STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	C 09/11/2014

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BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 9/11/14. Event ID# KS3S11.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview the facility failed to dress residents in their own personal night attire for 2 of 2 sampled residents (Resident # 38 and Resident # 57) who were able to state their preferences and had their own, clean, night attire available and for 1 of 1 residents (Resident # 122) who was cognitively impaired but had clean personal night attire available, provided by family. The findings included: 1. Resident # 38 was admitted on 8/2/2005 and had cumulative diagnoses that included: seizure disorder and depression. The Annual Minimum Data Set (MDS) Assessment dated 1/24/14 revealed Resident # 38 was cognitively intact and could state her own preferences. The MDS also indicated that she required extensive assistance with dressing and	F 242	F242 - 1 .Corrective Action was accomplished for the alleged deficient practice by the Director Of Nursing conducting interviews on 10-6-14 with resident #38, #57 and #122 regarding their preferences for night time attire. Each resident expressed preference to wear their own night time attire. These preferences regarding night time attire were communicated to nursing staff via the Nursing Communication Tool. 2. All residents have the potential to be affected by this alleged deficient practice. The Social Services Director and the Activity Director conducted interviews of alert and oriented residents and interviews with family members for cognitively impaired residents to determine preference related to night time attire. These interviews were completed on	10/21/14

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

Electronically Signed | 10/03/2014

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F 242	Continued From page 1 that it was very important to her to be able to choose what to wear. Review of the Care Plan dated 4/21/14 revealed she had a Plan of Care for behavioral symptoms identified as sad affect and crying related to depression. One of the approaches listed in this Plan of Care was " allow choices within individual's decision making capabilities. " Resident # 38 was observed on 9/9/14 at 9:23 AM. She was in bed and wearing a hospital gown. Resident # 38 was interviewed on 9/11/14 at 11:00 AM. She was in her room, up and dressed in her own daytime attire and was sitting in her wheelchair. When asked, Resident # 38 stated that she had worn a hospital gown to bed the previous night and that staff usually put her in a hospital gown at bedtime. She stated that she would prefer to wear her own nightgown and that she has told staff this. Resident # 38 gave permission to look in her closet and two clean nightgowns were located there although the resident said she only liked one of them. On 9/11/14 at 3:00 PM Administrative Staff # 1 was interviewed. She stated that she expected staff to dress residents in the night time attire of their choice. For residents who could not state their own preferences, she indicated that the family ' s preference should be followed. Administrative Staff # 1 also indicated that if the family provided personal night attire, like a nightgown, this suggested the family ' s preference to have the resident dressed in their own night time attire for the night.	F 242	10-15-14 and preferences regarding night time attire were communicated to the nursing staff via the Nursing Communication Tool. 3. The Facility encourages residents to dress daily in their own clothing, including night time attire. All Nursing staff including those working on the weekends and as needed will be re-educated by the Director of Nursing, Staff Development Coordinator or Unit Manager to adhere to the resident□s preferences and assist residents to dress in their own clothing to include the resident□s choice regarding their night time attire. The re-education will be completed by 10-15-14. The Director of Nursing or Unit Manager will randomly observe and interview 10 residents during 3rd shift, weekly for 12 weeks to verify night time attire choices are being honored, the results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily as identified by the Director of Nursing or Unit Manager. 4. The results of these observations and interviews will be submitted to the QAPI Committee by the DON or Unit Manager for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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Nursing Assistant (NA # 3) was interviewed on 9/11/14 at 4:00 PM. She stated that she was assigned to Resident # 38 the previous evening as well as the evening of 9/11/14. She acknowledged that she dressed Resident # 38 in a hospital gown at bedtime and indicated that she did this as it was the resident ' s preference.

2. Resident # 57 was admitted 8/10/14 with cumulative diagnoses including: dementia, hearing loss, right humerus fracture and anxiety.

Review of the Admission Minimum Data Set (MDS) dated 8/17/14 revealed Resident # 57 was cognitively impaired but could state her own preferences. The MDS also indicated that she required extensive assistance with dressing and that it was very important to her to be able to choose what to wear.

Review of the Care Plan dated 8/23/14 revealed Resident # 57 had a Plan of Care for " requires extensive assistance and intervention for completion of ADL (Activities of Daily Living). " One of the approaches listed in this Plan of Care was " encourage active participation in tasks. "

Resident # 57 was observed on 9/9/14 at 8:00 AM in bed and wearing a hospital gown.

Resident # 57 was observed on 9/11/14 at 9:25 AM in bed and wearing a hospital gown. The resident was awake and interviewed at this time. She stated she did not know why the staff put her in a hospital gown at night " they just put me in what they want " . Resident # 57 gave permission to look in her closet. A clean, light flannel, short sleeved nightgown was located in her closet. The nightgown had snaps all the way up the front of

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the gown (from the hemline to the neckline).

On 9/11/14 at 3:00 PM Administrative Staff # 1 was interviewed. She stated that she expected staff to dress residents in the night time attire of their choice. For residents who could not state their own preferences, she indicated that the family ' s preference should be followed. Administrative Staff # 1 also indicated that if the family provided personal night attire, like a nightgown, this suggested the family ' s preference to have the resident dressed in their own night time attire for the night.

3. Resident # 122 was admitted on 7/19/14 with cumulative diagnoses including Alzheimer ' s disease, Psychotic Disorder, Anxiety and Depression.

Review of the Admission Minimum Data Set (MDS) dated 7/26/14 revealed Resident # 122 was cognitively impaired and unable to state her own preferences. The MDS also indicated that she required extensive assistance with dressing.

Review of the Care Plan dated 7/28/14 revealed Resident #122 had a Plan of Care for " requires extensive assistance and intervention for completion of ADL (Activities of Daily Living). " One of the approaches listed in this Plan of Care was " encourage active participation in tasks. " There was also a Plan of Care for verbal and physical behavioral symptoms with a target behavior listed as " yells out " . One of the approaches listed in this Plan of Care was " allow choices within individual ' s decision making capabilities. "

On 9/9/14 at 9:27 AM resident # 122 was

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observed in bed wearing a hospital gown.

On 9/11/14 at 9:00 AM Resident # 122 was observed in bed wearing a hospital gown.

On 9/11/14 at 9:15 AM Nursing Assistant # 4 was interviewed. She stated that she did not know why the resident was dressed in a hospital gown at night time because she only worked day shift. She also said that this resident often had a hospital gown on in the morning as did many other residents. She looked in the resident ' s closet at this time and was able to locate a clean nightgown.

On 9/11/14 at 3 PM Administrative Staff # 1 was interviewed. She stated that she expected staff to dress residents in the night time attire of their choice. For residents who could not state their own preferences, she indicated that the family ' s preference should be followed. Administrative Staff # 1 also indicated that if the family provided personal night attire, like a nightgown, this suggested the family ' s preference to have the resident dressed in their own night time attire for the night.

Nursing Assistant (NA # 3) was interviewed on 9/11/14 at 4:00 PM. She stated that she was assigned to Resident # 122 the previous evening as well as the evening of 9/11/14. She acknowledged that she dressed Resident # 122 in a hospital gown at bedtime and indicated that she did this as the resident was often combative when care was given.

