STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345445	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENAIRE	4000 GLENAIRE CIRCLE CARY, NC 27511

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E 000	Initial Comments An unannounced Recertification survey was conducted on 02/25/19 through 02/28/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #: LL4W11	E 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews, and record review, the facility neglected to provide complete information to the physician about a resident's complaints of pain of the left leg, causing a delay in getting an X-ray that indicated an acute femur fracture to Resident #46's left leg for 1 of 2 residents reviewed for accidents. Furthermore, the nurse delayed telling the physician the x-ray results. The findings included: Resident #46 was admitted on 2/4/16 with diagnoses of Coronary Artery Disease, Dementia,	F 600	This plan of correction represents Glenaires allegation of compliance. The submission of the following plan of correction does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by the survey consultants from NCDHSR relating to alleged deficient practice.	3/29/19

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

Electronically Signed | 03/22/2019

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F 600	Continued From page 1 Generalized Muscle Weakness and Dysphagia. Resident #46 also had a history of ORIF (Open Reduction and Internal Fixation) of the left hip done on 2014. The Minimum Data Set (MDS) Assessment dated 1/1/19 indicated that Resident #46 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3. Resident #46 was also coded as having no behaviors. The MDS further indicated that Resident #46 requires extensive assistance with two+ persons physical assist with both bed mobility and transfers. The MDS also indicated that Resident #46 has frequent urinary and bowel incontinence. Interview with NA (Nursing Assistant) #8 on 2/26/19 at 6:57 AM revealed Resident #46 complained of leg pain after she was put to bed on 1/27/19 at 7:00 PM. NA #5 assisted NA #8 in transferring Resident #46 using the sit to stand lift from wheelchair to bed. After Resident #46 was put to bed, NA #5 left the room. NA #8 said Resident #46 complained of pain when NA #8 turned Resident #46 to her side to provide incontinent care. Resident #46 pointed to the front of her left thigh and said, "it hurts." NA #8 touched it and felt a "bump," and notified Nurse #8. Interview with NA #5 on 2/26/19 at 3:16 PM verified that NA #5 assisted NA #8 with the transfer of Resident #46 on 1/27/19 at 7:00 PM from wheelchair to bed. While NA #5 and NA #8 were transferring Resident #46 using the sit to stand lift, Resident #46 started complaining of pain. Resident #46 stated, "my leg hurts," and continued to complain of pain when NA #5 and NA #8 repositioned Resident #46 in the bed.	F 600	It is the policy and practice of Glenaire to keep residents free from neglect. 1. What corrective action will be accomplished for residents affected? A. Resident #46 was discharged to the hospital on 1/28/2019. B. In-service initiated for licensed nurses on Reporting Injuries 1/28/2019. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? A. The daily 24 hour household report which includes all residents of the nursing home was reviewed by the Director of Nursing and Nurse mentors to determine if any changes in condition (s) had occurred that may warrant Physician notification had been completely conveyed to the Physician. 3. What measures will be put into place to ensure this practice does not recur? A. A triage Protocol was implemented to help guide the nursing staff on promptly/completely reporting resident conditions, acute changes, lab, diagnostic tests to the Physician. B. Licensed nursing staff will be in-serviced on the Triage Protocol by March 29th, 2019. C. Licensed nurses were in-serviced by the Director of Nursing and her designee(s) on reporting injuries/wounds. this was completed by 1/28/2019. D. Any nurse not able to attend the scheduled in-service training will be	

