STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT REIDSVILLE	**543 MAPLE AVENUE REIDSVILLE, NC 27320**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have comprehensive emergency preparedness (EP) plan. The EP manual failed to include community based risk assessment, facility risk assessment and associated strategies, the emergency plans and procedures did not include missing resident in their EP program. The EP plan failed to identify its resident population. The EP manual did not include policy and procedures for sheltered residents and staff who remained in the facility,	E 001	The maintenance Director in cooperation with the other department heads and reaching out to community resources will correct all deficient aspects of the emergency manual. The manual will include a community based risk assessment, facility based risk assessment and associated strategies the completion for this was 2/22/18. The EP will include strategies for missing residents This was completed 2/22/18.	2/22/18

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

Electronically Signed | 02/16/2018

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E 001	Continued From page 1 policy and procedures to track residents and staff who were moved to other facilities and policy and procedure for staff, residents and others who remained in the facility during an emergency. The Manual did not include policy and procedures to preserve resident information and protect resident confidentiality, secure and maintain availability of resident's medical records. The EP communication plan failed to include contact information of staff, resident's physician and other facilities, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman. The EP Communication plan failed to include procedure of sharing information and medical documentation of its resident with other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency. The EP communication plan failed to establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives. Findings included: 1. A. Record review of the EP manual provided by the facility revealed the EP manual was not updated to include the community based risk assessment, the facility risk assessment and associated strategies. The emergency plans and procedures did not include missing resident in their EP program. B. Review of the EP manual provided by the facility revealed resident population within the	E 001	The EP manual will include policies and procedures for sheltered residents who remain in the facility, policies and procedures to track residents and staff who were moved to other facilities and policies and procedures for staff, residents and others who remained in the facility during an emergency this was completed 2/22/18. The EP manual will include policies and procedures to preserve resident information and protect resident confidentiality and secure and maintain availability of residents medical records this was completed2/22/18. The EP communication plan will include contact information of staff, resident's physician and other facilities contact information this was completed 2/22/18. The EP manual will include contact information of the state licensing agency and state long term care Ombudsman this was completed 2/22/18. The EP communication plan will include a procedure for sharing information and medical documentation of its residents with other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency this was completed 2/22/18. The EP communication plan will establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives The facility is going to this at a planned family night in march. The EP manual will address the	

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E 001	Continued From page 2 facility were not addressed. The manual did not recognize residents that need specific care like resident who were immobile, residents needing oxygen and so on. The manual also did not include the type of services that the facility was capable to provide to its residents during an emergency. Continuity of operations and succession plan were also not included in the EP program. Further review of the EP program also revealed that the risk assessment for the facility had not been completed. C. Review of the EP manual provided by the facility revealed no plan or procedure in place to track residents and staff on duty who remained in the facility during emergencies. The manual did not include any tracking system for residents and staff who left facility and were sheltered by other facilities. D. Review of the EP manual provided by the facility revealed the facility did not establish a criteria for its residents or staff who will be sheltered in the facility in case of emergency. The facility did not include a procedure for sheltering its staff, residents and others who remained in the facility in an event when evacuation could not be executed. E. Review of the EP manual provided by the facility revealed lack of policies and procedures on how the resident's confidentiality would be maintained, how the resident's medical information would be protected and how the resident's medical records will be available for continuity of care when the residents were evacuated or transferred to other facilities during an emergency.	E 001	current resident population and their specific needs ie; immobile, O2 dependent etc. this was completed 2/22/18. Along the a risk assessment the EP manual will include the types of services that the facility is capable of providing to its residents during an emergency this was completed 2/22/18. The EP program will also include a succession plan and will plan for continuity of operations this was completed 2/22/18. The EP plan will include a list of staff and contact numbers of staff left working at the facility this was completed 2/22/18. The EP manual will be updated to also reflect the fire drills, tornado drills, missing resident drills etc., to clearly reflect facility staff had participated in these drills this was completed 2/22/18. All residents have the potential to be affected by this until the facility has an effective EP program. Systematically going forward, once the EP manual is up to date all new information regarding Emergency preparedness will be added to the manual and all staff will be in serviced. This Emergency preparedness information will be taken to QA&A times 6 months. The Administrator is responsible for implementing the approved plan of correction.	

