STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345253	A. BUILDING _____ B. WING _____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT MILLS RIVER	5593 OLD HAYWOOD ROAD MILLS RIVER, NC 28759

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID# T46511.	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 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	F 278		9/15/17

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

Electronically Signed | 09/23/2017

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

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code discharge destinations for 2 of 3 sampled residents (Resident #54 and #135) who had discharge minimum data set (MDS) assessments completed. Findings included: 1. Record review revealed Resident #135 was admitted to the facility on 04/29/17 and discharged from the facility on 05/11/17. The resident's documented diagnoses included diabetes, hypertension, hyperlipidemia, and aftercare following joint replacement surgery. The resident's 05/11/17 discharge minimum data set (MDS) documented he was discharged to an acute care hospital. A 05/12/17 progress note (late entry for 05/11/17 3:00 PM) documented Resident #13 "attended ortho appt (orthopedic appointment) with orders for OK to d/c (discharge) home, amb (ambulating) via r/w (rolling walker) steady gait, (family member designation) at side and involved with d/c, reviewed med (medications) and d/c orders, stated had all meds at home..." At 11:38 AM on 09/08/17 the MDS Nurse stated she coded the discharge destination in the MDS system based on her review of resident progress notes. After reviewing Resident #135's progress notes, she reported her coding of the resident's discharge destination was inaccurate. She explained the resident went home, and not to the hospital as she documented in the resident's 05/11/17 discharge MDS. According to the MDS	F 278	What corrective action will be accomplished by facility to correct deficient practice: Facility was notified by surveyor that 2 of the 3 resident MDS Discharge Destinations were incorrect. MDS Coorindator immediately corrected error and transmitted and received acceptance of change. How will facility identify other issues having potential to affect residents and what corrective action will be taken. An audit will be conducted to review all Discharge Destinations from January 1, 2017 through present to insure that Discharge Destinations are correct. Any errors will be corrected and transmitted. This will be completed by Friday, September 15. What measures will be put in place that you will make to insure deficient practice does not occur MDS coordinator will complete MDS Assessment and DON will review Discharge Destination prior to MDS being transmitted. This will be done daily or as needed for 4 weeks and documented on Audit Tool. Then DON and or	

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F 278	Continued From page 2 Nurse, when she saw the progress note about Resident #135 going out of the facility to an orthopedic appointment, she must have gotten this resident mixed up with another resident who went from a doctor's appointment to the hospital. At 4:25 PM on 09/08/17 the Director of Nursing (DON) stated it was her expectation that the information on the MDS assessments be coded correctly. 2. Record review revealed Resident #54 was readmitted to the facility on 03/17/17 and discharged from the facility on 04/06/17. The resident's documented diagnoses included hypertension, atrial fibrillation, and hypothyroidism. A 04/05/17 5:55 PM Therapy Note documented, "Occupational Therapy (OT) discharge performed during today's session with evaluation and assessment of patient's functional progress toward short and long term goals and carryover of therapeutic gains. Recommendations for discharge include caregiver assist/supervision for all self-care with home health therapy to evaluate and treat as indicated to facilitate safe return to PLOF (previous level of function) with ADLs (activities of daily living) within the home." A 04/05/17 12:17 PM Therapy Note documented, "Physical Therapy (PT) plan of care and PT goals/safety training for falls prevention reviewed with patient with PT discharge summary completed and written." The resident's 04/06/17 discharge minimum data set (MDS) documented he was discharged to an	F 278	Administrator will check weekly for compliance. How will corrective actions be monitored to ensure deficient practice will not recur MDS coordinator will complete MDS Assessment and DON will review Discharge Destination prior to MDS being transmitted. This will be done daily or as needed for 4 weeks and documented on Audit Tool. Then DON and or Administrator will check weekly for compliance. Results of Audit will be reviewed at QA for the next 3 months by the DON and Administrator	

