STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(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 1/13/20 through 1/17/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # SEUS11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 1/13/20 through 1/17/20. 4 allegations out of the total 7 allegations were substantiated. Event ID SEUS11	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure an alert and oriented resident ' s call bell was kept within reach for 1 of 1 resident (Resident #58) reviewed for accommodation of needs. The findings included: Resident #58 was admitted to the facility on 11/25/19 from a hospital. The resident ' s cumulative diagnoses included aphonia (loss of the ability to speak), tracheostomy status (a surgically created opening through the neck into the trachea or windpipe), and a personal history of sudden cardiac arrest.	F 558	White Oak Manor Burlington provides services in the facility with reasonable accommodation of resident needs. Resident #58 call light was placed within reach during the survey and a clip was placed on the call light on 1/14/2020 to secure it within the reach of the resident. The other residents call lights were checked on 1/15/2020 for clips needing to be replaced and to ensure call lights were in reach of the residents. The Maintenance Director replaced the	2/16/20

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

Electronically Signed | 02/11/2020

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F 558	Continued From page 1 A review of Resident #58 ' s admission Minimum Data Set (MDS) dated 12/2/19 revealed the resident was assessed as having intact cognitive skills for daily decision making and was able to make himself understood. He required extensive assistance for bed mobility, dressing, eating, toileting, and personal hygiene. The resident required limited assistance only for locomotion on and off the unit with the use of a wheelchair. Section O of the MDS indicated he received supplemental oxygen, tracheostomy care, and suctioning while a resident at the facility. A review of Resident #58 ' s comprehensive care plan included the following area of focus: Resident exhibits Activities of Daily Living (ADL) deficit related to decreased mobility and obesity (11/25/19). The planned interventions included keeping the resident ' s call bell within reach at all times while he was in his room. An observation was conducted and interview attempted with Resident #58 on 1/14/20 at 8:35 AM as he was lying in his bed. The resident appeared to have some difficulty with verbalization but could express himself by nodding/shaking his head to indicate "yes" or "no." The resident's call bell was observed on the floor at the time of the observation. The resident was asked if the call bell was usually within reach. He emphatically shook his head and indicated it was not. When the call bell was placed within his reach, the resident immediately pushed the call bell button. The facility's Director of Nursing (DON) was observed as she promptly responded to the bell, but appeared to have some difficulty identifying what the resident wanted. Administrative Staff #1 then came into the room.	F 558	clips on the call lights by 2/16/2020 to assist in securing the call lights to stay within reach of the residents. The facility staff were re-educated on ensuring the call lights are within reach of the residents and the clips are attached to the call lights by the DON and Staff Development Coordinator (SDC). Re-education to be completed by 2/16/2020. Newly hired staff will receive this education during their job specific orientation by the SDC. Facility rounds by the nurse managers (DON, ADON, SDC and unit coordinators) to monitor the call lights are within reach of the resident will start the week of 2/10/2020. The nurse managers will monitor a total of 10 observations of the call lights per week for 4 weeks, then 3 observations per week for 4 weeks and then as needed thereafter. The identified trends or issues will be discussed during the morning Quality Improvement (QI) meetings Monday-Friday and then brought to the Quality Assurance Committee meeting for further recommendations as needed. The Administrator, DON and Unit Coordinators are responsible for continued compliance of Tag F558.	

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F 558	Continued From page 2	F 558		

After asking the resident several questions, she raised the head of his bed. When Administrative Staff #1 was told Resident #58 ' s call bell was found on the floor, she was observed as she called maintenance and requested a clip be attached to the resident ' s call bell to keep it in place and within reach of the resident.

An observation was conducted of Resident #58 on 1/16/20 at 7:10 AM. The resident was observed to be lying in bed awake. His call bell was on the floor under the bed. Neither the call bell button nor the cord of the call bell were within reach of the resident.

Upon request, Nursing Assistant (NA) #6 entered Resident #58 ' s room on 1/16/20 at 7:20 AM. When she entered the room, the resident was lying in bed awake and his call bell was observed to be on the floor under his bed. NA #6 picked the call bell up and clipped it to the resident's bed covering within his reach. The resident was observed as he appeared to smile when the call bell was placed within reach. During the observation, Resident #58 did not push the call bell for assistance after it was placed within his reach. An interview was conducted with NA #6 at that time. The NA confirmed the resident could use his call bell to ask for assistance when it was within reach.

An interview was conducted 1/17/20 at 1:30 PM with the facility ' s DON. During the interview, the concerns regarding Resident #58's call bell not being kept within his reach were discussed. When talking about the initial incident when the call bell was found on the floor, the DON stated she recalled the event when she had responded to his call bell. She also recalled Administrator

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F 558	Continued From page 3 Staff #1 came into the room after her and then contacted maintenance to get a clip for his call bell. After the second incident was discussed, the DON reported she would want her staff to keep the bell within reach for a resident such as Resident #58 (who could use the call bell) and to be conscientious about the call bell placement.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate the discharge location (Resident #126 and Resident #128) or the Preadmission Screening and Resident Review (PASRR) Level II status (Resident #87) for 3 of 24 residents whose MDS assessments were reviewed. Findings include: 1.Resident #126 was admitted to the facility on 10/13/19 with diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, depression and dementia. The discharge summary dated 10/17/19 revealed the resident was admitted on 10/13/19 for respite care. On 10/17/19 the resident had acute episode with extremely elevated blood pressure/ pulse and oxygen desaturation. Nurse Practitioner was notified and orders to send resident to emergency department for evaluation. Resident left facility via	F 641	White Oak Manor Burlington ensures accuracy of assessments. Resident #126's discharge location was corrected on resident's Discharge Minimum Data Set (MDS) assessment dated 10/17/19 on 1/17/2020 from community to acute hospital. Resident #128's discharge location was corrected on resident's Discharge MDS dated 10/27/19 on 1/17/2020 from acute hospital to community. Resident #87's PASRR Level II status was corrected on the resident's annual MDS assessment dated 8/21/2020 to be considered by the State Level II PASRR status to have a serious mental health and/or intellectual disability. discharged residents for the last 30 days were audited for accuracy of discharge	2/16/20

