STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN OAKS NURSING AND REHABILITATION CENTER	1704 NC HIGHWAY 39 N LOUISBURG, NC 27549

(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
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change Minimum Data Set Assessment for 1 of 2 residents that had a significant change is status (Resident #76). The findings included: Resident #76 was admitted to the facility on 6/29/18 and had a diagnosis of dementia with behavioral disturbance. The Care Plan for Resident #76 dated 7/2/18 noted the resident wandered and was at risk for unsupervised exit from the facility. The Care Plan did not list other behaviors for the resident. The Admission Minimum Data Set (MDS) Assessment dated 7/6/18 revealed the resident had severe cognitive impairment, required extensive assistance with activities of daily living and oversight, encouragement and cueing with	F 637	Franklin Oaks Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Franklin Oaks Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Franklin Oaks Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure	12/6/18

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

Electronically Signed | 11/21/2018

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F 637	Continued From page 1 eating. It was noted the resident ' s weight was 173 pounds. Review of the resident ' s weights revealed the resident weighed 170 pounds on 7/25/18 and 8/1/18. A nursing progress note dated 8/6/18 revealed the resident was anxious/agitated and pacing and hollering at the staff and other residents. A nursing progress note dated 8/14/18 at 2:44 PM noted the resident was pacing in the hallway and had a poor PO (by mouth) intake. A nurse ' s note dated 8/24/18 at 3:48 PM noted the resident was anxious and pacing and refused breakfast and lunch and snacks were given in between meals. The resident ' s weight was documented as 133 pounds on 8/30/18. A progress note by the Registered Dietician dated 8/30/18 revealed the following: Resident had a significant weight loss of 37 pounds (21.8 percent) in 30 days and the weight loss was not desired. Diet-changed to finger foods 8/29/18. Average PO (by mouth) intake 55 percent of meals with 4 meals declined in 7 days. Remeron 7.5mg started on 8/29/18 to increase appetite. Recommendations: 60 milliliters Resource 2.0 (nutritional supplement) three times a day with med pass. A nursing behavior note dated 8/30/18 at 8:04 PM noted the resident walked the hallways most of the shift. Unsuccessfully redirected to sit to rest. A physician ' s progress note dated 9/4/18 noted the resident had lost weight due to decreased oral intake and was given nutritional	F 637	and/or any other administrative or legal proceeding. F 637 The process that lead to the deficiency was the Minimum Data Set (MDS) Nurse failed to complete a significant change assessment for resident # 76. On 11/21/2018 the MDS nurse completed a significant change assessment in the area of weight loss and increased behaviors for resident # 76. MDS for Resident # 76 was transmitted and accepted into the National Repository on 11/21/2018. A 100% audit of all residents current MDS assessment was initiated on 11/19/2018 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Nurse (RN) Unit Managers to include Resident # 76 to identify any significant changes in resident status. This audit will be completed by the DON, ADON, RN Unit Managers using a resident census. A significant change assessment will be completed by the MDS nurse during the audit for any identified areas of concern with the oversight from the DON to be completed 11/30/2018. An in-service was completed on 11/19/2018 for the MDS nurses by the Registered Nurse MDS Consultant regarding the definition of a significant change, how to identify a significant change in resident status. All newly hired	

