STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY CARE CENTER	3625 WILLARD FARROW DRIVE CHARLOTTE, NC 28215

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigaton Event ID WQTF11.	F 000		
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, record review and interviews the facility failed to maintain the temperature of the nourishment freezer to keep the contents frozen for 1 of 3 nourishment refrigerators for 3 of 3 observations.	F 371	1. Corrective action for the residents affected by the alleged deficient practice: The four boxes of ice cream and the two boxes of nourishment shakes that were in the freezer on the third floor were discarded on 9/20/17 by the Director of	10/16/17

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

Electronically Signed | 10/11/2017

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F 371	Continued From page 1 The findings included: During an observation of the 3rd floor nourishment freezer on 9/18/17 at 12:30 pm the contents including 4 boxes of ice cream and 2 boxes of nourishment shakes were observed to be thawed and soft to the touch. A review of the temperature monitoring form posted on the door of the freezer reveled the acceptable temperature range for of the freezer was 0 degrees to 10 degrees. An observation of the thermometer revealed the temperature of the freezer was 15 degrees. During an observation of the 3rd floor nourishment freezer on 9/20/17 at 12:05 pm revealed 4 boxes of ice cream and the 2 boxes of nourishment shakes continued to be thawed and soft to the touch. The Food Service Director was interviewed on 9/20/17 at 12:30 pm. He observed the ice cream and nourishment shakes. He stated the ice cream was partially thawed. He stated the current temperature of the freezer was 18 degrees. He observed the temperature monitoring log which revealed the temperature recorded on 9/18/18 was 28 degrees and the temperature recorded on 9/19/17 was 12 degrees in the morning and 18 degrees in the evening. The Food Service Director stated he was unsure why the out of acceptable range temperatures were recorded but no action was taken to resolve the out of acceptable range temperatures. He stated he had not been informed of the freezer temperature but the freezer was not cold enough to keep the ice cream and nourishment shakes frozen so they needed to be discarded	F 371	Dining Services. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: All three of the nourishment freezers were audited on 9/20/17 by the Director of Dining Services. The temperature log showed that the freezers consistently maintained a temperature range of 0-10 degrees Fahrenheit and on 9/20/17 during the audit, all foods were frozen solid. 3. Measures/systemic changes put in place to assure the alleged deficient practice does not re occur: The full time and part time dietary staff for Asbury will be in serviced by the Director of Dining Services/designee on policy and procedure regarding monitoring temps and functionality of freezers by 10/7/17. PRN dietary staff will be in serviced prior to their first scheduled shift by the Director of Dining Services or his designee. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: All three nourishment freezers will be audited by the Director of Dining Services/designee for proper temperature and contents of the freezer will be checked to see if food is frozen solid 5 days a week x 3 weeks, 3 days a week x 3 weeks, 1 day a week for 3 weeks, then monthly for 3 months. The Administrator will conduct a separate audit once a week x 10 weeks to ensure that the Director of Dining Services' audits are being conducted and to ensure that the freezers are keeping frozen foods frozen solid. Results of these two separate audits will be brought to the	

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F 371	Continued From page 2 On 9/20/17 at 2:30 pm the Administrator stated the freezer had previously failed to maintain the correct temperature and had to be repaired.	F 371	monthly QAPI meeting by the Dining Services Director/designee and the Administrator to ensure that a systemic change has been made.	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		10/16/17

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F 431	Continued From page 3 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 and staff interviews the facility failed to keep an unattended treatment cart locked for 2 of 4 treatment carts observed unlocked and failed to keep an unattended medication cart locked for 2 of 6 medication carts observed unlocked. Findings included: 1.a. On 9/18/2017 at 11:04 AM the 100 hall treatment cart was observed parked near the nurses' station. The lock was observed in the unlocked position. No nursing staff were observed in the immediate area. An interview with nurse #2 was conducted 9/18/2017 at 11:05 AM. The nurse opened a drawer on the cart without using a key and stated	F 431	1. Corrective action for the residents affected by the alleged deficient practice: On 9/20/17, the Administrator checked the 100 hall treatment cart, the 200 hall treatment cart, the 100 hall medication cart, and the 300 hall medication cart to ensure that those carts were locked. Nurses present that day were immediately in serviced regarding the policy and procedure involving the locking of carts. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: All the medication carts and treatment carts were audited to ensure that they were locked when a nurse was not in the immediate area. 3. Measures/systemic changes put in	