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F 278	Continued From page 3 acute care hospital. At 11:38 AM on 09/08/17 the MDS Nurse stated she coded the discharge destination in the MDS system based on her review of resident progress notes. After reviewing Resident #54's progress notes, she reported her coding of the resident's discharge destination was inaccurate. She explained the resident went home with home health services, and not to the hospital as she documented in the resident's 04/06/17 discharge MDS. According to the MDS nurse, she could not explain why she coded Resident #54's discharge destination as an acute care hospital when the therapy notes clearly indicated the resident was going home. At 4:25 PM on 09/08/17 the Director of Nursing (DON) stated it was her expectation that the information on the MDS assessments be coded correctly.	F 278		
F 281 SS=E	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 and physician interviews the facility failed to administer a medication ordered by the physician for 1 of 5 residents (Resident #33) whose medications were reviewed. Findings included:	F 281	What corrective action will be accomplished by facility to correct deficient practice: Facility was notified by surveyors that	9/15/17

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F 281	Continued From page 4 Review of the Quarterly Minimum Data Set (MDS) dated 07/11/17 revealed Resident #33 was admitted to the facility on 04/08/17 with diagnoses of dementia, anxiety disorder, and anemia. Resident #33 was moderately cognitively impaired. Review of the "Consultant Pharmacist Communication to Physician" form dated 07/14/17 revealed a recommendation to increase Resident #33's dose of donepezil (Aricept) to 10 milligrams (mg) every evening to optimize the potential benefits of the medication. There was a handwritten response from the physician dated 07/22/17 to increase Aricept (donepezil) to 10mg by mouth every evening. There were no initials or notations from a nurse that the order had been noted. Review of the July, August, and September 2017 Medication Administration Records (MAR) revealed the physician order, dated 07/22/17, of increasing the daily dose of Aricept was never transcribed on the MAR. As a result, Resident #33 received a daily dose of 5 mg of donepezil (Aricept) for dementia instead of 10 mg for 49 days. In an interview on 09/07/17 at 4:05 PM Resident #33's Physician stated the rationale for increasing the dose of the Aricept was to stabilize Resident #33's dementia. He stated he was not aware that his order was not being followed and that he expected the facility to follow his orders. In an interview on 09/07/17 at 4:24 PM Unit Manager (UM) #1 stated the "Consultant Pharmacist Communication to Physician" form	F 281	pharmacy recommendation from July for Aricept medication change was not followed. Unit Manager immediately notified the family of recommendation and the family needed to have a family conference to decide on increasing the Aricept or leaving at the current dosage. Unit Manager contacted Pharmacist to have him review all pharmacy recommendations from July and August to insure compliance. This will be completed by Wednesday, September 13. Any noncompliance issues will be immediately addressed. See attached Pharmacy Statement of Review How will facility identify other issues having potential to affect residents and what corrective action will be taken. DON contacted Pharmacist to have him review all pharmacy recommendations from July and August to insure compliance. This will be completed by Wednesday, September 13. Any noncompliance issues will be immediately addressed. What measures will be put in place that you will make to insure deficient practice does not occur. When pharmacist conducts current medication regimen and chart review, they will also review prior month□s reviews for	

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F 281	Continued From page 5 would be considered an order once filled out and signed by the Physician. He indicated the process would be to note the order and transcribe it to the MAR. UM #1 indicated the order should then be initiated. In an interview on 09/07/17 at 4:38 PM the Director of Nursing (DON) stated the "Consultant Pharmacist Communication" form would be considered an order once signed by the Physician. She indicated the process was for the Physician to give her the signed recommendations and that she would then give the recommendation to a Unit Manager or a nurse. She indicated the order would then be placed on the MAR and carried out. In an interview on 09/08/17 at 9:40 AM UM #2 indicated she had received the signed "Consultant Pharmacist Communication" form. She stated she spoke to Resident #33's family on 07/24/17 but they were unsure if they wanted Resident #33 to receive an increased dose of Aricept. She indicated she had not updated the MAR for the increased dosage as she was waiting for a response from Resident #33's family. She stated she had not done any other follow-up until the morning of 09/08/17 when she spoke with a member of Resident #33's family.	F 281	compliance. This will occur monthly going forward. How will corrective actions be monitored to ensure deficient practice will not recur After pharmacist completes medication regimen and chart review the audit will be given to the Medical Director for review. After review, DON will have Staff nurses transcribe any new medication orders or changes to the MAR. DON and or Unit Managers will review orders for compliance and initial and date each review noting verification. Administrator will then review Pharmacy Review for compliance. Results of Audit will be reviewed at QA for the next 3 months by the DON and Administrator	
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	F 329		9/22/17