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F 637	Continued From page 2 supplements. A Weight review note dated 9/6/18 revealed the resident was currently being reviewed by the weight committee for weight loss and revealed the following: Ideal body weight 130-145. Usual weight 170. Current weight 135. Diet changed to finger foods related to her behaviors of constant activity and pacing. Registered dietician has seen. Placed on Remeron and then changed to Marinol (appetite stimulant) and 2 mighty shakes with meals. The resident ' s weight was documented as 135 pounds on 9/5/18, 136 pounds on 9/12/18 and 137 pounds on 9/19/18. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 9/24/18 revealed the resident required extensive assistance with activities of daily living except for eating with which she required supervision and cueing to eat. The resident ' s weight was documented as 136 pounds and the resident had not experienced a significant weight loss in the past month. A physician ' s progress note dated 10/30/18 revealed the staff reported the resident had a decreased oral intake over the weekend. The note revealed the resident remained incoherent, not agitated and was cooperative at that time. On 11/6/18 at 1:57 PM an interview was conducted with Nurse #1 and the dietary manager. Nurse #1 stated she was responsible for entering weights in the resident ' s chart and signed the MDS dated 9/24/18 for Resident #76. Nurse #1 stated the resident was very active and moving a lot with repetitive movements and this	F 637	MDS nurses will be provided the in-service during orientation by the Staff Facilitator (SF) regarding the definition of a significant change, how to identify a significant change in resident status. 10% of completed residents MDS□s to include Resident # 76, will be reviewed by the DON, ADON and RN Unit Managers to ensure significant changes are identified and a significant change assessment was completed when identified utilizing an MDS Accuracy QI Tool weekly for 8 weeks and monthly X 1 month. Any identified areas of concern will be immediately addressed by the DON to include additional training and modifications to the MDS assessment as indicated. The Administrator will review and initial the MDS Accuracy QI Tool weekly for eight weeks and then monthly for one month for accuracy and to ensure all areas of concerns have been addressed. The Administrator will forward the results of the MDS Accuracy QI Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months to review the audit results of the MDS Accuracy QI Tool. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	

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F 637	Continued From page 3	F 637		

was the reason for the weight loss. The Dietary Manager stated when he coded the quarterly MDS assessment the resident ' s weight had stabilized.

On 11/6/18 at 3:02 PM, Nurse #3 stated in an interview the staff have to sit with the resident and encourage her to eat. The Nurse further stated the resident would pace around on the unit and would not sit down.

On 11/7/18 at 8:25 AM an interview was conducted with Nurse #2 who worked on the unit where Resident #76 resided. The Nurse stated the resident was getting medication for her appetite and she was now eating 75-100 percent of meals. The Nurse stated the only behavior she had seen from the resident was her constant pacing on the unit.

On 11/7/18 at 9:57 AM a second interview was conducted with Nurse #1. The Nurse stated the resident ' s weight loss was due to her constant pacing on the unit and felt the issue in the beginning was not so much her not eating but the constant pacing. The Nurse further stated when the weight loss was noted on 8/30/18 they jumped on it and put interventions in place.

The Director of Nursing (DON) stated in an interview on 11/7/18 at 1:17 PM that when first admitted the resident was pacing but her pacing increased over time. The DON stated on admission the resident was weighed weekly for 4 weeks and her weight was stable so they went to monthly weights per their policy.

The facility ' s MDS Consultant stated in an interview on 11/7/18 at 2:08 PM they had some

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F 637	Continued From page 4 nurses fill in for the MDS Nurse. The Consultant further stated the resident had a change in two areas and a significant change MDS should have been done. The Consultant further stated the MDS Nurse would not have coded the increased behaviors unless the staff told her and felt the problem was due to a communication issue.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of diagnoses (Resident #120), and level II Preadmission Screening and Resident Review (PASRR) (Resident #89) for 2 of 25 sampled residents reviewed for MDS accuracy. The findings included: 1. Resident #120 was admitted to the facility on 2/19/2016. Her face sheet listed multiple diagnoses including major depressive disorder dated for 2/19/2016. A review of Resident #120's annual MDS dated 10/16/2018 did not include a diagnosis of depression. A review of previous MDS assessments dated 3/19/2018, 6/17/2018 and 7/16/2018, did not include a diagnosis of depression. A review of a Physician order dated 8/30/2017	F 641	F 641 The process that led to this deficiency was Minimum Data Set Nurse (MDS) failed to code diagnosis in section I for resident # 120. MDS Nurse failed to code Level 2 Preadmission Screening and Resident Review (PASRR) in section A for resident # 89. Resident # 120, Minimum Data Set (MDS) assessment was modified by the MDS nurse on 11/9/2018 to reflect an accurate coding of the diagnosis of depression. Resident # 89, MDS assessment was modified by the MDS nurse on 11/7/2018 to reflect level 2 PASRR. MDS for Resident #120 was transmitted and accepted into the National Repository on 11/9/2018 and the MDS for Resident # 89 was transmitted and accepted into the National Repository on 11/8/2018.	12/6/18