Review of the Nursing Notes, Medication Administration Record, Treatment Administration Record and Behavior sheet revealed no

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F 242	Continued From page 5 documented behaviors on 9/9/14 through 9/11/14.	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for significant weight	F 278	F278 1. The Quarterly MDS for Resident #80 with ARD 8-22-14 was corrected on	10/21/14

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F 278	Continued From page 6 loss for 1 (Resident #80) of 3 sampled residents and failed to accurately code the MDS for pressure ulcer for 1 (Resident #163) of 4 sampled residents. The findings included: 1. Resident #80 was admitted to the facility 7/1/2011. A Quarterly Minimum Data Set (MDS) dated 8/22/14 specified Resident #80 weighed 105 pounds with no significant weight loss or gain. Review of Resident #80 ' s medical record revealed the following documented weights: 2/23/14 124.2 pounds 3/31/14 122.1 pounds 4/27/14 110.6 pounds 5/19/14 115.6 pounds 6/24/14 106.4 pounds 7/21/14 107.2 pounds 8/4/14 105 pounds 8/12/14 104.4 pounds 8/18/14 104.2 pounds A Dietary progress note dated 8/14/14 stated Resident #80's current body weight was 105 pounds which was a weight loss of 19 percent in 180 days. On 9/10/14 at 4:28 PM, the dietary manager stated she should have coded the MDS dated 8/22/14 with a significant weight loss because the resident experienced a weight loss of 19.35 percent during the previous six month period. She said it was an oversight on her part. 2. Resident # 163 was originally admitted to the facility on 5/2/14 with multiple diagnoses including Peripheral Vascular Disease.	F 278	10-1-14 by the Resident Care Management Director to accurately reflect the significant weight loss. The Significant Change MDS for Resident #163 with ARD 9-7-14 was corrected on 10-1-14 by the Resident Care Management Director to accurately reflect the status of pressure ulcers present upon admission. 2. The coding of the MDS of Residents with significant weight loss and/or pressure ulcers have the potential of being affected by this alleged deficient practice. The Director of Nursing, Unit Manager and Resident Care Management Director will complete an audit of all Residents with significant weight loss and/or pressure ulcers by reviewing the weekly and monthly Weight Logs and the weekly Pressure Ulcer Logs to validate the Admission MDS assessment and the most recent MDS assessment have been coded accurately to reflect the status of the resident. This audit will be completed by 10-15-14. Opportunities identified will be corrected by submitting a corrected MDS by 10-15-14. 3. The Regional Care Management Director will re-educate all MDS staff including those working as needed by 10-15-14 on the accurate completion of sections K and M on the MDS. The Resident Care Management Director or the MDS Coordinator will randomly review 10 completed MDS assessments weekly for 12 weeks to verify accurate completion, the results of this monitoring	

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F 278	Continued From page 7 The nursing admission intake form dated 5/2/14 indicated that Resident #163 was admitted with no pressure ulcer. The admission Minimum Data Set (MDS) assessment dated 5/18/14 indicated that Resident #163 had no pressure ulcer. The quarterly MDS assessment dated 8/5/14 indicated that Resident #163 had 2 areas of stage III pressure ulcers and the pressure ulcers were present on admission. The physician's orders for Resident #163 were reviewed. There were no treatment orders for pressure ulcers until 5/27/14. The weekly pressure ulcer records for Resident #163 were reviewed. The records dated 6/1/14 indicated that Resident #163 had a pressure ulcer on the coccyx and on the right ankle. On 9/11/14 at 11:40 AM, MDS Nurse #1 was interviewed. She could not find any documentation that Resident #163 had pressure ulcers or was treated for pressure ulcers on admission. She further stated that the pressure ulcer should not have been coded as present on admission on the quarterly assessment dated 8/5/14.	F 278	will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Resident Care Management Director or MDS Coordinator as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Resident Care Management Director for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		10/21/14

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F 279	Continued From page 8 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to develop a care plan for two of two sampled residents with contractures (Resident #80 and #103). The findings included: 1. Resident #80 was admitted to the facility 7/1/2011. Cumulative diagnoses included: Alzheimer's disease and Dementia. A Quarterly Minimum Data Set (MDS) dated 8/22/14 indicated there was no functional limitation in range of motion for the upper/ lower extremities. Medical record review revealed a physician's order dated 7/7/14 for a wrist splint/ palm protector applied to left hand to prevent contracture. A physician's history and physical dated 9/3/14 indicated contractures left hand extremities with atrophy (decrease in muscle mass).	F 279	F279 1. A Contracture Care Plan reflecting current interventions was initiated for Resident #80 and Resident #103 by the Resident Care Management Director on 10-6-14. 2. Residents with contractures have the potential to be affected by this alleged deficient practice. The Rehab Director and Resident Care Management Director will complete an audit of all Residents with Contracture, by reviewing residents currently coding for decreased range of motion on the most recent MDS with subsequent therapy screening as required. The Resident Care Manager will validate a Care Plan is in place that reflects current interventions for Contracture Management. This audit will be completed by 10-15-14. 3. The Interdisciplinary Team, which	

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F 279	Continued From page 9 On 9/10/14 at 10:30AM, Resident #80 was observed lying in bed. She had a brace on her right foot and her left hand was bandaged. Contractures were noted of both legs and arms. Nurse #3 stated Resident #80 had contractures of her arms, legs and left hand. She stated a wedge was used between Resident #80's legs when she was up in the wheelchair and a right foot brace was used for pressure ulcer prevention/ contracture management. Nurse #3 said Resident #80 had her left hand bandaged to reduce pressure reduction between the fingers. She stated she did not recall that a hand splint had been used for the left hand contracture. A review of the care plan for Resident #80 revealed there was not a care plan in place for contracture management. On 9/11/14 at 8:23 AM, the occupational therapist stated she saw Resident #80 from 7/4/14 through 7/18/14 for a palm/ protector splint for the left hand. She stated the splint was recommended by occupational therapy for prevention of the fingers from digging into the palm and prevented further flexion contracture of the fingers and left hand of Resident #80. On 9/11/14 at 11:12AM, Administrative staff #1 stated she would expect the care plan for Resident #80 to include a care plan for contracture management and use of any assistive devices. 2. Resident # 103 was admitted to the facility on 7/31/13 with multiple diagnoses including Dementia and Osteoarthritis.	F 279	includes the Resident Care Management Director, MDS Coordinators, and Rehab Program Manager will be re-educated by the Regional Care Management Director by 10-15-14 related to the development of Comprehensive Care Plans, including the requirement for Care Planning related to Contractures. The Resident Care Management Director or the MDS Coordinator will randomly observe 10 residents to validate care planned interventions for Contracture management are in place and review the Resident Care Plans for accuracy weekly for 12 weeks. The results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Regional Care Management Director or MDS Coordinator as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Resident Care Management Director for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 279	Continued From page 10 The annual Minimum Data Set (MDS) assessment dated 7/21/14 indicated that Resident # 103 was cognitively impaired and had no limitation in range of motion of the upper extremities. The medical records for Resident # 103 were reviewed. The communication form dated 8/18/14 from nursing to therapy indicated that Resident #103 had a left hand contracture. She had discomfort when the staff attempted to straighten out her hand. The form further indicated that Resident #103 yelled out in pain when her left hand was straightened out. On 9/10/14 at 4:20 PM and 9/11/14 at 8:50 AM, Resident #103 was observed. Her left hand was in a fist position with no device observed to prevent further decline in contracture. Review of the care plan revealed that Resident #103 had no care plan to address the left hand contracture. On 9/11/14 at 11:40 AM, MDS Nurse #1 was interviewed. She stated that she was not aware that Resident #103 had a left hand contracture. She added that if she would have known she would have developed a care plan to address the contracture.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		10/21/14

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F 282	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to follow their care plan on pressure ulcer for 3 (Resident #112, #163 and # 80) of 4 sampled residents with pressure ulcers and failed to follow the care plan on dialysis for 1 (Resident #9) of 1 sampled resident on dialysis. The findings included: 1. Resident #163 was originally admitted to the facility on 5/2/14 with multiple diagnoses including Peripheral Vascular Disease (PVD). The quarterly MDS assessment dated 8/5/14 indicated that Resident #163 had 2 areas of stage III pressure ulcers. The care plan for pressure ulcer (no revision date) was reviewed. The care plan problem was pressure ulcers on the right ankle and coccyx. One of the approaches was " measure and stage wound weekly using the pressure ulcer healing assessment form. " The weekly pressure ulcer records were reviewed. The records dated 6/1/14 indicated that Resident #163 had a pressure ulcer on the right ankle measuring 1.5 x (by) 1.3 centimeter (cm), and the wound bed was yellow in color. The stage of the pressure ulcer and the date of onset were blank. There were no records of weekly measurement and staging of the pressure ulcer completed on 7/1/14, 7/8/14, 7/29/14, 8/5/14, 8/12/14 and 8/19/14. The weekly pressure ulcer records dated 6/1/14 also revealed that Resident #163 had a pressure	F 282	F282 1. Resident #112 and Resident #9 no longer reside at the facility. The Director of Nursing reviewed the Care Plans for Resident #80 and Resident #163 on 10-4-14, the Interdisciplinary Team reviewed and updated the interventions to reflect current resident needs and validated the interventions are in place as outlined in the Care Plan. 2. Residents with Pressure Ulcers and Residents receiving Dialysis services have the potential to be affected by this alleged deficient practice. The Director of Nursing and the Resident Care Management Director will complete an audit of all Residents with Pressure Ulcers and/ or receiving Dialysis to validate a Care Plan is in place that reflects current interventions for Pressure Ulcers and/or Dialysis is in place. The Director of Nursing and the Resident Care Management Director will observe all Residents with Pressure Ulcers and/ or Dialysis to validate the facility staff are aware of Care Planned interventions and observe these interventions are in place. This audit will be completed by 10-15-14. 3. The DON, Staff Development Coordinator or Unit Manager will re-educate all Nursing Staff including those working on the weekends and as needed by 10-15-14 related to following the Resident Care Plans for Pressure Ulcers and Dialysis Services, including	