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F 600	Continued From page 2 Review of document entitled Clinical Note Entry dated 1/27/19 at 8:06 PM by Nurse #8 revealed Resident #46 was being assisted to bed when staff noted her complaining of left leg pain. The clinical note entry further revealed that staff noted a "lump/mass measuring approximately 10 cm (centimeter) x 11 cm on anterior left upper thigh." There were no signs of trauma, bruising, or warmth noted at that time. Resident #46 complained of pain when the area was touched and was given Tylenol 650 mg. An interview with Nurse #8 on 2/26/19 at 10:01 AM was conducted to verify Nurse #8's clinical note entry dated 1/27/19 at 8:06 PM. The interview revealed that Nurse #8 was called by NA #8 to look at Resident #46's thigh on 1/27/19 at 8:00 PM after Resident #46 was laid down in bed. Nurse #8 noted a "bump" which looked like a mass on Resident #46's left upper thigh. Nurse #8 did not perform a full head to toe assessment. Nurse #8 decided not to report it because Resident #46 was not complaining of pain at that time. Resident #46 only complained of pain when the area was touched. Further interview with NA #8 on 2/26/19 at 6:57 AM revealed when NA #8 provided incontinent care to Resident #46 on 1/27/19 at 10:00 PM, Resident #46 complained of pain again when NA #8 turned Resident #46. When NA #8 turned Resident #46 to her left side, NA #8 noticed that Resident #46's left leg was not aligned. Phone interview with NA #6 on 2/27/19 at 6:40 PM revealed NA #6 worked night shift on 1/27/19 with Resident #46. At shift change between evening and night shifts, Nurse #8 reported that	F 600	in-serviced prior to reporting to work. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A "notification log" was developed by the Director of Nursing for the licensed staff nurses to record reporting resident conditions, acute changes, lab, diagnostic tests to the physician. The logs were placed at the nurses station of reach household by the Director of Nursing and licensed nursing staff will be educated on how to complete the log by March 29th, 2019. The Director of Nursing and the Nurse Mentors will then review the log and compare that information to the 24 hour report, incident reports and nurses notes to assure proper reporting has occurred. this will be done daily for 2 weeks, then weekly for 2 months, then monthly for 2 months. The result of the reviewed will be recorded on a "Notification Audit Tool" and the Director of Nursing will report the results at the monthly Quality Assurance Performance Improvement Committee meetings where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 600	Continued From page 3	F 600		

Resident #46 had a knot on her left leg. When NA #6, Nurse #7 and Nurse #8 checked for the knot on 1/27/19 at 10:30 PM, it was already gone. At shift change, NA #6 heard Nurse #7 and Nurse #8 talking about Resident #46's left leg being shorter than the right leg.

Further interview with Nurse #8 on 2/26/19 at 10:01 AM revealed at shift change with Nurse #7, Nurse #8 went back to reassess Resident #46 and noted that the "lump" has disappeared. Both Nurse #7 and Nurse #8 also noted that Resident #46's left leg was shorter than the other leg. According to this interview, Nurse #8 notified the physician on 1/27/19 at 10:45 PM of Resident #46's left leg being shorter than the other leg.

Review of document entitled Clinical Note Entry dated 1/27/19 at 11:17 PM by Nurse #8 revealed that the left leg was reassessed and Resident #46 had no pain at rest but complained when left leg was touched. The clinical note entry also stated, "Left leg noted to be shorter than the right leg. The doctor was made aware. Order noted to do X-ray of left leg to rule out fracture. Order placed at this time."

Phone interview with the physician was conducted on 2/26/19 at 2:00 PM to verify the information provided by Nurse #8. The physician received a phone call before midnight on 1/27/19 notifying him of a bump that staff had noted on Resident #46's left leg. Nurse #8 told the physician that Resident #46 did not have any falls but with her history of a previous hip replacement, the physician determined that there was a need for an X-ray. The physician ordered a STAT X-ray of the left leg at 11:00 PM. The interview further revealed that Nurse #8 reported to the

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physician about the "bump" on Resident #46's left thigh. The physician stated that if he had known about the left leg being shorter than the right and that there was external rotation of the left leg at 11:00 PM, he would have given an order to send Resident #46 out to the hospital instead of just giving an order for X-ray of the left leg.

Interview with Nurse #7 on 2/26/19 at 9:47 AM indicated that Nurse #7 placed the order for X-ray of the left leg around midnight. This was confirmed with a phone interview with the Imaging Supervisor on 2/28/19 at 8:11 AM. The technician received the request for an X-ray of the left leg on Resident #46 on 1/28/19 at 12:21 AM. The Imaging Supervisor said the technician arrived at the facility to perform the X-ray at 1:24 AM.