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F 329	Continued From page 6 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-- (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 and staff and physician interviews the facility failed to follow-up on a urine culture which resulted in the administration of unnecessary antibiotics for 1 of 5 residents (Resident #33) whose medications were reviewed. Findings included:	F 329	What corrective action will be accomplished by facility to correct deficient practice: Facility was notified by surveyors that the regimen for a resident□s course of	

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F 329	Continued From page 7 Review of the Quarterly Minimum Data Set (MDS) dated 07/11/17 revealed Resident #33 was admitted to the facility on 04/08/17 with diagnoses of anemia, dementia and anxiety disorder. Resident #33 was moderately cognitively impaired and occasionally incontinent of bladder. Review of the Physician Telephone Orders dated 07/30/17 revealed an order to obtain a urine sample for culture and sensitivity. A second Telephone Order dated 07/30/17 revealed an order for Amoxicillin (an antibiotic) 875 mg (milligrams) by mouth twice each day for seven days for a UTI (urinary tract infection). Review of the Laboratory urine Culture and Sensitivity results reported 08/02/17 revealed no growth in 48 hours (signifying no infection). Review of the August 2017 Medication Administration Record revealed Resident #33 continued to receive Amoxicillin 875 mg for the full seven day course even though the urine culture and sensitivity was negative. In a telephone interview on 09/08/17 at 10:30 AM Resident #33's Physician indicated someone at the facility should have reviewed the laboratory urine culture results and contacted him. He stated if the facility had notified him he would have discontinued the antibiotic since the results were negative. In an interview on 09/08/17 at 11:00 AM the Director of Nursing (DON) stated she did not review urine culture and sensitivity results. She indicated she expected the resident's nurse to review any laboratory results for the resident.	F 329	antibiotic treatment for a UTI was completed, even though the initial urine culture came back negative 3 days after antibiotic was started. Facility failed to notify physician of lab results. How will facility identify other issues having potential to affect residents and what corrective action will be taken. Facility will utilize a lab tracking sheet noting resident name, what lab was being ordered and date; results and date; physician notification and date; and physician recommendations. This will begin Wednesday, September 13. See attached Nursing Inservice, which will be completed by Friday September 22. What measures will be put in place that you will make to insure deficient practice does not occur. DON, Unit Manager and or Staff Nurse will audit daily the lab tracking sheet for completed lab results and insure that the physician has been notified and recommendations are in compliance. How will corrective actions be monitored to ensure deficient practice will not recur DON, Unit Manager and or Staff Nurse will audit daily the lab tracking sheet for	

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F 329	Continued From page 8 She also expected the nurse to notify the physician of any results needing follow-up. She stated the physician should have been notified of the negative culture result so the medication could have been discontinued. In a telephone interview on 09/08/17 at 11:40 AM Nurse #1, who was Resident #33's nurse during a 12 hour shift on 08/02/17, stated she did not remember seeing the laboratory results for the urine culture and sensitivity. She indicated the results were faxed to the facility and anyone could have picked up the results. Nurse #1 stated that since she never saw the results she did not notify the physician and did not follow-up on the culture results.	F 329	completed lab results and insure that the physician has been notified and recommendations are in compliance. Results of Audit will be reviewed at QA for the next 3 months by the DON and Administrator	
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 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.	F 371		9/22/17

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F 371	Continued From page 9 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep the cold salad filling in sandwiches at or below 41 degrees Fahrenheit during operation of the trayline, failed to cover the facial hair of an employee handling sanitized kitchenware, and failed to wash fresh fruit before cutting it up. The facility also failed to air dry tray pans prior to stacking them on top of one another on storage shelving, and failed to remove dried food particles from the interior top of the microwave. Findings included: 1. At 5:30 PM on 09/05/17 the kitchen trayline was in operation. A large baking pan containing chicken salad sandwiches was laying across empty wells of the steam table next to a well which contained hot soup. At 5:32 PM on 09/05/17 a calibrated thermometer was used to check the temperature of the chicken salad filling in the sandwiches. The thermometer registered 64.6 degrees Fahrenheit. At this time a dietary employee stated there were still six residents in the dining room yet to be served. She stated the trayline had begun operation at 4:50 PM on 09/05/17. At 5:35 PM on 09/05/17 the Dietary Manager (DM) provided the trayline temperature log, and no food temperatures were recorded at any meal on 09/05/17. However, the DM reported she did take the temperature of the chicken salad filling	F 371	1. What corrective action will be accomplished by facility to correct deficient practice: Facility was notified by surveyors that the chicken salad sandwiches were above the maximum 41 degree threshold on the serving line, 45 minutes into the dining meal service. Dietary staff informed surveyor that dinner meal service was almost completed with six (6) residents remaining to be served. How will facility identify other issues having potential to affect residents and what corrective action will be taken. Dietary Manager will conduct inservice on proper handling of cold food products storage and service. Inservice will be completed by Friday, September 22. Dietary Manager, Cook and or Administrator will revise storage serving procedures for cold food prepared items. Cold food prepared items will be placed in a double stacked hotel pan, placed on a bed of ice and placed on the tray line at the farthest point away from a steam table well that is in use to prevent excessive	