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F 641	Continued From page 4 emergency medical services stretcher. Resident #126's Physician orders dated 10/17/19 read in part " Sent to emergency room to be evaluated". The resident's Discharge MDS assessment, dated 10/17/19, revealed Resident #126 was discharged to the community. During an interview on 1/17/19 at 11:05 AM, the Social Worker Director indicated her assistant incorrectly coded the MDS. She stated it was a technical error and the MDS should be coded as discharge to hospital verses discharge to community. The Social Services Assistant was not available for an interview. 2. Resident #128 was admitted to the facility on 10/25/19 with diagnoses that included dysphagia, Alzheimer's, dementia, weight loss, hypertension and anemia. The discharge summary dated 10/27/19 revealed the resident was on respite care. Resident received no therapy and had no acute events while in facility. Resident was discharged home with family via personal vehicle to continue same respite services. A general note dated 10/2719 read in part "Resident responsible party (RP) in facility to take resident home. All belongings and medications to release to RP. No concerns voiced. The resident's Discharge MDS assessment, dated 10/27/19, revealed Resident #128 was discharged to an acute hospital.	F 641	location on their Discharge MDS assessments. The other residents with Level II PASRR were audited for accuracy on their Comprehensive Assessments. The Social Services Director (SSD) completed the audit on 2/10/2020. The SSD re-educated the Social Services Assistant (SSA) on ensuring the accuracy of MDS assessments for discharge location and PASRR Level. This re-education was completed on 1/28/2020. Newly hired social services staff will receive this education during their job specific orientation by the Corporate Social Services Consultant. The SSD will monitor all residents with Discharge MDS assessments for accuracy of discharge location and all residents with level ii PASRR for accuracy on their new comprehensive MDS assessments weekly for 3 months then as needed therafter. Any identified trends or issues will be addressed and discussed during the morning Quality Improvement (QI0 meetings Monday-Friday and then brought to the Quality Assurance Committee meetings for further recommendations as needed. The SSD is responsible for the ongoing compliance of Tag F641.	

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F 641	Continued From page 5	F 641		

On 1/7/20 at 9:59 AM, the MDS nurse reviewed the MDS and the social worker note that indicated the resident was discharged. MDS nurse stated that the resident's 10/27/19 Discharge MDS was incorrectly coded as discharged to the hospital.

During an interview on 1/17/20 at 8:53 AM, the Administrator stated several residents within the facility have been admitted under the same medical management respite program as Resident #128 for brief services anywhere from 3 to 90 days. The program was designed and utilized for temporary care and services to families of the community for short term measures, which the resident would receive the same care, treatment and services as if they were a long-term care resident. The administrator stated the resident's discharge MDS should be coded accurately.

3. Resident #87 was admitted to the facility on 11/1/13 with a cumulative diagnoses which included severe intellectual disabilities.

Review of a Preadmission Screening and Resident Review (PASRR) Level II list provided by the facility revealed Resident #87 had an intellectual disability and a PASRR number which ended with the letter "B" (indicative of a PASRR Level II determination). Determination of a PASRR Level II resident is made by an in-depth evaluation. Results of the evaluation would be used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care.

Resident #87 ' s annual Minimum Data Set (MDS) assessment dated 8/21/19 was reviewed. Section A1500 of the MDS indicated the resident

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F 641	Continued From page 6 was not considered by the State Level II PASRR process to have a serious mental illness and/or intellectual disability. An interview was conducted on 1/16/20 at 4:25 PM with the facility ' s Social Services Director. Social Services was identified as the department responsible for coding a resident ' s PASRR status within Section A of the MDS assessment. When asked, the Social Services Director reported Resident #87 was a PASRR Level II resident. The Director reviewed the resident's 8/21/19 annual MDS assessment and reported Section A1500 was incorrectly coded. She stated this section should have indicated Resident #87 was a PASRR Level II resident. The Social Services Director reported her assistant had incorrectly coded the MDS. The Social Services Assistant was not available for an interview. An interview was conducted on 1/17/20 at 1:30 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect the resident ' s MDS assessment to be accurate.	F 641		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff members, a consultant pharmacist and physician, the facility failed to administer an "as needed"	F 658	White Oak Manor Burlington provides services to meet professional standards.	2/16/20

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F 658	Continued From page 7 (PRN) medication used to treat low blood pressure in accordance with the parameters indicated by a physician ' s order for 1 of 6 residents (Resident #80) reviewed for unnecessary medications. The findings included: Resident #80 was admitted to the facility on 4/4/18 from a hospital. Her cumulative diagnoses included end stage renal disease requiring hemodialysis. A review of the resident ' s physician orders, which were in place during the months of December 2019 and January 2020, included the following, in part: --5 mg midodrine given as one tablet by mouth every 8 hours as needed (PRN) for systolic blood pressure (BP) less than 90 (Order Date 8/27/19). Systolic blood pressure refers to the top number of a BP reading which indicates the amount of pressure in the arteries when the heart contracts. --Blood pressure every shift with a notation to see the PRN midodrine order for a systolic blood pressure less than 90 (Order Date 8/28/19). -- Send with resident to dialysis 10 milligram (mg) midodrine (a medication used to prevent or treat symptomatic low blood pressure) to be given as one tablet by mouth daily as needed during dialysis for low blood pressure (BP) with a systolic blood pressure less than 110 (Order Date 10/8/18). --Call provider if systolic blood pressure is less than 80 (Order Date 11/29/19). Resident #80 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 12/11/19 revealed she had intact cognitive skills for daily	F 658	Resident #80 had no adverse effects from not receiving the as needed (PRN) medication used to treat low blood pressure in accordance with the parameters indicated by the physician order. Resident #80 and the physician order for the Midodrine 5mg PRN and blood pressure taken every shift were assessed and reviewed by the attending physician on 1/16/2020. The physician order to treat the low blood pressure was continued. Residents with similar order for receiving PRN medication used to treat low blood pressure in accordance with the parameters indicated by the physician were audited on 2/1/2020 with no issues noted. Newly admitted residents with PRN medication used to treat low blood pressure will be monitored for the medication administered as indicated. The licensed nurses were re-educated by the DON and SDC on ensuring the physician orders are being followed as instructed, particularly for PRN medication to treat low blood pressure in accordance with the parameters indicated by the physician order. This re-education will be completed by 2/16/2020. Newly hired nurses will receive this education during their job specific orientation by the SDC. The nurse managers (Don, ADON, SDC and unit coordinators) will monitor current residents with prn medication used to treat low blood pressure in accordance with the parameters indicated by the	

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F 658	Continued From page 8	F 658		

decision making. Section G of the MDS indicated Resident #80 required supervision for bed mobility; limited assistance for walking in her room and the corridor, locomotion on/off the unit, and toileting. She required extensive assistance for transfers, dressing, eating, and personal hygiene.