Review of document entitled Clinical Note Entry dated 1/28/19 at 3:29 AM by Nurse #7 indicated Resident #46's left leg was shorter than the right leg. The left leg was also rotated to the left side. Resident #46 complained of pain when the left leg was touched. Resident #46 was medicated with Tylenol, and the X-ray was done around 1:45 AM.

The interview with Nurse #7 conducted on 2/26/19 at 9:47 AM further revealed Nurse #7 assessed Resident #46 at shift change with Nurse #8 on 1/27/19. Nurse #7 noted that Resident #46's left leg was shorter than the right leg. Nurse #7 further noted that Resident #46's left leg was rotated outwards and was not aligned with the knee. Resident #46 did not complain of pain unless she was touched. The X-ray was done on 1/28/19 at 1:45 AM, and Nurse #7 received the result around 4:00 AM. Nurse #7

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confirmed that the result indicated a fracture, but Nurse #7 decided not to call the physician at 4:00 AM because Resident #46 was sleeping. Nurse #7 gave Tylenol to Resident #46 prior to the X-ray, and Resident #46 did not complain of continuous pain.

The phone interview with the Imaging Supervisor on 2/28/19 at 8:11 AM further revealed the technician called the result of Resident #46's X-ray of the left leg to Nurse #7 on 1/28/19 at 4:10 AM. The technician also faxed the result to the facility at 4:10 AM.

Review of document entitled Left Femur X-ray report for Resident #46 dated 1/28/19 revealed the following result: Acute oblique displaced fracture of the tip of the distal aspect of the intramedullary femoral metallic prothesis. The report was faxed to the facility on 1/28/19 at 4:01 AM.

Review of document entitled Clinical Note Entry dated 1/28/19 at 7:24 AM by Nurse #7 indicated that the X-ray result was received, and the physician was notified of the result.

Continuation of the phone interview with the physician on 2/26/19 at 2:00 PM revealed the physician received a phone call from Nurse #7 on 1/28/19 at 7:00 AM notifying him of the result of the X-ray. The physician was notified at this time of the left leg being noted as externally rotated. This prompted the physician to send Resident #46 to the hospital for further treatment. The physician stated he expected to have been called at 4:00 AM when the result came in and indicated that Resident #46 had a fracture.

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F 600	Continued From page 6 The discharge summary indicated that Resident #46 had Left Femur ORIF (Open Reduction & Internal Fixation) done in the hospital on 1/29/19. Review of document entitled Left Femur X-ray report dated 1/29/19 indicated internal surgical fixation of femoral fracture by means of side plate and screws without complications. Interview with the Director of Nursing (DON) and the Administrator on 2/26/19 at 11:03 AM revealed DON and Administrator became aware of Resident #46 having a fracture on 1/28/19 at 7:30 AM. The DON stated that on 1/27/19 at 10 PM, when staff noted Resident #46's left leg being shorter than the right leg, DON expected the staff to notify the physician and DON at that time. It was the DON's expectation that the physician be notified of any abnormal X-ray result right away. A follow-up interview with the Administrator, Administrator-In-Training (AIT), DON and Corporate representative was done on 2/28/19 at 11:46 AM. The interview revealed that they were all in agreement that the physician should have been notified sooner than when he was of the acute femur fracture result on Resident #46. They all agreed that there was a delay in the treatment of Resident #46.	F 600		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course	F 661		3/29/19

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F 661	Continued From page 7 of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge summary for 1 of 1 residents (Resident #68) reviewed for a planned discharge. Findings included: Resident #68 was admitted to the facility on 11/30/2018 with diagnoses that included Bacteremia, muscle weakness, hypertension, and low back pain. Review of the Discharge Tracking MDS (Minimum Data Set) dated 1/31/2019 revealed the resident had been assessed as being	F 661	It is the policy and practice of Glenaire when a discharge is anticipated to complete a discharge summary that includes the requirements found at 483.21(c)(2). 1. What corrective action will be accomplished for residents affected? A. Resident #68 no longer resides at the Assisted Living community that she was discharged to from Glenaire, therefore, no action taken. B. But the following information was sent upon discharge: FL2, Medication List, Information for Electric Bed order,	

