STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(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 A complaint investigation survey and on-site revisit was conducted on July 9, 2019. Two of the three allegations were substantiated.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		8/2/19

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

Electronically Signed | 08/02/2019

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F 636	Continued From page 1 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive assessment every 12 months using the Resident Assessment Instrument (RAI) for 1 of 12 sampled residents reviewed (Resident #2). Findings included: Resident #2 was admitted to the facility on 01/15/15 with diagnoses that included Parkinson's disease, chronic kidney disease,	F 636	The facility failed to complete an annual Comprehensive Minimum Data Set(MDS)On Resident #2. The annual Comprehensive assessment for resident #2 was completed on 6/25/19 and transmitted on 7/11/2019 by the Corporate MDS Nurse. 2. Residents in the facility have the potential to be affected by the deficient practice. An audit was completed on	

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F 636	Continued From page 2 diabetes, anxiety, and depression. Review of Resident #2's electronic medical record revealed the most recently completed annual comprehensive assessment had an ARD (Assessment Reference Date) of 06/04/18. Further review of Resident #2's electronic medical record revealed an incomplete annual comprehensive Minimum Data Set (MDS) assessment with an ARD of 06/05/19. The status of this assessment was "in progress" which indicated it was not completed. An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the facility currently did not have a MDS Coordinator. The Administrator explained when the MDS Coordinator's position became vacant the job duties were reassigned to the Director of Nursing (DON), but the DON resigned on 06/27/19. The Administrator stated she was aware there was an issue with MDS assessments not being completed or transmitted within the regulatory timeframe and had requested assistance from the corporate office with completing MDS assessments. She added the facility had not received the requested assistance and acknowledged resident MDS assessments were late.	F 636	annual assessments by the Administrator on 7/11/2019 any concerns identified were addressed. 3. A experienced RN MDS coordinator was hired on 7/22/2019. The MDS coordinator was educated by the Administrator on 7/24/2019 regarding the survey results that the facility failed to complete an annual Comprehensive MDS and that the facility must conduct a comprehensive assessment on residents in accordance with specific time frames. 4.Monitoring: The Director of Nursing (DON) and or Administrator will audit the completion status up to five (5) MDS per week x's 4 weeks then three (3) per week x's 4 weeks starting 8/2/2019. 5. Data will be summarized and presented to the facility Quality Assurance Committee one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and or Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	

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F 638	Continued From page 3	F 638		
F 638 SS=E	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 record review and staff interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments every three months using the Resident Assessment Instrument (RAI) for 4 of 12 sampled residents reviewed (Residents #3, #6, #10, and #12). Findings included: 1. Resident #3 was admitted to the facility on 08/26/17 and had multiple diagnoses that included congestive heart failure, chronic knee pain, diabetes, and chronic renal failure. Review of Resident #3's electronic medical record revealed the most recently completed quarterly MDS assessment had an ARD (Assessment Reference Date) of 03/14/19. Further review of Resident #3's electronic medical record revealed an incomplete quarterly MDS assessment with an ARD of 06/14/19. The status of this assessment was "in progress" which indicated it was not completed. An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the facility currently did not have a MDS Coordinator. The Administrator	F 638	The facility completed the quarterly assessments for resident #3 on 7/26/19 and accepted on 7/30/19, resident #6 on 7/29/2019 and accepted on 7/30/2019, resident #12 on 7/25/19 accepted on 7/26/19 and resident #10 completed on 8/2/19, by the Facility MDS nurse. 2. Residents in the facility have the potential to be affected by the alleged deficient practice. An audit was completed by the Administrator on 8/2/19 on quarterly assessments any concerns identified were addressed. 3. Education: The RN MDS coordinator started employment on 7/22/19. The MDS coordinator was educated on 7/24/19 regarding the survey results that the facility failed to complete quarterly assessments. In addition, the facility must complete timely quarterly assessments and make necessary revisions to ensure accuracy and once completed transmit to CMS. 4. The Director of nursing (DON) and or Administrator will audit the completion of quarterly assessments status up to five	8/2/19

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F 638	Continued From page 4 explained when the MDS Coordinator's position became vacant the job duties were reassigned to the Director of Nursing (DON), but the DON resigned on 06/27/19. The Administrator stated she was aware there was an issue with MDS assessments not being completed or transmitted within the regulatory timeframe and had requested assistance from the corporate office with completing MDS assessments. She added the facility had not received the requested assistance and acknowledged resident MDS assessments were late. 2. Resident #6 was admitted to the facility on 09/26/16 and had multiple diagnoses that included congestive heart failure, dysphagia (difficulty swallowing), chronic kidney disease and diabetes. Review of Resident #6's electronic medical record revealed the most recently completed quarterly MDS assessment had an ARD (Assessment Reference Date) of 03/09/19. Further review of Resident #6's electronic medical record revealed an incomplete quarterly MDS assessment with an ARD of 06/09/19. The status of this assessment was "in progress" which indicated it was not completed. An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the facility currently did not have a MDS Coordinator. The Administrator explained when the MDS Coordinator's position became vacant the job duties were reassigned to the Director of Nursing (DON), but the DON resigned on 06/27/19. The Administrator stated she was aware there was an issue with MDS	F 638	(5) quarterly MDS per week x's four (4) weeks then three (3) per week X's 4 weeks starting 8/2/19. Data will be summarized and presented to the facility Quality Assurance Committee one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and or Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	

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F 638	Continued From page 5	F 638		

assessments not being completed or transmitted within the regulatory timeframe and had requested assistance from the corporate office with completing MDS assessments. She added the facility had not received the requested assistance and acknowledged resident MDS assessments were late.