Resident #80 ' s current Care plan included the following area of focus, in part:
--Risk for cardiovascular complication related to diagnoses of hypertension and atrial fibrillation (a type of irregular heart beat). The care plan goal indicated the resident ' s blood pressure would be closely monitored each shift during the review (Start Date 2/13/19).

A review of Resident #80 ' s December 2019 Medication Administration Record (MAR) revealed the resident experienced 5 episodes of a low BP reading with a systolic blood pressure less than 90 as follows:
--On 12/1/19 at 5:36 AM the BP reading was 89/48. There was no documentation on the MAR to indicate a dose of the PRN 5 mg midodrine was administered to the resident on that date.
--On 12/14/19 at 8:01 AM the BP reading was 88/46. There was no documentation on the MAR to indicate a dose of the PRN 5 mg midodrine was administered to the resident on that date. Information on the MAR indicated the resident ' s next BP reading (scheduled for 12/14/19 at 2:30 PM) was 112/60.
--On 12/22/19 at 4:57 AM the BP reading was 80/46. There was no documentation on the MAR to indicate a dose of the PRN 5 mg midodrine was administered to the resident on that date. Information on the MAR indicated the resident ' s next BP reading (scheduled for 12/22/19 at 2:30

physician order weekly for 3 months then as needed thereafter.

Any identified trends or issues will be addressed and discussed during the morning Quality Improvement(QI) meetings Monday-Friday and then brought to the Quality Assurance Committee meetings for further recommendations as needed.

The DON is responsible for the ongoing compliance of Tag F658.

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F 658	Continued From page 9	F 658		

PM) was 126/58.
--On 12/29/19 4:40 AM the BP reading was 86/48. Nurse #12 documented on the MAR a PRN 5 mg dose of midodrine was administered to the resident on 12/29/19 at 4:41 AM.
--On 12/29/19 at 9:29 PM the BP reading was 88/52. There was no documentation on the MAR to indicate a dose of the PRN 5 mg midodrine was administered at that time as a result of this blood pressure reading. Information on the MAR indicated the resident ' s next BP reading (scheduled for 12/30/19 at 6:30 AM) was 113/62.

Resident #80 ' s January 2020 MAR revealed the resident experienced 1 episode of a low BP reading with a systolic blood pressure less than 90 as follows:
--On 1/13/20 at 4:56 AM the BP reading was 88/55. There was no documentation on the MAR to indicate a dose of the PRN 5 mg midodrine was administered to the resident on that date. Information on the MAR indicated the resident ' s next BP reading (scheduled for 1/13/20 at 2:00 PM) was 116/54.

An interview was conducted on 1/15/20 at 5:09 PM with Nurse #10. Nurse #10 was identified as the nurse who was assigned to care for Resident #80 and documented a low BP reading of 89/48 on 12/1/19 at 5:36 AM. A review of the resident ' s December MAR was conducted with the nurse, including the BP results from 12/1/19. After reviewing the documentation, Nurse #10 stated the PRN midodrine, "should have been given and I completely missed it."

An interview was conducted on 1/16/20 at 7:10 AM with Nurse #11. Nurse #11 was identified as the nurse who was assigned to care for Resident

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F 658	Continued From page 10	F 658		

#80 and documented a low BP reading of 88/46 on 12/14/19 at 8:01 AM. A review of the resident ' s December MAR was conducted with the nurse, including the BP results from 12/14/19. After reviewing the documentation, Nurse #11 reported she believed she was looking at the physician ' s order on the MAR which directed the nurse to call a provider for a systolic blood pressure less than 80. Upon further review of the information, the nurse stated, "It (PRN midodrine) should have been given."

A telephone interview was conducted on 1/16/20 at 9:45 AM with Nurse #12. Nurse #12 was identified as the nurse who was assigned to care for Resident #80 and documented low BP readings of 80/46 on 12/22/19 at 4:57 AM, 88/52 on 12/29/19 at 9:29 PM, and 88/55 on 1/13/20 at 4:56 AM. No PRN midodrine was documented as having been administered for a systolic blood pressure less than 90 on these occasions. During the interview, Nurse #12 recalled Resident #80 did have low blood pressures on occasions, but noted her BP would sometimes go up when she sat up or started moving around. The nurse reported if the resident's systolic blood pressure was less than 90 on a dialysis day, she may have just sent the midodrine with her to the dialysis center and let them decide if they wanted to give the medication. If a low systolic blood pressure was on a non-dialysis day, Nurse #12 reported she would have intended to give the midodrine as ordered by the physician. Upon review of the low BP episodes noted, only one date (1/13/20) was a dialysis day.

An interview was conducted on 1/16/20 at 10:10 AM with the facility ' s Medical Director in regards to the resident's blood pressure readings and the

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F 658	Continued From page 11 physician ' s order for PRN midodrine. During the interview, the Medical Director reported she would expect the PRN midodrine to have been given for a systolic blood pressure less than 90 in accordance with the physician ' s orders. An interview was conducted on 1/16/20 at 2:15 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding Resident #80's low blood pressures and failure to administer PRN midodrine based upon the parameter given in the physician ' s orders were discussed. The DON stated she would have expected the PRN midodrine to have been given in accordance with the physician's orders. An interview was conducted on 1/16/20 at 2:40 PM with the facility's Consultant Pharmacist #2. During the interview, the facility ' s failure to administer PRN midodrine to Resident #80 for a systolic blood pressure less than 90 was discussed. The pharmacist stated now that this had been brought to his attention, he also shared the concern. Consultant Pharmacist #2 reported this problem would need to be fixed.	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		2/16/20

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F 684	Continued From page 12	F 684		

by:
Based on resident, staff, nurse practitioner and physician interviews and record review, the facility failed to assess the resident after a nursing aide (NA) reported a "pop" sound during activity of daily living (ADL) for 1 of 4 residents reviewed for accidents. (Resident #121).

The following day Resident #121's right leg was X-rayed and showed the resident had a distal femur fracture.

Findings included:

Resident #121 was admitted to the facility on 4/4/12 with multiple diagnoses that included multiple sclerosis, pain, generalized edema, age related osteoporosis, contracture of the left knee, delusion disorder and dementia.

The most comprehensive Minimum Data Set (MDS) dated 10/3/19 revealed, Resident # 121 was cognitively intact. Resident #121 was coded as needing extensive assistance with 2 people for toileting, extensive assistance with one person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was also coded as being impaired on both sides of lower extremities.

