STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING ______ B. WING ______	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(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 000	INITIAL COMMENTS Recert was scheduled for week of 09/11/18 and was postponed due to Hurricane Florence. BW	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete a quarterly minimum data set (MDS) at least every three months for 1 of 23 sampled residents (Resident #1) whose MDS assessments were reviewed. Findings included: Record review revealed Resident #1 was originally admitted to the facility on 09/08/16, and readmitted to the facility on 02/27/18. The resident's last full MDS was a 11/15/17 annual assessment which was signed as complete on 11/28/17. The resident's most recent MDS was a 05/29/18 quarterly assessment which was signed as complete on 06/06/18. On 11/16/18 at 12:25 PM MDS Nurse #1 stated Resident #1 should have had another quarterly MDS completed in late August or early September 2018. She reported a quarterly MDS assessment had been overlooked. Nurse #1 was unable to explain how this assessment was	F 638	MDS Nurse completed and submitted annual assessment to bring resident assessment schedule up to date. MDS completed audit for all current residents to ensure all residents have an assessment completed within past 3 months. Identified that Resident #1 was omitted from assessment schedule because she was out of the building on extended leave of absence when the schedule was created. Administrator and MDS Nurses will now receive electronic notice when a resident returns to the building from a leave of absence. Once notification is received, MDS Nurse will add the resident to monthly calendar for projected assessments. 12/5/18 - Inservice completed with both MDS Nurses on expectation related to scheduling assessments upon receipt of electronic notifications. Also inserviced on an alternate way to review admissions/return from leave of absence -	12/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/06/2018

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

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F 638	Continued From page 1 missed since she commented the MDS nurses had the ability to run a computer generated tickler file which documented those residents who had MDS assessments due within date parameters. On 11/16/18 at 12:50 PM, after reviewing Resident #1's MDS history, the Administrator stated a quarterly MDS assessment was missed for the resident. However, she reported she was not sure how it was overlooked because the missing assessment should have been captured in a case mix written/manual review of MDS assessments and/or electronically through the calendar system that reminded the MDS team when assessments were due.	F 638	to ensure all residents are included on monthly calendar. Assessment schedule for all residents who have returned from leave of absence will be reviewed no less than once per month for three months, then quarterly for three quarters. This review will be logged on QA logs and reviewed by Administrator. These will be included in quarterly QAPI meeting for review. First three entries will be completed by 3/21/19 and the final entries by 1/16/20. If it is determined that a team member is not following correct procedures, he/she will be re-inserviced. If same team member fails to follow correct procedures again, disciplinary action will be taken.	
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 staff interview and record review the facility failed to accurately code Minimum Data Set (MDS) assessments to reflect the history of falls for 2 of 3 sampled residents (Resident #40 and #51) reviewed for accidents. Findings included: 1. Record review revealed Resident #51 was admitted to the facility on 12/05/17 and readmitted on 07/27/18. The resident's	F 641	MDS Nurse corrected previously submitted assessments (ARD 7/24/18 for Resident #51, ARD 12/25/17 for Resident #40 and ARD 9/21/18 for Resident #40). 12/5/18 - Inservice completed with MDS Nurses demonstrating alternate way to review falls in the electronic record. Reviewed expectation that all falls are captured in the MDS assessment.	12/10/18

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F 641	Continued From page 2 documented diagnoses included muscle weakness, difficulty walking, and history of falls. The resident's 06/05/18 quarterly MDS documented the resident's cognition was moderately impaired, and she had not experienced any falls since her previous MDS assessment. A 07/18/18 7:53 PM fall report documented Resident #51 unlocked her wheelchair and tried to stand up unassisted which resulted in the resident sliding out of the wheelchair and onto the floor, landing on her left hip. After the incident the resident complained of pain in her left hip, and a x-ray documented the resident sustained a fracture to the hip. A 07/24/18 discharge with return anticipated MDS documented Resident #51 was discharged to the hospital on 07/24/18. The assessment also documented the resident had not experienced any falls since the previous MDS assessment (the 06/05/18 quarterly MDS). On 11/16/18 at 9:35 AM the Director of Nursing (DON) stated when residents experienced falls her expectation was that the falls and the fall history be coded accurately on all MDS assessments. On 11/16/18 at 11:38 AM MDS Nurse #1 stated Resident #51's 07/24/18 discharge return anticipated MDS should have been coded to reflect that the resident experienced a fall with major injury since the previous MDS assessment. She reported she was unable to explain how the error in documentation occurred other than it being the result of human error.	F 641	12/10/18 - audited all residents with falls since 11/1/18 to ensure that corresponding MDS assessment was coded accurately. Corrections needed were recorded on QA Log. All residents with falls will be recorded on monthly QA logs. Administrator and MDS Nurses will review the log no less than monthly for three months - to ensure that each fall is recorded correctly on the appropriate MDS assessment. After first three reviews, reviews will be completed no less than quarterly for three quarters. All QA logs will be included in quarterly QAPIP meeting for review. First three entries will be completed by 3/21/19 and the final entries by 1/16/20. If it is determined that team member is not following correct procedures, he/she will be re-inserviced. If same team member fails to follow correct procedures again, disciplinary action will be taken.	