3. Resident #10 was admitted to the facility on 08/05/15 and had multiple diagnoses that included anemia, seizure disorder, anxiety, and depression.

Review of Resident #10's electronic medical record revealed the most recently completed quarterly MDS assessment had an ARD (Assessment Reference Date) of 02/20/19. Further review revealed an incomplete significant change MDS assessment with an ARD of 04/28/19 was started and "in progress" but no other MDS assessments were completed or submitted after 02/20/19.

An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the facility currently did not have a MDS Coordinator. The Administrator explained when the MDS Coordinator's position became vacant the job duties were reassigned to the Director of Nursing (DON), but the DON resigned on 06/27/19. The Administrator stated she was aware there was an issue with MDS assessments not being completed or transmitted within the regulatory timeframe and had requested assistance from the corporate office with completing MDS assessments. She added the facility had not received the requested assistance and acknowledged resident MDS assessments were late.

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F 638	Continued From page 6 4. Resident #12 was admitted to the facility on 09/23/16 and had multiple diagnoses that included anemia, heart failure, hypertension, and neurogenic bladder (lack of bladder control). Review of Resident #12's electronic medical record revealed the most recently completed quarterly MDS assessment had an ARD (Assessment Reference Date) of 03/09/19. Further review of Resident #12's electronic medical record revealed an incomplete quarterly MDS assessment with an ARD of 06/09/19. The status of this assessment was "in progress" which indicated it was not completed. An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the facility currently did not have a MDS Coordinator. The Administrator explained when the MDS Coordinator's position became vacant the job duties were reassigned to the Director of Nursing (DON), but the DON resigned on 06/27/19. The Administrator stated she was aware there was an issue with MDS assessments not being completed or transmitted within the regulatory timeframe and had requested assistance from the corporate office with completing MDS assessments. She added the facility had not received the requested assistance and acknowledged resident MDS assessments were late.	F 638		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement-	F 640		8/2/19

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F 640	Continued From page 7	F 640		

§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that

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F 640	Continued From page 8 does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to transmit a comprehensive MDS (Minimum Data Set) within 14 days of the completion date for 1 of 12 sampled residents reviewed (Resident #5). Findings included: Resident #5 was admitted to the facility on 05/14/15. Review of Resident #5's electronic medical record revealed the last transmitted MDS was coded as a quarterly assessment with an ARD (Assessment Reference Date) of 04/02/19. Further review of Resident #5's electronic medical record revealed an annual MDS assessment with an ARD of 04/10/19 was signed as completed on 06/05/19. The status of this assessment was "export ready" which indicated it was not transmitted. An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the facility currently did not have a MDS Coordinator. The Administrator explained when the MDS Coordinator's position became vacant the job duties were reassigned to the Director of Nursing (DON), but the DON	F 640	The Comprehensive MDS was completed on resident #5 on 6/5/19 and transmitted on 7/11/19 by the Corporate MDS Nurse. 2. Residents have the potential to be affected by the deficient practice. An audit was completed by the Administrator any concerns or issues were addressed. 3. Education: The MDS coordinator was educated by the Administrator on 7/24/19 regarding the survey results that the facility failed to transmit the signed and completed assessment and assessments must be transmitted within 7 days after completion. 4. Monitoring: The Director of Nursing and or Administrator will audit the transmission of completed assessments up five (5) MDS per week x's 4 weeks then three (3) x's per week x's 4 weeks starting 8/2/19. Data will be summarized and presented to the facility Quality Assurance Committee one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends	

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F 640	Continued From page 9 resigned on 06/27/19. The Administrator stated she was aware there was an issue with MDS assessments not being completed or transmitted within the regulatory timeframe and had requested assistance from the corporate office with completing MDS assessments. She added the facility had not received the requested assistance and acknowledged resident MDS assessments were late.	F 640	identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and or Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide incontinence care for 1 of 3 residents reviewed for assistance with activities of daily living (Resident #3). Findings included: Resident #3 was admitted to the facility on 2/27/19 with diagnoses which included anxiety, chronic renal failure and congestive heart failure (CHF). Resident #3 was coded on the quarterly Minimum Data Set (MDS) dated 3/14/19 as being cognitively intact, required total assistance with all	F 677	Resident #3 was provided incontinence care immediately by C.N.A #1 on 7/9/19 once informed by the Administrator regarding the resident need. 2. Residents have the potential to be affected by the deficient practice; however, in order to ensure the facility is able to identify other residents the Administrator had conducted an audit on 7/10/19 on five (5)alert and oriented residents on each hall in order to ensure ADL compliance any issues or concerns identified were addressed. 3.In order to ensure the deficient practice	8/2/19