Review of the care plan dated 10/15/19 revealed the resident had a care plan for restorative nursing program activities of daily living (ADL) related to muscle weakness due to multiple sclerosis. The goal was initiated on 3/18/19. Intervention included was to notify charge nurse if pain was noted with ADL care and care stopped immediately.

During an interview on 1/13/19 at 11:10 AM,

White Oak Manor Burlington ensures that residents receive treatment and care in accordance with professional standards of practice based on the comprehensive assessment of a resident.

Resident #121 was evaluated and treated for the mildly impacted fracture of the distal femur with soft tissue swelling. Pain scale was initiated on 1/16/2020 to check pain scale once a day for 6 weeks. A full assessment on resident #121 was completed on 2/4/20. On 1/17/20, resident #121 had a physician order change in pain medication, Oxycodone HCL 5mg PRN and scheduled Tylenol 2 tablets (1000 mg)to be administered every 6 hours for pain management since resident #121 declined the narcotic medication.

An audit list of current residents with similar diagnoses of osteoporosis, osteopenia and multiple sclerosis were compiled and a skilled assessment including pain/discomfort was completed by the nurse managers (ADON, Weekend Supervisor and Unit Coordinator by 2/7/2020. The current resident's care plans were also updated on 2/5/2020 by the MDS nurses to reflect their appropriate pain scale procedures. Newly admitted residents will have their skilled assessments completed upon admission and as indicated.

The nursing staff (licensed nurses and CNA's) were re-educated by the SDC and

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F 684	Continued From page 13 Resident # 121 stated on 12/18/19, nurse aide (NA) #1 was assisting her with putting on pants. NA #1 had put on the pants to left mid-calf first and was trying to put it on the right leg. NA tried to bend the leg. Resident # 121 stated the NA was told that her leg does not bend, however the NA continued to bend the leg. Resident # 121 stated both the resident and NA#1 heard a "pop" sound. Resident # 121 stated she was not assessed by nursing staff and proceeded to go to her dental appointment. Resident # 121 indicated she had mild pain. Resident #121 indicated on 12/19/19 (the following day), the resident complained of pain and was assessed by Nurse Practitioner (NP). An X-ray was ordered, and results indicated femur fracture. Review of nursing note dated 12/18/19 at 10:44 PM revealed Resident # 121 refused evening ADL care, stating her leg was hurting. Resident refused to be turned. As needed (PRN) pain medication was offered but was refused. Review of nursing note dated 12/19/19 at 12:12 AM revealed Resident# 121 was complaining of leg pain. The nursing note read in part "pain medication administered. Note left in physician communication book. " During an interview on 1/14/19 at 4:30 PM, NA #1 stated on 12/18/19, resident had a dental appointment at around 11 and was assisting the resident getting dressed. NA stated the resident was in bed when she first placed resident's left foot in the pant. The pant just crossed /past the left foot, when NA attempted to raise the right leg, that was when both resident and NA heard a "pop" sound. Resident stated "Oh! my leg". NA #1 confirmed she did notify Nurse # 3	F 684	DON on ensuring that if they hear a pop on a resident or the resident is complaining of or non-verbally expressing pain, the CNA is not to move or relocate the resident until after the resident is assessed and determined by the licensed nurse. The nursing staff is to listen to the resident if they are stating a directive about his/her care such as resident #121, and trying to dress the resident if he/she states they can not bend their leg. Licensed nurses are to complete skilled assessments whether or not an issue or injury is noted. After an incident, resident will be monitor for 72 hours for the acute episode like a fracture, which includes monitoring for pain, the effectiveness from administering the pain medication, and documenting it. Documentation of an incident is important to be completed every time and reported off to the next shift, along with reporting to the attending physician. This education will be completed by 2/16/2020. Newly hired staff will receive this education during their job specific orientation by the SDC. The nurse managers (DON, ADON, SDC and unit coordinators) will monitor 5 residents weekly for 4 weeks to ensure assessments, if indicated were completed, then 3 residents weekly for 4 weeks, then 2 residents weekly for 4 weeks, and as needed thereafter. Any identified trends or issues will be addressed and discussed during the morning Quality Improvement (QI) meetings Monday-Friday and then	

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F 684	Continued From page 14 immediately when the incident occurred, however the nurse had not come in to do the assessment or check on the resident when the incident was reported. NA stated she continued to dress the resident. The resident did not complain of any pain at that time. After assisting the resident with dressing, NA # 1 stated she requested NA # 2 to assist her with mechanical lift to transfer resident from her bed to the wheelchair. NA #1 indicated during the transfer the resident requested NA #2 to hold her legs as her leg was hurting. NA #1 continued that few minutes later Nurse#3 requested her to bring in the mechanical lift to B hallway to reposition the resident in her wheelchair again. NA #1 stated with the assistance of Nurse #3 and other nurses in the hallway, the resident was raised in the mechanical lift, and repositioned. The resident did not complain of any pain or discomfort at this time and proceeded to her appointment. During an interview on 1/14/20 at 11:18 AM, Nurse # 3 indicated she was assigned to the resident on 12/18/19 from 7AM - 3 PM. Nurse # 3 stated on 12/18/19 (unsure of the exact time) the resident was scheduled for a dental appointment. Nurse indicated NA # 2 had informed her about hearing a "pop" sound while resident was being dressed. Nurse# 3 stated prior to the resident leaving the facility for her appointment, she along with NA # 1 and other hall nurses assisted with repositioning Resident # 121 in her wheelchair with the aid of mechanical lift in the hallway. Nurse indicated after transfer the resident's leg was observed by pressing on the upper thigh and along the leg. The resident denied pain when pressed. Nurse #3 stated as the resident did not convey any pain, a full assessment was not completed. Nurse # 3 indicated she did not	F 684	brought to the Quality Assurance Committee Meetings for further recommendations as needed. The DON is responsible for ongoing compliance of Tag F684.	

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document the incident but provided a verbal report to the nurse supervisor and incoming staff.

During an interview on 1/14/19 at 4:15 PM, Nurse # 4 indicated she was assigned to the resident on 12/18/19 from 3 PM to 11 PM. Nurse # 4 stated she did not receive any report about staff hearing a "pop" sound in the leg while the resident was being dressed earlier that day. Nurse # 4 further stated the resident later that night had complained of pain and was offered Tylenol, which was declined. Nurse stated when she asked the resident where the resident was having pain, the resident indicated "all over". Nurse # 4 stated she does recollect the resident indicated a pain scale of 7. Nurse stated as the resident reported overall pain no assessment was complete.