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F 641	Continued From page 3	F 641		

2. Resident #40 was initially admitted to the facility on 10/29/12 with reentry to the facility on 2/23/16. Her cumulative diagnoses included, in part, Alzheimer ' s disease, unspecified dementia with behavioral disturbance, and a history of falls.

A review of Resident #40 ' s electronic Falls Report and facility ' s Huddle Report (an interdisciplinary report completed after a resident has a fall) revealed the resident had a fall on 12/14/17. The resident was found on the floor after she apparently lost her balance while attempting to transfer herself from her chair to the wheelchair.

Resident #40 ' s quarterly Minimum Data Set (MDS) assessment dated 12/25/17 was reviewed. The MDS indicated the resident had intact cognitive skills for daily decision making. Section J of the MDS reported the resident did not have any falls since admission or prior assessment, whichever was more recent. Her previous MDS assessment was dated 9/25/17.

Further review of Resident #40 ' s electronic Falls Report and facility ' s Huddle Report revealed the resident had another fall on 9/5/18. The resident was observed on the floor when she apparently slid out of the wheelchair while self-propelling herself in the hallway.

Resident #40 ' s quarterly Minimum Data Set (MDS) assessment dated 9/21/18 was reviewed. The MDS indicated the resident had moderately impaired cognitive skills for daily decision making.

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F 641	Continued From page 4 Section J of the MDS reported the resident did not have any falls since admission or prior assessment, whichever was more recent. Her previous MDS assessment was dated 6/21/18. An interview was conducted on 11/15/18 at 3:38 PM with MDS Coordinator #1. Upon request, MDS Coordinator #1 reviewed Resident #40 ' s MDS assessments dated 12/25/17 and 9/21/18, in addition to the electronic Falls Reports. When asked, the MDS Coordinator confirmed the resident had a fall on 12/14/18 and on 9/5/18. Upon further review of the 12/25/17 and 9/21/18 MDS assessments, the MDS Coordinator confirmed these assessments were coded incorrectly. She stated both the 12/25/17 and 9/21/18 MDS assessments should have reported Resident #40 had a fall. An interview was conducted on 11/16/18 at 9:35 AM with the facility's Director of Nursing (DON) in the presence of the Administrator and Assistant Director of Nursing. The facility ' s failure to code Resident #40 ' s falls from 12/14/17 and 9/5/18 on the MDS assessments (dated 12/25/17 and 9/25/18, respectively) was discussed. When asked what her expectation was, the DON stated, "If they (residents) have a fall, would expect it to be coded." During the interview, the Administrator reported she supervised the MDS process. When asked what her expectation was, the Administrator agreed with the DON's statement and added she thought it was, "human error."	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		12/10/18

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F 655	Continued From page 5 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655		

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F 655	Continued From page 6 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to develop and implement a baseline care plan within 48 hours of admission for 1 of 11 newly admitted residents reviewed (Resident #60). The findings included: Resident #60 was admitted to the facility on 9/6/18 from the community. His cumulative diagnoses included, in part: renal insufficiency, coronary artery disease, heart failure, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. A review of the resident ' s electronic medical record included a baseline care plan dated 9/11/18 with the following areas of focus: --I use the bathroom with the help of 2 people; --I dress with the help of 1 person; --I do hygiene/grooming tasks with the help of 1 person; --Oral care: I clean my teeth/gums if you set out what I need; --Vision: I wear glasses; --Repositioning--reposition me at least every 2 hours, elevate the head of my bed. Additional areas of focus added to the resident ' s care plan on 9/13/18 included: --I need dietary staff to provide my ordered diet honor my likes and dislikes; --I need Social Services to set up my referrals; --I need Activity staff to assess my interests.	F 655	12/6/18 - All licensed Nurses inserviced on expectation to complete a person-centered baseline care plan for each resident within 48 hours of admission. Registered Nurses educated on specific requirements of baseline care plans and how to enter into electronic medical record. 12/10/18 - building wide audit of all current residents who were admitted or re-admitted since 11/1/17. Outcomes of this review noted on QA Log for Baseline Care Plans. Administrator and Administrative Nurses will review all admissions daily (Monday - Friday) during clinical meeting to ensure that all residents have a baseline care plan and that they are completed within 48 hours of entry. This review will continue to be a part of our clinical meeting going forward, without end. If not complete, Administrative Nurses will complete baseline care plan at that time. QA Log for Baseline Care Plans will be reviewed by Administrator and Director of Nursing no less than once per month for three months then quarterly for three quarters. QA Log will be included in quarterly QAPI meeting for review. First three entries will be completed by	