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F 641	Continued From page 5 documented Effexor (an anti-depressant) 150 milligrams (mg) every morning for depression. A review of a Physician order dated 9/19/2018 documented Effexor 220 mg daily for depression. On 11/6/2018 at 11:49 AM, an interview was conducted with the MDS nurse #1. The MDS nurse #1 stated Resident #120 had a diagnosis of depression and was not sure how it was not listed on the MDS assessments. The MDS nurse stated she would make a modification. On 11/8/2018 at 9:06 AM, an interview was conducted with the Director of Nursing (DON) who stated the diagnosis of depression was first identified from a Psychiatric Physician note dated 3/24/2016, and the face sheet with the date of diagnosis was incorrect. The DON stated she expected the MDS to be coded correctly. 2. Resident #89 had been admitted on 11/4/15 with diagnoses including bipolar disorder, major depressive disorder, unspecified psychosis and dementia. Resident #89's admission forms indicated identification as a Level II PASRR (a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines). A review of Resident #89's most recent comprehensive MDS assessment dated 1/6/18 did not indicate identification as a Level II PASRR. On 11/05/18 at 1:24 PM an interview with the Social Worker (SW) was conducted. The SW stated since admission, Resident #89 had been identified as Level II PASRR.	F 641	A 100% audit of all residents most current MDS assessments was initiated on 11/19/2018 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Nurse (RN) Unit Managers to include Resident # 120 and resident # 89 to ensure all completed MDS assessments are coded accurately to include diagnosis of depression and level 2 PASRR. This audit will be completed by the DON, ADON, RN Unit Managers using a resident census. Modifications will be completed by the MDS nurse during the audit for any identified areas of concern with the oversight from the DON to be completed 11/30/2018. An in-service was completed on 11/19/2018 for the MDS nurses by the Registered Nurse MDS Consultant regarding the proper coding of MDS assessments as indicated in the Resident Assessment Instrument (RAI) manual with emphasis that all MDS assessments are completed accurately and coded correctly to include a diagnosis of depression and level 2 PASRR. All newly hired MDS nurses will be provided the in-service during orientation by the Staff Facilitator (SF) regarding the proper coding of MDS assessments as indicated in the RAI manual with emphasis that all MDS assessments are completed accurately and coded correctly to include a diagnosis of depression and level 2 PASRR. 10% of all current residents completed MDS assessments to include Resident #	

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F 641	Continued From page 6 On 11/07/18 at 11:33 AM an interview with MDS nurse #1 was conducted. MDS nurse #1 stated Resident #89 had a Level II PASRR identification. MDS nurse #1 also stated Resident #89's most recent comprehensive assessment had not been coded correctly. On 11/08/18 at 9:05 AM an interview was conducted with the Administrator (AD). The AD stated resident #89 had been identified as a Level II PASRR. She stated the MDS should have been coded correctly and reflected the Level II PASRR identification.	F 641	120 and resident # 89, will be reviewed by the DON to ensure accurate coding of the MDS assessments, including for a diagnosis of depression and level 2 PASRR utilizing an MDS Accuracy QI Tool weekly for 8 weeks and monthly X 1 month. Any identified areas of concern will be immediately addressed by the DON to include additional training and modifications to the MDS assessment as indicated. The Administrator will review and initial the MDS Accuracy QI Tool weekly for eight weeks and then monthly for one month for accuracy and to ensure all areas of concerns have been addressed. The Administrator will forward the results of the MDS Accuracy QI Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months to review the audit results of the MDS Accuracy QI Tool. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		12/6/18

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F 657	Continued From page 7 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a resident's Care Plan to reflect weight loss and increased behaviors of pacing for 1 of 2 residents with a significant change in status (Resident # 76). The facility also failed to update the Care Plan for care of a peripherally inserted central catheter (PICC) for 2 of 2 residents reviewed with PICC lines (Resident #124 and #278). The findings included: 1. Resident #76 was admitted to the facility on 6/29/18 and had a diagnosis of dementia with behavioral disturbance. The Care Plan for Resident #76 dated 7/2/18	F 657	F657 The process that led to this deficiency was Minimum Data Set Nurse (MDS) failed to update a Residents care plan for a significant change in status for Resident # 76. MDS Nurse failed to update the care plans for care of a peripherally inserted central catheter (PICC) for Residents # 124 and Resident # 278 with PICC lines. Resident # 76 Care Plan was reviewed and revised on 11/8/2018 to reflect interventions to prevent weight loss and increased behaviors that were identified by Director of Nursing. Resident # 124 and Resident # 278 care plans were	

