STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 08/12/19 through 09/04/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Prepardness. Event ID # LZU611.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility for an unannounced recertification and complaint survey conducted from 08/12/19 through 08/16/19. Additional information was obtained on 08/26/19 and 09/04/19. Therefore, the exit date was changed to 09/04/19. A total of 27 allegations were investigated and 4 were substantiated.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to assess the ability of a resident to self-administer eye drops kept at the bedside (Resident #64) and failed to assess the ability of a resident to self-administer an eye vitamin kept at the bedside (Resident #44) for 2 of 2 residents reviewed for self-administration of medications. Findings included: 1. Resident #64 was admitted to the facility 12/04/17 with diagnoses including anemia and respiratory failure.	F 554	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	9/13/19

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

Electronically Signed | 09/12/2019

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F 554	Continued From page 1 Review of the quarterly Minimum Data Set (MDS) dated 07/27/19 revealed Resident #64 was cognitively intact. Review of Resident #64's care plan last updated 08/02/19 revealed he was not care planned to self-administer medication. Review of Resident #64's medical record revealed he was not assessed to self-administer medication. A review of Resident #64's Physician's orders revealed an order dated 07/30/19 for olopatadine 0.1% 1 drop in both eyes twice a day for allergies/conjunctivitis (inflammation of the eye) and an order dated 05/23/19 for eye lubricant drops 1 drop in both eyes four times a day for dry eyes. An observation of Resident #64's overbed table on 08/13/19 at 4:14 PM revealed a bottle of lubricant eye drops and a bottle of olopatadine 0.1% eye drops sitting on top. An interview with Resident #64 on 08/13/19 at 4:16 PM revealed the eye drops were left on his overbed table by the nursing staff and he had been administering them to himself because nursing staff was not available to administer his eye drops when he needed them. Resident #64 stated he was not sure how long he had been administering his own eye drops. An interview with Nurse #4 on 08/13/19 at 4:17 PM revealed Resident #64 administered his own eye drops and she just reminded him when it was time to administer the drops. Nurse #4 confirmed	F 554	F554 How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice. Resident #44 medications removed from bedside placed in cart for safe keeping. Resident #44 did not express desire to self-administer medication. How the facility will identify other residents having the potential to be affected by the same deficient practice: All patient rooms were checked for medications (prescription or over-the-counter) on 08/14/19, to ensure that no other medications were found at bedside. When a medication during the initial audit was identified it was removed from the patients room until determination by the Interdepartmental Team and could evaluate the abilities of the resident to safely administer medication. A patient with a BIMS score of 12 or less will not, be considered for self-administration due to patients inconsistent cognitive function. Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nurses, certified nursing assistants, and Department Managers were educated on Nursing Policy 1805, Self-Administration of Medication at bedside and making sure that attention is paid to resident rooms when providing care and making rounds for any medications (prescription or	

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F 554	Continued From page 2 Resident #64 had no Physician's order to self-administer his eye drops. An interview with the Director of Nursing (DON) on 08/13/19 at 4:41PM revealed there were no residents in the facility that were assessed to self-administer medications. The DON stated if a resident were going to self-administer their medications there would need to be a Physician's order to leave the medications in the room and should be assessed by nursing staff to administer their own medication. The DON stated the lubricant eye drops and olopatadine eye drops were provided by the facility's pharmacy and should have been stored in the medication cart unless there was a Physician's order to self-administer the eye drops. An interview with the Nurse Practitioner on 08/16/19 at 9:30 AM revealed she expected the facility's nursing staff to follow their policy regarding residents self-administering their medications. The Nurse Practitioner also stated if she did not specifically write an order for a resident to self-administer medication the medication should not be left in the resident's room. 2. Resident #44 was admitted to the facility 05/17/19 with diagnoses including anemia and a malignant neoplasm of the parotid gland. Review of the quarterly Minimum Data Set (MDS) dated 07/08/19 revealed Resident #44 was cognitively intact. Review of Resident #44's care plan last updated 07/11/19 revealed he was not care planned to self-administer medication.	F 554	over-the-counter), by Regional Nurse Consultant and Staff Development Coordinator, and were educated to notify the Director of Nursing or Administrator of any medications seen at bedside by 9/13/2019. Administrator or Director of nursing will review so that appropriate steps are taken to properly determine the patient□s ability to safely administer medications and properly secured in a lock box if determination is made by the IDT that the patient can safely administer the medications. Rounds observing for medications at bedside will be started on 09/13/2019. If medications are found then the medications are removed and given to the DON or Administrator so that they can ensure that the patient is evaluated as to their ability to self-administer medications. If the resident expresses desire to self-administer their own medication the DON will review the residents BIMS to assess and confirm the resident is safely able to self-administer, then she will notify the charge nurse responsible for this resident confirming the resident is either safe or unsafe who will then complete the self-administration assessment and make a note in the progress note. All new hired employees will be educated on the process for Self-Administration of Medication at bedside and making sure that attention is paid to in resident rooms when providing care and making rounds for any medications (prescription or over-the-counter). The admissions team was educated on 9/13/2019 regarding policy 1805, and will discuss with all new residents□ or their family upon admitting	