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F 655	Continued From page 7 An interview was conducted on 11/16/18 at 9:30 AM with the facility's Director of Nursing (DON) in the presence of the Administrator and Assistant Director of Nursing. During the interview, a review of the resident's electronic baseline care plan was conducted. This review confirmed the earliest electronic records for Resident #60 ' s baseline care plan were dated 9/11/18, which indicated the resident ' s baseline care plan was not completed within 48 hours of his admission to the facility. On 11/16/18 at 9:35 AM, the facility's Administrator was asked what her expectation was in regards to the development of a baseline care plan for a newly admitted resident. The Administrator stated, "Within 48 hours is our norm."	F 655	3/21/19 and final entries by 1/16/20. If it is determined that team member is not following correct procedures, he/she will be re-inserviced. If same team member fails to follow correct procedures again, disciplinary action will be taken.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		12/10/18

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F 692	Continued From page 8 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure nutritional supplements were provided as ordered to meet the nutritional needs for 2 of 4 sampled residents (Resident #50 and Resident #64) reviewed for nutrition. Findings included: 1. Record review revealed Resident #64 was admitted to the facility on 04/18/18 and readmitted on 07/26/18. The resident's documented diagnoses included Alzheimer dementia, osteoporosis, vitamin D deficiency, hyperlipidemia, and anemia. Resident #64's weight record documented she weighed 97.6 pounds on 04/20/18. On 04/25/18 Resident #64's care plan identified, "I have the potential to unintended weight loss because I have poor appetite and dementia as well as anxiety and I have weight that is at lower IBW (ideal body weight) range" as a problem. Approaches to this problem included providing nutritional supplements as ordered by the physician. Resident #64's weight record documented she weighed 97 pounds on 05/22/18, 94.6 pounds on 06/18/18, and 93.8 pounds on 07/25/18. A 08/03/18 physician's order initiated fortified cran-apple juice for Resident #64 at lunch. A 08/15/18 physician's order initiated ice cream	F 692	All Nursing and Dietary staff were inserviced on the difference between preferences and supplements as well as the expectation that supplements are given and documented appropriately by Nursing staff. Inservice also outlined the new system in which supplements will be managed. All supplements will be individually labeled with Resident name, type of supplement and when to be given. Supplements will be delivered to the neighborhood by Dietary staff, three times per day. Nurse on neighborhood will ensure that all residents receive supplements as ordered and document appropriately on MAR. Day shift Nurse will print orders for supplements daily, acknowledge that all were given on the printed sheet and then turn in to Neighborhood Coordinator for review. Neighborhood Coordinators, Food Service Director, Director of Nursing and Administrator will review daily sheets at least monthly for three months and then for at least three quarters. Notes from these reviews will be included in Quarterly QAPI meetings. First review will be completed by 3/21/19	

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F 692	Continued From page 9	F 692		

for Resident #64 at supper.

Resident #64's weight record documented she weighed 92.6 pounds on 08/21/18 and 96.6 pounds on 09/21/18.

The resident's 10/10/18 quarterly minimum data set (MDS) documented her cognition was severely impaired, she exhibited no behaviors including resistance to care, she was independent with eating once she received set up assistance, she was five feet tall and weighed 97 pounds, and her weight was stable.

In her 10/11/18 Dietary Progress Note the Food Service Director documented, "Weight is stable. Resident's current diet is a regular. Resident is able to feed herself independently. Resident's meal intake percentage is 82%. Resident's skin is intact. Resident's weight 10/07/18 97# (pounds)....She receives fortified juice at lunch consuming 50%. She also receives ice cream at supper consuming 0 - 25%. Will continue to monitor, honor food preferences, offer snacks of choice. RD prn (Registered Dietitian as needed)."