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E 001	Continued From page 3 F. Review of the EP manual provided by the facility revealed the communication plan did not include the names and contact information of all staff working in the facility, the name and contact information of residents' physicians and names and contact information of other facilities including but not limited to its sister facilities that would be providing services and care to the residents during an emergency. G. Review of the EP manual provided by the facility revealed the communication plan did not include contact information of the North Carolina Nursing Home Licensure and Certification Agency and contact information of Long Term Care Ombudsman. H .Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure that indicated how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations in an emergency situation. I. Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure as to how the facility would communicate and share information of its occupancy/ residents needs and the facility's ability to provide assistance to authority having jurisdiction or "the Incident Command Center" during an emergency situation. J. Review of the Communication Plan in the EP manual provided by the facility revealed no documentation as to how the facility's emergency	E 001	Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

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E 001	Continued From page 4	E 001		

plan would be shared with its residents, family members and/ or resident representatives.

During an interview on 1/25/18 at 9:00 AM, the Administrator indicated he had joined the facility two (2) days prior to the survey start date (1/22/18). He further stated the facility Maintenance Director was more aware of the EP plan as he was involved in the process and had all the documentation.

Interview with the Maintenance Director (MD) on 1/25/18 at 5:05 PM, revealed fire, tornado and elopement drills were completed by the facility. The MD indicated that the drills were perfect and no updated or revisions were needed to them. He was unable provide information if agency staff were involved during drill, strategies and plan that would be used for missing residents during emergency and if community resources were included during the drill. The MD indicated he was unaware that a risk assessment was needed in an EP program. He was unsure what method of tracking would be used by the facility to track its residents and staff during an emergency situation. The MD indicated he had no access to resident's electronic records and it was the management decision on how these documents would be handled. He also indicated that the names and contact information of the facility staff were easily assessable from the facility's Human Resource (HR) personnel. He stated he was unaware that all contact information was needed to be included in the communication plan. The Maintenance Director indicated that he had no documentation or information that he could share with the residents, family members or resident representatives related to emergency preparedness.

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E 001	Continued From page 5 Interview with the facility consultant on 1/25/18 at 5:15 PM revealed the facility did not use paper charts and all medical records were electronic. The consultant also indicated that the medical records could be easily shared and accessed electronically by their sister facilities. She further stated that the facility MD and the previous Administrator were responsible for the emergency preparedness. She indicated she was unsure why the EP manual was not completed.	E 001		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		2/22/18

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F 561	Continued From page 6	F 561		

participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to provide a shower as scheduled for 1 of 1 sampled resident reviewed for choices (Resident #344).

Findings included:

Resident #344 was admitted on 7/18/17 with multiple diagnoses including hemiplegia (paralysis of one side of the body), dialysis, related to end stage renal (kidney) disease, both legs amputation and diabetes mellitus. The quarterly Minimum Data Set assessment, dated 1/5/18, indicated that Resident #344 had moderate cognitive impairment. He required extensive assistance with activities of daily living (ADL), including shower.

Review of Resident 344 ' s plan of care, dated 1/5/18, revealed that the resident had ADL self-care performance deficit, related to hemiplegia and both legs amputation. The goal was to improve current level of function in ADL. The interventions were to provide assistance with ADLs, including shower twice a week.

Record review revealed the shower schedule for Resident #344, indicated a shower on Tuesday and Friday during first shift.

Record review of multiple nurses ' notes for January 2018, indicated that Resident #344 received dialysis outside of facility on Monday,

Corrective action has been accomplished for the alleged deficient practice in regards to resident #344. Shower days changed to Tuesday and Friday on second shift per resident request.

Current facility residents have the potential to be affected by the alleged deficient practice. Nurse management completed a 100% audit to ensure all residents showers were given timely and as they request.

Measures put in place to ensure the alleged deficient practice does not re-occur include; Director of Nursing or nurse management started in-servicing all nursing staff on February 20th on new shower days and times and it will also be put on the kardex that nurse aides use to ensure resident preferences are followed. All CNA's are being in-serviced on point of care shower documentation. The Director of Nursing or nurse manager will conduct shower audits 4 times a week for 4 weeks, 3 times a week for 4 weeks ,2 times a week for 4 weeks and then weekly for 4 weeks. Any refusals must be reported to nursing for appropriate changes.