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F 554	Continued From page 3 Review of Resident #44's medical record revealed he was not assessed to self-administer medication. A review of Resident #44's Physician's orders revealed there was no order for eye vitamins. An observation of Resident #44's bedside table on 08/12/19 at 4:27 PM revealed a bottle of eye vitamins 120 soft gels sitting on top of the table. An interview with Resident #44 on 08/12/19 at 4:48 PM revealed he brought the eye vitamins in from home in May of 2019 and he took the medication when he felt like it. Resident #44 stated he was not sure when he last took the medication. An observation of Resident #44's bedside table revealed the bottle of eye vitamins was sitting on top of the table and was visible from the doorway of Resident #44's room. A follow up interview with Resident #44 on 08/14/19 at 8:38 AM revealed 2 nurses removed the eye vitamins from his room the evening of 08/13/19. An interview with the MDS Coordinator on 08/14/19 at 9:34 AM revealed she was passing out dinner trays the evening of 08/13/19 and saw the bottle of eye vitamins sitting on Resident #44's bedside table. The MDS Coordinator stated she told Resident #44 she needed to remove the medication from his room and gave the medication to Resident #44's nurse. The MDS Coordinator stated the medication should not have been on Resident #44's bedside table.	F 554	the resident to the facility regarding self-administration. The resident or family member will sign or initial the facilities policy of understanding and agreement that will be uploaded to the residents record. How facility plans to monitor its performance to make sure that solutions are sustained: Beginning on 9/13/2019 Department Heads will do and complete rounds three times each week completing a round sheet for assigned rooms for a period of 3 months, observing for medications (prescription or over-the-counter) at bedside and report findings in morning Stand-up meeting. Administrator or Director of nursing will ensure that the appropriate evaluation is completed to ensure the patient is able to safely self-administer medications and ensure that the room has appropriate secured storage placed in the patient s room. The Director of Nursing will review data obtained from the weekly audits; analyze the data and report patterns/trends to the QAPI committee for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on the identified trends/outcomes to ensure continued compliance. Alleged Completion Date: 9/13/19	

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F 554	Continued From page 4 An interview with the Director of Nursing (DON) on 08/14/19 at 9:46 AM revealed the nursing staff did not place the bottle of eye vitamins in Resident #44's room and could not control everything the family brought to the resident's room. An interview with the Nurse Practitioner on 08/16/19 at 9:30 AM revealed she expected the facility's nursing staff to follow their policy regarding residents self-administering their medications. The Nurse Practitioner also stated if she did not specifically write an order for a resident to self-administer medication the medication should not be left in the resident's room. An interview with the Administrator on 08/16/19 at 3:47 PM revealed Resident #44 should not have had the eye vitamins at his bedside.	F 554		
F 561 SS=B	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		9/13/19