Resident #64's weight record documented she weighed 97 pounds on 10/23/18 and 101 pounds on 11/09/18.

During a continuous observation of the lunch meal on 11/14/18 Resident #64 was eating in the unit dining room. At 12:11 AM the resident received eight ounces of tea before her meal arrived. At 12:24 PM the resident received her food with no additional beverages. At 12:49 PM the resident left the dining room without receiving any fortified juice even though an observation of

Provider's Plan of Correction (F 692):

and three quarterly reviews completed by 1/16/20.

If it is determined that a team member is not following correct procedures, he/she will be re-inserviced. If same team member fails to follow correct procedures again, disciplinary action will be taken.

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F 692	Continued From page 10	F 692		

her tray slip revealed the juice was documented as a supplement.

During a continuous observation of the supper meal on 11/14/18 Resident #64 was eating in the unit dining room. At 5:46 PM the resident received her plate of food, and no ice cream was served with it. At 6:10 PM the resident received cheesecake, the dessert scheduled to be provided to all residents for the meal. At 6:20 PM the resident left the dining room without receiving any ice cream even though an observation of her tray slip revealed the ice cream was documented as a supplement.

During a continuous observation of the lunch meal on 11/15/18 Resident #64 was eating in the unit dining room. At 12:00 noon the resident received eight ounces of tea before her meal arrived. At 12:26 PM the resident received her food with no additional beverages. At 12:56 PM the resident left the dining room without receiving any fortified juice even though an observation of her tray slip revealed the juice was documented as a supplement.

On 11/15/18 at 12:58 PM Nursing Assistant (NA) #1 stated the dietary employee working behind the dining room counter provided all the nutritional supplements listed on the tray slips to the NAs who placed them in front of residents on the tables, serving the residents restaurant style.

On 11/15/18 at 1:07 PM Dietary Aide (DA) #2 stated either the dietary aide placing food on the plates or the NAs passing out the food could obtain supplements listed on the tray slips and provide them to the residents. She reported it was like a double check system because the

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F 692	Continued From page 11	F 692		

dietary aides read the tray slips as they prepared the plates, and then the NAs reviewed the tray slips when the food was handed off to them by the dietary aides in the units. She commented there should be no reason why residents would not receive nutritional supplements documented on their tray slips.

On 11/15/18 at 1:15 PM the Food Service Director stated NAs pre-poured beverages to be served while residents waited on their meals to be served in the dining rooms so they could pre-pour and serve fortified juice. She reported ice cream was given out after residents had finished eating their meals in the dining rooms, and the ice cream could also be given out by NAs. However, she commented the dietary department was ultimately held responsible for providing all nutritional supplements served with meals so if the NAs actually obtained the supplement products they were supposed to show them to the DAs working in the neighborhood dining rooms so the dietary employees could verify that the residents were receiving the nutrition supplements documented on their tray slips.

On 11/16/18 at 9:35 AM the Adminsitrator stated if there was an order for nutritional supplements, she expected those supplements to be documented on tray slips and to be served to the residents.

2. Resident #50 was initially admitted to the facility on 12/13/11 with reentry to the facility on 11/23/14 from a hospital. Her cumulative diagnoses included, in part, Alzheimer ' s disease and adult failure to thrive.

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	345554	A. BUILDING ______ B. WING ______	11/16/2018

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TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

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Resident #50 ' s quarterly Minimum Data Set (MDS) assessment dated 11/30/17 indicated the resident had severely impaired cognitive skills for daily decision making. Resident #50 was assessed to be totally dependent on staff for eating. Section K of the MDS assessment indicated the resident was 65 inches tall and weighed 128 pounds (#).

A review of the resident ' s medical record included a Dietary Progress note dated 12/14/17. The note reported Resident #50 received fortified juice at breakfast, fortified juice at lunch, and ice cream at supper to help maintain her weight.

A review of Resident #50 ' s quarterly MDS assessment dated 2/27/18 reported the resident ' s weight was 125#. A review of the resident ' s quarterly MDS dated 4/19/18 revealed she weighed 120#.

Further review of Resident #50 ' s weight history included the following: 5/5/18 = 121.6#; 6/8/18 = 119#; and 7/5/18 = 118.8#.

A review of the resident ' s Nutrition Progress notes included an annual review dated 7/11/18. The review noted the resident was on comfort care measures and reported a 7.7% weight loss in the past 6 months. The note indicated monthly weights would continue to be followed.

