STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		11/15/18

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

Electronically Signed | 11/10/2018

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on a resident interview, physician interview, pharmacy technician interview, staff interviews and medical record review, the facility failed to notify the physician that pain medication was not available for administration per the physician's order for 1 of 1 sampled residents reviewed for pain management (Resident #54). The findings include: Resident #54 was readmitted to the facility on 11/13/17 with medical diagnoses inclusive of chronic obstructive pulmonary disease. Resident #54 started services with Hospice on 1/16/18. Resident #54's minimum data set (MDS) identified as a significant change was dated 1/29/18. The MDS assessed Resident #54 with intact cognition and occasional pain. A review of Resident #54's medical record revealed a physician's order dated 9/24/18 for Morphine 20mg/ml. Give 10mg (0.5ml) by mouth or under the tongue every 6 hours scheduled. Quantity #120 ml dispense in partial fills, dispense #30 per fill. A review of Resident #54's October 2018 medication administration record and the nursing	F 580	F580 Notify of Changes 1. The facility failed to notify the physician that pain medication was not available for administration per the physician's order for hospice resident #54 from 10/12/18-10/14/18. Facility contacted Hospice to obtain a new script from physician. Hospice faxed over script to pharmacy and medication delivered to facility on 10/14/18. Resident #54 had no adverse outcome. 2. Hospice residents who receive pain medication have the potential to be affected by this alleged deficient practice. Nurse Management completed an audit of hospice residents on 10/22/18 to ensure pain medications available. 3. Director of Nursing or Nurse Management will re-educate licensed nurses on Notifying Physician when pain medication not available, on medications available in Omnicell (automated medication dispensing system), process on ordering and receiving medication from the pharmacy by 11/15/18. Administrator, Director of Nursing and nurse management held meeting with Hospice	

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F 580	Continued From page 2 progress notes revealed on 10/12/18 Nurse #4 noted medication on order for the 8:00AM and 12:00 PM dose. On 10/13/18, Nurse #6 noted medication was on order for the 8:00 AM and the 12:00 PM dose. On 10/14/18, Nurse #6 noted medication was on hold for the 2:00 AM dose and Nurse #7 noted medication was not available for the 8:00 AM and 12:00 PM dose. An interview with Resident #54 on 10/15/18 at 03:28 PM, Resident #54 reported he had been prescribed Morphine. Resident #54 stated he received Morphine early Friday morning, 10/12/18 and did not receive the Morphine again until the afternoon of 10/14/18. Resident #54 stated he was told by the nursing staff the Morphine was not available. An interview with Nurse #3 on 10/18/18 at 3:30 PM, Nurse #3 stated she worked as the stand in supervisor during the weekend of 10/13/18 and 10/14/18 on the day shift (7:00 AM - 7:00 PM). Nurse 3# reported on 10/13/18, Nurse #5 informed her no Morphine was available to administer to Resident #54. Nurse #3 stated she instructed Nurse #5 to contact Hospice to request a refill for Resident #54's Morphine. Nurse #3 stated on 10/14/18, Nurse #6 informed her no Morphine was available to administer to Resident #54. Nurse #3 stated she assumed the Morphine had been delivered and given on 10/13/18. Nurse #3 stated she had not notified the facility on call physician or nurse practitioner on 10/13/18 nor on 10/14/18 that Resident #54 had not received Morphine as ordered. During an interview on 10/18/18 at 4:37 PM with a supervisor for technicians in the pharmacy, the supervisor stated controlled medications such as	F 580	on 10/23/18 and with pharmacy on 10/22/18. Director of Nursing/Nurse Management will audit hospice residents 2 times a week times 12 weeks then to ensure pain medication available. 4. The Director of Nursing or Assistant Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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Morphine cannot be ordered through the electronic health record system. The supervisor stated when a medication was not available for administration, the physician should be notified by the nursing staff for further direction to provide medication when not available for administration.