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F 282	Continued From page 12 ulcer on the coccyx measuring 1.1 x 0.5 x 0.3 cm and the wound bed was yellow in color. The record did not indicate the stage of the pressure ulcer or the date of onset. The ulcer was measured on 6/10, 6/17, 6/24, 7/15, and 7/22/14 but the stage was blank. There were no records of weekly pressure ulcer assessment completed on 7/1, 7/8, 7/29 and 8/21/14. On 8/22/14, the resident was sent to the hospital for other reason not related to the pressure ulcer and was readmitted on 8/31/14. On 9/10/14 at 9:00 AM, Resident #163 was observed during dressing change. The pressure ulcer on the coccyx was noted to have a small amount of slough on the wound bed and the wound bed on the right ankle was covered with slough. On 9/11/14 at 1:30 PM, Nurse #2 was interviewed. She stated that the treatment nurse had left a month or so ago and recently she was assigned to complete the weekly assessment of the pressure ulcer. She acknowledged that she had completed some assessments but not on a weekly basis. On 9/11/14 at 2:25 PM, administrative staff #1 was interviewed. She stated that she was aware that the facility had issues for not assessing the pressure ulcer on a weekly basis. She indicated that the facility had lost the treatment nurse a month ago and they had a lot of changes on their administrative staff. Her expectation was for the nursing staff to assess the pressure ulcers weekly using the facility form which include the stage, measurement (width, length, depth) and description of the wound.	F 282	completion and implementation of all care planned interventions. The DON or Unit Manager will randomly observe 10 Residents with Pressure Ulcers and/or receiving Dialysis to review their Care Plans for required interventions weekly for 12 weeks and to validate staff are aware of care planned interventions and these interventions are in place. The results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Director of Nursing or Unit Manager as identified during these audits 4. The results of these reviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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2. Resident #112 was admitted to the facility on 5/5/14 with multiple diagnoses including Diabetes Mellitus and status post left humeral fracture. He was discharged to an assisted living facility on 7/22/14. The admission Minimum Data Set (MDS) assessment dated 5/19/14 indicated that Resident #112 had no pressure ulcer.

The nursing admission intake form dated 5/5/14 indicated that Resident #112 was admitted with no pressure ulcer.

The care plan for pressure ulcer (no revision date) was reviewed. The problem was pressure ulcers, stage III on right and left heels. One of the approaches was " measure and stage wound weekly using the pressure ulcer healing assessment form. "

The physician's orders were reviewed. On 5/7/14, there was an order to apply skin prep to bilateral heels twice a day. On 6/3/14, there was an order to apply hydrocolloid to right heel and santyl (enzymatic debrider which removes dead tissues) to the left heel. On 6/17/14, there was an order to apply santyl to both heels.

Review of the resident's medical records revealed no weekly assessments of the pressure ulcers since admission to the discharge date.

On 9/11/14 at 1:30 PM, Nurse #2 was interviewed. She stated that the treatment nurse had left a month or so ago and recently she was assigned to complete the weekly assessment of the pressure ulcer. She indicated that in May, 2014, the facility had a treatment nurse but she did not know if the weekly pressure ulcer

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F 282	Continued From page 14 assessments were completed or not. On 9/11/14 at 2:25 PM, administrative staff #1 was interviewed. She stated that she was aware that the facility had issues for not assessing the pressure ulcer on a weekly basis. She indicated that the facility had lost the treatment nurse a month ago and they had a lot of changes on their administrative staff. Her expectation was for the nursing staff to assess the pressure ulcers weekly using the facility form which include the stage, measurement (width, length and depth) and description of the wound. 3. Resident #80 was admitted to the facility 7/1/11. Cumulative diagnoses included: Alzheimer's disease and Dementia. A Quarterly Minimum Data Set (MDS) assessment dated 8/22/14 indicated Resident #80 had a stage two (2) pressure ulcer with the oldest stage date of 8/3/14. A care plan dated 6/4/14 and last reviewed 8/22/14 stated Resident #80 had a stage 2 pressure ulcer to the coccyx/ sacral area. On 9/9/14, the care plan noted the stage 2 pressure ulcer to the coccyx/ sacral area was now a stage three (3). Approaches included, in part, measure and stage wound weekly using the pressure ulcer healing assessment form. Weekly pressure ulcer records documented by facility staff were reviewed and revealed the following: 8/7/14 stage 2 pressure ulcer to the left coccyx; date on onset 8/3/14. Measurements: 1 ¼ cm. (centimeters) x 2 cm. 8/14/14 stage 2 to the left coccyx. Measurements: 1.0 cm. x 1.8 cm. 8/21/14 stage	F 282		

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F 282	Continued From page 15 2 to the left coccyx. Measurements: 3 cm. x 3 cm. 8/27/14 stage 2 to the left coccyx. Measurements: 2.8 cm. x 2.5 cm. 9/9/14 stage 2 to the left coccyx. Measurements:3.0 cm. x 2.0 cm. No pressure ulcer measurements were recorded between 8/27/14 and 9/8/14. Hospice notes were reviewed and revealed the following: 7/31/14 Redness noted to coccyx and barrier cream (skin protectant cream) applied. 8/7/14 pressure ulcer on right buttock 1 1/4 cm. x 2 cm. stage 2. 8/14/14 wounds: coccyx (no measurements) 8/21/14 Sacral wound is worsening bright red 3 cm. x 3 cm. 8/27/14 FS (facility staff) stated that wound was dressed and appeared to have no change from last week. No measurements were noted. 9/8/14 1st wound larger 3 cm. x 2 cm. with small amt. (amount) of slough (yellow/ green tissue). New wound 1 cm. x 0.5 cm. On 9/10/14 at 11:50AM, Administrative staff #1 stated the hospice nurse assessed the pressure ulcer and wound documentation would be in the hospice nursing notes. She reviewed the hospice nursing notes and said no wound measurements were documented between 8/27/14 and 9/8/14. On 9/10/14 at 3:30PM, Hospice nurse #1 stated she measured the stage 2 pressure ulcer on Resident #80's coccyx as often as she could. She stated she usually visited Resident #80 in the afternoon and Resident #80 was not always in her bed for wound measurements to be obtained. 4. Resident #9 was admitted to the facility on	F 282		

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F 282	Continued From page 16 8/27/14 with multiple diagnoses including End Stage Renal Disease, Diabetes Mellitus, Congestive Heart Failure, history of Cerebral Vascular Accident, Atrial Fibrillation, history of Gastrointestinal Bleed and Hypertension. A review of the Policy and Procedure for Hemodialysis revised July 2014 was conducted. The review revealed the staff was expected to check vital signs (VS) every shift for the 24 hours post-dialysis or in accordance with the physician ' s orders. A review of the Care Plan dated 8/27/14 for resident #9 was conducted. The plan of care indicated the resident received hemodialysis three times per week on Monday, Wednesday and Friday. The interventions included to check the resident ' s VS every shift for 24 hours post-dialysis or according to the physician ' s orders. A review of the Physician ' s Order for resident #9 from 8/27/14 to 9/10/14 was conducted. A physician ' s order to check VS was not identified. A review of the facility transportation records revealed resident #9 was taken to the dialysis clinic and received hemodialysis on 8/29/14, 9/1/14, 9/3/14, and 9/10/14. A review of the Nursing Daily Skilled Summary and the VS and Weight Flow Sheet from 8/29/14 to 9/11/14 was conducted. The VS were obtained one time during the 24 hour post-dialysis period after receiving dialysis on 8/29/14. The VS were not obtained during the 24 hour post dialysis period after receiving dialysis on 9/1/14. The VS were obtained one time during the 24 hour	F 282		