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F 657	Continued From page 8 noted the resident wandered and was at risk for unsupervised exits from the facility related to cognitive impairment. There was not a care plan for other behaviors or for nutrition. The Admission Minimum Data Set (MDS) Assessment dated 7/6/18 revealed the resident had severe cognitive impairment, required extensive assistance for activities of daily living except for supervision, encouragement and cueing for eating. It was noted the resident's weight was 173 pounds. Review of the resident's weights revealed the resident weighed 170 pounds on 7/25/18 and 8/1/18. A nursing progress note dated 8/6/18 revealed the resident was anxious/agitated and pacing and hollering at the staff and other residents. A nursing progress note dated 8/14/18 at 2:44 PM noted the resident was pacing in the hallway and had a poor PO (by mouth) intake. A nurse's note dated 8/24/18 at 3:48 PM noted the resident was anxious and pacing and refused breakfast and lunch and snacks were given in between meals. The resident's weight was documented as 133 pounds on 8/30/18. A progress note by the Registered Dietician dated 8/30/18 revealed the following: Resident had a significant weight loss of 37 pounds (21.8 percent) in 30 days and the weight loss was not desired. Diet-changed to finger foods 8/29/18. Average PO (by mouth) intake 55 percent of meals with 4 meals declined in 7 days. Remeron 7.5mg started on 8/29/18 to increase appetite. Recommendations: 60 milliliters Resource 2.0	F 657	reviewed and revised on 11/9/2018 to reflect that Peripherally Inserted Central Catheter (PICC) were identified by the Director of Nursing. A 100% audit of all care plans was initiated on 11/19/2018 by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and Registered Nurse (RN) Unit Managers, including care plans for residents # 76, resident # 124 and resident # 278 and residents with weight loss, behaviors and PICC lines to ensure that all areas of the care plan reflect the resident□s individual needs to be completed by 11/30/2018. Any care plans with areas of concerns will be updated to reflect the significant change in status and care of resident by 11/30/2018 by the MDS Nurse with oversight from the Director of Nursing. An in-service was completed on 11/19/2018 by the Registered Nurse MDS Consultant with the interdisciplinary care plan team members: Minimum Data Set (MDS) Coordinator, MDS nurse, Director of Nursing, Assistant Director of Nursing, RN Unit Managers, Dietary Manager (DM), Social Worker (SW) and Activities Director on the requirements for completing a comprehensive care plan for each resident and to review and revise the care plan for each resident change as needed. An audit will be completed of 10% of all resident□s care plans to include care plans for resident # 76, resident # 124 and	

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F 657	Continued From page 9 (nutritional supplement) three times a day with med pass. A nursing behavior note dated 8/30/18 at 8:04 PM noted the resident walked the hallways most of the shift. Unsuccessfully redirected to sit to rest. A physician's progress note dated 9/4/18 noted the resident had lost weight due to decreased oral intake and was given nutritional supplements. A Weight review note dated 9/6/18 revealed the resident was currently being reviewed by the weight committee for weight loss and revealed the following: Ideal body weight 130-145 pounds. Usual weight 170. Current weight 135. Diet changed to finger foods related to her behaviors of constant activity and pacing. Registered dietician has seen. Placed on Remeron and then changed to Marinol (appetite stimulant) and 2 mighty shakes with meals. The resident's weight was documented as 135 pounds on 9/5/18, 136 pounds on 9/12/18 and 137 pounds on 9/19/18. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 9/24/18 revealed the resident required extensive assistance with activities of daily living except for eating with which she required supervision and cueing to eat. The resident's weight was documented as 136 pounds and the resident had not experienced a significant weight loss in the past month. The resident's Care Plan was not updated to reflect the weight loss and interventions or of the resident's increased behavior of pacing on the	F 657	resident # 278 weekly x 8 weeks then monthly x 1 month by the DON, ADON or RN Unit Managers to ensure that the care plans accurately reflects the resident utilizing the QI Care Plan Audit Tool. The interdisciplinary care plan team members will be retrained and the care plan will be revised immediately by Director of Nursing for any identified areas of concern. The Administrator will review and initial the QI Care Plan Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Administrator will present the findings of the QI care plan audit tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the QI care plan audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 657	Continued From page 10	F 657		

unit.