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F 561	Continued From page 5 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide resident food preferences for 2 of 3 sampled residents (Resident #56 and Resident #16) reviewed for choices. The findings included: 1. Resident #56 was admitted to the facility on 07/08/19 from the hospital. Her admitting diagnoses included fractures and other multiple trauma from a fall, hypertension and diabetes mellitus (DM). A review of Resident #56's admission Minimum Data Set (MDS) dated 07/15/19 revealed she was cognitively intact for daily decision making and was coded as independent with eating after set up. On 08/13/19 at 8:30 AM Resident #56 was observed to have eaten her meal except for a sausage patty left on her plate. She stated she	F 561	F561 How corrective action will be accomplished for those residents found to have been affected: The facility failed to honor the food preferences for Residents #56 and #16. The facility served steamed rice and Asian blend vegetables to resident #16 that had previously reported those items as dislikes. Resident was immediately offered the alternate menu item that was available. The facility served sausage to resident #56 when she had previously indicated that she dislike sausage. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Dining Services Manager in-serviced/reeducated dietary staff on 8/16/2019 regarding the requirement of honoring resident□s food preferences. The resident patient menu	

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F 561	Continued From page 6 did not like sausage and had told the person who interviewed her about food likes and dislikes that she did not like sausage. She stated she had received a sausage patty yesterday on her breakfast plate and she had not eaten it either. A review on 08/13/19 of Resident #56's meal card for breakfast revealed bacon underlined. An interview on 08/13/19 at 3:30 PM with the Corporate Registered Dietician (RD) revealed anything that was underlined was to be served to the resident daily. She stated the Dietary Manager interviewed residents for likes and dislikes and any special requests for daily meals were underlined to ensure the resident received them every day. The Corporate RD said according to Resident #56's card she should have received bacon every morning for breakfast. She stated they do monthly accuracy audits regarding likes and dislikes of the residents but stated they only do a percentage and not the entire facility. An interview on 08/15/19 at 3:19 PM with the Dietary Manager revealed sausage was included on her meal ticket along with bacon; however, bacon was underlined and should have been served to Resident #56 daily. She stated she would update Resident #56's information to include sausage as a dislike and make sure she received bacon daily with her breakfast tray. An interview on 08/16/19 at 8:43 AM with the Administrator and Director of Nursing (DON) revealed they expected the dietary staff to honor resident preferences of food and not be served any foods on their dislikes list. The Administrator and DON stated Resident #56 should not have	F 561	profile report was reviewed by dining services manager on 8/16/2019 to ensure all residents profiles were correct in meal tracker menu system. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 9/13/2019 a tray accuracy evaluation will be completed by the Corporate Registered Dietitian or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions, food preparation and tray accuracy. Any deficient practice identified through the tray accuracy evaluation will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for food preparation and menu adequacy to honor food preferences. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Dietary Director will review data obtained from the weekly audits; analyze the data and report patterns/trends to the QAPI committee for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on the identified trends/outcomes to ensure continued compliance. Alleged Completion Date: 9/13/19	

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been served sausage for breakfast.

2. Resident #16's medical record revealed she was first admitted to the facility on 2/25/15 with diagnoses that included heart failure, hypertension and vitamin D deficiency.

Resident #16's Quarterly Minimum Data Set (MDS) Assessment dated 5/31/19 revealed she was cognitively intact and required extensive physical assistance with most Activities of Daily Living (ADL) including eating.

Resident #16's List of Dislikes from a nutritional assessment completed by the Registered Dietician on 7/16/19 included rice and mixed vegetables.

On 8/12/19 at 3:44 PM, an interview with Resident #16 revealed she did not like fish and rice and has told one of the staff members that she didn't like them, but she still got served fish and rice.

On 8/15/19 at 12:35 PM, an observation made of Resident #16's lunch tray with Nurse #5 revealed rice and mixed vegetables on her plate. A review of the meal ticket that was on the tray revealed the following menu items served for Resident #16's lunch: Chicken Teriyaki, Asian vegetables, Steamed rice and Egg roll.

On 8/15/19 at 2:35 PM, an interview conducted with Resident #16 revealed she got served rice for lunch, but she didn't eat it and she sent it right back. Resident #16 stated she did not know why she kept on getting served rice. Resident #16 further stated the Dietary Manager (DM) talked to her after lunch but she never talked to her about

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her dislikes. Resident #16 stated the DM only asked her if she liked the chicken.