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F 282	Continued From page 17 post-dialysis period after receiving dialysis on 9/3/14. The VS were not obtained during the 24 hour post-dialysis period after receiving dialysis on 9/10/14. An interview was conducted with Nurse #1 at 11:40 AM on 9/10/14. She stated the VS for residents receiving hemodialysis were obtained once a day. Nurse #1 stated she was not aware the nursing staff was expected to obtain VS on residents receiving hemodialysis every shift during the 24 hour post-dialysis period. An interview was conducted with Nurse #2 at 3:29 AM 9/10/14. She stated the nursing staff was expected to obtain VS on residents receiving hemodialysis once a day. Nurse #2 stated she was not aware the nursing staff was expected to obtain VS on residents receiving hemodialysis every shift during the 24 hour post-dialysis period. An interview was conducted with Administrative Staff #1 on 9/10/14 at 5:09 PM. She stated she expected the nursing staff to obtain VS every shift for a 24 hour period after a resident receives hemodialysis.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		10/21/14

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F 314	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to follow the recommended setting for the air mattress to promote wound healing and to measure and stage the pressure ulcer consistently on a weekly basis for one of four sampled residents (Resident #163) reviewed for pressure ulcers. The findings included: 1a. Resident #163 was originally admitted to the facility on 5/2/14 with multiple diagnoses including Peripheral Vascular Disease (PVD). The admission Minimum Data Set (MDS) assessment dated 5/18/14 indicated that Resident #163 had no pressure ulcer. The quarterly MDS assessment dated 8/5/14 indicated that Resident #163 had 2 areas of stage III pressure ulcers. The care plan for pressure ulcer (no revision date) was reviewed. The care plan problem was pressure ulcers on the right ankle and coccyx. The approaches included " measure and stage wound weekly using the pressure ulcer healing assessment form and pressure reduction mattress to bed. " The weekly pressure ulcer records were reviewed. The records dated 6/1/14 indicated that Resident #163 had a pressure ulcer on the right ankle measuring 1.5 x (by) 1.3 centimeter (cm), and the wound bed was yellow in color. The stage of the pressure ulcer and the date of onset were blank. There were no records of weekly measurement and staging of the pressure ulcer completed on 7/1/14, 7/8/14, 7/29/14, 8/5/14, 8/12/14 and 8/19/14.	F 314	F314 1. The Director of Nursing validated the air mattress settings for Resident #163 were correct settings to promote wound healing on 10-4-14. The Director of Nursing/Unit Manager completed a Nursing Assessment of the Pressure Ulcers present for resident #163 including measuring and documentation of staging on the Weekly Pressure Ulcer Log on 9-19-14. 2. Residents with Pressure Ulcers have the potential to be affected by this alleged deficient practice. The Director of Nursing and Unit Manager completed an observation and assessment of all residents with Pressure Ulcers and validated the current measurements and wound staging to be accurate on 10-4-14. The Director of Nursing and Unit Manager completed an audit of all resident□s with an air mattress to validate accurate settings according to the manufacturer□s recommendations on 10-4-14. 3. The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate the Licensed Nursing Staff including those working on weekends and as needed, regarding the assessment of pressure ulcers including staging, measuring and documentation of observations of the pressure ulcer. This education will be completed by 10-15-14. The Director of Nursing, Staff Development Coordinator or Unit	

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F 314	Continued From page 19 The weekly pressure ulcer records dated 6/1/14 also revealed that Resident #163 had a pressure ulcer on the coccyx measuring 1.1 x 0.5 x 0.3 cm and the wound bed was yellow in color. The record did not indicate the stage of the pressure ulcer or the date of onset. The ulcer was measured on 6/10, 6/17, 6/24, 7/15, and 7/22/14 but the stage was blank. There was no record of weekly pressure ulcer assessment completed on 7/1, 7/8, 7/29 and 8/21/14. On 8/22/14, the resident was sent to the hospital for other reason not related to the pressure ulcer and was readmitted on 8/31/14. On 9/10/14, there was doctor's order to cleanse area to coccyx with NA (sodium) hypochloride solution (1/2 strength Dakins solution, a broad spectrum antimicrobial), apply santyl (enzymatic debrider which removes dead tissues) and cover with wet to dry with ½ strength Dakins daily and to cleanse right ankle with ½ strength Dakins solution and cover with wet to dry with ½ strength Dakins daily and as needed. On 9/10/14 at 9:00 AM, Resident #163 was observed during dressing change. The pressure ulcer on the coccyx was noted to have a small amount of slough on the wound bed and the wound bed on the right ankle was covered with slough. The pressure ulcer on the coccyx was cleaned with ½ strength Dakins solution and santyl ointment was applied. The pressure ulcer on the right ankle was cleaned with ½ strength Dakins solution and wet to dry dressing with Dakins solution was applied. On 9/11/14 at 1:30 PM, Nurse #2 was interviewed. She stated that the treatment nurse	F 314	Manager will re-educate all Nursing Staff including those working on weekends and as needed regarding the proper settings for resident air mattresses according to the manufacturer□s recommendation. The DON or Unit Manager will review current Residents with Pressure Ulcers weekly for 12 weeks to validate documentation of Pressure Ulcer measurements and staging are completed. The DON or Unit Manager will randomly observe 10 residents requiring air mattresses weekly for 12 weeks to ensure accurate settings are maintained according to the manufacturer□s recommendation. The results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Director of Nursing or Unit Manager as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed. A Direct Plan of correction regarding F314 was submitted to CMS regarding ongoing sustainability of correction for F314.	

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F 314	Continued From page 20 had left a month or so ago and recently she was assigned to complete the weekly assessment of the pressure ulcer. She acknowledged that she had completed some assessments but not on a weekly basis. On 9/11/14 at 2:25 PM, administrative staff #1 was interviewed. She stated that she was aware that the facility had issues for not assessing the pressure ulcer on a weekly basis. She indicated that the facility had lost the treatment nurse a month ago and they had a lot of changes on their administrative staff. Her expectation was for the nursing staff to assess the pressure ulcers weekly using the facility form which include the stage, measurement (width, length, depth) and description of the wound. She added that nurses should have been checking the air mattress setting daily for proper setting and functioning. 1b. Resident #163 was originally admitted to the facility on 5/2/14 with multiple diagnoses including Peripheral Vascular Disease (PVD). The admission Minimum Data Set (MDS) assessment dated 5/23/14 indicated that Resident #163 had no pressure ulcer. The quarterly MDS assessment dated 8/19/14 indicated that Resident #163 had 2 areas of stage III pressure ulcers. The care plan for pressure ulcer (no revision date) was reviewed. The care plan problem was pressure ulcers on the right ankle and coccyx. One of the approaches was " pressure reduction mattress to bed. " On 9/10/14 at 9:10 AM and on 9/11/14 at 9:45	F 314		

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F 314	Continued From page 21 AM, Resident #163 was observed in bed with an air mattress. The air mattress had a setting of 8 led lights The resident's air mattress was set on 4 (4th led light from the bottom). The recommended setting written on the machine was " 1-2 led lights from the bottom. " On 9/11/14 at 9:50 AM, Nurse #3 was interviewed. She stated that the nurse supervisor was responsible for recommending the setting of the air mattress depending on the resident's weight and the nurses should be checking the setting daily but obviously the setting had not been checked. Nurse #3 acknowledged that the setting was not correct and stated that she would correct the setting by following the recommended setting written on the machine. On 9/11/14 at 2:25 PM, administrative staff #1 was interviewed. She stated that nurses should have been checking the air mattress setting daily for proper setting and functioning.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide contracture	F 318	F318 1. The Rehab Director and the Director of	10/21/14