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F 661	Continued From page 8 cognitively impaired. The documentation on the MDS also indicated the resident required extensive assistance with her activities of daily living. The MDS was coded as resident being discharged to the community and the discharge was a planned discharge. A review of resident's active care plan dated 11/30/2018 revealed an active care plan was in place for the resident to be discharged to the community. Review of a physician order dated 1/31/2019 revealed the order was for the resident to be discharged to an assisted living facility. During a review of the medical record, there was no documentation to indicate a discharge summary had been completed prior to the discharge on 1/31/19. During an interview with the Administrator and Director of Nursing on 2/27/2019 at 4:00 pm, they both indicated a discharge summary should have been completed on the day of discharge. .	F 661	and physician progress notes. 2. How will the facility identify other residents having the potential to be affected by they same practice and what corrective action will be taken? A. Medical records for all Discharges from February 28th through March 29th, 2019 were reviewed by the Director of Nursing, Nurse Mentors, or their designee(s) by March 29th, 2019 to determine if discharge summaries were completed. Discharge summaries were completed with instructions to the receiving entity/resident/resident representative for all. recapitulations were completed by March 29th and placed in the medical record. 3. What measures will be put into place to ensure this practice does not recur? A. The discharge summary was revised along with the related policies and procedures by March 29th 2019 to include a recapitulation of the residents stay, a final summary, a medication reconciliation including both pre and post discharge medications and a post discharge plan of care. B. The staff will be in-serviced on the new discharge forms and policies and procedures by the Director of Nursing or her designee by March 29th, 2019. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The social worker will ensure that all	

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F 661	Continued From page 9	F 661	discharges have appropriate forms completed prior to discharge. The Nursing Home Administrator or their designee will review all discharges for completeness. This will be done every week for 3 weeks, then monthly for 3 months. Results will be recorded on an audit tool "discharge Summary Audit." The results from the audit will be reported by the Administrator at the monthly API meetings where they will be reviewed and discussed. The QAPI team will assess and modify the action plan as needed to ensure continued compliance.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide a safe environment for 2 of 2 resident rooms with space heaters on the North House unit (Resident #10 and Resident #31). Findings included: 1a. Resident #10 was admitted to the facility on 5/30/14 with diagnosis of Alzheimer's Disease. The most recent quarterly Minimum Data Set	F 689	1. What corrective action will be accomplished for residents affected? The Facility Service Director and the maintenance technician removed the space heaters in rooms 5402 and 5430 immediately on 2/28/2019. The heating unit that serves room 5430 cannot be replaced until April. So the facility offered the resident representative a temporary room change until the unit could be replaced to assure the residents	3/29/19

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F 689	Continued From page 10 (MDS) dated 12/10/18 indicated Resident #10 was totally dependent on staff for bed mobility and transfers. On 2/25/19 at 10:48 am an observation of Room 5430, where Resident #10 resided, revealed a white space heater positioned on the floor, across the room from the bed, plugged into the wall but not operating. On 2/28/19 at 8:12am, an observation of Room 5430 was made with the Maintenance Director. The space heater was positioned on the floor across from the bed, unplugged and not operating. b. Resident #31 was originally admitted to the facility on 11/25/13 and readmitted on 1/12/19 with diagnoses including Coronary Artery Disease, Depression and Non-Alzheimer's Dementia. The most recent admission Minimum Data Set (MDS) dated 2/8/19 indicated Resident #31 was totally dependent on staff for bed mobility and transfers. On 02/26/19 at 8:30am an observation of Room 5402, where Resident #31 resided, revealed a gray space heater, positioned on top of a dresser, blowing warm air. At 9:00am, an observation of Room 5430 revealed a space heater positioned on the floor, across from the bed, plugged into the wall but not operating. On 02/27/19 at 8:17am, an observation of Room 5402 revealed a gray space heater positioned on the dresser but not operating. At 9:00am, an observation of Room 5430 revealed a space heater positioned on the floor across from the bed, unplugged. On 2/28/19 at 8:30am, an observation of Room 5402, made with the Maintenance Director, revealed a gray space heater positioned on top of the dresser, blowing out warm air.	F 689	desired room temperature could be met. This was done by the Administrator on 3/21/2019. The residents representative did not wish to move the resident and voiced no further concerns about the temperature in room 5430. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? The Facility Service Director and the maintenance technician inspected all 71 licensed resident rooms, staff offices, and public spaces to ensure space heaters were not in use within the facility on 2/28/2019, no other space heaters were found. 3. What measures will be put into place to ensure this practice does not occur? A. All staff of North House and all the maintenance staff will be in-serviced on the use of space heaters in a nursing facility by the Facility Service Director, the Director of Nursing, or their designee. This will be completed by March 29th, 2019. Staff will be instructed to report to the Administrator of the Facility Service Director immediately if space heaters were found in any rooms. B. The admission packet was reviewed to assure the prohibition of using personal heating devices in the rooms was included in the admission information on March 21st, 2019. Residents and families on North House will be remined of the prohibition of personal heating devices by email by March 29th, 2019.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENAIRE	4000 GLENAIRE CIRCLE CARY, NC 27511