An interview with the Hospice Nurse on 10/17/18 at 4:57 PM, the nurse reported on 10/10/18 she contacted the Hospice Company's office and requested an order for Resident #54 to have a refill for Morphine. The Hospice nurse identified the process by which the facility received medications for Hospice residents ordered by the Hospice physician. The Hospice nurse reported the Hospice physician signed the medication order, then the order was sent via facsimile to the pharmacy. The Hospice nurse stated the facility would also receive a copy of the medication order that had been sent to the pharmacy via facsimile. The Hospice nurse stated she was informed by Resident #54 on 10/15/18 that he had not received Morphine as prescribed during the weekend of October 12, 2018 through October 14, 2018. The Hospice nurse stated she was contacted by the facility on 10/12/18 regarding no Morphine available for Resident #54. The Hospice nurse stated she informed the facility she had requested a refill order on 10/12/18. The Hospice nurse stated she had not informed the Hospice physician on 10/15/18 that Resident #54 had not received scheduled Morphine by the facility's nursing staff.

A Hospice physician for Resident #54 was interviewed on 10/18/18 at 05:19 PM. The physician stated when Resident #54 received the last dose of Morphine on 10/12/18, the expectation from the facility should have

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F 580	Continued From page 4	F 580		

contacted the Hospice on call service and requested a refill for the Morphine as prescribed. The Hospice physician stated Resident #54 may have experienced flu like symptoms and worsening of shortness of breath during the time when he had not received the scheduled Morphine. The Hospice physician stated Resident #54's condition would not be life threatening over a short period of time of no Morphine. The Hospice physician stated the Hospice physicians had not been informed Resident #54 had missed administration doses of Morphine during the weekend of October 12, 2018 through October 14, 2018.

During an interview with Nurse #5 on 10/17/18 at 6:01 PM, Nurse #5 reported she reviewed the electronic medication administration record on 10/13/18 and the Morphine for Resident #54 was identified as on order. Nurse #5 notified Nurse #3 the Morphine was not in the medication cart. Nurse #5 she stated she had not notified the facility's physician, nurse practitioner, or the Hospice physician the medication was not available to be administered to Resident #54 on 10/13/18.

During an interview with Nurse #4 on 10/17/18 at 06:05 PM, Nurse #4 stated on 10/12/18 she notified Nurse #1 Resident #54 had no Morphine available to administer for the scheduled morning dose. Nurse #4 stated she was instructed by Nurse #1 to contact the Hospice nurse to request a refill of the Morphine. Nurse #4 stated she contacted the Hospice nurse and was told a refill had been requested on 10/10/18. Nurse #4 contacted the pharmacy and was informed the refill on 10/10/18 was invalid due to no physician signature. Nurse #4 stated she did not contact

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F 580	Continued From page 5 the facility's physician or nurse practitioner regarding Resident #54's order for Morphine not available for administration. Nurse #4 stated when she informed the Hospice nurse the medication order was invalid, Nurse #4 stated the hospice nurse indicated she would have the refill sent to the pharmacy immediately. During a telephone interview on 10/18/18 at 6:36 PM, Nurse #8 stated that she administered the prescribed dose of Morphine to Resident #54 on 10/12/18 at 2:00 AM. Nurse #8 stated she reported to Nurse #4, Resident #54 had no Morphine available for his next scheduled dose. Nurse #8 stated she had not notified the facility's physician or nurse practitioner that Resident #54 had received his last dose of Morphine with no medication available for his scheduled next dose nor did she receive an order to hold the medication until available from pharmacy. During an interview with the Director of Nursing (DON) on 10/18/18 at 6:40 PM, the DON stated her expectation of nursing staff would have been to contact the physician to obtain an order from the facility physician or nurse practitioner and obtain medication from the automated medication dispensing system. The DON stated the automated medication dispensing system had Morphine available for use on 10/12/18.	F 580		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		11/15/18

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F 755	Continued From page 6 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interviews, physician interview, pharmacy technician interview, staff interviews and medical record review, the facility failed to maintain a sufficient supply and administer pain medication as ordered by the physician for 1 of 2 sampled residents reviewed for pain management (Resident #54). The findings include: Resident #54 was readmitted to the facility on	F 755	F755 Pharmacy Services 1. The facility failed to maintain a supply of pain medication from 10/12/18-10/14/18 for resident #54 as ordered by the physician. Facility contacted Hospice to obtain a new script from physician. Hospice faxed over script to pharmacy and medication delivered to facility on 10/14/18. Resident #54 had no adverse outcome. 2. Hospice residents who receive pain	