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F 677	Continued From page 10 activities of daily living (ADL) except eating, was incontinent of bowel and bladder. Review of Resident #3's care plan with a review dated 3/14/19 revealed she was care planned for ADL/self-care performance deficit related to CHF and gout. The goal was for the resident to have care needs with as much assistance from her as possible through the review date. The care plan indicated resident required extensive physical assistance by staff for incontinence care and wore briefs. An observation on 7/09/19 at 10:55 AM of Nurse Aide (NA) #1 who provided incontinence care revealed Resident #3's brief was saturated from front to back with urine and had a medium amount of soft formed brown substance and the bed pad was wet. Resident #3's skin was intact with no redness, but resident did complain of burning and itching. An interview was conducted on 7/09/19 at 4:59 PM with Resident #3 who stated she had rung her call bell multiple times during the afternoon and told a housekeeper, the Business Officer Manager, Nurse #1, and the Administrator that she needed to be changed. Resident #3 indicated she had not been changed since the morning when this surveyor had observed her being changed. She also stated she wanted to be changed more frequently and felt bad when left to lay in a wet brief. Resident #3 reported she had severe itching under her brief which made her physically uncomfortable. The interview further revealed when the Administrator answered Resident #3's call bell the resident had informed the Administrator she had already asked three other staff members to notify NA #1 she needed	F 677	does not recur as of 7/10/19 the C.N.A's have been informed by the Administrator to ask cognitive residents if they need to go to the restroom or be changed if wearing a brief. In additions, incontinence rounds will be performed by the C.N.A's during morning ADL care, before breakfast, after breakfast, before and or after lunch, before and or after dinner and as needed. In addition, the Environmental Service Director and Business office manager were in-serviced by the Administrator on 7/30/19 regarding answering residents call-lights and addressing their concerns immediately to a C.N.A or License Nurse. All Nursing Staff were provided in-service on 7/26/19 and 7/29/19 by the Director of Nursing regarding providing incontinence care in a timely manner, the instructions to provide incontinent care before and or after every meal and the license Nurses were informed to provide assistance if the C.N.A's are behind. 4.Monitoring to ensure that solutions are sustained the Director of Nursing and or designee will randomly audit five (5) alert and oriented residents and resident's that are not cognitive intact on each hall 5 x's per week x's 4 weeks then 3x's per week x's 4 weeks starting 7/29/2019. In addition, above in-services will be included in the new hires orientation package starting 8/02/19. Data will be summarized and presented to the facility Quality Assurance Committee	

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F 677	Continued From page 11 to be changed. An observation on 7/09/19 at 5:00 PM of NA #1 and NA #5 who provided incontinence care revealed Resident #3's brief was saturated from front to back with urine and had a smear of dried brown substance on it. Her skin was intact with no redness, but she did complain of itching and burning. An interview on 7/09/19 at 5:53 PM with Housekeeper #1 revealed he had answered Resident #3's call light and she requested to be changed. He further revealed he was unsure what time he had answered her call light, but he had forgotten to tell the NA #1 that Resident #3 had requested to be changed. An interview on 7/09/19 at 5:56 PM with the Business Office Manager revealed he had answered Resident #3's call light and she requested to be changed and he told NA #1. He was unsure what time he had answered her call light but stated it was after lunch. He did not know if NA #1 had changed Resident #3. An interview on 7/09/19 at 5:54 PM with Nurse #1 revealed she had answered Resident #3's call light twice since lunch but did not remember the times. She stated the first time the resident requested ice water which she provided and the second time she answered the call light the resident requested to be changed and she told NA #1. Nurse #1 did not know if NA #1 had changed Resident #3 and she did not indicate why she had not changed her. An interview on 7/09/19 at 5:00 PM with NA #1 revealed she had not changed Resident #3 since	F 677	one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	

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F 677	Continued From page 12 10:55 AM and no one told her the resident needed to be changed. NA #1 stated she was responsible for residents on the hall which included Resident #3 but that she had been too busy to change residents every 2 hours as she was supposed to. NA #1 explained she was supposed to work from 7:00 AM to 3:00 PM but worked late. She stated she did not recall anyone telling her Resident #3 needed to be changed. An interview on 7/09/19 at 6:00 PM with the Administrator revealed she was aware Resident #3 had requested to be changed four times after lunch and had not been changed until 5:00 PM. The Administrator confirmed she had talked with Resident #3 when she answered her call light and notified NA #1 that the resident had requested to be changed. An interview on 7/09/19 at 7:01 PM with the Administrator revealed she expected the staff to check and/or change incontinent residents every 2 hours. She did not know why Resident #3 had not been changed from 10:55 AM until 5:00 PM.	F 677		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		8/2/19

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F 727	Continued From page 13 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to designate a Registered Nurse (RN) to serve as the Director of Nursing (DON) when the previous DON resigned her position on 06/27/19. The facility also failed to schedule a RN for at least 8 consecutive hours a day for 5 of 12 days reviewed (07/03/19, 07/04/19, 07/05/19, 07/06/19, and 07/07/19). Findings included: Review of the facility's nursing department staff roster revealed they currently employed 3 part-time RNs. Other than the DON, there were no full-time RNs noted on the roster. Review of the facility's timecard detail report for the period 06/27/19 to 07/09/19 revealed a RN did not work 8 consecutive hours on the following days: 07/03/19, 07/04/19, 07/05/19, 07/06/19, and 07/07/19. A telephone interview was conducted with the facility's former DON on 07/09/19 at 1:52 PM. The DON stated she turned in her resignation on 06/27/19 and was prepared to work a 30-day notice but was told by the Administrator it would not be necessary. She confirmed the last day she worked at the facility was on 06/27/19. An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the DON resigned her position on 06/27/19 but stated the last day she	F 727	The facility hired a new DON on 7/17/19 No resident was affected by the deficient practice. No resident was affected by the deficient practice. 2. Residents have the potential to be affected by the deficient practice in order to ensure that the deficient practice does not recur the facility has also employed a RN MDS nurse on 7/22/19 that will be able to fill the role as a charge nurse until a new DON is selected and hired. In addition, the Company has employed the services of a compliance company that will send a RN to help fill the position if it becomes vacant again. In addition, schedules are being monitored daily by the Director of Nursing and Administrator and re-staffing when call-off occurs. 3. Education: The Corporate Nurse had received in-service by the Corporate Administrator on 7/10/19 on ensuring that the Corporate Office will provide support to the facility and provide a RN from home office to assist the facility until a RN is retained for 8hrs 7 days a week or a full-time DON. 4. Monitoring: The Administrator or Director of Nursing will sign off 1 x per Month for three Months that the facility is in compliance with RN staffing starting	