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F 689	Continued From page 11 An interview with the Maintenance Director on 2/28/19 at 8:35am revealed the heating unit that served Room 5430 (North House) was functioning poorly and there was only one heating unit for 3 resident rooms. When the facility had problems with a heating unit, the facility provided a space heater until the unit was fixed. The facility tried to keep space heaters in resident rooms no more than 2 days. The resident may have a space heater in their room more than 2 days if the facility had problems getting the parts in to repair a heating unit. A resident should not have a space heater more than 10-14 days. He stated it has been difficult keeping Room 5430 warm therefore the space heater has been used in this room for several months. The heating unit that serves Room 5430 will be replaced in April. The interview further revealed the space heater in room 5402 did not belong to the facility. The Maintenance Director stated he was not aware there was a space heater in Room 5402. The Maintenance Director stated he was not aware space heaters should not be used in resident rooms. An interview, conducted with NA #13 on 2/28/19 at 8:51am, revealed the space heater in Room 5402 has been there for approximately 2 months. On 2/28/19 at 8:58am an interview was conducted with the Director of Nursing and the Administrator, both of whom stated there should not be space heaters in resident rooms. resident rooms. When the facility had problems with a heating unit, the facility provided a space heater until the unit was fixed. The facility tried to keep space heaters in resident rooms no more than 2 days. The resident may have a space heater in their room more than 2 days if the facility had problems getting the parts in to repair a heating	F 689	4. How will corrective actions be monitored to ensure the deficient practice will not re-occur (i.e. what quality assurance program will be put into place?)? The Maintenance Department staff will inspect all resident rooms once a day for one week, then once a month thereafter for three months to ensure no space heaters are being used. The Facility Services Director will keep a log of these inspections and report the results at the monthly Quality Assurance Performance Improvement Committee meetings where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 689	Continued From page 12 unit. A resident should not have a space heater more than 10-14 days. He stated it has been difficult keeping Room 5430 warm therefore the space heater has been used in this room for several months. The heating unit that serves Room 5430 will be replaced in April. The interview further revealed the space heater in room 5402 did not belong to the facility. The Maintenance Director stated he was not aware there was a space heater in Room 5402. The Maintenance Director stated he was not aware space heaters should not be used in resident rooms. An interview, conducted with NA #13 on 2/28/19 at 8:51am, revealed the space heater in Room 5402 has been there for approximately 2 months. On 2/28/19 at 8:58am an interview was conducted with the Director of Nursing and the Administrator, both of whom stated there should not be space heaters in resident rooms.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		3/29/19