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F 755	Continued From page 7 11/13/17 with medical diagnoses inclusive of chronic obstructive pulmonary disease. Resident #54 started services with Hospice on 1/16/18. Resident #54's minimum data set (MDS) identified as a significant change was dated 1/29/18. The MDS assessed Resident #54 with intact cognition and occasional pain. A review of Resident #54's medical record revealed a physician's order dated 9/24/18 for Morphine 20mg/ml. Give 10mg (0.5ml) by mouth or under the tongue every 6 hours scheduled. Quantity #120ml dispense in partial fills, dispense #30 per fill. Review of Resident #54's October 2018 medication administration record and the nursing progress notes revealed on 10/12/18 Nurse #4 noted medication on order for the 8:00AM and 12:00 PM dose. On 10/13/18, Nurse #6 noted medication was on order for the 8:00 AM and the 12:00 PM dose. On 10/14/18, Nurse #6 noted medication was on hold for the 2:00 AM dose and Nurse #7 noted medication was not available for the 8:00 AM and 12:00 PM dose. An interview with Resident #54 on 10/15/18 at 03:28 PM, Resident #54 reported he had been prescribed Morphine. Resident #54 stated he received Morphine early Friday morning, 10/12/18 and did not receive the Morphine again until the afternoon of 10/14/18. Resident #54 stated he was told by the nursing staff the Morphine was not available. An interview with the Hospice Nurse on 10/17/18 at 4:57 PM, the nurse reported on 10/10/18 she contacted the Hospice company's office and requested an order for Resident #54 to have a refill for Morphine. The Hospice nurse identified	F 755	medication have the potential to be affected by this alleged deficient practice. Nurse Management completed an audit of hospice residents to ensure pain medications available on 10/22/18. 3. Director of Nursing or Nurse Management will re-educate licensed nurses on Pharmacy Services including education on Omnicell (automated medication dispensing system), reordering and receiving medication from the pharmacy by 11/15/18. Administrator, Director of Nursing and nurse management held meeting with representatives from the Pharmacy on 10/22/18. Director of Nursing/Nurse Management will audit hospice residents 2 times a week times 12 weeks to ensure pain medication available. 4. The Director of Nursing or the Assistant Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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the process by which the facility received medications for Hospice residents ordered by the Hospice physician. The Hospice nurse reported the Hospice physician signed the medication order, then the order was sent via facsimile to the pharmacy. The Hospice nurse stated the facility would also receive a copy of the medication order that had been sent to the pharmacy via facsimile. The Hospice nurse stated she was informed by Resident #54 on 10/15/18 that he had not received Morphine as prescribed during the weekend of October 12, 2018 through October 14, 2018. The Hospice nurse stated she was contacted by the facility on 10/12/18 regarding no Morphine available for Resident #54. The Hospice nurse stated she informed the facility she had requested a refill order on 10/12/18. The Hospice nurse stated she had not informed the Hospice physician on 10/15/18 that Resident #54 had not received scheduled Morphine by the facility's nursing staff.

During an interview with Nurse #5 on 10/17/18 at 6:01 PM, Nurse #5 reported she reviewed the electronic medication administration record on 10/13/18 and the Morphine for Resident #54 was identified as on order. Nurse #5 notified Nurse #3 the Morphine was not in the medication cart. Nurse #5 she stated she had not notified the facility's physician, nurse practitioner, or the Hospice physician the medication was not available to be administered to Resident #54 on 10/13/18.

During an interview with Nurse #4 on 10/17/18 at 06:05 PM, Nurse #4 stated on 10/12/18 she notified Nurse #1 Resident #54 had no Morphine available to administer for the scheduled morning dose. Nurse #4 stated she was instructed by

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Nurse #1 to contact the Hospice nurse to request a refill of the Morphine. Nurse #4 stated she contacted the Hospice nurse and was told a refill had been requested on 10/10/18. Nurse #4 contacted the pharmacy and was informed the refill on 10/10/18 was invalid due to no physician signature. Nurse #4 stated she did not contact the facility's physician or nurse practitioner regarding Resident #54's order for Morphine not available for administration. Nurse #4 stated when she informed the Hospice nurse the medication order was invalid, Nurse #4 stated the hospice nurse indicated she would have the refill sent to the pharmacy immediately.