A physician's progress note dated 10/30/18 revealed the staff reported the resident had a decreased oral intake over the weekend. The note revealed the resident remained incoherent, not agitated and was cooperative at that time.

On 11/6/18 at 1:57 PM Nurse #1 stated in an interview the resident was very active and moving a lot with repetitive movements and this was the reason for the weight loss.

On 11/6/18 at 3:02 PM, Nurse #3 stated in an interview the staff have to sit with the resident and encourage her to eat. The Nurse further stated the resident would pace around on the unit and would not sit down.

On 11/7/18 at 8:25 AM an interview was conducted with Nurse #2 who worked on the unit where Resident #76 resided. The Nurse stated the resident was getting medication for her appetite and she was now eating 75-100 percent of meals. The Nurse stated the only behavior she had seen from the resident was her constant pacing on the unit.

On 11/7/18 at 9:57 AM a second interview was conducted with Nurse #1. The Nurse stated the resident's weight loss was due to her constant pacing on the unit and felt the issue in the beginning was not so much her not eating but the constant pacing. The Nurse further stated when the weight loss was noted on 8/30/18 they jumped on it and put interventions in place.

On 11/7/18 at 10:27 AM an interview was conducted with Nurse #1 and the Dietary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING _____ B. WING _____	C 11/08/2018

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F 657	Continued From page 11	F 657		

Manager. The Nurse stated when they noted the resident's weight loss on 8/30/18 they jumped on it and put interventions in place. The Dietary Manager stated when he did her assessment in mid-September 2018 he noted the resident's weight loss and she was still within her ideal body weight range and her weight was slowly increasing so he did not add nutrition or weight loss to the resident's Care Plan.

On 11/7/18 at 10:33 AM MDS Nurse #1 stated in an interview they have weekly weight loss meetings and the dietary manager is the one who updates the care plan. The Nurse further stated the weight loss should have been added to the Care Plan.

The Director of Nursing (DON) stated in an interview on 11/7/18 at 1:17 PM that when first admitted the resident was pacing but her pacing increased over time.

On 11/7/18 at 1:45 PM an interview was conducted with the Unit Manager of the unit where the resident resided. The Manager stated the resident was pacing some when first admitted to the unit but her pacing increased over time.

On 11/7/18 at 2:08 PM the facility's MDS Consultant stated there were 2 areas in which the resident had a change in status and a significant change MDS should have been done and these areas added to the Care Plan.

2. Resident #124 was admitted to the facility on 7/3/2017. Resident #124 was discharged to the hospital on 9/17/2018 and re-admitted to the

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F 657	Continued From page 12	F 657		

facility on 10/3/2018 with diagnosis to include infection to the right hip prothesis, and a peripherally inserted central catheter (PICC) line (an intravenous line used to administer antibiotics). Her Minimum Data Set (MDS) assessment dated 10/10/2018 revealed her cognition to be intact. She had received intravenous antibiotics for 7 days prior to the assessment date.

A Physician order dated 10/3/2018, was reviewed for Vancomycin (an antibiotic) 1.25 Grams in 250 milliliters (Sodium Chloride) administered intravenous (IV) every day.

Resident #124's care plan last revised on 10/4/2018 did not include a plan with measurable objectives and care to address the PICC line.

On 11/5/2018 at 9:51 AM, an interview was conducted with Resident #124 and an observation of the PICC line in her right upper arm. Resident #124 stated she just had the PICC line replaced on 11/3/2018.

On 11/7/2018 at 1:42 PM, an interview was conducted with the MDS nurse who stated she would have expected to see the PICC line added to the care plan, and it was an oversight.

On 11/8/2018 at 9:05 AM, an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation for the care plan to be done correctly, and for the PICC line to be addressed in the care plan.