On 8/15/19 at 2:40 PM, an interview conducted with Nurse Aide (NA) #1 revealed she was familiar with Resident #16 and was aware that she did not like fish and rice. NA #1 further stated Resident #16 only ate the egg roll for lunch because she did not like the rice and the Asian vegetables that were served. NA #1 had told the previous DM about this.

On 8/15/19 at 3:19 PM, an interview with the DM revealed she talked to Resident #16 after lunch on 8/15/19 because she was told by NA #1 that she did not eat lunch except for the egg roll. When the DM talked to Resident #16, the DM stated she asked her "if she liked the lunch," and Resident #16 told her that she wasn't hungry. The DM did not ask Resident #16 about each specific food item on her lunch tray if she liked it or not. When the DM checked Resident #16's food dislikes, she noted that rice and mixed vegetables were listed. The DM stated when they printed out the meal tickets for lunch, the dislikes showed up on the ticket because they were not listed on the dislikes exactly as in the meal ticket. On Resident #16's dislike list, rice and mixed vegetables were listed while on the meal ticket, they were listed as steamed rice and Asian vegetables. The DM stated the meal tickets do not reflect the dislikes but would only show whatever the resident could have based on their dislikes list. Since they were not listed with exact wording, the computer was not able to decipher that both items were the same. The DM stated she last updated Resident #16's food preferences on 7/25/19 but did not remember being told that Resident #16 did not like rice or fish. The DM

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F 561	Continued From page 9 also stated they did monthly accuracy audits of meals being served based on food preferences but only a certain percentage of the facility was completed. On 8/16/19 at 8:43 AM, an interview with the Administrator was conducted with the Director of Nursing (DON) present. The Administrator stated it was her expectation that the facility honored the food preferences of residents and should not be served anything on their dislikes list. The Administrator stated Resident #16 should not have been served rice on 8/15/19 if it was on her dislikes list.	F 561		
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 observations, record review, resident and staff interviews, the facility failed to provide a referral to a podiatrist for nail care for 1 of 1 diabetic resident (Resident #42) dependent on staff reviewed for activities of daily living. Findings included: Resident #42 was admitted to the facility on 07/01/19 with diagnoses which included diabetes mellitus. A review of Resident #42's most recent Minimum Data Set (MDS) dated 07/08/19 revealed she was	F 677	F677 How the corrective action will be accomplished for the resident(s) affected. Resident #42 was seen by the podiatrist on 8/16/2019. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. The Staff Development Coordinator or Director of Nursing in-serviced/re-educated all nurses regarding skin assessment to include	9/13/19

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F 677	Continued From page 10 severely cognitively impaired for daily decision making but was able to make her needs known. Resident #42's MDS also revealed she required extensive assistance of one staff with dressing, personal hygiene, bathing and toileting. An observation on 08/13/19 at 10:28 AM was made of Resident #42. She was lying in bed with her pajamas on watching TV. Her feet were uncovered and her toenails on both feet were approximately ¼ to ½ inch beyond the end of her toe. When asked if she liked them long, she said "no, they need cut and they hurt sometimes." An observation on 08/14/19 at 9:36 AM was made of Resident #42. She was lying in bed with the head of the bed elevated with her eyes closed and appeared to be sleeping. The resident's feet were uncovered with no socks on and her toenails remained approximately ¼ to ½ inch beyond the end of her toe. An observation on 08/15/19 at 10:47 AM was made of Nurse Aide (NA) #3 providing incontinence care for Resident #42. NA #3 and the Surveyor observed Resident #42's toenails, and when asked about the length of the toenail's she stated she had reported them to Nurse #3 three weeks ago but nothing had been done for the resident. NA #3 stated she could not cut them because Resident #42 was diabetic, and her toenails were thick, and she needed to be referred to the podiatrist. An interview and observation on 08/15/19 at 11:13 AM with Nurse #3 revealed she had not noticed Resident #42's toenails but agreed they needed to be cut. She asked the resident if they hurt and the resident responded, "yes they hurt	F 677	resident nail length and needs for podiatry services. Any active nurse who does not receive this education by 9/13/2019 will not be allowed to work until completed. All new nursing hires will be oriented to this process before being assigned to the unit. A 100% audit of all current residents will be completed by 9/13/2019. Measures put in place to ensure practices will not re-occur. Staff Development Coordinator will complete (5) random skin audits to verify proper length of resident toe nails starting on 9/13/2019. Audit will include notification of podiatry services if needed. This audit will be completed weekly for 4 weeks, then bi-weekly for 1 month, and then monthly for 1 month. How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Nursing will review data obtained from the weekly skin/podiatry notification audits; analyze the data and report patterns/trends to the QAPI committee for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on the identified trends/outcomes to ensure continued compliance. Alleged Completion Date: 9/13/19	