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F 431	Continued From page 4 the treatment cart should be locked because it contained alcohol swabs and other ointments for treatments. The nurse then locked the treatment cart. An interview with the Director of Nursing (DON) was conducted on 9/20/2017 at 4:45 PM. The DON stated treatment and medication carts should be locked when they are unattended. 1.b. On 9/19/2017 at 8:16 AM the 100 hall treatment cart was observed parked near the nurses' station. The lock was observed in the unlocked position. No nursing staff were observed in the immediate area. An interview with nurse #4 was conducted on 9/19/2017 at 8:17 AM. The nurse stated the cart should be locked. Nurse #3 activated the lock on the cart while nurse #4 was speaking. An interview with the Director of Nursing (DON) was conducted on 9/20/2017 at 4:45 PM. The DON stated treatment and medication carts should be locked when they are unattended. 2. On 9/20/2017 at 9:20 AM the 200 hall treatment cart was observed parked near the nurses' station. The lock was observed in the unlocked position. No nursing staff were observed in the immediate area. An interview with nurse #5 was conducted on 9/20/2017 at 9:21 AM. The nurse opened the treatment cart drawers without using a key. Prescription ointments and dressings were observed in the drawers. The nurse stated the treatment cart should be kept locked. She then locked the cart.	F 431	place to assure the alleged deficient practice does not re occur: All full time and part time nurses who operate a cart will be in serviced by the ADON/designee on policy and procedure for locking carts by 10/7/17. PRN staff will be in serviced prior to their first scheduled shift. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: A nurse supervisor/designee will audit 1 random treatment cart and 1 random med cart once per shift 7 days a week x 3 weeks, once per shift 3 days a week x 3 weeks, once per shift 1 day a week x 3 weeks, and one random shift a month for 3 months. Results of these audits will be brought by the ADON/designee to the monthly QAPI meeting to ensure that a systemic change has been made.	

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F 431	Continued From page 5 An interview with the Director of Nursing (DON) was conducted on 9/20/2017 at 4:45 PM. The DON stated treatment and medication carts should be locked when they are unattended. 3. On 9/20/2017 at 3:06 PM the 100 hall medication cart was observed parked near the nurses' station. The lock was observed in the unlocked position. No nursing staff were observed in the immediate area. An interview with nurse #2 was conducted on 9/20/2017 at 3:07 PM. The nurse activated the lock and stated he knew he should not leave the medication cart unlocked. An interview with the Director of Nursing (DON) was conducted on 9/20/2017 at 4:45 PM. The DON stated treatment and medication carts should be locked when they are unattended. 4.) During observation on 9/18/17 at 11:17 AM the 300 hall medication cart was observed to be unlocked and unattended next to the nurse's station which was across from the day area. There were 11 residents observed in a coloring activity in the day area and the closest resident was approximately 15 feet away from the unlocked medication cart. During an interview on 9/18/17 at 11:18 AM Nurse #1 stated that it was her cart. She further stated it was left unlocked and that no medication carts were supposed to be left unlocked and unattended. During an interview on 9/20/17 at 4:45 PM the Director of Nursing stated medication carts should be locked when unattended.	F 431		

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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 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	F 520		10/16/17

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F 520	Continued From page 7 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance committee failed to maintain implemented procedures and monitor the interventions that the facility put into place. This was for one federal deficiency which was originally cited on the August 11, 2016 recertification survey and was recited on the current recertification survey. The deficiency was cited in the area of food safety. The continued failure shows the facility's inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to: F 371E - Based on observations, record review and interviews the facility failed to maintain the temperature of nourishment freezer to keep the contents frozen for 1 of 3 nourishment freezers for 3 of 3 observations. During the recertification survey of 8/11/16 the facility was cited for failing to air dry plastic glasses and service trays, stacking them while still wet, and failing to maintain the temperature of thickened liquids below 41 degrees Fahrenheit during the operation of the tray line. During an interview with the Administrator on 9/21/17 at 11:24 am he stated the Quality Assurance Committee met monthly and they had identified areas of concern plus conducted root cause analysis and put actions plan into place. The Administrator added that he expected the committee to identify areas that could require	F 520	1. Corrective action for the residents affected by the alleged deficient practice: The four boxes of ice cream and the two boxes of nourishment shakes that were in the freezer on the third floor were discarded on 9/20/17 by the Director of Dining Services. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: The Administrator and the Director of Dining Services made a thorough walkthrough of all kitchen areas in the skilled nursing facility on 9/20/17. Other deficient practices in the kitchen/serving areas were not noticed. A plan of correction was developed with a scheduled monitoring/audit system designed to ensure a systemic change in how nourishment freezers are monitored. 3. Measures/systemic changes put in place to assure the alleged deficient practice does not re occur: The Administrator will check all three nourishment freezers once a week for ten weeks to ensure that the Director of Dining Services/designee is monitoring the nourishment freezers per our plan of correction. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: Quarterly for the next four quarters, the Director of Risk Management/Quality Assurance of Aldersgate will attend the quarterly QAPI	

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F 520	Continued From page 8 improvement and provide monitoring until the deficient practice was resolved. He expected not to have a repeat deficiency.	F 520	meetings to ensure that the audit tools for the deficiencies cited are being monitored.	