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F 318	Continued From page 22 management to prevent further decline to 1 (Resident #103) of 2 sampled residents with contracture. The findings included: Resident # 103 was admitted to the facility on 7/31/13 with multiple diagnoses including Dementia and Osteoarthritis. The annual Minimum Data Set (MDS) assessment dated 7/21/14 indicated that Resident # 103 was cognitively impaired and had no limitation in range of motion of the upper extremities. The medical records for Resident # 103 were reviewed. The records revealed that on 8/18/14, Resident #103 was noted to have left hand contracture. The communication form to therapy indicated that Resident #103 had contracture on the left hand. She had discomfort when the staff attempted to straighten out her hand. The form further indicated that Resident #103 yelled out in pain when her left hand was straightened out. The therapy notes were reviewed. The notes dated 8/19/14 indicated therapy received an in house communication from the nursing staff that Resident #103's left hand is starting to get contracted. Resident #103 was on hospice care, so the hospice nurse was contacted. The hospice nurse deferred the therapy and recommended that nurses to position the hand with a wash cloth. The hospice notes were reviewed. The notes indicated that on 8/27/14, the hospice nurse came to see Resident #103 and noted that her left hand was contracted and was edematous. The nurse provided passive range of motion to	F 318	Nursing validated Resident #103 has a current contracture management plan in place on 10-4-14. 2. Resident's with contractures have the potential to be affected by this alleged deficient practice. The Rehab Director, the Director of Nursing and the Resident Care Management Director will complete an audit of all Residents with Contractures to validate required Contracture Management is in place by reviewing residents currently coded for decreased range of motion on the most recent MDS with subsequent therapy screening as required. The Rehab Director and the Director of Nursing will complete an audit of all Residents with Contractures to validate required interventions are in place, the Care Plan is in place, and reflects current interventions. This audit will be completed by 10-15-14. The Administrator and Director of Nursing met with Hospice providers on 9/15/14 to explain the requirement of an entrance and exit conference with the Director of Nursing or Unit Manager to discuss current residents needs and to review the care plan. 3. The Director of Rehab will educate the Licensed Nursing Staff including those working weekends and as needed and the Therapy Staff by 10-15-14 related to Contracture Management, including splint application and removal. The Rehab Director or Occupational Therapist will randomly observe 10 residents with contracture management plans weekly to 12 weeks to validate interventions for contracture management are	

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F 318	Continued From page 23 the resident's left hand/fingers. She also indicated that the resident was unable to keep a rolled cloth in her hand to reduce contracture. The notes further indicated that the hospice staff visited the resident on 8/28/14, 9/3/14, 9/4/14 and 9/8/14 and the notes did not indicate whether range of motion exercises or any device was tried to prevent further decline in contracture to the resident's left hand. On 9/10/14 at 4:20 PM and 9/11/14 at 8:50 AM, Resident #103 was observed. Her left hand was on a fist position with no device observed to prevent further decline in contracture. On 9/11/14 at 9:30 AM, the therapy staff #1 was interviewed. He stated that the therapy department had received a communication form from the nursing staff regarding Resident #103's left hand contracture. He added because the resident was on hospice, the hospice nurse was called and indicated to defer the therapy and for the facility's nursing staff to apply rolled washcloth to the resident's left hand. On 9/11/14 at 10:04 AM, Nurse #2 was interviewed. She stated that she was aware of the Resident #103's left hand contracture. She indicated that the resident was referred to therapy and therapy had called the hospice nurse. She had seen the hospice nurse visiting the resident but she did not know what care/treatment was provided for the left hand contracture. On 9/11/14 at 1:08 PM, a hospice nurse #2 was interviewed via telephone. She indicated that the hospice nurse who was seeing Resident #103 was not available. Her expectation though that if a resident had a contracture, a rolled washcloth	F 318	implemented. The results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Director of Rehab as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Director of Rehab for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 318	Continued From page 24 or any device was placed on the contracted hand to keep her fingers from digging into her palm. She added that there should have a communication between the hospice nurse and the facility nursing staff as to what contracture management to provide for the resident. On 9/11/14 at 2:25 PM, administrative staff #1 was interviewed. She stated that her expectation was for the hospice nurse and the facility's nursing staff to communicate as to what contracture management can be done for the resident. She also indicated that she would ensure that Resident #103 will be provided care to prevent her left hand to have further decline in contracture.	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		10/21/14

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F 322	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to check the gastrostomy (G) tube placement prior to administering the medications to 1(Resident # 143)of 1 sampled resident observed receiving tube feeding. The finding included: 1. Resident #143 was admitted to the facility on 5/8/14 with multiple diagnoses including cerebro vascular accident (CVA) and dysphagia. The admission Minimum Data Set (MDS) assessment dated 5/15/14 indicated that Resident #143 had impaired cognition and was on tube feeding. The physician's orders were reviewed. Resident #143 had an order dated 6/13/14 for Jevity 1.5 cal (calorie) per G tube at 70 milliliter (ml) per hour for 20 hours (4:00 PM to 12 noon) via pump. On 9/10/14 at 4:30 PM, Nurse #4 was observed during the medication pass. Nurse #1 was observed to flush the G tube with water and followed with crushed medication dissolved in water. Nurse #1 was not observed to check the placement or the residual prior to flushing and administering the medications. On 9/10/11 at 5:05 PM, Nurse #4 was interviewed. She stated that she only checked the placement for nasogastric tube and not for G tube. She added that she only checked the	F 322	F322 1. The Physician was notified of the lack of Gastrostomy Tube placement verification prior to medication administration for Resident #143 by the Director of Nursing on 9-11-14. There were no new orders as a result of this notification. One to one re-education was completed by the Director of Nursing on 9-11-14 with Nurse #1 related to verifying Gastrostomy Tube placement prior to medication administration with return demonstration. 2. Residents with Gastronomy tubes have the potential of being affected by this alleged deficient practice. The Director of Nursing and Unit Manager conducted an audit of all residents with Gastrostomy Tubes to validate a Physician□s Order has been obtained to verify placement prior to medication administration on 10-15-14. 3. The DON, Staff Development Coordinator or Unit Manager will re-educate Licensed Nursing Staff including those working weekends and as needed, by 10-15-14 related to the care of a Gastrostomy Tube including verification of placement prior to medication administration with a return demonstration to validate understanding. The Director of	

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F 322	Continued From page 26 residual if the resident had problems like vomiting. On 9/11/14 at 2:15 PM, administrative staff #1 was interviewed. She stated that nurses were supposed to check the placement/residual prior to administering medications or water flush to a resident on tube feeding.	F 322	Nursing or Unit Manager will complete 10 random observations of Licensed Nurses to include those working during all shifts and weekends, weekly for 12 weeks to validate the verification of placement of the Gastrostomy Tube prior to medication administration. The results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Director of Nursing or Unit Manager as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Director of Rehab for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 334		10/21/14

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F 334	Continued From page 27 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5	F 334		

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F 334	Continued From page 28 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to offer an annual influenza vaccine to 2 of 5 (Resident #7 and Resident #80) sampled residents. The findings included: 1. Resident #7 was admitted to the facility on 8/12/04 with multiple diagnoses including diabetes mellitus, a history of pneumonia and a history of a cerebral vascular accident with hemiparesis. A review of the medical record revealed resident #7 was not offered an influenza vaccine for the 2013-2014 influenza season. An interview was conducted with Administrative Staff #1 on 9/11/14 at 10:44 AM. She stated the nursing staff was expected to offer the influenza vaccine and to explain the risk factors to all of the residents residing in the facility. The nursing staff was expected to obtain consent or refusal of the influenza vaccine from every resident or responsible party. The nursing staff was expected to administer the influenza vaccine if requested and to record the administration on the Medical Administration Record. Administrative Staff #1 also stated she expected the resident's immunization information to be accessible for the	F 334	F334 1. The Unit Manager offered Resident #7 and Resident #80 the Influenza Vaccine on 10-3-14 and signed consent obtained and administered. 2. Current residents have the potential to be affected by this alleged deficient practice. The Unit Manager or Charge Nurse will offer all residents the 2014-2015 Influenza Vaccine. The Unit Manager or Charge will provide documentation of consent obtained by 10-31-14. Administration of the Influenza Vaccine will occur upon delivery of previously ordered vaccine. New admissions into the facility will also be offered the Influenza vaccine by the Unit Manager of the Charge Nurse upon admission through March 31, 2015. 3. The DON, Staff Development Coordinator or Unit Manager will re-educate Licensed Nursing Staff including those working on weekends and as needed by 10-15-14 related to the requirement of obtaining consent and offering the Influenza Vaccine annually to current residents and new admissions. The DON or Unit Manager will randomly review the Influenza Consent Form and	