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F 677	Continued From page 11	F 677		

sometimes." Nurse #3 stated she would see if the resident could be referred out to the Podiatrist and coordinate with the Scheduler to get her seen as soon as possible. Nurse #3 stated she did not recall NA #3 telling her about Resident #42's toenails being long and needing to be cut. Nurse #3 stated the usual process for residents was for the NAs to let the nurses know they needed their nails trimmed or the nurses could refer residents when they noted their nails needed trimming. She stated the NAs usually observed nails after showers or baths and the nurses observed nails during skin assessments done weekly. She stated if nails need to be trimmed and staff were unable to do it they were referred to the Scheduler to be added to the podiatry list or be referred out to the podiatrist if it was something that could not wait for the next visit.

An interview and observation on 08/15/19 at 11:00 AM with the Scheduler revealed she was not aware of Resident #42 needing a referral to the podiatrist. The Scheduler observed Resident #42's toenails and agreed she needed to be referred to have them cut. She stated she would talk with the nurse and get her referred to the podiatrist. The Scheduler stated she would send her out and not make her wait until the in-house podiatrist made his rounds for August.

An interview and observation on 08/15/17 at 11:37 AM with the Director of Nursing (DON) revealed she was not aware Resident #42's toenails were so long and stated she needed them to be clipped. The DON observed the resident's toenails and asked her if they hurt and the resident responded, "yes sometimes." The DON stated she would make sure the staff referred the resident to the podiatrist as soon as

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F 677	Continued From page 12 possible. She stated the usual process for referring residents to the podiatrist is that all diabetics with thick and long nails are referred, NAs that have observed long nails during bathing and nurses that have observed long nails during skin assessments can all refer a resident to be seen by the podiatrist, The DON also stated if it was something that could not wait for the inhouse podiatrist, residents could be referred out to the local podiatrist with which they are contracted.	F 677		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		9/13/19

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F 756	Continued From page 13 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Pharmacy Consultant interviews, the Pharmacy Consultant failed to identify and address an irregularity in lab values to monitor an anticonvulsant medication for 1 of 1 resident ' s reviewed for medication regimen review (Resident #54). The findings included: Resident #54 was re-admitted to the facility on 12/20/18 and readmitted on 04/03/19 with diagnoses which included seizure disorder, narcolepsy and epilepsy. Review of the admission minimum data set (MDS) dated 12/20/18 revealed Resident #54 was cognitively intact and required extensive one-person assistance with most activities of daily living. On 05/31/19 Resident #54 was sent to the emergency department on this date for evaluation after having a seizure, resulting in a fall and striking his head.	F 756	F756 How the corrective action will be accomplished for the resident(s) affected. Pharmacist failed to identify and address a lab on Resident #54 in June. Lab had been addressed by the Practitioner at the time of survey. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The pharmacy consultant reviewed all current residents for medication levels that are out of therapeutic range and reported labs out of range to the physician. A 100% audit was completed by 9/13/2019. Measures in place to ensure practices will not re-occur. The Pharmacy Consultant was educated by the Administrator and Corporate Nurse Consultant that during Pharmacy Consultant Reviews that is an anticonvulsant that requires a therapeutic	