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F 761	Continued From page 13 §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 discard expired medications in 2 of 2 medication rooms. The findings included: Review of the facility's policy, "Storage of Medications" revised April 2007, stated the nursing staff shall be responsible for maintaining medication storage and the facility shall not use discontinued, outdated, or deteriorated drugs. On 2/27/2019 at 2:15pm, medications in the Central House medication room were reviewed with Nurse #11 present. Two expired medications were found in the stock storage bin. Zyrtec 10 mg (for allergies), in a blister pack, expired on 1/9/2019. Fioricet 50/3 (for pain), in a blister pack, expired 1/11/19. Medications stored in the North House medication room were reviewed with Nurse #12 present. A 12 ounce bottle of Mintox antacid, unopened, was observed with expiration date of 01/2019. An interview, conducted with Nurse #11 on 2/27/19 at 2:20pm, revealed the third shift nurses and the pharmacist checked the medication rooms at least weekly for expired medications. An interview, conducted with Nurse #12 on 2/27/19 at 2:30pm, revealed the third shift nurses checked the medication rooms for expired	F 761	It is the policy and practice of Glenaire to safely store Drugs and Biologicals according to State and Federal Law. 1. What corrective action will be accomplished for residents affected? The expired medications (Zyrtec and Fioricet) on Central House and (Mintox) on North House were discarded immediately on 2/27/2019 by the Nurse Mentors of North House and Central House. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be take? All facility medication rooms were inspected by the nurse Mentors on 2/27/2019 to ensure there were no expired medications. No other expired medications were found. 3. What measures will be put into place to ensure this practice does not recur? A process to monitor the medication rooms was implemented as follows:	

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F 761	Continued From page 14 medications at least weekly. On 2/27/19 at 3:19pm an interview was conducted with the Director of Nursing (DON) who stated that the third shift nurses are responsible for auditing the medication rooms for expired medications at least weekly. The Nursing Mentors should have checked and confirmed the audits were done at least weekly. The DON further stated that her expectation is that there are no expired medications in the medication rooms.	F 761	A. The charge nurses on the night shift will inspect the medication room on their household for expired medications each night. Any expired medications found will be discarded according to facility policy. A medication log was developed to record medications room inspections. B. The medication logs will be reviewed by the nurse mentors the next working day C. The charge nurses were in-serviced on the new process by the Director of Nursing and the Nurse Mentors on 2/27/2019. The Director of Nursing, Nurse Mentors, and Staff Development Coordinator will do a follow up in-service with licensed nurses by 3/29/2019. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A. The nurse Mentors will review the medication logs each day to assure the nigh charge nurse has inspected the medication room according to the new process. B. Medication rooms will be inspected by the Nurse Mentors to ensure all expired medications are discarded prior to expiration date. These inspections will be conducted weekly for 4 weeks, then monthly for 4 months. The results will be recorded on an audit tool "Medication Room Inspections." C. The results from the audit will be reported by the Director of Nursing at the monthly Quality Assurance Performance Improvement Committee meetings where	

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F 761	Continued From page 15	F 761	they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired food items, failed to label and date opened food items stored in 1 of 2 walk in coolers, and a facility staff member failed to cover her hair while in a food preparation area. The findings included: On 2/27/19 at 4:30 PM an observation of the	F 812	It is the policy and practice of Glenaire to store, prepare, distribute and serve food in accordance with professional standards for food service safety. 1. What corrective action will be accomplished for residents affected? A. The cauliflower florets, whipped cream spread and clock of queso cheese was thrown out immediately on 2/27/2019	3/29/19

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F 812	Continued From page 16 facility kitchen with the Dietary Manager revealed a staff member in the food preparation area with her hair unsecured and uncovered. On 2/27/19 at 4:33 PM an observation of the first walk-in cooler revealed a bag of fresh cauliflower florets wrapped in plastic with gray discoloration visible on the surface of the florets. The bag was labeled 2/19/19. On 2/27/19 at 4:35 PM an observation of the first walk- in cooler revealed an opened partially used container of whipped cream spread and an opened partially used block of queso cheese. No date opened was visible on either item. On 2/27/19 at 5:14 PM an interview with the dietary manager revealed that it was her expectation that staff present in food preparation areas would have their hair covered. She further indicated that it was her expectation that leftover food would be clearly labeled and dated before being refrigerated and that leftover food would be used within three days or discarded.	F 812	by the Nutrition Mentor. B. The staff member with unsecured and uncovered hair put on a hair net was in-serviced on 3/22/2019 and counseled about the policy for wearing protective hair covering when inn the food preparation areas by the Dining Services Coordinator. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? A. The Dining Director inspected all other coolers and refrigerators for outdated food items and properly labeled food items on 2/28/2019. B. The Dining Director observed each dining facility staff member to assure all others were wearing appropriate hair coverings on 2/28/2019. 3. What measures will be put into place to ensure this practice does not recur? A. All dining staff will be in-serviced by the Dining Services Coordinator regarding discarding expired food items, proper labeling of food items and the need tow ear protective hair covering when in the kitchen/food serving areas by March 29th, 2019. B. At the start of each shift the Production Manager, Director of Dining, Dining Services Coordinator, or their designee will inspect the coolers to ensure no outdated product is in the coolers. If outdated items are found, they will be discarded immediately. C. At the start of each shift the	