During a telephone interview on 1/16/20 at 7:53 AM, NA #5 indicated she was assigned to the resident on 12/18/19 from 11 PM - 7 AM. NA stated during shift change, she was made aware by the previous shift NA that the resident was refusing ADL care that night as her leg was hurting. NA #5 stated when she entered the resident's room, the resident indicated she got hurt earlier that day and her leg was really sore. Resident#121 had stated she did not want the previous shift NA to provide incontinent care and was waiting for NA #5 to complete her ADL care. NA #5 stated Nurse#5 was notified immediately. Nurse spoke with the resident and provided her with pain medication. NA stated the resident was sore when she tried to turn and change the resident. Resident was verbalizing pain. NA# 5 with the help of another NA (name unknow) completed ADL care for the resident.

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During a telephone interview with Nurse # 5 on 1/15/20 at 8:59 AM, Nurse indicated she was assigned to the resident on 12/18/19 from 11 AM to 7 PM. Nurse # 5 stated the resident was complaining her leg was hurting. Nurse indicated the resident never complained before of any pain or discomfort and did not like to be woken up. Nurse # 5 stated this was unusual for the resident to be awake, complaining of pain, so a note was written in the doctor's communication book for the physician to assess the resident the following day. Nurse # 5 confirmed she did not call the physician. Nurse indicated she did not assess the resident or move the leg. Nurse # 5 stated no information related to any incident that occurred during the day was given to her during the shift report.

During an interview on 1/14/20 at 11:18 AM, Nurse # 3 indicated she was assigned to the resident on 12/19/19 from 7 AM to 3 PM. Nurse # 3 stated that during the shift report, she was made aware about the resident's leg pain and pain medication administered during the night. Nurse indicated according to Resident #121, while NA #1 was trying to put her legs in her pants and assisting her with dressing the previous day, they heard a "pop" sound. Nurse # 3 stated she notified the unit manager who assessed the resident. Nurse confirmed she did not complete any assessment. Nurse confirmed the resident was in pain at that time.

During an interview on 1/16/20 at 9:00 AM, the unit manager indicated on 12/19/19 during morning shift report she was made aware that Resident # 121 was complaining of pain the previous night. The unit manager indicated she observed resident's leg in her room, which appeared to be swollen. The unit manager

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confirmed the resident was in pain and that she did not conduct the head to toe assessment but gave a verbal report to the Nurse Practitioner (NP).

Record review revealed there was no documentation of the resident assessment / nursing assessment on 12/18/19 and on 12/19/19.

Review of nursing note dated 12/19/19 at 8:56 AM revealed the resident was complaining of pain to her right knee and lower leg. Note read in part "Stated when she was getting dressed yesterday, she felt her knee pop. Nurse Practitioner (NP) notified. Orders for X-ray of right knee, tib/fib and ankle was received."

During an interview on 1/14/20 at 4:30 PM, NA #1 indicated she was assigned to the resident on 12/19/19 from 7 AM to 3 PM. NA # 1 stated on 12/19/19 during ADL care the resident had indicated her leg was hurting. Nurse #1 was notified about resident's pain.

Review of the radiology report of the right knee, right tibia/fibula and ankle dated 12/19/19 revealed mildly impacted distal femur fracture. Soft tissue swelling present.

Review of the Nurse Practitioner (NP) note dated 12/19/19 revealed resident had an evaluation of right leg pain. Note read in part "the resident states that when been changed yesterday and when her pant was been pulled up, she felt a "pop". Experienced pain 6/10, aching from her right knee up to her thigh. Resident has a history of osteoporosis and Multiple sclerosis which put the resident at risk for fracture. An x-ray was

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obtained on her right leg which revealed right femur fracture. Resident was placed on oxycodone for pain".

Physician orders dated 12/19/19 indicated Oxycodone HCL 5 milligrams(mg), 1 tablet every 6 hours for pain management.

Review of the updated care plan dated 12/20/19 revealed the resident had a care plan risk of increased level of pain related right distal femur fracture. Interventions included administration of pain medication as ordered and assessing pain level using 1-10 scale.

Review of medication administration record (MAR) for December 2019 revealed, Oxycodone was administered every 6 hours starting 12/19/19 for pain management. From 12/19/19 to 1/17/19, there was no pain assessment documentation that indicated the pain scale before or after medication administration.

During an interview on 1/16/20 at 9:00 AM, the unit manager stated the pain scale documentation was only required prior to any as need pain medication administration. Unit manager further stated she was unaware of Resident # 121's updated care plan that indicated the pain scale 1-10 should be documented daily. She confirmed no follow-up assessments were completed after the incident and no monitoring tools were put in place.

During an interview on 1/16/20 at 9:27 AM, the Director of Nursing (DON) stated she was made aware of the incident on 12/20/19. DON stated when the nurse was made aware of the popping sound, the nurse should have completed an

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assessment, which should include physical assessment of leg and should be documented. After assessment if the resident was not in distress and leg was not deformed or any issues/ deviation from normal then the resident could go ahead with her daily routine. DON further stated the nurse should document the incident in chart. During an acute episode all staff should document any observations or conditions of the resident and able to demonstrate ongoing monitoring of the resident. The Unit manager should coordinate care. The resident should have been monitored for 72 hour for acute episode like a fracture and this included the effectiveness of any pain medication.

During an interview with the Physician in presence of the NP on 1/16/20 on 10:01 AM, Physician indicated if the resident complained of pain then an evaluation should be completed. The resident should be evaluated by the nurse prior to transfer, if there was popping sound accompanied by pain which included "Ouch my leg hurts". NP stated the resident was bed bound and very rarely moves out of bed except to get her hair done. The physician stated that the resident was prone to a pathological fracture when her legs were moved due to resident's diagnosis of osteoporosis, osteopenia and multiple sclerosis. Both NP and physician indicated that they did not consider that the resident had a delay in treatment. The resident was assessed, X-ray ordered and sent to Ortho clinic when results indicated a fracture. NP added that the resident was not a surgical candidate and consider the ortho consult recommendations to be appropriate. Related to pain medication, Physician stated when narcotics were administered as pain medication, the nursing staff