Further review of Resident #50 ' s weight history included the following: 8/3/18 = 117.6# and 9/7/18 = 113.4#.

Resident #50 ' s most recent quarterly Minimum Data Set (MDS) assessment was dated 10/2/18. The MDS indicated the resident had severely

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impaired cognitive skills for daily decision making. Section G of the MDS revealed the resident continued to be totally dependent on staff for eating. Section K of the MDS assessment indicated the resident weighed 114 pounds (#).

A review of the resident ' s care plan included the following area of focus, in part:
-- (Dated 8/17/18) "I have had a weight loss of 6# within the last 3 months. I am at risk for further weight loss due to my diagnosis of Alzheimer ' s. I don't understand need to eat because I have a diagnosis of Alzheimer's and unspecified dementia which places me at risk for not understanding the need to eat." The goal set forth included: " ...I will have no further weight loss ..." An evaluation of her progress (dated 10/16/18) revealed the resident continued to have further weight loss with her current weight on 10/8/18 noted as 111#. The care plan reported changes to her nutritional supplements were made on this date (10/16/18) in an attempt to keep Resident #50 ' s weight stable at the current level or to see a weight gain. The evaluation referenced the consultant Registered Dietitian ' s (RD ' s) Dietary Progress note dated 10/16/18 for further details.

The facility ' s consultant RD ' s Dietary Progress note dated 10/16/18 reviewed Resident #50 ' s weight history and noted a 7.6% weight decrease in 6 months, 6.5% weight decrease over the past 3 months, and 2.1% weight decrease during the past one month. The RD noted her continued weight loss and reported her planned supplements would be changed to include a Magic Cup with her lunch and supper meals. Magic Cup is a fortified nutritional product that provides 290 calories and 9 grams of protein per

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F 692	Continued From page 14 serving. Each individual container of Magic Cup is distinctively labeled with large lettering on the container. A Physician ' s Order was received on 10/16/18 to add Magic Cup to Resident #50 ' s lunch and supper meals. Further review of Resident #50 ' s weight history indicated she weighed 110.6# on 11/13/18. A review of the resident ' s tray slips indicated she would receive the following supplements at mealtime: Breakfast--fortified orange juice - 1 serving; Lunch--fortified orange juice-1 serving; Magic Cup - 1 serving; Supper--Magic Cup - 1 serving. A continuous observation of the lunch meal was conducted on 11/14/18 at 12:15 PM as Resident #50 was fed her meal in the neighborhood dining room. No Magic Cup was provided to the resident during this meal. A continuous observation of the lunch meal fed to Resident #50 in the neighborhood dining room was conducted on 11/15/18. The resident required much encouragement to eat and was observed to have a poor appetite (consuming less than 25% of her lunch meal). At 12:43 PM, the resident was brought one serving of a pink frozen dessert in a plain white container with no labeling on the sides of the container, which she accepted. No Magic Cup was provided to the resident at this meal. An interview was conducted on 11/15/18 at 12:47 PM with Dietary Aide #1. Upon inquiry, the	F 692		

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F 692	Continued From page 15 Dietary Aide confirmed Resident #50 had just received strawberry ice cream (not a Magic Cup). An interview was conducted on 11/15/18 at 4:10 PM with the facility's Food Service Director (FSD). During the interview, the lunch time observations made on 11/14/18 and 11/15/18 of Resident #50 were discussed, noting the resident did not receive a Magic Cup at these meals. The FSD confirmed Magic Cup was written on the resident ' s meal slip, indicating she should have received this supplement at lunchtime. The FSD stated, "If a supplement is on the tray card, it is our (the Dietary Department ' s) responsibility to be sure they get it." An interview was conducted on 11/16/18 at 9:35 AM with the facility's Administrator. During the interview, the concern regarding the facility ' s failure to provide a Magic Cup to Resident #50 during two meal services was discussed. The Administrator stated if there was an order for nutritional supplements, she expected those supplements to be documented on the residents ' tray slips and to be served to the residents.	F 692		
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	F 761		12/10/18