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F 727	Continued From page 14 worked at the facility was on 06/30/19. The Administrator verified she was responsible for the staffing schedules and explained the RNs currently employed by the facility were only able to work certain days. She added on the days there was no RN coverage she relied on a local Staffing Agency to provide RN staff for the facility. Follow-up interviews were conducted with the Administrator on 07/09/19 at 5:05 PM and 7:00 PM. The Administrator stated she was aware of the regulation that required a RN to be designated to serve as the DON as well as have a RN that worked 8 consecutive hours per day. She confirmed there was currently no RN designated to serve as the DON and upon reviewing the timecard detail report along with the Staffing Agency's invoices, she acknowledged there were several days during the time frame of 06/27/19 to 07/09/19 in which the facility had no RN coverage. The Administrator added the corporate office was aware the DON resigned on 06/27/19 and stated they have not sent anyone to the facility to fill-in as the Interim DON until the position could be filled.	F 727	7/17/19. Data will be summarized and presented to the facility Quality Assurance Committee one (1) x per month x's three (3) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and or Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	
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		8/2/19

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F 761	Continued From page 15 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to date a Novolog insulin Flexpen when opened, discard an opened expired bottle of Vitamin B1 tablets and an opened bottle of Famotidine (stomach acid reducer) with no expiration date that were available for use in 1 of 2 medication carts. The facility also failed to discard 3 expired vials of influenza vaccine in 1 of 1 medication storage room. Findings included: 1. Observation of medication cart #2 on 7/9/19 at 9:45 AM revealed a Novolog Flexpen had a handwritten name on it with no other identifiers and no open date was observed on ready for resident use. An interview conducted on 7/9/19 at 9:45 AM with Nurse #2 revealed it was her second day at the facility and she did not give insulin on her shift, so	F 761	The facility discarded the Novolog insulin Flexpen and the expired bottle of vitamin B1 tablets famotidine, and viral influenza vaccine on 7/9/2019. 2. No resident was found to be affected by the deficient practice; however, there is the potential for residents to be affected by the deficient practice. In order to ensure that the deficient practice does not recur an audit of the facility medication carts and medication storage room was conducted by the Administrator on 7/09/19 and 7/10/19 any concerns identified were addressed. 3. All licensed nursing staff were re-educated on 7/26/19 and 7/29/19 to date medications when open and expiration dates (Insulins), to check to make sure residents name, dosage, and route of administration is on the	

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F 761	Continued From page 16 she had not looked at the insulin pens. She further stated she had been taught insulin pens should have an open date and a discard date as well as resident identifier information and should not be used unless it had that information on it. An interview conducted on 7/9/19 at 11:24 AM with the physician revealed he expected the facility to follow the rules regarding expired medications and insulin pens. An interview conducted on 7/9/19 at 10:30 AM with the Administrator revealed insulin pens should have identifier information sticker which included resident name, open date and discard date and she was unable to explain why this insulin pen did not have that information on it. The Administrator stated when the nurse opened the flexpen they should write the open and discard dates on the label. The Administrator stated each nurse should check medications for an expiration date before administering it and the night shift nurse was responsible for checking the medication carts for expired and undated medications. 2. Observation of medication cart #1 on 7/9/19 at 9:15 AM revealed an open bottle of Vitamin B1 which expired on 02/19 was observed ready for resident use. An interview conducted on 7/9/19 at 9:30 AM with Nurse #1 revealed she did not know why expired bottle of Vitamin B1 was on the medication cart available for resident use, but it should not have been on the cart. Nurse #1 stated she did not know who checked the medication carts for expired medications.	F 761	medication card and discarding expired medications by the Director of Nursing. 4 Monitoring: The Director of Nursing, license nurses, and or designee will audit Medication carts and the Medication Storage room 5 x's per week x's 4 weeks then 4 x's per week x's 4 weeks to ensure compliance is maintained starting 0n 8/2/19. Data will be summarized and presented to the facility Quality Assurance Committee one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and Licensed nurses are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	

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F 761	Continued From page 17	F 761		

An interview conducted on 7/9/19 at 11:24 AM with the physician revealed he expected the facility to follow the rules regarding expired medications and insulin pens.

An interview conducted on 7/9/19 at 10:30 AM with the Administrator revealed expired medications should not be on the medication cart and should not be given to residents. The Administrator was unable to explain why this expired medication was on the medication cart. The Administrator stated each nurse should check medications for an expiration date before administering it and the night shift nurse was responsible for checking the medication carts for expired and undated medications.

3. Observation of medication cart #1 on 7/9/19 at 9:15 AM revealed an open bottle of Famotidine which had no legible expiration date was observed ready for resident use.