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F 684	Continued From page 20 should indicate the pain scale to indicated if the medication was effective or non-effective. Physician stated the Physician or NP should be notified prior to the resident leaving to the dental appointment when the "pop" sound was heard, and pain indicated. Both further indicated that the nursing staff should communication to them via phone when not available in the facility. Physician stated the nursing staff should be monitoring the resident for 72 hours after the incident.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, nurse practitioner interviews and physician interview, the facility failed to provide care in a manner to a dependent resident, who required extensive assistance with dressing, to prevent injury for 1 of 4 sampled residents reviewed for accidents (Resident #121). Resident #121 had informed the nurse aide (NA), who was assisting her to put on her pants that her leg would not bend, The NA continued to dress the resident, when both Resident #121 and the NA heard a "pop" sound. The resident experienced pain in her leg. The following day an x-ray of the resident's leg revealed Resident #121 sustained a femur	F 689	White Oak Manor Burlington provides care in a manner to prevent accidents during care. Resident #121 was evaluated and treated for the mildly impacted fracture of the distal femur with soft tissue swelling. Pain scale was initiated on 1/16/2020 to check pain scale once a day for 6 weeks. A full assessment on resident #121 was completed on 2/4/2020. On 1/17/2020 resident #121 had a physician order change in pain medication, Oxycodone HCL 5mg PRN and scheduled Tylenol 2	2/16/20

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F 689	Continued From page 21 fracture. Findings include: Resident #121 was admitted to the facility on 4/4/12 with multiple diagnoses that included multiple sclerosis, pain, generalized edema, age related osteoporosis, contracture of the left knee, delusion disorder and dementia. The comprehensive Minimum Data Set (MDS) dated 10/3/19 revealed, Resident # 121 was cognitively intact. Resident #121 was coded as needing extensive assistance with 2 people for toileting, extensive assistance with one person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was also coded as being impaired on both sides of lower extremities. During the look back period, Resident #121 was on restorative program for bed mobility and dressing for 3 of 7 days. The care plan dated 10/15/19 revealed the resident had a care plan for restorative nursing program activities of daily living (ADL) related to muscle weakness due to multiple sclerosis. The goal was initiated on 3/18/19. Interventions included were 1) restorative nurse to be notified if resident refused, declined or had inability to assist with ADL care. 2) Charge nurse to be notified if pain was noted during ADL care. ADL care to be stopped immediately. During an interview on 1/13/19 at 11:10 AM, Resident # 121 stated on 12/18/19, nurse aide (NA) #1 was assisting her with putting on pants. NA #1 had put on the pants to left mid-calf first and was trying to put it on the right leg. NA tried to bend the leg. Resident # 121 stated the NA was	F 689	tablets (1000 mg) to be administered every 6 hours for pain management since resident #121 declined the narcotic medication. Resident #121 is being provided ADL care in a manner that prevents accidents. An audit of current residents with similar diagnoses of osteoporosis, osteopenia and multiple sclerosis were compiled and a skilled assessment including pain/discomfort was completed by the nurse managers (ADON, Weekend Supervisor and Unit Coordinator) by 2/7/2020. Newly admitted residents will have their skilled assessments completed upon admission and as indicated. The nursing staff (licensed and CNA's) were re-educated by the DON and SDC on ensuring care provided to residents in a manner that will not cause injury. The nursing staff is to listen to the resident when they are stating a directive about his/her care such as resident #121 when trying to dress the resident and he/she states they can not bend their leg. This education will be completed by 2/16/2020. Newly hired nursing staff will receive this education during their job specific orientation by the SDC. The nurse managers (DON, ADON, SDC and unit managers) will monitor 5 resident weekly for 4 weeks by randomly observing the residents ADL care to ensure care in a manner that prevents injury, then 3 residents weekly for 4 weeks, then 2 residents weekly for 4 weeks and as	

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F 689	Continued From page 22 told that her leg does not bend, however the NA continued to bend the leg. Resident # 121 stated both the resident and NA#1 heard a "pop" sound and she felt pain in her leg. Resident#121 further stated the X-ray indicated a broken femur bone to her right leg. Resident #121 stated on 12/31/19, the facility social worker (SW) had assisted her in filing a grievance related to the incident. The Resident #121 stated she did inform the administrator that the NA#1 was reckless and yanked her leg in order to assist her with putting on her pants. The grievance report dated 12/31/19 read in part "on 12/18/19, the NA while putting pants on left leg they weren't all the way on when she tried to twist the right leg and foot. NA grabbed the right foot and leg and yanked it while holding the leg in her hand and trying to bend it. Resident heard a pop and thought there was a break. Resident hollered, but NA kept trying to force the right leg in the pants. Resident was very disappointed about this and being caused a lot of pain and grief.". During an interview on 1/14/19 at 4:30 PM, NA #1 indicated she was assigned to the resident on 12/18/19. NA#1 stated on 12/18/19, Resident #121 had a dental appointment at around 11 AM and she was assisting the resident to get dressed. NA #1 stated the resident was in bed when she first placed resident's left foot in the pant. The pant just crossed /past the left foot, when NA attempted to raise the right leg, that was when both resident and NA heard a "pop" sound. Resident stated "Oh! my leg". NA stated she requested the resident to give her a second and she went to notify Nurse # 3 who was assigned to the resident. Nurse# 3 was notified that she and	F 689	needed thereafter. Any identified trends or issues will be addressed and discussed during the morning Quality Improvement (QI) meetings Monday-Friday and then brought to the Quality Assurance meetings for further recommendations as needed. The DON is responsible for the ongoing compliance of Tag F689.	

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the resident heard a "pop" while dressing the resident. NA stated she returned to the resident's room and she continued to dress the resident. NA #1 stated the resident did not complain of any pain at that time. After assisting the resident with dressing, NA # 1 stated she requested NA # 2 assistance with transferring the resident from her bed to the wheelchair using a mechanical lift. NA #1 indicated during the transfer the resident requested NA #2 to hold her legs as her leg was hurting. NA #1 further stated a few minutes later Nurse #3 requested her to bring the mechanical lift to the B hallway because Resident #121 needed to be repositioned in her wheelchair. NA #1 stated with the assistance of Nurse #3 and other nurses in the hallway, the resident was raised in the mechanical lift, and repositioned. The resident did not complain of any pain or discomfort at this time and proceeded to her scheduled dental appointment.

During an interview on 1/14/19 at 11:50 AM, NA # 2 stated on 12/18/19, NA# 1 had requested her (unsure of the time) to assist Resident #121 with transfer from her bed to her wheelchair using the mechanical lift. NA #2 stated during the transfer process Resident #121 was requesting NA # 2 to hold her legs and not let her legs down as her leg was hurting. NA # 2 stated after the transfer, NA #1 had informed her that while trying to get the pants on Resident #121 they heard a "pop" sound and resident was complaining of pain.