An interview with Nurse #3 on 10/18/18 at 3:30 PM, Nurse #3 stated she worked as the stand in supervisor during the weekend of 10/13/18 and 10/14/18 on the day shift (7:00 AM - 7:00 PM). Nurse 3# reported on 10/13/18, Nurse #5 informed her no Morphine was available to administer to Resident #54. Nurse #3 stated she instructed Nurse #5 to contact Hospice to request a refill for Resident #54's Morphine. Nurse #3 stated on 10/14/18, Nurse #6 informed her no Morphine was available to administer to Resident #54. Nurse #3 stated she assumed the Morphine had been delivered and given on 10/13/18. Nurse #3 stated she had not notified the facility on call physician or nurse practitioner on 10/13/18 nor on 10/14/18 that Resident #54 had not received Morphine as ordered.

During an interview with the area staff development coordinator on 10/18/18 at 4:37 PM, the coordinator stated the Director of Nursing (DON) and Assistant Director of Nursing (ADON) trained nursing staff during their orientation on how to reorder medications from the pharmacy.

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The coordinator stated there was a reorder arrow indicator on the electronic medication card. The coordinator also stated if there was no reorder arrow indicator on the medication card, then normally within ten doses, nursing staff needed to call the pharmacy. The coordinator stated when liquid medications are down to the last four doses, nursing staff should reorder the medication. The coordinator reported when a medication was not available nursing staff had other options to obtain the medication. The staff coordinator stated nursing staff could check to see if ordered medication was in the automated medication dispensing machine and the nursing staff could contact the facility's physician to determine if an alternative medication could be given until the ordered medication arrived at the facility. The staff development coordinator stated she expected staff to follow the process to get the medication for the residents.

A Hospice physician for Resident #54 was interviewed on 10/18/18 at 05:19 PM. The physician stated when Resident #54 received the last dose of Morphine on 10/12/18, the expectation from the facility should have contacted the Hospice on call service and requested a refill for the Morphine as prescribed. The Hospice physician stated Resident #54 may have experienced flu like symptoms and worsening of shortness of breath during the time when he had not received the scheduled Morphine. The Hospice physician stated Resident #54's condition would not be life threatening over a short period of time of no Morphine. The Hospice physician stated the Hospice physicians had not been informed Resident #54 had missed administration doses of Morphine during the weekend of October 12,

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2018 through October 14, 2018.

During an interview on 10/18/18 at 6:32 PM with the supervisor for front end pharmacy technicians, the supervisor stated when the refill order for Resident #54's Morphine was received on 10/10/18, the facility was notified via facsimile and called by the triage technician informing the facility the order was invalid due to no physician signature. The supervisor stated the initial facsimile was sent on 10/10/18 at 3:50 PM and a second facsimile was sent at 4:13 PM. The supervisor stated the pharmacy attempted to call the facility, however, the facility's receptionist stated the nurse on the hall was not available. The supervisor stated the facility had not contacted the pharmacy until 10/14/18. Called at 4:13pm on 10-10-18. The supervisor stated the facility was not set up on automatic renewal.

During a telephone interview on 10/18/18 at 6:36 PM, Nurse #8 stated that she administered the prescribed dose of Morphine to Resident #54 on 10/12/18 at 2:00 AM. Nurse #8 stated she reported to Nurse #4, Resident #54 had no Morphine available for his next scheduled dose. Nurse #8 stated she had not notified the facility's physician or nurse practitioner that Resident #54 had received his last dose of Morphine with no medication available for his scheduled next dose nor did she receive an order to hold the medication until available from pharmacy.

During an interview with the DON on 10/18/18 at 6:40 PM, the DON stated her expectation of nursing staff would have been to contact the facility physician or nurse practitioner and obtain an order for the prescribed medication when the medication was not available for administration.

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F 755	Continued From page 12 The DON stated Morphine was available in the automated medication dispensing system on 10/12/18. The DON stated nursing staff should have contacted the pharmacy on 10/10/18 to confirm the refill for Morphine had been received and would be sent to the facility prior to the facility receiving the last dose.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals 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	F 761	F761 Label/Storage Drugs	11/15/18