The Director of Nursing or Nurse Manager will analyze audits/review for

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F 561	Continued From page 7 Wednesday and Friday during first shift. Record review revealed Resident 344 ' s care tracker, indicated that from 12/27/17 to 1/25/18 the resident did not receive showers 23 days and refused it 3 times. The resident receive bed bath daily. On 1/25/18 at 11:20 AM, during the observation/interview, Resident #344 indicated that he should have two shower days per week but the staff had not offered a shower. Every time he asked for shower, the aides came to provide the bed bath. "When I asked for shower, the staff provided bed bath only, with no explanation". The resident confirmed he was out of facility for dialysis on Monday, Wednesday and Friday between 10 AM and 4 PM every week. On 1/25/18 at 11:25 AM, during an interview, Nurse Aide #2 indicated that Resident #344 required extensive ADL assistance, including shower, scheduled on Tuesday and Friday. Nurse Aide #2 worked with the resident on 1/19/18, Friday, but did not provide shower on that day, and she could not recall when he received shower last time. She confirmed, if the shower was not provided, the Nurse Aide should notify the floor nurse. On 1/25/18 at 11:35 AM, during an interview, Nurse #6 indicated that Resident #344 ' s shower scheduled for first shift on Tuesday and Friday. The resident received dialysis outside of facility on Monday, Wednesday and Friday on first shift. Nurse #6 stated that the staff did not notify her for not providing shower for the resident. On 1/25/18 at 1:15 PM, during an interview, the	F 561	patterns/trends and report in the Quality Assessment and Assurance Committee (QA&A) monthly for 4 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Administrator is responsible for implementing the accepted plan of correction. Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 561	Continued From page 8 Director of Nursing (DON) indicated that her expectation the staff to follow residents ' preferences as much as possible, including the choice to have shower. Resident 344 ' s shower was scheduled twice a week on first shift. The DON could not provide documentation to confirm that Resident #344 received shower during the last thirty days.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to	F 565		2/22/18

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F 565	Continued From page 9 participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and review of the resident council meeting minutes, the facility failed to document and resolve group grievances that were reported in the resident council meetings for five consecutive months for 6 of 8 residents in the group (Resident #72, #37, #20, #27, #43, and #292). The facility failed to respond to individual grievance for 1 of 1 sample residents that was told not to use the call light (Resident #343). The findings included: 1. During the group meeting on 1/25/18 at 1:59 PM, the group members identified several concerns that had been discussed for several months that had not been documented in the resident council minutes or resolved. The identified concerns included lack of supplies (briefs, wipes, gowns, gloves and pads for the bed), lack of variety of food (fish and chicken three times a week), food texture (hard rice, mushy vegetables), taste of food (no taste or flavor, no condiments other than salt and pepper or butter offered), medications not given on time, lack of transportation provided for outside activities and bedtime snacks not being offered. The group members stated when concerns were brought up in group staff did not tell us how things would be fixed or improved. The response would	F 565	Corrective action has been accomplished for the alleged deficient practice in regards to resident #'s 72,37,20,27,43,292,343. All grievances have been investigated, responded to residents and residents agree with actions taken to correct. The Director of Nursing has resolved the grievance of resident #343 and reported back to the social worker and resident for satisfactory resolution. Current facility residents have the potential to be affected by the alleged deficient practice by not having resident concerns responded to timely with actions taken. Measures put into place to ensure the alleged deficient practice does not reoccur include; all concerns brought to the Activity Director during resident council meeting will be documented on grievance forms and given to the appropriate department heads for resolution. Those grievances will need to be reported on in the following month's resident council by the activity staff. The social worker will in-service all activity staff on the proper grievance procedure. All grievances will	

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F 565	Continued From page 10 be "the same old story was we are going to handle it. " a. During an interview on 1/25/18 at 1:59 PM, Resident #72 was identified as alert and oriented and regular attendee of the resident council group. Resident #72 stated that the facility staff continued to report during care that there was not enough supplies in the facility. The staff end up going around the facility searching for briefs, gloves and chucks. Resident #72 added there was no variety of foods offered in which chicken and fish were offered several times a week. The food was bland without taste. The residents were not offered any other spices other than salt, pepper or butter. The vegetables were mushy. In addition, medications were not being given on time and staff would tell us they would get back to them in a few. Resident #72 further stated the group was told only two residents were able to go out to do activities in the community at a time due lack of transportation. "We cannot go anywhere with our friends because of the poor transportation, not fair we cannot do things in our community." b. During an interview on 1/25/18 at 1:59 PM, Resident #37 was identified as alert and oriented and a regular attendee of the resident council group. Resident #37 stated there was not enough supplies available per nursing staff and they had to run around to find supplies to care for us. Resident #37 also reported the food had no flavor or taste. Residents were only offered salt and pepper and no other spices were offered to make the meal tasty. In addition, medications were not given on time, when requested or needed. Resident added staff would tell us to go back to the room and they would get back to them. Then	F 565	go through the grievance officer, which is the social worker who will summarize all grievances. The Administrator will sign off on each month's residents council's minutes to ensure issues were addressed from the previous month. The Activity Director will report on grievances to the QA&A committee monthly times 6 months. The Administrator is responsible for implementing the approved plan of correction. Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 565	Continued From page 11	F 565		