Nursing note, dated 12/19/19 at 8:56 AM, read in part "Resident complaining of pain to right knee and lower leg. Stated when she was getting dressed yesterday, she felt her knee pop. Nurse practitioner (NP) was notified, new orders received for X-ray of right knee, tibia/fibula and

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F 689	Continued From page 24	F 689		

ankle.".

The radiologist report dated 12/19/19 revealed Resident #121 had a mildly impacted fracture of the distal femur. with soft tissue swelling present.

The Nurse Practitioner (NP) note dated 12/19/19 revealed, the resident was seen as acute visit for evaluation of right leg pain. Note read in part " the resident states that was been changed yesterday and when her pant was been pulled up she felt a " pop". Hours later she experienced pain 6/10 aching from her right knee up to her thigh. Resident has a history of osteoporosis and multiple sclerosis which put her at risk for fracture. An x-ray was obtained on her right leg which revealed right femur fracture. Resident has an appointment with Orthopedic Clinic.".

During an interview on 1/14/20 at 12:07 PM, the Nurse Practitioner #1 (NP), stated when she arrived to at the facility on 12/19/19, she was informed by a nurse (name unknown) that the resident was complaining of pain in her leg. NP stated she was made aware that when the resident was changed, the pants were pulled quickly, and the staff heard a "pop "sound". NP indicated she had ordered a STAT X-ray due to the resident diagnosis of osteoporosis, osteopenia and multiple sclerosis which put the resident at high risk for fractures.

The Orthopedic clinic consultation report dated 12/19/19 revealed, the resident had right distal femur fracture with mild impaction and angulation.

During an interview on 1/14/20 at 11:18 AM, Nurse # 3 stated on 12/18/19 the resident was

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scheduled for a dental appointment. Nurse indicated NA # 2 had informed her about the hearing a "pop" sound while resident was being dressed for the appointment. Nurse# 3 stated prior to the resident leaving the facility for her appointment, Nurse #3, NA #1 and other nurses assisted the resident with repositioning on her wheelchair with the aid of mechanical lift. Resident #121 proceeded to her dental appointment after been repositioned.

During an interview on 1/14/120 at 4:54 PM, the NA # 3 confirmed she accompanied the resident to the dental appointment on 12/18/18. NA #3 stated while the resident was repositioned on the wheelchair with the help of a mechanical lift on the hallway, the resident had indicated aloud that her foot hurts. Resident#121 had indicated that somebody bumped her foot. NA #3 stated she assumed the assigned staff who were assisting the resident with transfer were aware about the pain, and she did not report it to anyone.

During an interview on 1/17/20 at 12:36 PM, the restorative nurse coordinator stated the resident was in restorative program which included bed mobility and activities of daily living related to dressing. Resident #121 can communicate her needs and able to let staff know which position may hurt her. Restorative nurse indicated no special training related to Resident # 121's dressing / care was provided to NAs . She added all NAs were trained regarding ADL care when acquiring their license.

During an interview with the Physician on 1/16/20 on 10:01 AM, Physician indicated the resident should be evaluated by the nurse prior to be transferred in mechanical lift, if there was popping

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F 689	Continued From page 26 sound accompanied by pain which included "Ouch my leg hurts". The physician stated that the resident was prone to a pathological fracture when her legs were moved due to resident diagnosis of osteoporosis, osteopenia and multiple sclerosis. During a telephone interview with the Orthopedic Clinic Physician on 1/16/20 at 3:20 PM, the Orthopedic Physician stated the resident has multiple sclerosis, hadn't walked in 8 years, and her bones were paper thin. The Orthopedic Physician stated the fracture was not unusual and not related to care concerns, trauma or force. He added that this occurrence could happen during routine care. During an interview on 01/17/20 10:11 AM, the Administrator stated the incident happened on 12/18/19 or 12/19/19. She stated the incident was discussed in the morning meeting, about hearing a pop sound while the resident was getting dressed. Administrator added the NP was notified, X-ray ordered, and the resident was sent to the Orthopedic Clinic and returned back to the facility with a brace to her leg. Administrator stated that after any incident the staff were in-serviced on residents' safety, to remind staff how fragile residents were, to be extra cautious and to ask for extra help if needed.	F 689		
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	F 761		2/16/20

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F 761	Continued From page 27 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and consultant pharmacist interviews, the facility: 1) Failed to date an oral electrolyte solution when opened and store it as instructed by the manufacturer in 1 of 3 medication carts observed (A-1 med cart); 2) Failed to dispose of an opened irrigation solution provided in a single dose container after its initial use as instructed by the manufacturer and stored in 1 of 3 med carts observed (C-2 med cart); and, 3) Failed to store a medication as specified by the manufacturer in 1 of 3 medication carts observed (A-2 med cart). The findings included: 1. Accompanied by Nurse #9, an observation was made on 1/14/20 at 9:30 AM of the A-1	F 761	White Oak Manor Burlington ensure medications are stored and labeled as required. The oral electrolyte (Pedialyte),the irrigation (acetic acid) solution and the prednisone ophthalmic suspension eye drops were discarded immediately on the date of the survey. The current licensed nurses received education on the manufacturers instructions to refrigerate and date/use within 48 hours of the oral electrolyte solution (Pedialyte), the irrigation (acetic acid) solution is a single use container and then must be discarded and the	

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F 761	Continued From page 28 medication cart. The observation revealed an opened and undated 1-liter bottle of Pedialyte unflavored electrolyte solution was stored on the medication cart. Approximately 200 milliliters (ml) of solution remained in the bottle. A review of the manufacturer ' s storage instructions read, "Refrigerate and use within 48 hours." An interview was conducted with the hall nurse at the time of the observation. During the interview, Nurse #9 reported she was not aware of the storage instructions and would be sure to pass this information along to others. An interview was conducted on 1/16/20 at 2:15 PM with the facility ' s Director of Nursing (DON). During the interview, the observations of medication storage were discussed. In regards to the Pedialyte solution found on the med cart, the DON stated she would have expected facility staff to follow the manufacturer's storage instructions. 2. Accompanied by Nurse #3, an observation was made on 1/14/20 at 9:45 AM of the C-2 medication cart. The observation revealed an opened 250 milliliter (ml) bottle of 0.25 % acetic acid solution for irrigation labeled for Resident #36 was stored on the medication cart. Approximately 225 ml of solution remained in the bottle. The bottle was dated as having been opened on 1/14/20. However, a review of the manufacturer ' s labeling on the bottle indicated the solution did not contain a bacteriostat (an agent that stops bacteria from reproducing). The manufacturer labeling indicated the bottle was a single-use container and instructed any remaining solution to be discarded after the bottle was opened. An interview was conducted with Nurse #3 on	F 761	prednisone ophthalmic suspension eye drop will be stored upright as indicated on the manufacturer's instructions. The education was completed by the DON and SDC by 2/16/19. Newly hired licensed nursing staff will receive this education by the SDC during their job specific orientation. The Pharmacy and Nursing Consultants updated policies to reflect following the manufacturer's instructions. The pharmacy consultants will continue to complete random observations of medication storage on their routine facility visits and share their findings with the DON. The DON, ADON or SDC will monitor the storage and labeling of the oral electrolyte solution (Pedialyte), the irrigation (acetic acid) solution and the prednisone ophthalmic suspension eye drop 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then twice per week for 4 weeks, then as needed thereafter. The identified trends or issues will be addressed and discussed during the morning quality improvement meetings Monday-Friday and then brought to the Quality Assurance Committee Meetings for further recommendations as needed. The DON is responsible for the ongoing compliance of Tag F761.	