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F 761	Continued From page 13 facility failed to discard an opened bottle of Loperamide Hydrochloride (anti-diarrheal) and two boxes of Nicotine transdermal (nicotine replacement) patches. These expired medications were available for use in 1 of 4 medication carts and 1 of 2 medication storage rooms. (300 hallway medication cart and 100/200 hallway medication storage room). Finding include: 1a. On 10/16/18 at 2:11 PM, an observation of the medication cart on the 300 Hall revealed an opened bottle of Loperamide Hydrochloride with an expiration date of 8/2018. An interview with Nurse #2 on 10/16/18 at 2:15 PM, Nurse #2 stated the medication should have been discarded by the expiration date of 8/2018. 1b. On 10/16/18 at 2:55 PM, an observation of the medication storage room on the 100/200 Hall revealed one opened box (2 patches) and one unopened box (14 patches) of Nicotine transdermal patches. The expiration date read 9/2018. An interview with Nurse #1 on 10/16/18 at 2:55 PM, Nurse #1 stated the patches should have been discarded by their expiration date of 9/2018. On 10/16/18 at 3:05 PM an interview was conducted with the Director of Nursing (DON), the DON stated her expectation is medication carts and medication storage rooms should have no expired medications. The DON stated expired medications should be discarded and replaced.	F 761	1. The facility failed to discard a bottle of Loperamide Hydrochloride (anti-diarrheal) with the expiration date of 8/2018 and two boxes of Nicotine transdermal (nicotine replacement) patches with the expiration date of 9/2018. Nurse #1 immediately discarded the bottle of Loperamide and Nurse #2 immediately discarded the 2 boxes of Nicotine patches. 2. Current residents receiving medications have the potential to be affected by this alleged deficient practice. On 10/24/18 Omnicare Pharmacy completed an audit of medication carts and medication rooms to ensure no medications were expired. 3. Nurse Management will re-educate licensed nurses on Medication Storage by 11/15/18. Director of Nursing or Nurse Management will audit medication storage 2 times a week times 12 weeks by randomly checking medication carts and medication rooms for expired medications. 4. The Director of Nursing or the Assistant Director of Nursing will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		11/15/18

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F 812 SS=E	Continued From page 14 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of the menu, the facility failed to maintain 10 servings of pureed watermelon and 30 servings of sliced watermelon at or below 41 degrees Fahrenheit for 1 of 2 observations of the tray line. The facility failed to serve sliced watermelon at or below 41 degrees Fahrenheit to 8 residents (Residents #1, 2, 4, 6, 7, 40, 45 and 47). The findings included: A kitchen observation on 10/17/18 at 5:22 PM revealed the dinner meal tray line was in progress. Review of the menu revealed the dessert for the dinner meal was fresh	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. The facility failed to have watermelon at the appropriate temperature of 41 degrees or below. The watermelon was immediately removed from all residents meal tray prior to it being delivered to the resident. 2. All residents residing in the facility have the potential to be affected, however the watermelon was removed from all residents trays immediately prior to being delivered to the resident. 3. Any fruit served during meal times will be prepared timely to ensure it is at appropriate temperature 41 degrees or	

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F 812	Continued From page 15 watermelon. On 10/17/18 at 5:28 PM a tray of 10 covered bowls of pureed watermelon and a tray of 30 covered bowls of sliced watermelon were observed stored on the tray line with each bowl of watermelon stored on top of a mixture of water and ice. Temperature monitoring was conducted with a digital thermometer by the district dietary manager (DDM) at the request of the surveyor. The results revealed the following: 2 bowls of pureed watermelon with a temperature of 55.5 degrees Fahrenheit (F) 1 bowl of sliced watermelon with a temperature of 57 degrees F An interview on 10/17/18 at 5:30 PM with the DDM revealed she visited the facility weekly or as needed and noted that it was the facility's typical practice to store all desserts on the tray line at the beginning of the tray line service. The DDM stated she noticed that a large quantity of watermelon was on the tray line on ice when she conducted temperature monitoring before the tray line began, but did not realize that the temperature of the watermelon would drop so quickly when stored outside of refrigeration. The DDM confirmed that the watermelon should have been maintained on the tray line at a temperature of 40 degrees F or less. The DDM stated that the facility would serve ice cream instead of the remaining bowls of watermelon. The DDM was observed to remove the tray of pureed watermelon while the bowls of sliced watermelon remained on the tray line. An interview occurred on 10/17/18 at 5:41 PM with dietary aide #1 (DA #1). She revealed that she removed the watermelon from refrigeration	F 812	below. All dietary staff has been in-serviced on 11/2/18 on taking and recording temperatures before the start of the tray line. The dietary manager/dietary aide will perform audits 2 times a week times 12 weeks on checking of fruit temperature to ensure an appropriate temperature of 41 degrees or below. 4. The Administrator or the Dietary Manager will report findings of the audits to QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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F 812	Continued From page 16 around 4:30 PM on 10/17/18. DA #1 further described that she pureed over 10 bowls of watermelon for the dinner tray line, returned the bowls to the walk in refrigerator and placed all bowls of pureed watermelon on the tray line about 5:00 PM. She stated that all cold foods should be maintained at least 40 degrees F or below. An interview occurred on 10/17/18 at 5:41 PM with DA #2. She stated that she sliced enough watermelon for 72 bowls around 3:30 PM or 4:00 PM on 10/17/18 for the dinner tray line. She stated that the watermelon was in refrigeration prior to prepping and once she finished she returned the bowls of sliced watermelon to the walk-in refrigerator until the tray line began around 5:00 PM. DA #2 confirmed that cold foods should be maintained at least 40 degrees F or below. After the interview she continued to plate the sliced watermelon for meal delivery. On 10/17/18 at 5:48 PM, DA #3 was observed to push a cart of meal trays for delivery to residents to the door and stated that the cart was ready for delivery. The surveyor requested further observation and identified sliced watermelon was on the cart for 8 residents, (Residents #1, 2, 4, 6, 7, 40, 45 and 47), after temperature monitoring revealed a bowl of the sliced watermelon was 57 degrees F. Interview with DA #3 revealed that the sliced watermelon should not be served because it had not been maintained on the tray line at least 40 degrees F or below. The DDM was observed to remove the bowls of sliced watermelon from the meal trays.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		11/15/18