An interview conducted on 7/9/19 at 9:30 AM with Nurse #1 revealed the expiration date on the bottle of Famotidine was not legible. She further stated she did not know why the bottle did not have a legible expiration date and was on the medication cart available for resident use. She also revealed she did not know who checked the medication carts for expired medications.

An interview conducted on 7/9/19 at 11:24 AM with the physician revealed he expected the facility to follow the rules regarding expired medications and insulin pens.

An interview conducted on 7/9/19 at 10:30 AM with the Administrator revealed medications should not be on the medication cart without a

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F 761	Continued From page 18	F 761		

legible expiration date and she was unable to explain why this medication with no legible expiration date was on the medication cart. The Administrator stated each nurse should check medications for an expiration date before administering it and the night shift nurse was responsible for checking the medication carts for expired and undated medications.

4. Observation of the medication storage room on 7/9/19 at 10:15 AM with Nurse #1 revealed 3 expired vials of influenza vaccine were observed ready for resident use. The vials of influenza vaccine had an expiration date of 6/30/19.

An interview conducted on 7/9/19 at 10:15 AM with Nurse #1 revealed the 3 influenza vaccine vials were expired and available for resident use and should not have been in the medication room. Nurse #1 did not know who was responsible for checking the medication storage room for expired medications.

An interview conducted on 7/9/19 at 11:24 AM with the physician revealed he expected the facility to follow the rules regarding expired medications and insulin pens.

An interview conducted on 7/9/19 at 10:30 AM with the Administrator revealed she had removed expired influenza vaccine vials from the medication storage room previously and did not know who had put them back available for resident use. She stated expired medications should not be given to residents. The Administrator further stated the night nurse was responsible for checking the medication storage room for expired medications.

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F 835	Continued From page 19	F 835		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's administration failed to provide effective leadership and oversight of processes to ensure facility staff completed and transmitted resident Minimum Data Set (MDS) assessments within the regulatory timeframe for 6 of 12 sampled residents reviewed (Residents #2, #3, #5, #6, #10, and #12). The facility's administration also failed to designate a Registered Nurse to serve as the Director of Nursing (DON) when the previous DON resigned her position on 06/27/19. Findings included: This tag was cross referenced to: 1a. F-636: Based on record review and staff interview, the facility failed to complete a comprehensive assessment every 12 months using the Resident Assessment Instrument (RAI) for 1 of 12 sampled residents reviewed (Resident #2). b. F-638: Based on record review and staff interview, the facility failed to complete quarterly MDS (Minimum Data Set) assessments every three months for 4 of 12 sampled residents reviewed (Residents #3, #6, #10, and #12).	F 835	The MDS nurse has completed and transmitted resident's MDS assessments for six (6) of 12 sampled residents reviewed . Residents # 2 on 7/11/19, #3 on 7/30/19, #5 on 7/11/19,#6 7/30/19, # 10 on 8/2/19 and # 12 on 7/26/19. The Director of Nursing was hired on 7/17/19. The facility also hired a RN MDS coordinator on 7/22/19. 2. Residents have the potential to be affected by the deficient practice. In order to ensure no other residents were affected and the deficient practice does not recur the MDS nurse conducted a audit on past and current Months of residents MDS on 7/23/19 any concerns identified were addressed. 3. The MDS coordinator was educated by the Administrator on 7/24/2019 regarding the survey results that the facility failed to complete an annual, quarterly and transmitting Comprehensive MDS and that the facility must conduct a comprehensive assessment on residents in accordance with specific time frames and when necessary revisions are needed	8/2/19

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F 835	Continued From page 20 c. F-640: Based on record review and staff interview, the facility failed to transmit a comprehensive MDS (Minimum Data Set) within 14 days of the completion date for 1 of 12 sampled residents reviewed (Resident #5). A telephone interview was conducted with the facility's former Director of Nursing (DON) on 07/09/19 at 1:52 PM. The DON confirmed part of her job duties included completing MDS assessments. The DON explained she did not have any formal training and only completed 2 MDS assessments while she was employed. An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the facility currently did not have a MDS Coordinator and acknowledged resident MDS assessments were late. The Administrator explained she was aware there was an issue with MDS assessments not being completed or transmitted within the regulatory timeframe and requested assistance from the corporate office with completing MDS assessments but had not received the requested assistance. 2. F-727: Based on record review and staff interview, the facility failed to designate a Registered Nurse (RN) to serve as the Director of Nursing (DON) when the previous DON resigned her position on 06/27/19. The facility also failed to schedule a RN for at least 8 consecutive hours a day for 5 of 12 days reviewed (07/03/19, 07/04/19, 07/05/19, 07/06/19, and 07/07/19). A telephone interview was conducted with the facility's former DON on 07/09/19 at 1:52 PM.	F 835	to ensure accuracy 4.Monitoring: The Director of Nursing (DON) and or Administrator will audit the completion status up to five (5) MDS per week x's 4 weeks then three (3) per week x's 4 weeks starting 8/2/2019, will audit the completion of quarterly assessments status up to five (5) quarterly MDS per week x's four (4) weeks then three (3) per week X's 4 weeks starting 8/2/19 and will audit the transmission of completed assessments up five (5) MDS per week x's 4 weeks then three (3) x's per week x's 4 weeks starting 8/2/19. Data will be summarized and presented to the facility Quality Assurance Committee one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and or Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	