it would be several hours later and you end up in pain for longer than necessary. Resident #37 further stated that there was not enough transportation available to go on activities outside of facility. "I feel stuck in the building doing the same old things."

c. During an interview on 1/25/18 at 1:59 PM, Resident #20 reported staff would tell residents there was not enough supplies to provide care. Staff would run around the building to get supplies from other resident rooms and tell us there were none available in the building. There were times you may get a brief that was too small. Resident #20 added that medications were not given on time and staff would tell him they would get back to him and it would be hours later.

d. During an interview on 1/25/18 at 1:59 PM, Resident #27 was identified as alert and oriented. Resident #27 stated her concerns was there was not enough transportation available to go on activities outside of facility. "I feel stuck in the building doing the same old things. I have been told that only two people can ride in the van at a time, if I want my friends to go somewhere with me they can ' t because there is not enough space, so why bother to go anywhere. We should not have to pay extra money to go do simple things in this community. We couldn ' t go see Christmas lights or do community stuff." Resident #27 also stated there was not enough supplies available per nursing staff. Additional, concerns included too much chicken/fish offered within a week, there was no other spices provided to give the food flavor and taste and the vegetables was mushy and soggy.

e. During an interview on 1/25/18 at 1:59 PM,

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Resident #43 was identified as alert and oriented. Resident #43 indicated her concern was lack of transportation to go on outside activities. The resident reported feeling stuck in the building doing the same old activities and only two people can go out of the facility at a time. Resident #43 also stated the food had no flavor or taste with only salt and pepper being offered. In addition, staff continue to report there was no supplies available to care of their needs and you have to wait for them to come back.

f. During an interview on 1/25/18 at 1:59 PM, Resident #292 stated her concern was she had to wait a long time to get medications and staff did not return to give medications when they should. Resident #292 also had concerns with the food cold and left on the hall too long. Staff would reheat the food, but why should a resident have to constantly ask staff to reheat the meal.

During an interview on 1/25/18 at 3:00 PM, the Activity Director (AD) stated the resident concerns were discussed monthly but not documented in the resident council minutes due to previous management instructions. The AD added that concerns were documented on the resident grievance form and submitted to the responsible department head and social worker. She added the expectation was for each department head to respond to the concern and return the form back to her to be discussed at the next monthly meeting. Review of the monthly meeting minutes revealed there were was no documentation of the concerns discussed in the group or the follow-up. The AD reviewed the resident council minutes and confirmed the resident council minutes did not reflect the concerns that were discussed in the group. She

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added she was uncertain whether the concerns had been follow-up or resolved.

During an interview on 1/25/18 at 3:45 PM, the Administrator and Nurse Consultant indicated that a new system would be implemented to address resident council concerns on a monthly bases and follow-up would be done with the resident council members.

During an interview on 1/25/18 at 5:00 PM, the Director of Nursing (DON) stated the expectation was the concerns from the group would be directed to the social worker. The SW would give information to the department heads. Each department head was responsible for addressing and resolving the concern. The department head would return the form to the social worker who would then address the concerns with the group. DON indicated she was unaware if the SW had addressed the concerns with the group.

During an interview on 1/25/18 at 5:15 PM, the Social Worker (SW) indicated she was responsible for submitting any individual grievances and resident council concerns to the appropriate department heads. The SW added the expectation was too addressed and follow-up on the concerns. The response should be submitted to the complainant within 5 days and within the next month for the resident council group.

