STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREMENT	180 SOUTHWOOD DRIVE CLINTON, NC 28328

(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 08/09/21 through 08/12/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #OSLQ11.	E 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		8/27/21

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

Electronically Signed | 08/27/2021

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F 655	Continued From page 1 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission related to physicians' orders and diagnosis for 2 of 8 residents reviewed for baseline care plans. (Resident #300 and 307). Findings included: 1. Resident #300 was admitted to the facility on 07/15/21 with diagnoses that included obstructive sleep apnea which required continuous positive airway pressure (CPAP), diabetes, and congestive heart failure. Record review of care plan revealed that the care plan was initiated on 07/19/21. Most recent Minimum Data Set (MDS) dated 07/22/21 revealed that Resident #300 was cognitively impaired and required extensive assistance from staff for activities of daily living (ADLs). During an interview with the Director of Nursing	F 655	F 655 Baseline Care Plan Corrective Actions for Resident #300: A corrective action was taken in order to ensure that the care plan for resident #300 was complete and accurately reflected the resident's current level of functioning, special needs and interventions to ensure that staff members would be correctly guided in providing appropriate and safe care for resident. This was completed on ___7_/_19___/2021 by the MDS Coordinator Gloria Howard, RN. Corrective Actions for Resident #307: A corrective action was taken in order to ensure that the care plan for resident #307 was complete and accurately reflected the resident's current level of functioning, special needs and interventions to ensure that staff members would be correctly guided in providing appropriate and safe care for resident. This was completed on __8__/___9_/2021 by the MDS	

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F 655	Continued From page 2 (DON) on 08/11/21 at 10:00 am revealed that the MDS Nurse completed the baseline care plan for all new admissions. She stated that the baseline care plan was usually done within 48 hours. She reported that the baseline care plan was to be completed within 48 hours of admission. During an interview with the MDS Nurse on 08/12/21 at 10:31 am revealed that Resident #300's care plan initiated on 07/19/21 was the baseline care plan. She reported that she was responsible to complete the baseline care plan and that it should be completed within 48 hours of admission. She stated she would usually complete the baseline care plan as soon as the new admission came to facility but was unable to determine why the baseline care plan was not completed timely for Resident #300. 2. Resident #307 was admitted to the facility on 08/06/21 with diagnoses that included end stage renal disease with dependence on hemodialysis, diabetes, and obstructive uropathy with indwelling foley catheter. Record review of care plan revealed that the care plan was initiated on 08/09/21. During an interview with the MDS Nurse on 08/10/21 at 4:27 pm revealed that the care plan dated 08/09/21 was the baseline care plan for Resident #307. She revealed that Resident #307 admitted to the facility late Friday evening and the baseline care plan was completed on Monday when she returned to the facility. She stated that the baseline care plan was not completed within 48 hours of admission. During an interview with the DON on 08/11/21 at	F 655	Coordinator Gloria Howard, RN. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who were admitted to the facility during the past 30 days was completed in order to ensure that each resident has an appropriate and up to date care plan in place. This audit was completed on 08/26/2021 by the Regional Minimum Data Set Nurse Consultant. The results of the audit are as follows: • 3 of 9 residents were identified as not having a baseline care plan initiated within the first 48 hours after admission to facility. These 3 residents were noted to have a complete care plan in place at the time of this audit, even though they had been initiated after the first 48 hours. • 6 of 9 residents were identified as having had a baseline care plan initiated within the first 48 hours after admission to facility. Systemic Changes On 08/27/21 the Regional Minimum Data Set Nurse Consultant provided in-service education to the facility Minimum Data Set Nurse on the requirements for Baseline Care Plan completion. This education included the importance of ensuring that all residents have a Baseline Care Plan implemented within the first 48 hours after admission to the facility. The Baseline Care Plan must include the minimum healthcare information necessary to properly care for a resident including, but	

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F 655	Continued From page 3 10:00 am revealed that the MDS Nurse completed the baseline care plan for all new admissions. She stated that the baseline care plan was typically completed within in the first two days of admission but reported that a weekend admission posed a problem for timely completion. The DON reported that the MDS Nurse would have completed the baseline care plan on Monday for those residents admitted late Friday or over the weekend.	F 655	not limited to following: • Initial goals based on admission orders • Physician orders • Dietary orders • Therapy services • Social services needs • PASARR recommendation, if applicable The educational material included the fact that the care plan is a tool used to communicate resident's condition, needs, preferences, strengths, special needs to the interdisciplinary team and primarily frontline staff, and that in order to provide the highest quality of care possible and to ensure residents' needs are met, the care plans must be person-centered and an accurate and current reflection of resident's condition and needs. This information has been integrated into the standard orientation training for new Minimum Data Set Nurses. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will conduct audits to ensure that all newly admitted residents have a Baseline Care Plan initiated within 48 hours of admission to facility. The Quality Assurance tool entitled "Baseline Care Plans QA Tool" will be completed weekly for 4 weeks then monthly for 2 months or until sustained compliance has been achieved. Reports will be presented to the weekly Quality Assurance committee by the Director of	