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F 334	Continued From page 29 facility staff to review. An interview was conducted with Administrative Staff #3 on 9/11/14 at 12:30 PM. She stated she was unable to locate the consent and administration record of the influenza vaccine for resident #7 for the 2013-2014 influenza season. 2. Resident #80 was admitted to the facility on 7/1/2011 with multiple diagnoses including a history of pneumonia, hypertension, depression, allergies and an irregular heart beat. A review of the medical record revealed resident #80 was not offered an influenza vaccine for the 2013-2014 influenza season. An interview was conducted with Administrative Staff #1 on 9/11/14 at 10:44 AM. She stated the nursing staff was expected to offer the influenza vaccine and to explain the risk factors to all of the residents residing in the facility. The nursing staff was expected to obtain consent or refusal of the influenza vaccine from every resident or responsible party. The nursing staff was expected to administer the influenza vaccine if requested and to record the administration on the Medical Administration Record. Administrative Staff #1 also stated she expected the resident's immunization information to be accessible for the facility staff to review. An interview was conducted with Administrative Staff #3 on 9/11/14 at 12:30 PM. She stated she was unable to locate the consent and administration record of the influenza vaccine for resident #80 for the 2013-2014 influenza season.	F 334	the Medication Administration Record of 10 residents weekly for 12 weeks to validate the Influenza Vaccine is being offered, consent is obtained prior to the administration of the Influenza Vaccine, and the Influenza Vaccine is administered. The results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Director of Nursing or Unit Manager as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 364	Continued From page 30	F 364		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on meal observation, staff interviews and resident interviews, the facility failed to provide palliative food for three of three sampled residents (Residents #79, #128 and #7). The findings included: An interview with Resident #79 on 9/8/14 at 3:33 pm was conducted. Resident #79 stated he ate his meals in the main dining room. He also stated the hot foods served during lunch were cold. An interview with Resident #128 on 9/8/14 at 3:59 pm was conducted. Resident #128 stated the food did not taste good 25% of the time. An interview on 9/8/14 at 4:27 pm with Resident #7 was conducted. Resident #7 stated the food did not taste good for most of the meals. He did not identify any particular meal of the day. On 9/10/14 at 1:06 pm a test tray was requested from the server on the steam table. A regular tray was placed on an open cart to be taken to the main dining room which was located outside the kitchen. The tray contained grilled chicken, french fries, a bun in a paper container, a plastic	F 364	F364 1. The Dietary Manager conducted interviews with Residents #7, #79 and #128 by 10-4-14 to identify specific concerns related to meals. These concerns will be documented on the Facility Concern Form, investigation completed by the Dietary Manager, and follow up completed as required by 10-6-14. 2. Current residents have the potential of being affected by this alleged deficient practice. The Dietary Manager will meet during the next scheduled Resident Council meeting to discuss any concerns related to meals as identified by the group, Concerns will be documented on the Facility Concern Form, investigation completed by the Dietary Manager and follow up completed as required. The Dietary Manager will interview alert and oriented residents to discuss any concerns related to meals as identified by the group. Concerns will be documented on the Facility Concern Form, investigation completed by the Dietary Manager, and follow up completed as	10/21/14

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F 364	Continued From page 31 container of tropical canned fruit, and a covered plastic bowl containing lettuce and tomatoes. The tray arrived in the main dining room at 1:06 pm and remained on the cart until the last resident ' s tray was served in the dining room at 1:30 pm. The dietary manager removed the tray from the cart and placed it on an empty table. The cover was removed from the plate with the french fries and grilled chicken on it. The dietary manager tasted the grilled chicken and commented it could use some salt and it was bland. The surveyor tasted the grilled chicken which was luke warm, dry in texture and lacked flavor. The surveyor tasted the french fries which were cold and were not seasoned. The dietary manager tasted the french fries and stated they were cold and were flavorless. The dietary manager indicated the food should be served hot and it should have seasoning on it and some flavor to it.	F 364	required. These interviews will be completed by 10-15-14. 3. The Dietary Manager will re-educate the Dietary Staff including those working on weekends and as needed by 10-15-14 related to enhancing taste of foods served and maintaining correct temperatures of foods served. The Administrator will sample a test tray served form the last meal cart leaving the kitchen 3 times per week for 12 weeks to ensure quality taste of foods served. The Dietary Manager will make random observations daily on tray line ensuring proper temps are maintained. The Dietary Manager, Social Services Director and Activities Director will randomly interview 10 residents weekly for 12 weeks related to specific concerns related to meals. The results of this monitoring will be documented on the facility monitoring tool. Concerns will be addressed daily by the Dietary Manager as they are identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Dietary Manager for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		10/21/14

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F 371	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to keep cole slaw made with mayonnaise/dressing, and milk cartons at or below 41 degrees during operation of the tray-line, failed to air dry kitchenware before stacking it in storage, failed to clean deep fryer after use, and failed to label and date opened food items stored in refrigerators. Findings included: 1. On 9/10/14 at 12:05 pm a digital thermometer was used to check the temperature of cole slaw that was being kept over ice in a 4 inch deep tray pan located beside the steam table. The thermometer registered 55 degrees Fahrenheit. At this time, the Dietary Manager (DM) reported the cole slaw was prepared in the facility. The DM stated the temperature should be 45 degrees Fahrenheit. The DM also indicated the cole slaw had been stored in the refrigerator and was brought out just after the tray line had been set up. The DM stated the temperature of the cole slaw was 30 degrees Fahrenheit at 11:30 am when it was brought out of the refrigerator. 2. On 9/10/14 at 12:06 pm a digital thermometer was used to check the temperature of milk that was being kept in a 6 inch deep tray pan with ice on the top of the milk containers and below the milk containers. The temperature of the milk was 43 degrees Fahrenheit. The DM indicated it was	F 371	F371 1. The deep fryer was drained and cleaned according to facility policy by the Dietary Manager on 9-10-14. Open and unlabeled or undated Food items were immediately discarded by the Dietary Manager 9-10-14. Dishes are now air dried prior to stacking. Cole slaw was discarded following unacceptable temperature measurement. 2. All residents have the potential of being affected by this alleged deficient practice related to the cleaning of the deep fryer, labeling dating and storing food items, proper food storage temperatures, and proper dish drying procedures. 3. The Dietary Manager will re-educate the Dietary Staff including those working weekends and as needed by 10-15-14 related to proper cleaning procedures according to the facility policy, frequency and documentation of the cleaning of the deep fryer, preparing and serving meals and the appropriate methods for storing and serving food at acceptable temperatures and acceptable methods for monitoring food temperatures including accurate documentation of food temperature monitoring logs, proper drying of cleaned dishes and dating and labeling of stored foods items. The Dietary Manager will observe the deep fryer 3	