Review of the resident council meeting minutes dated 8/25/17, 10/27/17, 11/27/17 and 12/29/17, revealed there were no resident concerns documented and/or follow-up on each month. The minutes did not identify or address any resident concerns each month. The only

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F 565	Continued From page 14 documented concern was on the resident ' s grievance form dated 9/29/17, identified lack of supplies and medications were not given. There was no response or resolution to identified concern at the 10/27/17 resident council meeting. 2. Review of Resident #343 Minimum Data Set dated 10/17/17, revealed her cognition was intact. Review of the facility grievance form dated 11/7/17, documented in part, the resident was upset about the nurse not responding to the call light and the nurse ' s response to her was " do not put the call light on again." Review of the Ombudsman record revealed he had met with Resident #343 on 11/6/17, to discuss her concerns about call light issues. The record documented that the administrator indicated the director of nursing would follow-up with the concern. During an interview on 1/22/18 at 12:36 PM, the Ombudsman indicated he had been contacted by complainants on behalf of the resident to address facility response to call light. In the process of the investigation the previous administration had informed him the director of nursing would investigate the concern. However, by the time he had come to follow-up on the concern with the resident she was discharged. During an interview on 1/25/17 at 11:09 AM, the Director of Nursing indicated that she had not followed up on the call light concern from the grievance submitted on the 11/7/17 by the resident.	F 565		
F 761	Label/Store Drugs and Biologicals	F 761		2/22/18

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F 761 SS=E	Continued From page 15 CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove one Azithromycin Oral Suspension container and one expired Lantus insulin multi dose vial from 1 of 2 medication carts on A hall; failed to label three opened Novolog insulin pens and one opened Lantus insulin pen from 2 of 2 medication carts on A hall. Findings Included:	F 761	Corrective action has been accomplished for the alleged deficient practice in regards to failure to remove expired Azithromycin oral suspension, Novolog insulin multi dose. and Lantus insulin multi dose. Failed to label 3 opened Lantus insulin pens. All Medications have been removed and discarded per facility protocols.	

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F 761	Continued From page 16 1. On 1/23/18 at 8:05 AM, during the observation of Lower A hall medication cart, with Nurse #1, there were: a. Novolog insulin multi dose vial, 100 units per ml, with 20 units left inside, marked to be discard in 28 days, opened but not dated. b. one Azithromycin Oral Suspension 200 mg (milligram) per 5 ml (milliliter) container, expired on 1/7/18 and one Lantus insulin multi dose vial, 100 units per ml, opened on 12/14/17 and expired 28 days later on 1/11/18. On 1/23/18 at 8:10 AM, during an interview, Nurse #1 indicated that the nurses, who worked on the medication carts, were responsible to check for expired medications and mark the date of opening on multi dose vials. The nurse confirmed that she had not checked the expiration date on medications in her medication administration cart at the beginning of her shift. 2. On 1/23/18 at 9:00 AM, during the observation of Upper A hall medication cart, with Nurse #3, there were: Novolog insulin multi dose vial, 100 units per ml, with 30 units left inside, marked to be discard in 28 days, opened but not dated. Lantus insulin, 100 units per ml, multi dose vial, with 60 units left inside, marked to be discard in 28 days, opened but no dated. Novolog insulin pen, marked to be discard in 28 days, opened but not dated. On 1/23/18 at 9:10 AM, during an interview, Nurse #3 indicated that the nurses, who worked on the medication carts, were responsible to check for expired medications and mark the date of opening on multi dose vials. The nurse confirmed that she had not checked the	F 761	Current facility residents have the potential to be affected by the alleged deficient practice. Actions to ensure compliance are; Director of Nursing completed a 100% cart audit on all med carts. Measures put in place to ensure the alleged deficient practice does not re-occur include; Education on med label/store drugs and biological provided to current nursing staff, and new licensed nursing staff in orientation. Education began on February 9th. The Director of Nursing or nurse management will preform the audits 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly for 4 weeks. The Director of Nursing or Nurse management will analyze audits/reviews for patterns/trends and report in the QA&A committee meeting monthly for 4 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Administrator is responsible for implementing the accepted plan of correction. Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because	

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F 761	Continued From page 17 expiration date on medications in her medication administration cart at the beginning of her shift. On 1/23/18 at 12:30 PM, during an interview, the Director of Nursing indicated that all the nurses were responsible to check medications ' expiration date and mark opened multi dose vials. Her expectation was that no expired medications be left in the medication carts.	F 761	it is required by the provisions of federal and state law.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and record reviews, the facility failed to offer or deliver bedtime snacks to 4 of 8 residents who requested or expressed preferences to receive a	F 809	Corrective action has been accomplished for the alleged deficient practice in regards to resident #72,37,20,and 27. Residents were interviewed for snack	2/22/18