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F 756	Continued From page 14 Review of the emergency department report dated 05/31/19 revealed Resident #54 had a Valproic acid level of 14 (normal level 50 to 100). Valproic acid level measures the Divalproex sodium (Anticonvulsant) concentration in the blood sample. The report revealed the resident had experienced two seizures and was found by staff at the nursing facility in the floor. Review of the emergency department (ED) report dated 06/04/19 revealed Resident #54 was evaluated in the ED due to multiple seizures. Review of a lab report dated 06/04/19 revealed Resident #54 had a Valproic acid level (measuring the concentration of Divalproex sodium in the blood) of 14 (normal range 50-100) in the ED. Review of a lab report dated 06/17/19 revealed Resident #54 had a Valproic acid level of 38.1. Review of the medication regimen review (MMR) dated 06/17/2019 revealed Resident #54 medication and lab values were evaluated on this date with no recommendations made. On 09/04/19 at 10:30 AM an interview was conducted with the Pharmacy Consultant. The pharmacist stated he conducted monthly medication reviews on each resident residing in the facility reviewing medication and lab work associated. He stated he had been reviewing Resident #54 ' s medication since December 2018 and had made recommendations once on April 5,2019 after a readmission from the hospital. The interview revealed during his monthly reviews he focuses on if the Valproic acid	F 756	level, a recommendation should be completed to indicate that the lab was seen and that the physician was notified. The expectation is that the Pharmacist will utilize this method during monthly chart reviews. The pharmacist will conduct and exit interview with the DON and Administrator notifying them of any sub-therapeutic lab levels for the anticonvulsants as well as notating this on his monthly report that is reviewed by the DON upon completion. The education was completed on 9/9/2019. Reviews by the Pharmacist will be scanned into the appropriate medical record by Medical Records once completed and reviewed by the Unit Managers or Director of Nursing which will be an on-going process. If during the review of Medication Reviews it is found that the Pharmacist overlooks a lab that is out of the therapeutic range for an anticonvulsant that they have reviewed, the Director of Nursing will address with the Consultant and this communication will be documented and notification of the Pharmacy Manager of continued missed reporting of the non-reporting of the lab values outside the therapeutic range, this process will be on-going. Director of Nursing or designee will audit Pharmacy recommendations for all patients on anti-seizure medications if they require a therapeutic level, monthly X 6 for labs and checking to ensure physician has been notified of lab value out of therapeutic via pharmacy recommendation, if not notify the	

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F 756	Continued From page 15 level is being monitored, leaving the actions and how the lab values are interrupted up to the facility Medical Director. He stated the residents Valproic acid level was low on multiple occasions but was being checked monthly. His recommendations for this lab work include conducting the lab work on a every 6-month basis and stated the facility was doing more than the recommendations he would have, by monitoring it monthly. The interview revealed he had not listed the subtherapeutic lab values in his pharmacy review.	F 756	physician and contact pharmacist and pharmacy manager of the missed reporting of the therapeutic level being out of range. This audit will begin on 9/13/2019. How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Nursing will review data obtained from the monthly audits; analyze the data and report patterns/trends to the QAPI committee for 6 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on the identified trends/outcomes to ensure continued compliance. Alleged Completion Date: 9/13/19	
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		9/13/19

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F 761	Continued From page 16 §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 date 3 medications after opening on 2 out of 5 medication carts reviewed for medication storage. Findings included: 1. An observation of the Camellia 1 medication cart on 08/15/19 at 4:25 PM revealed an opened and undated bottle of lubricant eye drops. An interview with Nurse #6 on 08/15/19 at 4:26 PM revealed the lubricant eye drops should have been dated when opened and it was the responsibility of the nurse who opened the eye drops to date them when they were opened. Nurse #6 stated she did not open the drops and did not know when the drops were opened. An interview with the Unit Manager on 08/15/19 at 4:34 PM revealed the lubricant eye drops should have been dated when they were opened by the nurse who opened them. An interview with the Director of Nursing (DON) on 08/15/19 at 5:38 PM revealed eye drops were to be dated when opened.	F 761	F761 How the corrective action will be accomplished for the resident(s) affected. Expired items were found on two medication carts. All items were removed and immediately destroyed. All active nurses were re-educated by 9/13/19. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. The Staff Development Coordinator or Director of Nursing in-serviced/re-educated all nurses regarding proper drug and biological storage according to the facility policy and completed by 9/13/2019. A 100% audit of the medication carts were completed by 9/13/2019. Drugs and biologicals in each medication cart will be audited and any expired items or unlabeled items will be removed and disposed of per the facility policy by 9/13/2019. Measures put in place to ensure practices will not re-occur. Beginning 9/13/2019 the	