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F 761	Continued From page 16 §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, staff interviews, and record reviews, the facility failed to secure all medications in a locked storage area for 1 of 2 medication carts observed (300-400 Medication Cart); and failed to ensure all medications were labeled with an expiration date on 1 of 2 medication carts observed (300-400 Medication Cart). 1. An observation was conducted on 11/14/18 at 3:52 PM of the 300-400 Nursing Station. The Nursing Station is a room directly off of the neighborhood ' s common hallway. The door to the Nursing Station was wide open and two residents (Resident #99 and Resident #27) were observed to be sitting in the room approximately 3 to 5 feet from an unlocked medication cart. No staff member was in the room nor visible from the windows in the room. The hall nurse was not observed from the hallway adjacent to the Nursing Station at the time of the observation. On 11/14/18 at 3:55 PM, Nurse #1 entered the	F 761	All licensed Nurses and Medication Aides inserviced on regulation and expectation that medications are appropriately labeled/dated when opened. All medications/treatments that are improperly labeled and/or expired will be disposed of immediately. All medication carts and treatment carts were audited by Neighborhood Coordinators to ensure that medications were stored/labeled properly and that carts are locked when not in use. Medication and treatment carts will be audited daily by the off-going Nurse and logged on daily audit sheet. Audit sheets will be turned in daily to Neighborhood Coordinator. Neighborhood Coordinators will review with Director of Nursing at least monthly for three months and three quarter thereafter. Notes from these reviews will be included in quarterly QAPI meetings with first notes entered by	

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F 761	Continued From page 17 Nursing Station. A review of Resident #99 ' s quarterly Minimum Data Set (MDS) assessment dated 10/30/18 revealed the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assist from staff for bed mobility, transfer, toilet use and personal hygiene; limited assist from staff for locomotion on unit/off unit; and supervision only for eating. She used a wheelchair for mobility. A review of Resident #27 ' s quarterly MDS assessment dated 9/2/18 revealed the resident had severely impaired cognitive skills for daily decision making. Section E of the MDS noted the resident exhibited "other behavioral symptoms not directed toward others" on 1 to 3 days out of 7 days; Section G indicated the resident was independent for bed mobility, transfers and walking in room, toilet use, eating; he required supervision only for walking in the corridor, dressing and personal hygiene. The resident was ambulatory and did not require a mobility device. An interview was conducted on 11/14/18 at 4:05 PM with Nurse #1. During the interview, the nurse was asked if she felt comfortable leaving the medication cart unlocked in the nurses station. The nurse responded, "No." A follow-up interview was conducted on 11/15/18 at 2:48 PM with Nurse #1. During the follow-up interview, Nurse #1 reported leaving the medication cart unlocked in the nursing station was not a usual practice. The nurse stated she had just left the Nursing Station to go to a medication room when the medication cart was observed to be unlocked. The nurse stated she	F 761	3/21/19 and final entries by 1/16/20. All licensed Nurses and Medication Aides inserviced on regulation and expectation that medication/treatment carts will be locked when not in use. Neighborhood Coordinators will check medication/treatment carts at least three times per week to ensure they are locked when not in use. Checks will be documented on audit tool. Neighborhood Coordinators will review findings at least monthly for three months and then for three quarters thereafter. Notes from these reviews and completed audit tools will be included in quarterly QAPI meetings with first notes entered by 3/21/19 and final entries by 1/16/20. If it is determined that a team member is not following correct procedures, he/she will be re-inserviced. If same team member fails to follow correct procedures again, disciplinary action will be taken.	

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F 761	Continued From page 18 reported the observation made on 11/14/18 of the med cart being left unlocked and unattended. Nurse #1 also reported she was in-serviced on this concern the morning of 11/15/18. An interview was conducted on 11/15/18 at 3:00 PM with the facility's Director of Nursing (DON). During the interview, the observation made on 11/14/18 of the 300-400 medication cart having been left unlocked and unattended was discussed. Upon inquiry, the DON stated she would expect, "for it (the medication cart) to be locked when the nurse is not actively using the med cart." 2. In the presence of Nurse #1, an observation was made of the 300-400 medication cart on 11/14/18 at 3:56 PM. An opened stock bottle originally containing 90 tablets of 81 milligrams (mg) aspirin chew tablets was observed to have no expiration date on the bottle. Upon a careful review of the labeling on the bottle, Nurse #1 verified there was no expiration date visible on the stock bottle. The nurse stated she thought the expiration date may have been inadvertently rubbed off of the label over time. Nurse #1 stated she needed to replace this stock bottle, "Because we don't know the expiration date." An interview was conducted on 11/15/18 at 3:00 PM with the facility's Director of Nursing (DON). During the interview, the medication storage observations were discussed. Upon inquiry, the DON stated she would expect a medication bottle to be discarded and replaced if the expiration date was no longer visible.	F 761		