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	345131	A. BUILDING _____ B. WING _____	C 01/10/2019

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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E 000	Initial Comments An unannounced Recertification survey was conducted on January 8, 2019 through Januarry 10, 2019. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness Event #ID 1VV611	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of this complaint investigation conducted on January 10, 2019 for Event ID # 1VV611	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		2/7/19

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

Electronically Signed | 01/26/2019

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview the facility failed to develop a care plan for 1 of 5 sampled residents (Resident #30) who had behavioral and psychiatric symptoms. Findings included: Resident #30 was admitted to the facility on 11-13-16 with multiple diagnoses that included dementia, major depression and anxiety The care plan for Resident #30 was dated 11-6-18 and did not include goals or interventions for resident's depression or anxiety but was noted to have a goal and intervention for the resident's psychotropic medications. The annual Minimum Data Set (MDS) dated 11-7-18 revealed Resident #30 was severely cognitively impaired and required extensive	F 656	CRITERIA I. Resident #30 had care plan reviewed and updated to include interventions related to anxiety and depression prior to survey exit. Updates included counseling services provided as well as psychiatric services scheduled. Comprehensive review of current behaviors and incidents of anxiety was conducted prior to the development and implementation of said care plan. CRITERIA II. Residents demonstrating behavioral symptoms and/or psychiatric diagnosis/anxiety will have comprehensive behavioral review to ensure current and accurate care plan no later than February 6, 2019. CRITERIA III. Education topics provided to staff related to this alleged deficient practice includes: 1. Behavior Monitoring	

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F 656	Continued From page 2 assistance with 2 people for bed mobility, transfers and toileting and total assistance with 2 people for personal hygiene. The MDS also revealed Resident #30 received antidepressant medication 7 out of 7 days. Resident #30 was interviewed on 1-8-19 at 10:33am. The resident stated she was upset because she had asked the nursing staff not to "crush my medication but they won't listen to me." Resident #30 also stated this was the reason she had been refusing to take her medication. A review of the nursing documentation dated 12-17-18 and 12-29-18 revealed documentation that Resident #30 refused her medication. Physician documentation from 12-27-18 to 1-7-19 revealed Resident #30 was continuing to have "persistent fixed delusions." The documentation revealed the resident was delusional about her medications and would often refuse her medication. During an interview with nursing assistant (NA)#4 and nurse #6 on 1-9-19 at 1:15pm, NA #4 stated Resident #30 was delusional at times and gave an example that the resident believed she had walked from the facility to New York. The NA also stated the resident would often refuse her medication because the resident believed the nurses were "crushing" her medication but nurse #6 denied that was happening. Nurse #6 stated if staff walked away and returned a few minutes later Resident #30 would take her medications. She also stated encouragement and education on the importance of each medication assisted with the resident in taking her medication. Nurse #6 and NA #4 stated there was no care plan or	F 656	2. Planning care of Residents with Behavioral issues, Anxiety and Depression. Education will be conducted by Staff Development Coordinator and/or Administrator by February 6, 2019. Audits and/or Monitoring related to this alleged deficient practice will include: 1. Residents with diagnosis of anxiety and depression will have care plan audits monthly for three (3) months, January, February and March 2019 to ensure accurate development of related plan of care. Practice Modification related to alleged deficient practice: 1. Upon admission, the Interdisciplinary team will review History and Physical to determine history or presence of current psychiatric/behavioral disturbance and/or anxiety. If present, the Interdisciplinary Team will initiate monitoring to determine resident's individual needs related to specific psychiatric/behavior and/or anxiety disorder. Through monitoring, as needs are identified, the development and implementation of care plans will be completed. 2. As new psychiatric/behavioral and/or anxiety disturbances are identified with new or existing residents, the same process will be implemented with a. monitoring and b. development of individual care plan. Audits will be completed by the Social Services Director, Administrator and/or Staff Development Coordinator no later than February 6, 2019. Development of Quality Assessment and	