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F 761	Continued From page 17 2. An observation of the 200 hall medication cart on 08/1519 at 5:32 PM revealed 2 open and undated bottles of fluticasone nasal spray (a medication used for allergies). An interview with the DON on 08/15/19 at 5:33 PM revealed 1 bottle of fluticasone was sent from the pharmacy on 05/25/19 and the other bottle of fluticasone was sent from the pharmacy on 05/30/19. The DON stated the fluticasone expired 6 weeks after being opened and the medications were most likely opened the day they were sent from the pharmacy or shortly thereafter. The DON stated the 2 bottles of fluticasone were considered to be out of date and should not have been in the medication cart and available for use. The DON stated the medication carts were checked for expired medication daily by the nursing staff.	F 761	Staff Development Coordinator will conduct audit of drug and biologicals on all medication carts weekly (there are 5 medication carts, therefore each day of the week a different cart will be audited) Mon-Fri for a period of 12 weeks. All new nursing hires will be oriented to this process before being assigned to the unit. How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Nursing will review data obtained from the weekly audits; analyze the data and report patterns/trends to the QAPI committee for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on the identified trends/outcomes to ensure continued compliance. Alleged Completion Date: 9/13/19	
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.	F 812		9/13/19

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F 812	Continued From page 18 (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 label and date food items stored in 1 of 1 walk-in refrigerator and 1 of 1 dry storage room in the facility's kitchen. Findings included: During the initial tour of the kitchen on 8/12/19 at 2:30 PM, the following were observed with the Dietary Supervisor (DS): An opened bag of dark brown meat that looked like roast beef was placed in a plastic bag that did not have a label or date in the walk-in refrigerator. An opened bag of bread crumbs was not labeled and dated in the kitchen's dry storage room. During the initial tour, as soon as the above items were identified, the DS discarded both opened and unlabeled food items. During an interview on 8/12/19 at 2:35 PM, the DS stated the bag of bread crumbs and the bag of roast beef should have been labeled and dated which was why she discarded both items. The DS stated she checked the kitchen daily, but she did not see both items that morning. The DS further stated the bread crumbs must have been used from the night before and the roast beef has been used to make alternate sandwiches for lunch.	F 812	F812 How corrective action will be accomplished for those residents found to have been affected: The facility staff failed to properly store and label food in walk-in cooler and dry storage room. On 8/13/19, a package of roast beef deli meat was found unlabeled in the walk-in cooler and a bag of bread crumbs was found unlabeled in the dry storage room. The bag of roast beef and bag of bread crumbs were immediately discarded. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/13/19, all Dining Services employees were in-serviced regarding proper procedures for procedure for properly labeling, dating and storing left over food in coolers, freezers and dry storage room. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A sanitation inspection will be conducted by Corporate Registered Dietician or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions and sanitation standards. The	

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F 812	Continued From page 19 On 8/14/19 at 11:45 AM, an interview conducted with the Dietary Manager (DM) revealed the bag of bread crumbs and the bag of roast beef should have been labeled and dated. The DM stated all opened items in the refrigerator and dry storage room should be labeled and dated. The DM further stated if these items were observed during their daily inspection of the kitchen, they would discard them because the staff won't be able to tell when they have been opened. The DM stated there were guidelines posted on the refrigerator door and dry storage room door about food storage and how long opened food items were safe to be stored. On 8/16/19 at 8:28 AM, an interview with the Administrator was conducted with the Director of Nursing (DON) present. The Administrator stated she expected every food item in the refrigerator and dry storage room to be labeled and dated.	F 812	initial sanitation audit was conducted 9/6/19. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for storing, preparing and distributing food safely. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Dietary Manager will review data obtained from the weekly audits; analyze the data and report patterns/trends to the QAPI committee for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on the identified trends/outcomes to ensure continued compliance. Alleged Completion Date: 9/13/19	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		9/13/19