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F 835	Continued From page 21 The DON stated she turned in her resignation on 06/27/19 and was prepared to work a 30-day notice but was told by the Administrator it would not be necessary. She confirmed the last day she worked at the facility was on 06/27/19. An interview was conducted with the Administrator on 07/09/19 at 3:50 PM. The Administrator confirmed the DON resigned her position on 06/27/19 but stated the last day she worked at the facility was on 06/30/19. The Administrator explained the RNs currently employed by the facility were only able to work certain days and on the days there was no RN coverage, she relied on a local Staffing Agency to provide RN staff for the facility. Follow-up interviews were conducted with the Administrator on 07/09/19 at 5:05 PM and 7:00 PM. The Administrator stated she was aware of the regulation that required a RN to be designated to serve as the DON as well as have a RN that worked 8 consecutive hours per day. She confirmed there was currently no RN designated to serve as the DON and upon reviewing the timecard detail report along with the Staffing Agency's invoices, she acknowledged there were several days during the time frame of 06/27/19 to 07/09/19 in which the facility had no RN coverage. The Administrator added the corporate office was aware the DON resigned on 06/27/19 and stated they have not sent anyone to the facility to fill-in as the Interim DON until the position could be filled.	F 835		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		8/2/19

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F 867	Continued From page 22 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the complaint investigation survey of 05/24/19. This was for two deficiencies that were originally cited in May of 2019 and subsequently recited on the current revisit and complaint investigation of 07/09/19. The recited deficiencies were in the areas of Activities of Daily Living (ADL) Care Provided for Dependent Residents and Labeling/Storage of Drugs and Biologicals. 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 Program. Findings included: This tag is cross referenced to: 1. a. F 677 ADL Care Provided for Dependent Residents: Based on observation, record review and staff interviews, the facility failed to provide incontinence care for 1 of 3 residents reviewed for assistance with activities of daily living (Resident #3). During complaint investigation of 05/24/19 the facility was cited for failure to provide incontinence care to two dependent residents.	F 867	No residents were identified as having been affected by the deficient practice 2.The Administrator had conducted an audit on 7/10/19 on five (5) alert and oriented residents on each hall to ensure ADL compliance any issues or concerns identified were addressed. The facility medication carts and medication storage room was conducted by the Administrator on 7/09/19 and 7/10/19 any concerns identified were addressed. 3. In order to ensure the deficient practice does not recur as of 7/10/19 the C.N.A's have been informed by the Administrator to ask cognitive residents if they need to go to the restroom or be changed if wearing a brief. In additions, incontinence rounds will be performed by the C.N.A's during morning ADL care, before breakfast, after breakfast, before and or after lunch, before and or after dinner and as needed. The Environmental Service Director and Business office manager were in-serviced by the Administrator on 7/30/19 regarding answering residents call-lights and addressing their concerns immediately to a C.N.A or License Nurse. All Nursing	

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	345307	A. BUILDING _____ B. WING _____	C 07/09/2019

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F 867	Continued From page 23 b. F 761 Labeling/Storage of Drugs and Biologicals: Based on observation, record review and staff interviews, the facility failed to date a Novolog insulin Flexpen when opened, discard an opened expired bottle of Vitamin B1 tablets and an opened bottle of Famotidine (stomach acid reducer) with no expiration date that were available for use in 1 of 2 medication carts. The facility also failed to discard 3 expired vials of influenza vaccine in 1 of 1 medication storage room. During the complaint investigation of 05/24/19 the facility was cited for failure to discard opened and expired Vitamin B1 tablets and B Liquid Complex capsules from the medication storage room and carts. During an interview on 07/09/19 at 3:50 PM the Administrator explained staffing had been an issue since starting her employment at the facility and she felt the systems put into place to correct the deficiencies broke down due to the difficulties finding and hiring qualified staff that would stay.	F 867	Staff were provided in-service on 7/26/19 and 7/29/19 by the Director of Nursing regarding providing incontinence care in a timely manner, the instructions to provide incontinent care before and or after every meal and the license Nurses were informed to provide assistance if the C.N.A's are behind. In addition, above in-services will be included in the new hire orientation package. All licensed nursing staff were re-educated on 7/26/19 and 7/29/19 to date medications when open and expiration dates (Insulins), to check to make sure residents name, dosage, and route of administration is on the medication card and discarding expired medications by the Director of Nursing. 4.Monitoring to ensure that solutions are sustained the Director of Nursing and or designee will audit five (5) alert and oriented residents and resident's that are not cognitive intact on each hall 5 x's per week x's 4 weeks then 3x's per week x's 4 weeks starting 7/29/2019 regarding ADL's/ incontinence care. In addition,the Director of Nursing, licensed Nurses, and or designee will audit Medication carts and the Medication Storage room 5 x's per week x's 4 weeks then 4 x's per week x's 4 weeks to ensure compliance is maintained starting on 8/2/19. Data will be summarized and presented to the facility Quality Assurance Committee	

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F 867	Continued From page 24	F 867	one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing, licensed Nurses and or Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	