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F 809	Continued From page 18 bedtime snack when interviewed during the resident council group (Resident #72, #37, #20 and #27). The findings included: 1. During an interview on 1/25/18 at 1:59 PM, Resident #72 was identified as alert and oriented. Resident #72 stated that bedtime snacks were not being offered. Resident #72 stated she would like to receive a bedtime snack. Review of the snack record for Resident #72 revealed that snacks had not been offered, accepted or refused. 2. During an interview on 1/25/18 at 1:59 PM, Resident #37 was identified as alert and oriented. Resident #37 stated she was not offered snacks at night. The snacks was supposed to come around 8 pm. When you ask for a snack staff would tell you they would get back to you and never bring anything back. Review of the snack record for Resident #37 revealed there was no documentation snacks were offered, accepted or refused. 3. During an interview on 1/25/18 at 1:59 PM, Resident #20 was identified as alert and oriented. Resident #20 stated he didn ' t get snacks at night, "they try to put you to bed before they come out around 8 pm and then don ' t deliver them and hope you are sleep so you don ' t ask." Review of the snack records for Resident # 20 revealed there was no documentation that snacks were offered, accepted or refused.	F 809	preferences and preferences provided. Current facility residents have the potential to be affected by the alleged deficient practice as all residents should be offered a bedtime snack as requested. Measures put into place to ensure the alleged deficient practice does not recur include; A) A 100% audit was conducted for resident snack preferences by the dietary manager. B)Nursing staff education on the availability of snacks and location has begun on February 20th. Nurse aides are responsible for passing out the snacks. Snack documentation has been added to the nurse aide Kardex and a tab for snack distribution has been added to point click care. The charge nurse on each shift will be responsible that the snacks were distributed. The Director of Nursing or nurse management will conduct snack audits 4 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks, and then weekly for 4 weeks. Snack availability will be reported to the resident council. The Director of Nursing or Nurse Management will analyze audits/reviews for patterns/trends and report in the QA&A committee meeting monthly for 4 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Administrator is responsible for implementation of the approved plan of correction.	

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F 809	Continued From page 19 4. During an interview on 1/25/18 at 1:59 PM, Resident #27 was identified as alert and oriented. Resident #27 stated snacks was not made available when scheduled at 8 pm. "Staff just don ' t offer or pass it out, you have to keep asking and they say they would get back to you and don ' t. I have to stock snacks away so I don ' t get hungry at night." Review of the snack records for Resident # 27revealed there was no documentation that snacks were offered, accepted or refused. During an interview on 1/25/18 at 5:30 PM, Nurse #2 stated the kitchen delivered the snacks to the nurse about 7:45 PM. Nursing would put the snacks in the office to prevent other residents from taking snacks that were not assigned to them. The expectation was for the aides to pass out snacks around 8 pm. During an interview on 1/25/18 at 5:45 PM, the Nurse Aide (NA) #6 indicated that the snacks were delivered to the unit around 7:30 PM from the kitchen and when they were given it would be documented in computer. During an interview on 1/25/18 at 5:48 PM, NA #7 indicated that the snacks were delivered to the resident around 8 pm. The aide was responsible for documenting in the computer whether the snack was offered, accepted or refused. During an interview on 1/25/18 at 6:00 PM, Nurse #6, indicated that snacks were received on the unit around 7pm and offered to the residents around 8 pm. The aides were expected to document in the computer whether the residents accepted or refused the snack.	F 809	Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is and/or executed solely because it is required by the provisions of federal and state law.	

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F 809	Continued From page 20 During an interview on 1/25/18 at 6:05 PM, the Dietary Manager (DM) stated snack was delivered directly to the nursing staff around 7:15 PM so that other residents don ' t take the snack. Staff was expected to deliver them to the assigned residents. During an interview on 1/25/18 at 6:31 PM, the Nurse Consultant indicated all residents should be provided with snacks from dietary. There was no documentation to indicate residents had received snacks. During an interview on 1/25/18 at 6:30 PM, the Director of Nursing (DON) stated the expectation was for all residents to be offered snacks.	F 809		