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F 371	Continued From page 33 safe to store milk at 45 degrees Fahrenheit. 3. On 9/11/14 at 10:52 am dietary aide #1 was observed placing plates coming out of the dish washing machine onto a stack of plates being stored in a plate warmer which was not plugged in. The DM was present at the time and began removing plates from the plate warmer. The DM indicated the stacked plates were ready to be used for service. There were 56 plates observed to have water on them. On the edge of the plate warmer were 3 small serving bowls that were stacked wet and 1 wet pie plate. Dietary aide #1 stated she usually left the dishes in the rack for a while before she stacked them in the warmer. Dietary aide #1 did not answer when asked if that was what she had done this time. On 9/11/24 at 10:53 am the DM stated the plates, bowls and pie plate should have been completely air dried prior to being stacked. 4. On 9/9/14 at 12:45 pm and on 9/10/14 at 12:05 pm the deep fryer was observed to have a layer of yellowish brown colored substance 1/4 inch thick floating on blackish brown colored oil in the front half of the deep fryer. On 9/9/14 at 1:40 pm the registered dietitian stated the deep fryer needed to be cleaned weekly or as needed and that the deep fryer should have been cleaned after the fish was cooked to prevent any cross contamination for any resident who may have an allergy to fish. 9/10/14 at 4:25 pm the DM stated "the deep fryer wasn't cleaned cause she did not have the oil so she could do her french fries today (9/10/14). " The DM stated on Monday (9/8/14) fish was fried	F 371	times per week for 12 weeks to ensure proper cleanliness is maintained and validate documentation of cleaning logs. The Dietary Manager will randomly observe and validate the accuracy of food temperatures obtained by the Dietary staff 3 times per week, to include all meals occurring both day and evening shifts, for 12 weeks and validate documentation of temperature monitoring logs. The Dietary Manager will monitor foods being stored in the Kitchen as well as in the Nursing Unit Nourishment Rooms 3 times per week for 12 weeks to ensure labeling and dating are completed. The Dietary Manager will make random observations of dishes to ensure dishes are being air dried prior to stacking. The Dietary Manager will observe 3 times per week for 12 weeks. Opportunities will be corrected daily by the Dietary Manager or the Cook as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Dietary manager for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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in the deep fryer and on Tuesday (9/9/14) crab cakes where fried in the fryer. The DM further stated that french fries were fried today (9/10/14) in the fryer.

On 9/10/14 at 12:53 pm cook #1 stated the deep fryer is cleaned weekly on Saturdays. Further discussion revealed fresh fish which she had breaded during preparation had been fried in the deep fryer on Monday (9/8/14) and the deep fryer was not cleaned after frying the fish. The cook indicated that as far as she knew, none of the residents were allergic to shellfish.

On 9/11/14 at 9:26 am the walk in refrigerator located in the kitchen was observed to have 3 crates containing 69 clear plastic containers with brown colored fluid in them with no label or date identifying what and when it was placed in the refrigerator. Cook #1 was present at the time and stated there should have been a label on the crates.

On 9/11/14 at 9:30 am an interview with the DM revealed she expected the staff to date and label all items placed in the refrigerator.

6. On 9/11/14 at 3:1 pm the refrigerator in the nourishment room located on the 400 hall was inspected. There were containers of nutritional supplements brought in by family members for specific residents observed in the refrigerator. The containers were not dated or labeled with the resident ' s name. There were four 8 ounces (oz) bottles of a nutritional supplement and 2 cartons of a nutritional supplement in the refrigerator which were undated and not labeled with the resident ' s name.

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F 371	Continued From page 35 Nurse Aide #2 on 9/11/14 at 3:15 pm stated all items stored in the refrigerator were to have a label and date on them. The nutritional supplements without a label or date on them were identified by the NA as items family members had brought in for a resident. On 9/11/14 an interview with the DM revealed that her staff was responsible for stocking the refrigerator in the nutritional room on the 400 hall. Also, the staff was responsible for checking all items stored in the refrigerator for dates and labels. On 9/11/14 at 3:34 pm an interview with dietary aide #2 revealed she was responsible for checking and stocking the refrigerator on the 400 hall. She indicated that she checked all of the items in the refrigerator for expirations dates, and that all the items were labeled and dated. Further discussion revealed that if she found items that were not labeled or dated or if she found expired items, she would throw them out. On 9/11/14 at 3:42 pm Nurse #4 confirmed the nutritional supplements in the refrigerator did not have a label or the date they were brought in on them. As she opened the refrigerator she read the sign on the outside of the refrigerator door that read: "everything in the refrigerator needs to have a date and name of the resident on it. " The nurse indicated that she did not know who the nutritional supplements belonged to. She also stated the nutritional supplements should have been labeled with the resident ' s name and date.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		10/21/14

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F 431	Continued From page 36 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review the facility failed to have a thermometer to monitor the temperature in 1 of 2	F 431	. F431	

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F 431	Continued From page 37 medication refrigerators (200/400 hall refrigerator), failed to store medications within the temperature range required for medications needing refrigeration (36 - 46 degrees Fahrenheit) for 1 of 2 medication refrigerators (100/300 hall refrigerator), failed to identify logged medication refrigerator temperature readings of 34 degrees Fahrenheit as under the safe medication refrigerator storage range, and failed to discard Tuberculin Purified Protein Derivative (PPD) within 30 days after opening in 1 of 2 medication refrigerators (200/400 hall refrigerator). The findings included: Review of the facility policy titled Storage and Expiration of Medication, Biologicals, Syringes and Needles revised 1/1/13 revealed, in part: " Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility staff should monitor the temperature of vaccines twice a day. " " Refrigeration 36 (degrees Fahrenheit) - 46 (degrees Fahrenheit). " " Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has shortened expiration once opened. " 1. On 9/11/14 at 11:35 AM the 200/400 hall medication refrigerator was observed with Nurse # 5. On observation this refrigerator did not have a thermometer. Nurse # 5 was interviewed at this time. She indicated that it was the night nurse	F 431	1. The Director of Nursing discarded the medications from the 100/300 Hall Refrigerator on 9-11-14. The Director of Nursing validated on 9-11-14 that the 200/400 Hall medication refrigerator has a thermometer in place and temperatures are being recorded daily with temperatures being maintained in the required range. The Director of Nursing validated on 9-11-14 that the 100/300 Hall medication refrigerator has a thermometer in place and temperatures are being recorded daily with temperatures being maintained in the required range. Expired medications were discarded by the Director of Nursing on 9-11-14. 2. All residents receiving medications requiring refrigerated storage have the potential to be affected by this alleged deficient practice. All of the medications stored in the 100/300 Hall refrigerator were discarded by the Director of Nursing on 9-11-14. 3. The DON, Staff Development Coordinator or Unit Manager will re-educate Licensed Nursing staff including those working weekends and as needed regarding storage and labeling of medications including acceptable parameters for refrigerator temperatures and monitoring of refrigerator temperatures by 10-15-14. The DON or Unit Manager will randomly audit refrigerators used for medication storage 2 times per week for 12 weeks to validate the presence of a thermometer to monitor temperatures, documentation of daily temperature monitoring, the maintenance of acceptable parameters of refrigerator	

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F 431	Continued From page 38 who was responsible for logging the medication refrigerator temperatures. She reviewed the temperature log on the front of this medication refrigerator and observed that a temperature of 36 degrees F was recorded for the previous night shift, but confirmed that a thermometer could not be located inside the medication refrigerator at this time. During an interview with Administrative Staff # 3 on 9/11/14 at 12:30 PM she indicated that she did not know what happened to the thermometer in the 200/400 hall medication refrigerator but if there had been a problem with it staff should have reported it to have it replaced. She added that the medications that had been stored in that refrigerator were being discarded. On 9/11/14 at 2:50 PM Nurse # 6 was interviewed. She stated that she had worked the previous night (9/10/14) and had been assigned responsibility for logging the medication refrigerator temperatures. Nurse # 6 said that when she went to get some medication out of one of the refrigerators she checked the temperature and it was 36. She added that she then checked the other medication refrigerator temperature and it was also 36. Nurse # 6 revealed that she did not record these temperatures herself as when she went to write them on the log she saw that the other nurse working with her had already done it. She further stated that both refrigerators had a thermometer at that time. 2. On 9/11/14 at 11:40 AM the 100/300 hall medication refrigerator was observed. On observation the thermometer inside this refrigerator read 26 degrees Fahrenheit (F).	F 431	temperatures, and the accurate dating and labeling of medications stored in these refrigerators. Opportunities will be corrected daily by the Director of Nursing or Unit Manager as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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Nurse # 5 was present and was asked to verify the reading on the thermometer. She stated that the thermometer read 26 degrees F. Nurse # 5 was interviewed at this time and stated that medications requiring refrigeration should not be stored under 32 degrees F. She was uncertain of the exact temperature range appropriate for refrigerated medications but indicated that 26 degrees was to cold.

