacist will document all physician recommendations in the consultant regimen review note. Each routine review notation will include documentation of the status of the previous month's request(s). All signed physician recommendations will be verified for completion by direct observation by the Consultant Pharmacist in both the paper and electronic records. Any physician recommendations pending from the previous month will result in a duplicate physician recommendation for the current month and the Director of Nursing will be notified of such duplicate requests. This will begin with the August 2017 review. The Assistant Director of Nursing will randomly audit the monthly pharmacy recommendations for completion of all orders beginning in August 2017 with 10 recommendations monthly X 6 months. Any concerns identified from any of these audits will be immediately corrected including disciplinary actions as necessary.	

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F 428	Continued From page 16 Review of Physician's orders for the month of June 2017 indicated no order had been written to reduce the antidepressant dosage of Resident #111. Review of the Medication Administration Record (MAR) for the months of June and July 2017 indicated Resident #111 continued to be given 15 milligrams of the antidepressant medication at night. During a phone interview on 07/12/17 with the pharmacist at 7:48 PM, he stated that sometimes the way diagnoses are written can be confusing, especially if they list a reason for the medication as depression and appetite. He also stated that he looks at dementia and weight loss issues and if the weight appeared stable to him, he looks at how long it has been since the last GDR and then writes a consult communication note to the physician with his recommendations. The pharmacist made a note on 6/22/17 that stated "MD approved Remeron GDR: follow efficacy." The pharmacist stated he must have missed the GDR not occurring when he looked at the MAR and stated "I don't know why I didn't catch it, I'm actually shocked that I didn't. The pharmacist further stated he probably would have caught the mistake at his July review as he tends to look back over the orders and what needs following up on. The pharmacist further stated Resident #111 had been on this medication for a while and in his clinical judgment had no negative side effects. The pharmacist acknowledged this had been a mistake but stated it would get straightened out with the facility. During a phone interview of 07/13/17 with the Medical Doctor (MD) at 12:28 PM, the MD stated	F 428	The Director of Nursing will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning in August 2017.	

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F 428	Continued From page 17 the delay in decreasing the antidepressant for Resident #111 would cause no harm to the resident. During an interview on 07/13/17 with the Director of Nursing (DON) at 2:07 PM, the DON stated her expectation was for the pharmacist to be able to physically look at the order to see that it was written. The DON also stated the pharmacy had already created their own plan of correction to deal with it on their end.	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is	F 431		8/7/17

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F 431	Continued From page 18 maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, manufacturer specifications, and facility policy, the facility failed to remove from use expired medications on 1 of 5 medication carts. Findings included: Manufacturer specifications for Latanoprost 0.005% eye drop storage per package insert included, "Protect from light. Store unopened	F 431	The expired bottle of eye drops for Resident #167 was immediately discarded on 7/12/17 and a new bottle was opened for use. All medication carts and medication storage rooms were audited by the Staff Development Coordinator on 7/20/17 to ensure there were no other concerns related to expired/beyond date medications and all concerns were	

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F 431	Continued From page 19 bottle(s) under refrigeration at 36 to 46 Fahrenheit (F). Once the bottle is opened for use, it may be stored at room temperature up to 77 F for 6 weeks." A review of the facility's Medication Storage Policy dated 01/31/17 under drug storage and expiration date guidelines indicated, "Latanoprost 0.005% will be expired 42 days after opened (Refrigerated before opening)." An observation of the medication cart at 500 Long Hall on 07/12/17 at 4:24 PM revealed 1 bottle of Latanoprost 0.005% 2.5 Milliliter (ml) eye drop opened on 05/10/17 was stored under the room temperature. The label contained an instruction of "Discard 42 days from date opened." Review of Medication Administration Record revealed that this particular expired Latanoprost eye drop was used once on 07/11/17 at 8:00 PM and it was administered by Nurse #4. Interview on 07/12/17 at 4:28 PM with Nurse #2 reveal that the Latanoprost eye drops was ordered for Resident #167 who had admitted to 500 Hall on 07/10/17 and she had not given Resident #167 the above expired eye drops for that day yet. Nurse #2 stated she had been checking each medications before administration and the Nurse Supervisor (NS) had checked for expired medication once weekly. Interview on 07/12/17 at 4:39 PM with Nurse #3 revealed that Resident #167 was hospitalized and readmitted to the facility from the Assisted Living section recently. The facility required all the nurses to check for expiration date each time before administration. As a NS, she had	F 431	immediately addressed and corrected. A list of all medications with specific dates of expiration and necessary storage information was placed in each medication room and on every medication cart for quick reference by nurses on each shift on 8/3/17. The Medication Administration General Guidelines policy/procedure will be revised on 8/7/17 to include the following: •all medication carts/medication storage rooms will be checked each night by the 3rd shift nurse assigned to each specific unit—any expired/beyond date medications or unlabeled medications will be immediately discarded. •the 3rd shift Nursing Supervisor will check each medication cart/medication storage room weekly—any expired/beyond date medications or unlabeled medications will be immediately discarded. •the Risk Management Coordinator will check each medication cart/medication storage room monthly (added to Job Description)—any expired/beyond date medications or unlabeled medications will be immediately discarded and disciplinary action will be taken as necessary for areas of concern. All nurses will be in-serviced on this policy revision and expectations by the Administrator between 8/3/17 – 8/7/17.	