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F 656	Continued From page 3 interventions for Resident #30's behaviors "We just tried different things." An interview was conducted on 1-9-19 at 1:45pm with NA #5. The NA stated Resident #30 was often delusional but denied there was a care plan or interventions for her to follow "so I just go along with it." The Administrator was interviewed on 1-10-19 at 2:02 pm. The Administrator stated he expected residents care plans to be developed per the residents individualized needs.	F 656	Performance Improvement Plan will be developed based upon this alleged deficient practice as outlined above to ensure compliance, completion and correction by February 6, 2019. The results from audits, education, monitoring, and practice changes proposed will be reviewed at ad hoc and/or regularly scheduled meeting to determine addition interventions, monitoring or alteration to plan.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's medication rate was greater than 5% as evidenced by 2 medication errors out of 27 opportunities for errors (Resident #3 and Resident #49). The medication error rate was 7.41%. Findings include: 1. Resident #49 was admitted to the facility on 3/23/18 with diagnoses that included Schizophrenia, periorbital cellulitis, and preglaucoma right eye. A review of Resident #49's medical record	F 759	CRITERIA ONE: The Artificial Tears observed being Self-Administered during survey without an order was immediately removed until discussion with Residnet, Provider, and Responsible Party could be completed. Upon discussion with Resident #49 and Resident #3 and provider, the determination was made for nursing staff to administer medications. Criteria Two: Residnets receiving Artificial Tears, and other eye drops were reviewed prior to survey exit to determine if there were	2/7/19

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F 759	Continued From page 4 revealed a physician's order dated 6/28/18 that read: 'Artificial Tears Solution 1.4% Instill 1 drop in both eyes four times a day for dry eye.' A review of Resident #49's medical record revealed no medication self-administration assessment or order for the resident to self-administer her eye drops. An observation of medication administration was made on 1/9/19 at 5:00pm with Nurse #2. Observed Nurse #2 give Resident #49 her medications. Observed Nurse #2 question the resident if the resident wanted to give herself her eye drops. Resident #49 replied that she did want to administer her own eye drops. Nurse #2 gave her the bottle of Artificial Tears and Resident #49 administered correctly. An interview was conducted with Nurse #2 on 1/9/19 at 5:05pm. Nurse #2 reported Resident #49 usually self-administered her eye drops because she liked to do them herself. 2. Resident #3 admitted to the facility on 3/18/16 with diagnoses that included Multiple Sclerosis, history of Pulmonary Embolism, and Dry Eye Syndrome. A review of Resident #3's medical record revealed a physician's order dated 8/7/18 that read: 'Artificial Tears Solution Instill 1 drop in both eyes two times a day for dry eyes.' A review of Resident #3's medical record revealed no medication self-administration assessment or order for the resident to	F 759	additional residents requesting to self administer their drops; no other incidents were identified. This review was completed January 17, 2019. Criteria Three: Education Plan Related to Deficient Practice: 1. Policy and Procedure of Self Administration of Medication Audits and Monitoring Related to Deficient Practice: 1. Med Pass Observations will be conducted by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Administrator to identify appropriate administration of medications and any incidents of self administration. 2. Residents identified with incidents of self administration will have medical record audit to ensure presence of physician order. Education were completed over several sessions January 31 - February 2, 2019. Education was completed on February 2, 2019 Criteria Four: The Quality Assessment and Performance Improvement committee will review the results of the education, observations, and audits/monitoring, monthly for three months February, March and April to ensure performance and ensure compliance with guidelines as well and ensure solutions are sustained.	

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F 759	Continued From page 5 self-administer her medications. An observation of medication administration was made on 1/10/19 at 9:00 am with Nurse #1. Observed Nurse #1 give Resident #3 medications except for the Artificial Tears eye drops. When Nurse #1 gave Resident #3 her medications, the resident reported she had already given herself her eye drops and showed the nurse the bottle. An interview was conducted with Nurse #1 on 1/10/19 at 9:15am. She reported Resident #3 self-administered own eye drops. She reported she just always asked the resident if she had done the eye drops and documented on the MAR (Medication Administration Record) that it was given. An interview was conducted on 1/10/19 at 11:00am with the ADON (Assistant Director of Nursing). She reported there were no residents in the building that self-administered medications that she knew of. She reported any resident that wanted to self-administer medications would have a self-administration assessment performed by the nursing staff and an order would be obtained from the physician for the resident to self-administer. She reported it was her expectation that no resident self-administer medications until an assessment was performed and an order was obtained.	F 759		
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	F 761		2/7/19