3. Resident #278 was admitted to the facility on 10/12/2018, with diagnoses to include

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F 657	Continued From page 13	F 657		

osteomyelitis of the ankle and foot, and a peripherally inserted central catheter (PICC) line (an intravenous line used to administer antibiotics). She was discharged to the hospital on 10/21/2018 and re-admitted on 10/24/2018. Her Minimum Data Set (MDS) assessment dated 11/3/2018 was still in progress, and no data was available.

A nurse's note dated 10/12/2018 revealed Resident #278 was alert and able to make her needs known to staff.

A nurse's note dated 10/12/2018 revealed Resident #278 had a peripherally inserted central catheter (PICC) line to her right arm that was intact with no swelling or drainage.

A Physician order dated for 10/24/2018 was reviewed for Daptomycin (an antibiotic) 500 milligrams (mg) every 24 hours for 14 days administered intravenous

Resident #278's care plan, initiated on 10/15/2018, did not include a plan with measurable objectives and care to address the PICC line.

On 11/5/2018 at 9:36 AM, an interview was conducted with Resident #278 and an observation of the PICC line in her right upper arm. Resident #278 stated she had not had problems with the PICC line.

On 11/7/2018 at 1:42 PM, an interview was conducted with the MDS nurse who stated she would have expected to see the PICC line added to the care plan, and it was an oversight.

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F 657	Continued From page 14 On 11/8/2018 at 9:05 AM, an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation for the care plan to be done correctly, and for the PICC line to be care planned.	F 657		
F 761 SS=D	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 observation and staff interviews the facility failed to store un-opened vial of insulin in the refrigerator and failed to remove an expired	F 761	F 761 The process that lead to the deficiency is the facility failed to remove expired	12/6/18

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F 761	Continued From page 15 medication from the medication cart for 1 of 4 medication carts observed. The findings included: 1. The manufacturer's package insert for Lantus Insulin, under drug storage read: "Store unused insulin vials in the refrigerator between 36 to 46 degrees Fahrenheit." An observation of the medication cart used to store medications for residents on the 400 Hall was conducted with the Director of Nursing (DON) on 11/7/18 at 2:25 PM. There was one vial of unopened, undated Lantus Insulin observed on the cart. The DON stated the medication should have been stored in the refrigerator until opened. 2. An observation of the medication cart used to store medications for residents on the 400 Hall was conducted with the Director of Nursing (DON) on 11/7/18 at 2:25 PM. There was a box of Glucagon on the cart with the date of expiration on the outside of the box listed as 10/2018. The expiration date of the unopened vial of Glucagon in the box read 10/2018. Glucagon is a medication given by injection in an emergency situation when a resident's blood sugar is very low and the resident unable to take anything by mouth. The DON stated the Glucagon was sent from the pharmacy about 2 weeks ago and did not realize the medication expired this soon.	F 761	Glucagon and unopened Lantus from 1 of 4 medication carts. The unopened vial of Lantus and out dated Glucagon were removed, discarded and reordered from the pharmacy on 11/7/2018 by the Director of Nursing. 100% audit of all medication carts and medication rooms was completed on 11/7/2018 by the Registered Nurse (RN) Unit Managers to ensure that medications were not expired and medications requiring storage in refrigerator until opened were not on medication carts or in medication rooms. For any identified areas of concern during the audit, the medication was immediately removed, discarded and reordered from pharmacy by Director of Nursing. 100% in-servicing was initiated on 11/7/2018 by the Staff Facilitator (SF) with all licensed nurses and medication aides regarding medication expiration dates and which medications must be stored in refrigerator until opened to be completed by 11/30/2018. All newly hired licensed nurses and medication aides will receive training during orientation by the Staff Facilitator regarding medication expiration dates and which medications must be stored in refrigerator until opened. The RN Unit Managers will monitor medication carts and medication rooms for expired medications and medications requiring refrigeration are refrigerated until opened utilizing the QI Audit tool	

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F 761	Continued From page 16	F 761	Expired\Unopened Medications weekly x 8 weeks and monthly x 1 month. All Licensed Nurses and Medication Aides will be re-educated by the Staff Facilitator for any identified areas of concern during the audit. The Director of Nursing (DON) will review and initial the QI Audit tool Expired\Unopened Medications weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The DON will present the findings of the QI Audit tool Expired\Unopened Medications to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the QI Audit tool Expired\Unopened Medications to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	