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F 371	Continued From page 10 as the trayline began operation, and the calibrated thermometer registered 40 degrees Fahrenheit. At 9:24 AM on 09/07/17 the ingredient label on a container of the commercially prepared chicken salad, served to residents at lunch on 09/05/17, documented the chicken salad contained chicken, salad dressing, egg yolks, vinegar, mustard, onion, and sweet pickle relish. At 3:04 PM on 09/08/17 the DM stated it was a challenge to keep the chilled filling of sandwiches at 41 degrees Fahrenheit or below without making the bread tough. She reported when the facility was serving cold salad plates the salads made with mayonnaise, eggs, and/or salad dressing were kept cold by placing them above steam table wells which had been turned off and filled with ice. At 3:12 PM on 09/08/17 Dietary Employee #1 stated she was trained to make up the sandwiches as they were needed by placing chilled salad filling stored over or in ice between slices of bread at the trayline. She reported if salads made with mayonnaise remained over 41 degrees Fahrenheit for long periods of time it increased the chance that bacteria could grow in them. 2. During observation of the dish machine process on 09/07/17 between 9:03 AM and 9:16 AM one dietary employee was loading and unloading kitchenware as it entered and exited the dish machine. This male was handling sanitized kitchenware as he unloaded it from racks and placed it in storage. He had side burns, a moustache, and a beard which were not	F 371	heat transfer. Food will be temped prior to meal service to insure proper serving temperature guidelines. What measures will be put in place that you will make to insure deficient practice does not occur. Dietary Manager, Cook and or Administrator will insure that food temperatures will be taken and documented on a temperature log sheet showing food temperature prior to meal service. How will corrective actions be monitored to ensure deficient practice will not recur Dietary Manager, Cook and or Administrator will insure that food temperatures will be taken and documented on a temperature log sheet showing temperature prior to meal service. Dietary Manager, Cook or Administrator will document cold food temperatures for all menu items that appear on the daily menu. Results of Audit will be reviewed at QA for the next 3 months by the Dietary Manager and Administrator 2. What corrective action will be accomplished	

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F 371	Continued From page 11 covered during the observation. The facial hair in the sideburns and moustache was 1/2 inch to 3/4 inch maximum in length, and the facial hair in the beard was 3/4 inch to one inch maximum in length. At 3:04 PM on 09/08/17 the Dietary Manager (DM) stated facial hair could contaminate kitchenware which was sanitized by the heat of the dish machine as an employee with uncovered facial hair was placing it in storage. At 3:12 PM on 09/08/17 Dietary Employee #1 stated hair found on kitchenware or in food could cause cross contamination by spreading germs and bacteria. She commented the elderly population was especially susceptible to sickness since they often had compromised immune systems. 3. At 10:55 AM on 09/07/17 the cook retrieved a whole watermelon from the walk-in refrigerator. She placed the melon on a cutting board and used a knife to slice it open without washing it first. At 3:04 PM on 09/08/17 the Dietary Manager (DM) stated whole fresh fruit should be washed before cut open because it had been transported and stored in places where the outside peel or rind could have become contaminated by dirt and bacteria. She reported if the fruit was not washed first, a knife could carry this dirt and bacteria from the rind into the flesh of the fruit as the knife passed through it. At 3:12 PM on 09/08/17 Dietary Employee #1 stated she was trained to always wash fresh fruit before cutting it up so that dirt and bacteria on	F 371	by facility to correct deficient practice: Facility surveyor notified Dietary Manager that one of the Dietary employees did not have his beard covered while in the kitchen. Dietary Manager immediately had employee cover his beard with a hair net. How will facility identify other issues having potential to affect residents and what corrective action will be taken. Dietary Manager will conduct inservice on proper hair and facial hair restraint. Inservice will be completed by Friday, September 22. What measures will be put in place that you will make to insure deficient practice does not occur Dietary Manager and or Administrator will monitor for compliance that all hair and facial hair will be restrained with a hair net while Dietary employees are in the kitchen How will corrective actions be monitored to ensure deficient practice will not recur Dietary Manager and or Administrator will monitor for compliance that all hair and facial hair will be restrained with a hair net while Dietary employees are in the kitchen	