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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(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 880	Continued From page 21 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, and staff interviews, the facility failed to follow enteric precautions for 1 of 3 residents (Resident #130) reviewed for transmission-based precautions. Findings included: A review of the Infection Control Policy and Procedure for the facility revealed the facility's guidelines for Infection Prevention and Isolation were derived from the Appendix A available from the Centers for Disease Control and Prevention. According to the guideline, for residents in a healthcare setting such as a facility with C. diff., Contact plus Standard precautions were required. A review of Resident #130's medical record revealed she was first admitted to the facility on 11/27/18 with a most recent re-admission from the hospital on 08/05/19. Resident #130's diagnoses included Clostridium difficile (bacterium that cause symptoms which range	F 880	F880 How the corrective action will be accomplished for the resident(s) affected. The certified nursing assistant enter Resident #130□s room without PPE. The certified nursing assistant was re-educated on the requirement of infection control regarding proper precautions for isolation rooms to include proper personal protective equipment by 9/13/2019. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. The Staff Development Coordinator in-serviced/re-educated all staff on the requirement of infection control regarding proper precautions for isolation rooms to include proper personal protective equipment and return demonstration and or by repeating proper	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 09/04/2019

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F 880	Continued From page 22 from diarrhea to life threatening inflammation of the colon). Further review of Resident #130's medical record revealed a stool culture dated 07/27/19 that was positive for Clostridium difficile (C. diff). An observation on 08/12/19 at 6:03 PM revealed a sign on the door of Resident #130's room that read in part: "Stop - Contact Precautions - Enteric Precautions - Perform hand hygiene before entering room and wash hands with Soap and Water for 15 seconds before leaving the room. Gloves when enter the room. Gown for direct patient care or whenever clothing may contact surfaces in the room." NA #1 was observed walking into Resident #130's room with her dinner tray with no Personal Protective Equipment (PPE) on. NA #1 moved around things on the resident's overbed table and placed her tray down. The resident's bedside table was moved by NA #1 closer to her, so she could reach her tray. NA #1 walked out of the room without washing her hands and proceeded down the hallway until she was stopped by Nurse #1. After Nurse #1 was finished talking with NA #1 she went into the soiled utility and washed her hands. An interview on 08/12/19 at 6:15 PM was conducted with NA #`1. She stated she had not put on PPE before entering Resident #130's room and stated she had not washed her hands with soap and water prior to leaving the room but had washed them after leaving the room. NA #1 stated she should have gowned and gloved prior to going into the resident's room and should have taken off her gown and gloves and thrown them in the biohazard trash and washed her hands with soap and water prior to leaving the resident's	F 880	infection control steps of the proper process by phone on 9/13/2019. Any active employee who does not receive this education and return demonstration will not be allowed to work until completed. All new employees will receive this education and must return demonstration before being assigned to their appropriate areas. Measures put in place to ensure practices will not re-occur. Beginning 9/13/2019 Staff Development Coordinator will complete (2) weekly audits of staff members for 1 month, then bi-weekly for 1 month, then 1 month, demonstrate the proper infection control precautions regarding person protective equipment for isolation rooms. How the facility plans to monitor and ensure correction is achieved and sustained. The Staff Development Coordinator will review data obtained from the weekly demonstration audits; analyze the data and report patterns/trends to the QAPI committee for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on the identified trends/outcomes to ensure continued compliance. Alleged Completion Date: 9/13/19	

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F 880	Continued From page 23	F 880		

room. She stated she did not know why she had not followed the precautions but stated she should have followed the procedure as outlined on the door and used a gown and gloves.

An interview on 08/14/19 at 9:07 AM was conducted with the Staff Development Coordinator (SDC) who also handled Infection Control. The SDC stated she expected all employees to follow the guidelines based on the type of isolation a resident was on and expected them to utilize the appropriate PPE. She stated all employees were educated on infection prevention when they were hired, annually, in prompt and through their computer-based education software called Relias. The SDC stated she had also provided reminders throughout the year and stated all staff should abide by the guidelines on the door of the residents on precautions.

An interview on 08/16/19 at 3:35 PM was conducted with the Director of Nursing (DON) and Administrator. The DON stated she would have expected NA #1 to have followed the PPE guidelines on the door prior to entering Resident #130's room to deliver her tray. She stated all employees were educated regarding precautions when they were hired and annually and stated several times a year the SDC provided updates and reminders.