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F 761	Continued From page 6 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to properly dispose of expired medications and unlabeled, opened medications in 1 of 2 medication carts (100 hall locked unit cart) reviewed for proper medication storage. Findings include: An observation was made on 1/9/19 at 10:02 am of the medication cart used for residents on the 100 hall which is the locked dementia unit of the facility. It was observed that there were 5 Humalog insulin 100units/1 ml (milliliter) vials that were opened and not dated. An observation was made that there were 2	F 761	Criteria One: The 5 Humalog insulin; 100u/1ml vials observed on the 100 Hall Medication cart to be unlabeled, were immediately discarded By nursing Staff. The 2 opened Humalog Insulin; 100u/1ml vials that were dated, but incorrectly dated or expired were immediately discarded by nursing staff. Criteria Two: Medication Carts on the 200 Hall as well as 300 Hall were checked by Director of Nursing and Assistant Director of Nursing for non dated, incorrectly dated, and /or expired injectable including Humalog	

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F 761	Continued From page 7 opened Humalog insulin 100 unit/1 ml vials in which one was dated as opened 12/5/18 with a discard date of 1/1/19 and the other as opened 11/20/18 with no discard date. An interview was conducted with Nurse #13 on 1/9/19 at 10:15am. She reported all opened insulin vials should be dated when opened. She reported all opened insulin vials should be discarded after 28 days of being opened. An interview was conducted on 1/9/19 at 12:30pm with the Administrator. He reported it was his expectation that all opened insulin vials be dated and labeled and then discarded after 28 days.	F 761	Insulin 100u/1ml vials, prior to survey exit. There were no other issues identified. Criteria Three: Education Provided related to Deficient Practice: 1. Storage and Labeling of Medications Education will be completed by Staff Development Coordinator. Audits/Monitoring: 1. Weekly med cart audits will be completed to ensure no inappropriately labeled or stored meds present, for 30 days. Audits will be completed by Director of Nursing, Staff Development Coordinator, and/or Administrator no later than 2/7/2019. 2. Nursing staff, with placing pharmacy deliveries will review stored vials to ensure appropriate labeling and storage. Audits and Monitoring will be completed by Director of Nursing and Assistant Director of Nursing. Education was conducted over several sessions January 31 - February 2, 2019. Criteria Four: The Quality Assessment and Performance Improvement committee will review the results of the education, monitoring, audits and process related to the deficient practice monthly for three months to ensure compliance and solutions are sustained, or the need for further interventions.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		2/7/19

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F 867	Continued From page 8 §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 record reviews and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the February 28, 2018 annual recertification and complaint survey and on January 10, 2019 annual recertification and compliant survey. This was for 3 recited deficiencies in the areas of Developing and Implementing Comprehensive Care Plans (F656), Care Plan Timing and Revision (F657), and Medication Storage (761). The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Progress. Findings include: F 656 Based on record review, staff interviews and resident interview the facility failed to develop a care plan for 1 of 5 sampled residents (Resident #30) who had behavioral and psychiatric symptoms. During the recertification and complaint survey dated February 28, 2018 the facility was cited for F656, the facility failed to develop and implement a comprehensive care plan on 1 out of 1 resident (Resident #36) who was on dialysis to monitor the graft access site and remove the dressing to site nightly.	F 867	The facility failed to implement Quality Assessment and Performance Improvement processes effectively to monitor, improve, and ensure regulatory compliance in the area of: 1. medication management, storage, and labeling, 2. Management of Expired Medications, Tube Feeding Solutions, IV Solutions, and Medical Supplies. 2. Care Plan Development, Implementation, Update, Revision, and Completion. This deficient practice resulted in repeated citations, and apparent need for Quality Assessment and Performance Improvement process. On January 24, 2019, The Director of Clinical Services provided in-service education for the Administrator and Director of Nursing related to the Quality Assurance and Performance Improvement Process. This education included the roles of committee, mandatory participants, Ad Hoc Process, Development of Improvement Plans, Audit Tools and Monitoring, Meetings, and Minutes. The Director of Clinical Services also provided education for the Administrator and Director of Nursing Services on the above mentioned repeated deficient practices to include:	