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F 431	Continued From page 20 conducted random checks for expired medications once weekly. Besides, the pharmacy had sent staff to facility to check for expired medications once monthly. Nurse #3 added the expired Latanoprost eye drops was caused by human error and it should be removed from the medication cart after its expiration. In an interview conducted on 07/13/17 at 12:34 PM, the Director of Nursing (DON) stated that the facility had a system in place to check for expired medication. Part of the second shift NS job description was to check for expired medication at least once weekly. Besides, the nurses were responsible to check for expired medication each time before administration. The pharmacy staff had conducted expired medication checks once monthly. It was her expectation for all the nurses to follow facility's policy and manufacturer's recommendations to discard Latanoprost after 42 days from the date it was opened. In an interview conducted via phone on 07/13/17 at 12:51 PM, Nurse #4 stated that she had checked for expired medications before each administration. She recalled the open date of this particular expired Latanoprost was 05/10/17 but she failed to see the fine print on the label stated the eye drops had to be discarded 42 days after it was opened. Nurse #4 considered the incident as a careless human error and the expired eye drop should be removed from the medication cart after its expiration. In an interview conducted on 07/13/17 at 12:59 PM, the Administrator stated that all the nursing staff were expected to follow the facility's policy for medication storage. It was her expectation for all the medication to be checked routinely and	F 431	The contracted pharmacy will perform monthly drug storage checks over the next (3) months beginning in August followed by quarterly checks thereafter. Documentation of drug storage checks will be provided to the Director of Nursing, including any trends or concerns noted. The licensed nurse assigned to each medication cart for each shift will complete an audit of their assigned medication cart to ensure there are no concerns related to expired/beyond date medications beginning on 8/7/17 daily X 2 weeks, followed by weekly X 6 weeks, and finally monthly X 4 months. Any concerns identified from any of these audits will be immediately corrected and all audits will be reviewed by the Risk Management Coordinator for concerns requiring disciplinary action as necessary. The Risk Management Coordinator will check each medication cart and medication storage room beginning on 8/7/17 weekly X 4 weeks, followed by every other week X 4 weeks, and finally monthly X 4 months. Any concerns identified from any of these audits will be immediately corrected including disciplinary action as necessary. The Staff Development Coordinator will monitor all audits completed by the Risk Management Coordinator to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6	

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F 431	Continued From page 21 removed from the storage once it was expired.	F 431	months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning in August.	
F 520 SS=E	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 (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	F 520		8/10/17

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F 520	Continued From page 22 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, record reviews, and staff and resident interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and to monitor these interventions that the committee put into place in July 2016 on a recertification survey. The deficiencies were in the areas of dietary services for food procurement, storage and sanitation and resident assessment accuracy and were originally cited in June 2016 and again on the present recertification survey. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. Findings included: This tag is cross referenced to: 1a. F 278 Accurate Assessment: Based on staff interviews and medical record review, the facility failed to accurately code an annual Minimum Data Set (MDS) to include active diagnoses (Resident#107) and an admission MDS regarding incontinence (Resident #47) for 2 of 19 sampled MDS reviewed. On a federal recertification survey in June 2016	F 520	(a) Bladder documentation for Resident #47 was reviewed and properly coded on the most recent MDS assessment—it was resubmitted to CMS by the MDS Coordinator on 7/14/17. Osteoporosis was added as a diagnosis for Resident #107-- it was resubmitted to CMS by the MDS Coordinator on 7/14/17. (b) All items of concern (sweet potatoes, bananas, and frozen biscuits) were immediately by the Food Service Director discarded on 7/10/17. The remaining bananas were placed in refrigerated storage for the appropriate temperature. (a) The most recent MDS assessment for all current residents was audited by the MDS Coordinators for accurate documentation of bladder and diagnosis—this audit will be complete and any inaccuracies in these areas will be corrected, properly coded, and resubmitted to CMS by the MDS Coordinator by 8/7/17.	