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F 655	Continued From page 4	F 655	Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Compliance date: 08/27/21	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		8/27/21

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F 761	Continued From page 5 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to date an opened medication vial and discard expired medications in 1 of 1 medication rooms and failed to date opened liquid supplements and discard expired medications in 2 of 4 medication carts (100, 400 hall). The findings included: 1 a. An observation was made on 08/12/21 at 10:20 AM of the facility's medication room. An opened 5 milliliter multidose vial of influenza vaccine was in the refrigerator with no date indicating when it was opened. The manufacture's label on the bottle instructed to discard thirty days after opening. The medication room refrigerator was observed to have 8 sealed boxes of influenza vaccine vials with the expiration date 06/30/21. Further observation revealed a bottle of 100-25 milligram tablets of diphenhydramine (an over-the-counter allergy medication) available for use with an expiration date of 03/2021 stamped on the bottle. During an interview on 08/12/21 at 10:45 AM, the Assistant Director of Nursing (ADON) confirmed the influenza vaccine and diphenhydramine medications were expired and should have been discarded. She further indicated nursing staff should check for expired medications and	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: The identified expired medications and flu vaccine were discarded on _8/12/21_____ by the __DON_____. The undated protein supplement was discarded on __8/12/21_____ by the ___DON_____. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications or supplements have the potential to be affected.	

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F 761	Continued From page 6 vaccines daily and discard them. The influenza vaccine vial should have been labeled with the date opened. b. An observation of 400 hall medication cart on 08/12/21 at 10:50 AM revealed the following: -A fluticasone propionate and salmeterol inhalation powder 250/50 inhaler belonging to a resident with the date opened of 4/2/21 handwritten on the label. The manufacturer instructions indicated the inhaler should be discarded 30 days after opening. -An opened 30-fluid ounce bottle of liquid protein supplement with no opened date indicated on bottle. The manufacturer label indicated the product did not need to be refrigerated and should be discarded 3 months after opening. -A half-full bottle of Valsartan (a medication given for high blood pressure) was labeled with a distributed date of 05/07/20 and potassium supplementation with 2 tabs left was labeled with a distributed date of 05/07/20 for Resident #1. During an interview 8/12/21 at 10:50 AM, Nurse #1 indicated all nurses should monitor the medication cart for expired medications and any nurse could remove expired medication from the cart. She stated medications received from the pharmacy were good for one year per facility policy. She further stated the protein supplement should have been dated with the date opened. During an interview on 08/12/21 at 11:30 AM, the Vice President of Operations revealed nursing staff should check for expired medications. She stated a nurse manager oversaw conducting audits on medications room and medication carts but could not recall how often.	F 761	Beginning on __8/16/21_____, the Unit Support Nurses audited all med carts and med rooms to identify any expired or undated medications or supplements. Corrections were made immediately as indicated. This was completed by _Charlene Strickland, LPN_. Beginning on ___8/16/21_____, the Central Supply Clerk completed an audit of the med rooms to identify any expired or undated medications or supplements. Corrections were made immediately as indicated. This was completed on __8/16/21_. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On __8/27/21_____, the Director of Nursing and nurse managers began educating all full time, part time, agency staff, and PRN Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Medication Aides on the following topics: • Checking medications for expiration date prior to administering the medication. • Labeling medications and supplements when opened with date open as indicated. • McNeill's Pharmacy recommended storage for selected items. • Protein supplements are only good for 3 months after opening.	

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F 761	Continued From page 7 c. An observation of the 100 hall medication cart on 8/12/21 at 11:00 AM revealed an opened 30-ounce bottle of liquid protein supplement with no date indicating when it was opened. The manufacturer label indicated the product did not need to be refrigerated and should be discarded 3 months after opening. During an interview on 08/12/21 at 11:05 AM, Nurse #2 revealed the bottle of protein supplement should have been labeled with the date opened. During an interview on 08/12/21 at 11:30 AM, the Vice President of Operations revealed nursing staff should check for expired medications and discard as needed. Nurses should label items after opening when needed. She stated a nurse manager oversaw conducting audits on medications room and medication carts.	F 761	• Schedule for cart and medication room audits. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 5pm on __8/30/21_____, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. In addition to this, any agency nurse or Medication Aide utilized by the facility will receive this in-service education prior to their shift. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The DON or designee will monitor for compliance with labeling medications and supplements with a date when opened and ensuring the cart and the medication room is free of expired medications. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health	

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F 761	Continued From page 8	F 761	Information Manager, and the Dietary Manager. Date of Compliance: ____8/30/21_____	