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F 867	Continued From page 9 F 657 Based on record review, staff interviews and resident interview the facility failed to revise a care plan for 1 of 5 sampled residents (Resident #10) whose care plans were reviewed. During the recertification and complaint survey date February 28, 2018 the facility was cited for F657, the facility failed to update the care plan for 3 of 3 residents that had experienced significant weight loss (Resident #50, Resident #179 and Resident #43.) F 761 Based on observations and staff interviews, the facility failed to properly dispose of expired medications and unlabeled, opened medications in 1 of 2 medication carts (100 hall locked unit cart) reviewed for proper medication storage. During the recertification and complaint survey date February 28, 2018 the facility was cited for F761, the facility failed to dispose of open expired lab tubes for3 of 3 medication rooms, expired tube feeding for 1 of 3 medication rooms, expired insulin syringes for 1 of 3 medication rooms and expired IV solution bags for 1 of 3 medication rooms. During an interview with the Administrator on January 10, 2018 at 2:38pm stated, "It is my expectation that the facility fully utilizes the QA (Quality Assurance) process to ensure compliance with state and federal regulations.	F 867	Medication Management, Medication Storage, Disposition of Expired Medications and Medical Products, and Care Planning Process. The facility Administrator will provide re-education to the Quality Assessment and Performance Improvement Committee members related to the process, reporting, auditing, development of plan, and identification of issues. During this initial meeting the Quality Assessment Performance Improvement Plan devised related to repeat citations described above will be discussed, reviewed, and initiated. Education was completed February 1, 2019. The Quality Assessment and Performance Improvement Committee will meet weekly for three weeks, then monthly to ensure compliance with Quality Assessment and Performance Improvement guidelines, as well as corrective measures for repeat citations and active Performance Improvement Plans. The Regional Director of Clinical Service will review Quality Assessment and Performance Improvement Plans as well as attend meetings to ensure compliance with committee and meeting guidelines as well as review progress with Performance Improvement Plans in efforts to ensure sustained solutions are achieved.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		2/7/19

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F 880	Continued From page 10 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 11 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an infection control program that established a surveillance plan which identified, tracked and monitored infections. This was evident in 3 of 3 monthly surveillance data reviewed (November 2018 to January 2019). Findings included: A review of the facility's Infection Control Policies	F 880	The facility failed to establish and maintain an infection control program, including a surveillance plan which identified, tracked and monitored infections within the facility The Administrator and Director of Nursing, through Quality Assessment and Performance Improvement sub committee will develop and implement an infection control program within the facility, to9 include surveillance plan to identify, track	

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	345131	A. BUILDING _____ B. WING _____	C 01/10/2019

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F 880	Continued From page 12 and Practices dated 7/2014 revealed the facility did not have a surveillance policy or protocol in place to identify, track or monitor infections. During a review of the facility's records for infection control from November 2018 to January 2019, there was no documentation of the implementation for identifying, tracking and monitoring infections. An interview with the Director of Nursing occurred on 1-10-19 at 1:55pm. The Director of Nursing stated the facility did not have a surveillance protocol and that infections had not been tracked or monitored but had been discussed in the facility's morning meeting. She also stated the discussion included which residents had an infection and if an antibiotic was being utilized but the information was not being tracked or monitored. The Administrator was interviewed on 1-10-19 at 2:02pm. The Administrator stated he was aware the facility did not have a surveillance program for tracking, identifying and monitoring infections but that the question was asked in the facility's morning meeting if there were any residents with an infection. He also stated the facility did not have an employee that was "SPICE" trained (North Carolina's training requirement for Certification in Infection Control) but expected to have the Assistant Director of Nursing attend the program in March 2019. The Administrator stated he also expected to implement and follow an infection control program per regulatory guidelines.	F 880	and monitor infections. This process will include: Review and revision if needed of current infection control policy, Review and revision of appropriate surveillance, tracking, and monitoring tools, review of most recent antibiotic utilization report and subsequent labs, Re-development and monitoring of the facility Infection Control Manual, education plan for comprehensive staff education and training. Upon establishing program, residents reviews will be contacted for infections from 1/1/2019, to identify historic trends relevant to current practice, and need for intervention. Tracking will be part of the weekly clinical meetings held 5xweek as well as comprehensive review at the weekly risk meetings. Through review, the Director of Nursing will audit findings and accuracy and compliance with program policy and procedures and submit findings to the facility Quality Assessment and Performance Improvement Committee for further recommendation and intervention if necessary to ensure ongoing compliance with regulatory requirements. Establishment and implementation will be completed on or before February 7, 2019. The Administrator and Director of Nursing is will be responsible for implementing this acceptable Plan of Correction.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		2/7/19