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F 812	Continued From page 17	F 812	Production Manager, Director of Dining, Dining Services Coordinator, or their designee will visually observe all kitchen staff to ensure they have protective hair coverings. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Production Manager, Director of Dining, Dining Services Coordinator, or their designee will inspect the coolers and refrigerators to determine if food has been labeled with an "opened date" and the date is not expired (need discarding) and will inspect kitchen staff to assure appropriate hair coverings are worn. These audits will be done daily for one month, then twice a week on food truck delivery days for one month, then once a week for one month. An audit tool was developed to record these results. The Dining Director will report the results at the monthly Quality Assurance Performance Improvement Committee meetings where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. The Dining Management Team will also discuss comments or concerns related to the monitoring of the outdated food product weekly at the Dining Managers meeting.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)	F 865		3/29/19

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F 865	Continued From page 18 §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the recertification survey of 04/05/18. This was for the deficiency originally cited in April 2018 and subsequently recited on the current recertification survey of 02/25/19 in the area of F812 Food Procurement Prepare/store/serve. The continued failure of the facility during two federal surveys of records show a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. The findings included: This tag is cross-referenced to: F812 Food	F 865	?nF865-It is the policy and practice of Glenaire to maintain a quality assessment and assurance committee consisting of the outlined members that meeting monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action designed to correct identified quality deficiencies. The facility has policies and procedures designed to maintain these goals. Quality Assurance monitoring, physician reviews, consultant reviews, and staff training are examples of the many components utilized. F812 Food Procurement: The following monitoring was implemented. The	

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F 865	Continued From page 19 Procurement- Prepare/store/serve - Based on observations and staff interviews the facility failed to discard expired food items, failed to label and date open food items stored in 1 of 2 walk in coolers, and a facility staff member failed to cover their hair while in food preparation areas. During the previous recertification survey of 04/05/18, the facility failed to discard outdated milk from 1 of 2 walk in corridors. On 2/28/19, during an interview with the Administrator and DON was conducted. The administrator stated that the facility's QA Program met quarterly and consisted of the Administrator, Director of Nursing, Medical Director and all facility department heads. The administrator reviewed the previous plan of correction and stated that checking for outdated milk was to be done daily for 1 month, then upon each food truck delivery, (no less than 2 times a week) for 1 month, then 1 x week for 1 month for a period of 3 months. If outdated milk was found, it was discarded. The Administrator stated that his expectation is that there will be no expired food products.	F 865	production manager, Director of Dining, Dining Services Coordinator, or their designee will inspect the coolers and refrigerators to determine if food has been labeled with an "opened date" and the date is not expired (need discarding) and will inspect kitchen staff to assure appropriate hair coverings are worn. These audits will be done daily for one month, then twice a week on food truck delivery days for one month, then once a week for one month. An audit tool was developed to record these results and will be reported to the QAPI team monthly for one year. The Dining Management Team will also discuss comments or concerns related to the monitoring of the outdated food product weekly at the Dining Managers meeting. The Facility Quality Assessment and Assurance Program was re-assessed by the Administrator and Executive Director on March 27th, 2019. The following revisions will be made and approved by the Medical Director and the QAPI committee members: A. The agenda was revised to include the reporting of audit results as stated above for F812 B. The QAPI review process for tag F812 has been extended to one year review by the QAPI team. Results from the audits for F812 will be reported by the Dining Director at the monthly quality assurance performance improvement committee meetings where they will be reviewed and discussed. The	

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F 865	Continued From page 20	F 865	quality assurance committee will assess and modify the action plan as needed ot ensure continued compliance.	