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F 000	INITIAL COMMENTS An on-site revisit was conducted on July 9, 2019. Tags F 561, F 568, F 583, and F 725 were corrected July 9, 2019. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide incontinence care for 1 of 3 residents reviewed for assistance with activities of daily living (Resident #3). Findings included: Resident #3 was admitted to the facility on 2/27/19 with diagnoses which included anxiety, chronic renal failure and congestive heart failure (CHF). Resident #3 was coded on the quarterly Minimum Data Set (MDS) dated 3/14/19 as being cognitively intact, required total assistance with all activities of daily living (ADL) except eating, was incontinent of bowel and bladder. Review of Resident #3's care plan with a review dated 3/14/19 revealed she was care planned for	{F 677}	Resident #3 was provided incontinence care immediately by C.N.A #1 on 7/9/19 once informed by the Administrator regarding the resident need. 2. Residents have the potential to be affected by the deficient practice; however, in order to ensure the facility is able to identify other residents the Administrator had conducted an audit on 7/10/19 on five (5)alert and oriented residents on each hall in order to ensure ADL compliance any issues or concerns identified were addressed. 3.In order to ensure the deficient practice does not recur as of 7/10/19 the C.N.A's have been informed by the Administrator to ask cognitive residents if they need to go to the restroom or be changed if wearing a brief. In additions, incontinence	8/2/19

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

Electronically Signed | 08/06/2019

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{F 677}	Continued From page 1 ADL/self-care performance deficit related to CHF and gout. The goal was for the resident to have care needs with as much assistance from her as possible through the review date. The care plan indicated resident required extensive physical assistance by staff for incontinence care and wore briefs. An observation on 7/09/19 at 10:55 AM of Nurse Aide (NA) #1 who provided incontinence care revealed Resident #3's brief was saturated from front to back with urine and had a medium amount of soft formed brown substance and the bed pad was wet. Resident #3's skin was intact with no redness, but resident did complain of burning and itching. An interview was conducted on 7/09/19 at 4:59 PM with Resident #3 who stated she had rung her call bell multiple times during the afternoon and told a housekeeper, the Business Officer Manager, Nurse #1, and the Administrator that she needed to be changed. Resident #3 indicated she had not been changed since the morning when this surveyor had observed her being changed. She also stated she wanted to be changed more frequently and felt bad when left to lay in a wet brief. Resident #3 reported she had severe itching under her brief which made her physically uncomfortable. The interview further revealed when the Administrator answered Resident #3's call bell the resident had informed the Administrator she had already asked 3 other people to notify NA #1 she needed to be changed. An observation on 7/09/19 at 5:00 PM of NA #1 and NA #5 who provided incontinence care revealed Resident #3's brief was saturated from	{F 677}	rounds will be performed by the C.N.A's during morning ADL care, before breakfast, after breakfast, before and or after lunch, before and or after dinner and as needed. In addition, the Environmental Service Director and Business office manager were in-serviced by the Administrator on 7/30/19 regarding answering residents call-lights and addressing their concerns immediately to a C.N.A or License Nurse. All Nursing Staff were provided in-service on 7/26/19 and 7/29/19 by the Director of Nursing regarding providing incontinence care in a timely manner, the instructions to provide incontinent care before and or after every meal and the license Nurses were informed to provide assistance if the C.N.A's are behind. 4.Monitoring to ensure that solutions are sustained the Director of Nursing and or designee will randomly audit five (5) alert and oriented residents and resident's that are not cognitive intact on each hall 5 x's per week x's 4 weeks then 3x's per week x's 4 weeks starting 7/29/2019. In addition, above in-services will be included in the new hires orientation package starting 8/02/19. Data will be summarized and presented to the facility Quality Assurance Committee one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement	

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{F 677}	Continued From page 2 front to back with urine and had a smear of dried brown substance on it. Her skin was intact with no redness, but she did complain of itching and burning. An interview on 7/09/19 at 5:53 PM with Housekeeper #1 revealed he had answered Resident #3's call light and she requested to be changed. He further revealed he was unsure what time he had answered her call light, but he had forgotten to tell the NA #1 that Resident #3 had requested to be changed. An interview on 7/09/19 at 5:56 PM with the Business Office Manager revealed he had answered Resident #3's call light and she requested to be changed and he told NA #1. He was unsure what time he had answered her call light but stated it was after lunch. He did not know if NA #1 had changed Resident #3. An interview on 7/09/19 at 5:54 PM with Nurse #1 revealed she had answered Resident #3's call light twice since lunch but did not remember the times. She stated the first time the resident requested ice water which she provided and the second time she answered the call light the resident requested to be changed and she told NA #1. Nurse #1 did not know if NA #1 had changed Resident #3 and she did not indicate why she had not changed her. An interview on 7/09/19 at 5:00 PM with NA #1 revealed she had not changed Resident #3 since 10:55 AM and no one told her the resident needed to be changed. NA #1 stated she was responsible for residents on the hall which included Resident #3 but that she had been too busy to change residents every 2 hours as she	{F 677}	Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	

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{F 677}	Continued From page 3 was supposed to. NA #1 explained she was supposed to work from 7:00 AM to 3:00 PM but worked late. She stated she did not recall anyone telling her Resident #3 needed to be changed. An interview on 7/09/19 at 6:00 PM with the Administrator revealed she was aware Resident #3 had requested to be changed four times after lunch and had not been changed until 5:00 PM. The Administrator confirmed she had talked with Resident #3 when she answered her call light and notified NA #1 that the resident had requested to be changed. An interview on 7/09/19 at 7:01 PM with the Administrator revealed she expected the staff to check and/or change incontinent residents every 2 hours. She did not know why Resident #3 had not been changed from 10:55 AM until 5:00 PM.	{F 677}		
{F 761} SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	{F 761}		8/2/19