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F 881	Continued From page 13 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an infection control program that established an antibiotic stewardship program with written protocols on antibiotic prescribing, documentation of the indication, dosage and duration of use of antibiotics. This was evident in 3 of 3 monthly surveillance data reviewed (November 2018 to January 2019). Findings included: A review of the antibiotic stewardship policy dated December 2016 revealed in part; antibiotics would be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of the antibiotic stewardship program was to monitor the use of antibiotics in the facility's residents. There would be orientation, training and education of the facility's staff. A nurse calling the physician to communicate a suspected infection would include the resident's signs and symptoms, when the signs and symptoms first occurred, the resident's hydration status, current medications, allergy information and type of infection. The physician prescribing an antibiotic over the phone	F 881	The facility failed to develop, implement and maintain an antibiotic stewardship program to include protocols for prescribing, documentation of the indication and dosage/duration of use of antibiotics. The facility also failed to have a SPICE certified nurse on staff. The Director of Nursing and Assistant Director of Nursing will implement the Antibiotic Stewardship program, with input and assistance by the Quality Assessment and Performance Improvement Sub Committee. This Assistant Director of Nursing is scheduled for the March 2019 SPICE Certification course, which is the earliest available course offered. The Process will include review and revision of the policy and procedure relative to deficient practice to include protocols on prescribing, documentation of indication, dosage and duration of antibiotics, as well as any verbal order obtained by a licensed nurse for antibiotic use would require a provider visit within 72 hours of initiation of treatment. Comprehensive staff education will be	

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F 881	Continued From page 14 would assess the resident within 72 hours. The policy for the antibiotic stewardship program did not include protocols on prescribing, documentation of the indication, dosage and duration of use of antibiotics. An interview with the Director of Nursing occurred on 1-10-19 at 1:55pm. The Director of Nursing stated the facility did not utilize the antibiotic stewardship program protocols. She also stated she was recently hired as the Director of Nurses 2 months ago but was aware that the facility needed an antibiotic stewardship program. The Administrator was interviewed on 1-10-19 at 2:02pm. The Administrator stated he was aware the facility did not have an antibiotic stewardship program in place. He also stated the facility did not have an employee that was "SPICE" trained (North Carolina's training requirement for Certification in Infection Control) but expected to have the Assistant Director of Nursing attend the program in March 2019. The Administrator stated he also expected to implement and follow an infection control program per regulatory guidelines.	F 881	completed related to the use of antibiotics as well as monitoring related to use, and guidelines for administration; documentation of symptoms, hydration status, current meds, allergy information and type of infection, and methods of identification of source of infection to ensure proper antibiotic usage by the Staff Development Coordinator, Director of Nursing, and Administrator, to be completed no later than February 2, 2019. Medical Director as well as other providers with prescriptive privileges will be notified and provided education on process for antibiotic use/stewardship. Education will be completed on or before February 7, 2019 by the Director of Nursing, Staff Development Coordinator and Administrator. As part of the weekly risk meeting and daily clinical review, the Director of Nursing and/or Assistant Director of Nursing will monitor the antibiotic stewardship program to ensure compliance, through logging antibiotic and ensuring elements of responsible usage is documented and followed. This audit will be documented and results will be present to the facility Quality Assessment and Performance Improvement Committee monthly for three months, for review, discussion, additional recommendation and determination of continued monthly monitoring. Establishment and implementation of program standards will be completed on or before February 7, 2019.	

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F 881	Continued From page 15	F 881	The Director of Nursing, Assistant Director of Nursing, and Administrator will be responsible for the compliance with this plan of correction.	