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F 371	Continued From page 12 the outside of the fruit did not contaminate the inside of the fruit which was eaten by residents. 4. At 9:12 AM on 09/07/17 3 of 10 tray pans stacked on top of one another on a storage shelf had moisture trapped inside of them. At this time the cook stated the tray pans were stacked wet the night before because today she had not yet run any tray pans through the three-compartment sink system. At 3:04 PM on 09/08/17 the Dietary Manager (DM) stated bacteria could grow in the moisture trapped inside of kitchenware which was stacked in storage overnight. She reported this practice had the potential of making residents sick. At 3:12 PM on 09/08/17 Dietary Employee #1 stated she was trained that all kitchenware was supposed to be air dried and clean before stacking items on top of one another in storage. 5. During initial tour of the kitchen, beginning at 2:32 PM on 09/05/17, the interior top of the microwave was covered in dried food particles. At 9:06 AM on 09/07/17, during a follow-up tour of the kitchen, the interior top of the microwave was covered in dried food particles. At 3:04 PM on 09/08/17 the Dietary Manager (DM) stated the microwave was on the cleaning schedule to be cleaned daily, and the assignment was rotated between the three cooks. However, she reported it looked like the cooks were wiping down the bottom and sides of the microwave, but forgetting to clean the interior top. She explained the dietary staff heated a lot of soup for the residents, and she thought that was where a lot of	F 371	3. What corrective action will be accomplished by facility to correct deficient practice: Facility surveyor notified Dietary Manager that one of the Dietary employees did not wash the fruit prior to preparation. At time of notification fruit was discarded. How will facility identify other issues having potential to affect residents and what corrective action will be taken. Dietary Manager will conduct inservice on proper preparation of fresh fruit and vegetables, to insure that all fresh produce is washed prior to meal service Inservice will be completed by Friday, September 15. What measures will be put in place that you will make to insure deficient practice does not occur Dietary Manager and or Administrator will monitor fresh fruit preparation daily, if it appears on daily menu for the first 4 weeks, then as needed based on daily menu for compliance. This will be documented on Audit Tool.	

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F 371	Continued From page 13 the dried food was coming from. According to the DM, these dried food particles could fall into fresh food which was being heated, causing contamination of the fresh food. At 3:12 PM on 09/08/17 Dietary Employee #1 stated she was trained that the microwave was supposed to be wiped out after each breakfast, lunch, and supper meal. She reported she was taught to clean the interior top, bottom, and sides of the microwave so dried food particles did not contaminate foods currently being heated in the microwave.	F 371	How will corrective actions be monitored to ensure deficient practice will not recur Dietary Manager and or Administrator will monitor fresh fruit preparation daily, if it appears on daily menu for the first 4 weeks, then as needed based on daily menu for compliance. This will be documented on Audit Tool. Results of Audit will be reviewed at QA for the next 3 months by the Dietary Manager and Administrator 4. What corrective action will be accomplished by facility to correct deficient practice: Facility was notified by surveyors that three tray pans were found stacked on the shelves and contained moisture. Dietary staff immediately removed tray pans from shelf and placed them in dirty dish area to be washed. How will facility identify other issues having potential to affect residents and what corrective action will be taken. Dietary Manager will conduct inservice on proper dish sanitation to insure that all pans are to be aired dried prior to them being stored away. Inservice will be completed by Friday, September 15. Dietary Manager, Cook and or	