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F 867	Continued From page 17 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in March 2018 and April 2018. This was for recited deficiencies which were originally cited during complaint investigations completed in February 2018 and March 2018. The deficiencies were in the areas of medication storage and physician notification. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F580: Based on a resident interview, physician interview, pharmacy technician interview, staff interviews and medical record review, the facility failed to notify the physician that pain medication was not available for administration per the physician's order for 1 of 1 sampled residents reviewed for pain management (Resident #54). The facility was recited for F580 during the current recertification survey regarding failure to	F 867	F867 QAPI/QAA 1. The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place in March 2018 and April 2018. This was for recited deficiencies which were originally cited during complaint investigations completed in February 2018 and March 2018. The deficiencies were in the areas of medication storage (F761) and physician notification (F580). Facility Administrator conducted a Quality Assurance and Improvement Committee meeting on 11/14/18 to discuss the current survey citations from survey exit on 10/18/18. 2. All residents residing in the facility have the potential to be affected. 3. The District Director of Clinical Services reeducated the Interdisciplinary team and members of the Quality Assurance and Improvement Committee on by 11/13/18 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to assure state and federal compliance in the facility. 4. The Interdisciplinary Team including the facility Medical Director will meet at	

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F 867	Continued From page 18 notify the physician that morphine was unavailable for administration as ordered. F580 was originally cited during a complaint investigation on 2/9/18 for failure to notify the physician of an elevated sodium level and that a STAT lab was not obtained as ordered. F580 was also cited during a complaint and onsite revisit survey on 3/13/18 for failure to notify the physician that a resident was not connected to a non-invasive mechanical ventilator for oxygen therapy. 1b. F 761: Based on observations and staff interviews, the facility failed to discard an opened bottle of Loperamide Hydrochloride (anti-diarrheal) and two boxes of Nicotine transdermal (nicotine replacement) patches. These expired medications were available for use in 1 of 4 medication carts and 1 of 2 medication storage rooms. (300 hallway medication cart and 100/200 hallway medication storage room). The facility was recited for F 761 during the current recertification survey regarding failure to discard expired medications. F761 was originally cited during a complaint investigation on 2/9/18 for failure to secure medication cards during a medication pass. An interview with the administrator and interim director of nursing on 10/18/18 at 5:50 PM revealed that they attributed a repeat deficiency related to medication storage and physician notification to a recent change in administration and management. Both stated they were new to the facility and they were not aware of the prior performance plan implemnted by the QAA committee prior to the current survey.	F 867	least monthly to conduct the facility□s Quality Assurance and Performance Improvement meeting. Should any interdisciplinary team member find that the facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any Adhoc meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement committee. The District Director of Operations or designee will review the facility QAPI meeting minutes at least monthly x 3 months.	