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	345264	A. BUILDING _____ B. WING _____	C 07/13/2017

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F 520	Continued From page 23 the facility failed to accurately code the admission Minimum Data Set (MDS) correctly to reflect a resident had been evaluated by Level II PASSR (Preadmission Screening and Review) and failed to code a significant change on the MDS to reflect dental status. On the present survey the facility continued to fail to accurately code a MDS. 1b. F371 Food Storage: Based on observations, staff interviews and review of the facility records, the facility failed to store bananas per vendor recommendations to prevent growth of bacteria (60-65 degrees Farenheit), produce to prevent the growth of bacteria (bananas), discard expired produce (sweet potatoes) and bananas) and store frozen biscuits in a secured container with a date of opening for 3 of 5 storage units observed. On a federal recertification survey in June 2016 the facility failed to provide sanitary conditions for distribution of food to residents in 1 or 3 areas where food was served. The facility did not have a cleaning process in place. Again on the present survey the facility continued to fail to store procedure correctly, discard expired produce, and frozen products in secure containers with the date of opening. During an interview on 07/13/2017 at 2:22 PM with the Administrator stated they did performance improvement plans. The department heads came up their plan and work with committees on the issue. The committees came up with a corrective action plan and their information came to the Quality Assurance committee for final review. Last year the issue was an MDS coding issue. The MDS Coordinator was to check the social worker's and food service's work. This year it is an MDS	F 520	(b) An audit was conducted by both the Kitchen Manager and Food Service Director together of the dry storage area and all freezers/coolers on 7/18/17— areas of concern were immediately addressed and/or discarded at that time. (a) The MDS Coordinators will attend a Myers & Stauffer MDS documentation training seminar on 8/8/17 and will also be re-educated on proper coding in Section H and Section I of the MDS through the use of online CMS videos specifically for “Section H training” and “MDS 3.0 Provider Updates for Section I” by 8/10/17. (b) The Food Storage policy for dietary services will be revised on 8/7/17 to include the proper storage of bananas following the NC Food Code requirements as well as a review of specifically assigned dietary staff to check for proper storage and appropriate labeling/dating and use of food items: • The 1st shift Cook will check all food storage areas (refrigerators/coolers, freezers, and dry storage) daily at the beginning of the shift to ensure all food items are properly stored, labeled/dated, and discarded as necessary. • The 2nd shift Cook will check all food storage areas (refrigerators/coolers,	

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F 520	Continued From page 24 Coordinator's error. Last year it was a dirty fan, but falls under the same rule area and this year it was a food storage issue. We will develop a new plan to correct the problem. It is my expectation that the MDS' will be coded accurately and all food will be stored properly.	F 520	freezers, and dry storage) daily at the end of the shift to ensure all food items are properly stored, labeled/dated, and discarded as necessary. • The Dietary Aide assigned to check in all groceries upon delivery will check all food storage areas (refrigerators/coolers, freezers, and dry storage) at the time groceries are being put away to ensure all food items are properly stored, labeled/dated, and discarded as necessary—this will occur at least once weekly. All dietary staff will be in-service by the Food Services Director on this policy revision and expectations between 8-4-17 and 8-10-17 (a) There are (2) MDS Coordinators employed full-time. Each MDS Coordinator will randomly audit the other MDS Coordinator's completed assessments for accuracy of bladder and diagnosis beginning on 8/7/17 with 3 comprehensive assessments from the weekly MDS calendar/schedule weekly X 4 weeks, followed by 3 comprehensive assessments from the weekly MDS calendar/schedules every other week X 4 weeks, and finally 5 comprehensive assessments from the weekly MDS calendar/schedules monthly X 4 months. Any concerns identified from any of these audits will be immediately corrected by the MDS Coordinator who completed the	

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F 520	Continued From page 25	F 520	assessment. The Director of Nursing will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning with the August 2017 QA&A Committee meeting. (b) The Kitchen Manager will conduct an audit of the dry storage and all coolers/freezers to ensure all food items are properly labeled/dated for use and no items are expired beginning on 8/7/17 weekly X 4 weeks, followed every other week X 4 weeks, and finally monthly X 4 months. Any concerns identified from any of these audits will be immediately corrected including disciplinary action as necessary. The Food Service Director will monitor all completed audits to ensure proper completion and corrective action taken as needed and will present results to the QA&A Committee monthly X 6 months. The QA&A Committee will assess and modify the action plan as needed to ensure continued compliance beginning in August 2017.	