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F 371	Continued From page 14	F 371	Administrator will check daily tray pans for proper storage and document on Daily Audit Tool. What measures will be put in place that you will make to insure deficient practice does not occur. Dietary Manager, Cook and or Administrator will check daily tray pans for proper storage and document on Daily Audit Tool for 4 weeks, then Weekly for 1 month and then BiWeekly. How will corrective actions be monitored to ensure deficient practice will not recur Dietary Manager, Cook and or Administrator will check daily tray pans for proper storage and document on Daily Audit Tool for 4 weeks, then Weekly for 1 month and then BiWeekly. Results of Audit will be reviewed at QA for the next 3 months by the Dietary Manager and Administrator 5. What corrective action will be accomplished by facility to correct deficient practice: Facility was notified by surveyor that the light bulb cover in the Kitchen Microwave was dirty. Dietary staff immediately	

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F 371	Continued From page 15	F 371	cleaned the microwave How will facility identify other issues having potential to affect residents and what corrective action will be taken. Dietary staff will follow a daily and weekly cleaning schedule to insure that all kitchen table surfaces and equipment are cleaned according to cleaning schedule. See attached Cleaning Schedule What measures will be put in place that you will make to insure deficient practice does not occur Dietary Manager will conduct inservice on cleaning schedule. Inservice will be completed by Friday, September 15. Dietary Manager, Cook and or Administrator will check daily the Kitchen Equipment and Table surfaces for proper cleaning and sanitation and document on Daily Audit Tool for 4 weeks, then Weekly for 1 month and then BiWeekly. See attached Inservice to be completed by September 15. How will corrective actions be monitored to ensure deficient practice will not recur Dietary Manager, Cook and or Administrator will check daily the Kitchen Equipment and Table surfaces for proper	

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F 371	Continued From page 16	F 371	cleaning and sanitation and document on Daily Audit Tool for 4 weeks, then Weekly for 1 month and then BiWeekly. Results of Audit will be reviewed at QA for the next 3 months by the Dietary Manager and Administrator	
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 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 428		9/13/17

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F 428	Continued From page 17 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 record review and staff, Consultant Pharmacist, and Physician interviews the Consultant Pharmacist failed to advise the facility that a medication dosage increase ordered by the Physician was not being administered. Findings included: Review of the Quarterly Minimum Data Set (MDS) dated 07/11/17 revealed Resident #33 was admitted to the facility on 04/08/17 with diagnoses of dementia, anxiety disorder, and anemia. Resident #33 was moderately cognitively impaired. Review of the "Consultant Pharmacist Communication to Physician" form dated 07/14/17 revealed a recommendation to increase Resident #33's dose of donepezil (Aricept) to 10	F 428	What corrective action will be accomplished by facility to correct deficient practice: Facility was notified by surveyors that Aricept 5mg was noted on a pharmacy recommendation in July to be increased to Aricept 10 mg. Facility immediately notified the family of recommendation and the family needed to have a family conference to decide on increasing the Aricept or leaving at the current dosage. How will facility identify other issues having potential to affect residents and what corrective action will be taken.	

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F 428	Continued From page 18 milligrams (mg) every evening to optimize the potential benefits of the medication. There was a handwritten response from the physician dated 07/22/17 to increase Aricept (donepezil) to 10 mg by mouth every evening. Review of the July, August, and September 2017 Medication Administration Records (MAR) revealed the physician order, dated 07/22/17, of increasing the daily dose of Aricept was never transcribed on the MAR. As a result, Resident #33 received a daily dose of 5 mg of donepezil (Aricept) for dementia instead of 10 mg for 49 days. In an interview on 09/07/17 at 4:05 PM Resident #33's Physician stated the rationale for increasing the dose of the Aricept was to stabilize Resident #33's dementia. He stated that when the Consultant Pharmacist reviewed the MAR's he should have seen the order for the Aricept was not increased and informed the facility. In a telephone interview on 09/08/17 at 9:00 AM the Consultant Pharmacist stated the process for the monthly medication review included reviewing the resident's MAR and monitoring any recommendations he made to the Physician. The Consultant Pharmacist stated it was unfortunate that Resident #33 had not received the Aricept as ordered and acknowledged that he should have informed the facility that the increase in Aricept had not been implemented.	F 428	DON contacted Pharmacist to have him review all pharmacy recommendations from July and August to insure compliance. This will be completed by Wednesday, September 13. Any noncompliance issues will be immediately addressed. What measures will be put in place that you will make to insure deficient practice does not occur. When pharmacist conducts current medication regimen and chart review, they will also review prior month□s reviews for compliance. This will occur monthly going forward. How will corrective actions be monitored to ensure deficient practice will not recur After pharmacist completes medication regimen and chart review the audit will be given to the Medical Director for review. After review, DON will have Staff nurses transcribe any new medication orders or changes to the MAR. DON and or Unit Managers will review orders for compliance and initial and date each review noting verification. Administrator will then review Pharmacy Review for compliance. Results of Audit will be reviewed at QA for the next 3 months by the DON and Administrator	