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{F 761}	Continued From page 4 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to date a Novolog insulin Flexpen when opened, discard an opened expired bottle of Vitamin B1 tablets and an opened bottle of Famotidine (stomach acid reducer) with no expiration date that were available for use in 1 of 2 medication carts. The facility also failed to discard 3 expired vials of influenza vaccine in 1 of 1 medication storage room. Findings included: 1. Observation of medication cart #2 on 7/9/19 at 9:45 AM revealed a Novolog Flexpen had a handwritten name on it with no other identifiers and no open date was observed on ready for resident use. An interview conducted on 7/9/19 at 9:45 AM with Nurse #2 revealed it was her second day at the facility and she did not give insulin on her shift, so she had not looked at the insulin pens. She further stated she had been taught insulin pens should have an open date and a discard date as well as resident identifier information and should not be used unless it had that information on it.	{F 761}	The facility discarded the Novolog insulin Flexpen and the expired bottle of vitamin B1 tablets famotidine, and viral influenza vaccine on 7/9/2019. 2. No resident was found to be affected by the deficient practice; however, there is the potential for residents to be affected by the deficient practice. In order to ensure that the deficient practice does not recur an audit of the facility medication carts and medication storage room was conducted by the Administrator on 7/09/19 and 7/10/19 any concerns identified were addressed. 3. All licensed nursing staff were re-educated on 7/26/19 and 7/29/19 to date medications when open and expiration dates (Insulins), to check to make sure residents name, dosage, and route of administration is on the medication card and discarding expired medications by the Director of Nursing. 4 Monitoring: The Director of Nursing, license nurses, and or designee will audit Medication carts and the Medication	

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{F 761}	Continued From page 5 An interview conducted on 7/9/19 at 11:24 AM with the physician revealed he expected the facility to follow the rules regarding expired medications and insulin pens. An interview conducted on 7/9/19 at 10:30 AM with the Administrator revealed insulin pens should have identifier information sticker which included resident name, open date and discard date and she was unable to explain why this insulin pen did not have that information on it. The Administrator stated when the nurse opened the flexpen they should write the open and discard dates on the label. The Administrator stated each nurse should check medications for an expiration date before administering it and the night shift nurse was responsible for checking the medication carts for expired and undated medications. 2. Observation of medication cart #1 on 7/9/19 at 9:15 AM revealed an open bottle of Vitamin B1 which expired on 02/19 was observed ready for resident use. An interview conducted on 7/9/19 at 9:30 AM with Nurse #1 revealed she did not know why expired bottle of Vitamin B1 was on the medication cart available for resident use, but it should not have been on the cart. Nurse #1 stated she did not know who checked the medication carts for expired medications. An interview conducted on 7/9/19 at 11:24 AM with the physician revealed he expected the facility to follow the rules regarding expired medications and insulin pens. An interview conducted on 7/9/19 at 10:30 AM	{F 761}	Storage room 5 x's per week x's 4 weeks then 4 x's per week x's 4 weeks to ensure compliance is maintained starting 0n 8/2/19. Data will be summarized and presented to the facility Quality Assurance Committee one (1) x per month x's two (2) months by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Quality Assurance Performance improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and Licensed nurses are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	

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{F 761}	Continued From page 6	{F 761}		

with the Administrator revealed expired medications should not be on the medication cart and should not be given to residents. The Administrator was unable to explain why this expired medication was on the medication cart. The Administrator stated each nurse should check medications for an expiration date before administering it and the night shift nurse was responsible for checking the medication carts for expired and undated medications.

3. Observation of medication cart #1 on 7/9/19 at 9:15 AM revealed an open bottle of Famotidine which had no legible expiration date was observed ready for resident use.

An interview conducted on 7/9/19 at 9:30 AM with Nurse #1 revealed the expiration date on the bottle of Famotidine was not legible. She further stated she did not know why the bottle did not have a legible expiration date and was on the medication cart available for resident use. She also revealed she did not know who checked the medication carts for expired medications.

An interview conducted on 7/9/19 at 11:24 AM with the physician revealed he expected the facility to follow the rules regarding expired medications and insulin pens.

An interview conducted on 7/9/19 at 10:30 AM with the Administrator revealed medications should not be on the medication cart without a legible expiration date and she was unable to explain why this medication with no legible expiration date was on the medication cart. The Administrator stated each nurse should check medications for an expiration date before administering it and the night shift nurse was

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{F 761}	Continued From page 7	{F 761}		

responsible for checking the medication carts for expired and undated medications.

4. Observation of the medication storage room on 7/9/19 at 10:15 AM with Nurse #1 revealed 3 expired vials of influenza vaccine were observed ready for resident use. The vials of influenza vaccine had an expiration date of 6/30/19.

An interview conducted on 7/9/19 at 10:15 AM with Nurse #1 revealed the 3 influenza vaccine vials were expired and available for resident use and should not have been in the medication room. Nurse #1 did not know who was responsible for checking the medication storage room for expired medications.

An interview conducted on 7/9/19 at 11:24 AM with the physician revealed he expected the facility to follow the rules regarding expired medications and insulin pens.

An interview conducted on 7/9/19 at 10:30 AM with the Administrator revealed she had removed expired influenza vaccine vials from the medication storage room previously and did not know who had put them back available for resident use. She stated expired medications should not be given to residents. The Administrator further stated the night nurse was responsible for checking the medication storage room for expired medications.

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L 000	INITIAL COMMENTS An on-site revisit was conducted on July 9, 2019. State Licensure tag 0006 was corrected as of July 9, 2019. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	L 000		