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1/14/20 at 9:55 AM. During the interview, the nurse reported the facility's dispensing pharmacy had instructed the nursing staff that it was acceptable to store and use the acetic acid solution for 48 hours after opening.

A review of Resident #36's medical record revealed the resident had a current physician's order for 30 ml of 0.25 % acetic acid irrigation solution to be used to flush his supra pubic catheter once every shift.

Upon request, an interview was conducted with Consultant Pharmacist #1 on 1/14/20 at 10:00 AM. During the interview, the consultant pharmacist discussed the acetic acid irrigation solution found on the med cart. The pharmacist reported he needed to check on the store requirements for the acetic acid solution. Also upon his request, a follow-up interview was conducted on 1/14/20 at 3:27 PM with Consultant Pharmacist #1. During this interview, he reported the pharmacy's recommendation allowing the acetic acid solution to be used for 48 hours after opening was based on information obtained several years ago. The pharmacist stated upon a review of the manufacturer ' s labeling and current information available, this recommendation needed to be changed. He confirmed the acetic acid irrigation solution bottle stored on the med cart was a single use product and any remaining solution needed to be disposed of after its initial use.

An interview was conducted on 1/16/20 at 2:15 PM with the facility ' s Director of Nursing (DON). During the interview, the observations of medication storage were discussed. In regards to the acetic acid solution found on the med cart, the

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F 761	Continued From page 30	F 761		

DON stated she would want the nurses to toss the remaining solution and bring the issue forward to discuss concerns related to this solution being provided in a single dose container.

3. Accompanied by Nurse #8, an observation was made on 1/13/20 at 3:50 PM of the Unit A-2 medication cart. The observation revealed an opened bottle of 1% prednisolone ophthalmic suspension (a steroid eye drop medication) labeled for Resident #50 was stored lying down on its side in a drawer of the medication cart. The manufacturer ' s storage instructions printed on the label of the eye drops read in capital letters, "Store Upright."

An interview was conducted on 1/13/20 at 4:00 PM with Nurse #8. During the interview, the nurse was shown the manufacturer ' s labeling on the eye drop medication and asked if she was aware the medication needed to be stored in an upright position. The nurse stated, "It ' s supposed to be."

A review of Resident #50's physician's orders revealed there was a current order for 1% prednisolone ophthalmic suspension eye drops to be instilled as one drop in the right eye three times daily.

Upon request, an interview was conducted with Consultant Pharmacist #1 on 1/14/20 at 10:00 AM. During the interview, the pharmacist reported he was previously unaware of the requirement for ophthalmic suspensions to be stored upright on the medication carts. He stated the facility would be getting dividers put in the med carts to allow for eye drop suspensions to stand upright in

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F 761	Continued From page 31 accordance with the manufacturer ' s storage instructions. An interview was conducted on 1/16/20 at 2:15 PM with the facility ' s Director of Nursing (DON). During the interview, the observations of medication storage were discussed. When asked, the DON reported the pharmacy was checking into potential solutions for the storage of eye drops on medication carts. The DON reported she would like to see the eye drops stored properly in an upright position in accordance with the manufacturer's storage instructions.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		2/16/20

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F 812	Continued From page 32 Based on observations and staff interviews, the facility failed to discard expired food from the kitchen ' s reach-in refrigerator and walk-in refrigerator. Findings included: 1. Observations of foods stored in kitchen refrigerator units revealed the following foods had expired expiration dates: a. On 1/13/20 at 10:10 AM, an observation of foods, stored in the kitchen ' s reach-in refrigerator revealed one opened plastic bag of pimento cheese, with an expired expiration date of 1/11/20. b. On 1/13/20 at 10:15 AM, an observation of foods, stored in the kitchen ' s walk-in refrigerator revealed two unopened 5 Lbs. plastic containers of cottage cheese with expired expiration dates. One of the plastic containers of cottage cheese had an expired expiration date of 12/14/19 and the other plastic container of cottage cheese had an expired expiration date of 1/11/20. On 1/13/20 at 10:20 AM, during an interview, the Kitchen Manager indicated that all expired food should be discarded appropriately. She mentioned that all kitchen employees were responsible to check the expiration dates every time, they restocking the food in refrigerators. On 1/15/20 at 11:20 AM, during an interview, the Cook indicated that all the kitchen staff was responsible for checking the expiration dates on foods and discard expired food daily, when they restocking the food in refrigerators.	F 812	White Oak Manor Burlington ensures food is store, prepared, distributed and served in accordance with professional standards for food safety. The items found expired were immediately discarded on the date of the survey. The dietary staff were re-educated by the Dietary Manager on not storing and discarding expired foods from the refrigerators. The re-education was completed on 2/10/2020. Newly hired dietary staff will receive this education during their job specific orientation by the Dietary Manager. The Dietary Manager will audit the refigerators daily on her morning rounds and the 2nd shift cook is responsible to check in the evening Monday-Friday. The 1st and 2nd shift cooks are responsible to check for expired items on the weekends. The Dietary manager will monitor that no food items are expired 5 times a week for the next 12 weeks, then weekly therafter. Any identified trends or issues will be addressed and discussed during the morning quality improvement meetings Monday-Friday, then as brought to the Quality Assurance Committee meetings for further recommendations as needed. The Dietary Manager is responsible for the ongoing compliance of	

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F 812	Continued From page 33 On 1/16/20 at 10:50 AM, during an interview, the Administrator indicated it was her expectation the kitchen staff to discard all expired food.	F 812		