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F 505 SS=D	483.50(a)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS (a) Laboratory Services (2) The facility must- (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to notify the physician of urine culture and sensitivity results which resulted in the administration of unnecessary antibiotics for 1 of 5 residents (Resident #33) whose medications were reviewed. Findings included: Review of the Quarterly Minimum Data Set (MDS) dated 07/11/17 revealed Resident #33 was admitted to the facility on 04/08/17 with diagnoses of anemia, dementia and anxiety disorder. Resident #33 was moderately cognitively impaired and occasionally incontinent of bladder. Review of the Physician Telephone Orders dated 07/30/17 revealed an order to obtain a urine sample for culture and sensitivity. A second Telephone Order dated 07/30/17 revealed an order for Amoxicillin (an antibiotic) 875 mg (milligrams) by mouth twice each day for seven days for a UTI (urinary tract infection). Review of the Laboratory urine Culture and	F 505	What corrective action will be accomplished by facility to correct deficient practice: Facility was notified by surveyors that the regimen for a resident□s course of antibiotic treatment for a UTI was completed, even though the initial urine culture came back negative 3 days after antibiotic was started. Facility failed to notify physician of lab results. How will facility identify other issues having potential to affect residents and what corrective action will be taken. Facility will utilize a lab tracking sheet noting resident name, what lab was being ordered and date; results and date; physician notification and date; and physician recommendations. This will begin Wednesday, September 13. See	9/22/17

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F 505	Continued From page 20 Sensitivity results reported 08/02/17 revealed no growth in 48 hours (signifying no infection). Review of the August 2017 Medication Administration Record revealed Resident #33 continued to receive Amoxicillin 875 mg for the full seven day course even though the urine culture and sensitivity was negative. In a telephone interview on 09/08/17 at 10:30 AM Resident #33's Physician indicated someone at the facility should have reviewed the laboratory urine culture results and contacted him. He stated if the facility had notified him he would have discontinued the antibiotic since the results were negative. In an interview on 09/08/17 at 11:00 AM the Director of Nursing (DON) stated she did not review urine culture and sensitivity results. She indicated the laboratory faxed the results to the facility. She indicated there was no one assigned to retrieve the results and provide them to the resident's nurse but that she expected the resident's nurse to review them. She stated she expected the nurses to notify the physician if any follow-up was needed including if the resident was on the wrong antibiotic. She stated the physician should have been notified of the negative culture result so the medication could have been discontinued. In a telephone interview on 09/08/17 at 11:40 AM Nurse #1, who was Resident #33's nurse during a 12 hour shift on 08/02/17, stated she did not remember seeing the laboratory results for the urine culture and sensitivity. She indicated laboratory results were faxed to the facility and anyone could have picked up the results. Nurse	F 505	attached Nursing Inservice, which will be completed by Friday September 22. What measures will be put in place that you will make to insure deficient practice does not occur. DON, Unit Manager and or Staff Nurse will audit daily the lab tracking sheet for completed lab results and insure that the physician has been notified and recommendations are in compliance. How will corrective actions be monitored to ensure deficient practice will not recur DON, Unit Manager and or Staff Nurse will audit daily the lab tracking sheet for completed lab results and insure that the physician has been notified and recommendations are in compliance. Results of Audit will be reviewed at QA for the next 3 months by the DON and Administrator	

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F 505	Continued From page 21 #1 stated that since she never saw the results she did not notify the physician and did not follow-up on the culture results. She indicated that whoever picked up the results from the fax machine should have provided the results to a nurse for review.	F 505		