During an interview with Administrative Staff # 3 on 9/11/14 at 12:30 PM she indicated that a temperature reading of 26 degrees F was too cold for refrigerated medications but that the temperature had been recorded as 36 degrees F the previous night. She added that the medications that had been stored in that refrigerator were being discarded.

3. Review of the 200/400 hall medication refrigerator temperature log that was on the front of the refrigerator revealed that on September 1, 2 and 3, 2014 the temperature was recorded as 34 degrees (outside the 36 - 36 degree F temperature range for medications requiring refrigeration). There were no notations of any action taken regarding this. The logged temperatures from 9/4/14 - 9/10/14 were all within 36 - 46 degrees F.

Interview with Administrative Staff # 3 on 9/11/14 at 12:30 PM revealed that the temperature log forms that had been on the front of the 200/400 and 100/300 hall medication refrigerators for the month of September 2014 were not the standard corporate or facility forms for logging the medication refrigerator temperatures. She also stated that the form that should have been used has the acceptable temperature range written on

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F 431	Continued From page 40 it as a reminder of the out of range temperatures so they can then adjust the temperature or report the problem if it does not resolve. 4. Review of the Product Information Sheet for Tuberculin PPD (TUBERSOL) dated February 2013 revealed " A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. " On 9/11/14 at 11:37 AM the 200 and 400 hall medication refrigerator was observed to contain 3 vials of opened Tuberculin PPD. All 3 vials were opened and dated when opened. One of the 3 vials was dated as being opened on 8/1/14, the remaining two had been open less than 30 days. Nurse # 5 was present at this time and confirmed that the Tuberculin PPD vial had a hand written date of 8/1/14 indicating it was opened more than 30 days ago. Nurse # 5 stated she was aware the Tuberculin ppd needed to be discarded after opening within a particular time frame but she thought it was greater than 30 days. During interview with Administrative Staff # 3 on 9/11/14 at 12:30 PM she acknowledged that Tuberculin PPD should be discarded 30 days after it is opened for use.	F 431		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		10/21/14

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F 520	Continued From page 41 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility ' s quality assessment and assurance committee failed to maintain implemented procedures and monitor these interventions that the committee put in to place in June 2013 and February 2014. This was for five cited deficiencies which were originally cited June 2013 during a recertification survey and February 2014 during a complaint investigation. The deficiencies were in the areas of assessment, development of care plans, treatment and services to prevent/ heal pressure ulcers, sanitation in the kitchen and drug labeling/ storage. The continued failure of the facility during two federal surveys and one complaint investigation of record show a pattern of the facility ' s inability to sustain an effective quality assurance program. The findings included:	F 520	F520 1. The Administrator held a Quality Assurance Performance Improvement meeting with the Interdisciplinary Team including the Medical Director, Director of Nursing, Director of Rehab, Social Services Assistant, Dietary Manager on 9-25-14, focusing on the areas of MDS assessment, development of Care Plans, treatment and services to prevent/heal pressure ulcers, Sanitation in the kitchen and drug labeling and storage with implementation of a plan of correction including on going monitoring to sustain improvement. 2. All residents have the potential to be affected by this alleged deficient practice. The QAPI committee led by the	

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F 520	Continued From page 42 1 a. assessment accuracy. Cross refer F278. Based on medical record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) for pressure ulcers for 1 (Resident #63) of 4 sampled residents and for significant weight loss for 1 (Resident #80) of three sampled residents. During a recertification survey conducted 6/27/13, the facility was cited for F278 for failing to ensure each section of the MDS was signed by the individual who completed it prior to the completion date. On the current follow up/ recertification survey/ complaint investigation, the facility was again cited for failing to accurately code the MDS for pressure ulcers and for significant weight loss. On 9/11/14 at 4:46 PM, Administrative staff #3 stated there had been many changes in staff in the MDS department. She stated the two people currently working in the MDS department had not participated in the MDS assessments that had been wrongly coded. She stated there had been PRN (as needed) people that had cone in to do the MDS but a new person had been hired and she felt that this problem would be resolved with the addition of a new person. 1 b. development of care plan. Cross refer F 279. Based on observation, medical record review and staff interview, the facility failed to develop a care plan for contracture management and limitation in range of motion in the left hand for two of two sampled residents reviewed for contracture management (Resident #80 and #103).	F 520	Administrator met on 9-25-14 and reviewed the Survey citations and plans of corrections completed by the facility during the last 36 months related to MDS Assessments, development of Care Plans and treatment and services to prevent/heal Pressure Ulcers, Kitchen Sanitation and Drug labeling and storage. A root cause analysis was completed and a plan for sustainability was developed and submitted to CMS to include monthly reporting by the Director of Nursing and Administrator. 3. The Divisional Director of Clinical Services will re-educate the facility Quality Assurance Performance Improvement committee by 10-15-14 on the requirements of the committee related to identification of areas of opportunity, implementation of actions, items to correct opportunities, and on going monitoring to maintain implemented interventions. The Quality Assurance Performance Improvement committee will continue to meet on at the least, a monthly basis identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Divisional Director of Clinical Services will attend a QAPI meeting monthly for 3 months for validation, opportunities will be corrected as identified by the Administrator and the Divisional Director of Clinical Services. 4. The results of these reviews will be submitted to the QAPI Committee by the Administrator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness	

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F 520	Continued From page 43 During a recertification survey conducted 6/27/13, the facility was cited for F279 for failing to develop a care plan for one resident for appropriate use of medications. On the current follow up/ recertification survey/complaint investigation, the facility was again recited for failure to develop a care plan for contracture management and limitation in range of motion. 1c. treatment/ services to prevent/ heal pressure ulcers. Cross refer F 314. Based on observation, medical record review and staff interview, the facility failed to follow the recommended setting for the air mattress to promote wound healing and to measure and stage the pressure ulcer consistently on a weekly basis for one of four residents reviewed for pressure ulcers. (Resident #163). During a complaint investigation dated 2/20/14, the facility was cited at F 314 for failure to float a resident ' s heels as ordered for treatment of pressure ulcers. On the current follow up/recertification survey/complaint investigation, the facility failed to follow the recommended setting for an air mattress to promote wound healing and failing to measure and stage the pressure ulcer consistently. On 9/11/14 at 4:46 PM, Administrative staff #3 stated the facility's previous plans were to monitor the care plans weekly at the risk meeting and the problem was ongoing. She stated they continued to have the risk meeting until mid July when the meetings dwindled out until the second week in August. Administrative staff #4 stated the problems regarding pressure ulcers, development of the care plans and revision of the care plans was due	F 520	and amend as needed.	

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to so many changes that the facility had experienced with interim Director of Nursing staff and, somewhere along the way, the ball was dropped. Administrative staff #4 stated the plan did not work because of the system changes within administration.

1 d. sanitary conditions. Cross refer F 371. Based on observation, record review, and staff interview the facility failed to keep slaw salad made with mayonnaise/dressing at or below 41 degrees during operation of the tray-line, failed to air dry kitchenware before stacking it in storage, failed to clean deep fryer after use, and failed to label and date opened food items stored in refrigerators.

During the recertification survey conducted 6/27/13, the facility was cited at F 371 for failure to maintain a deep fryer free from greasy buildup and to maintain one of two meal carts free from debris between scheduled cleanings. On the current follow up/recertification survey/complaint investigation, the facility was again cited for failure to clean the deep fryer after use.

On 9/11/14 at 4:46 PM, Administrative staff #3 stated the problem with cleaning the fryer had been resolved and was not felt to be a concern. She stated Administrative staff #4 monitored the kitchen on a weekly basis and there had been no concerns. Administrative staff #3 stated there would be new monitoring.

1 e. drug label/ storage. Cross refer F 431. Based on observation, staff interview and document review the facility failed to have a thermometer to monitor the temperature in 1 of 2 medication refrigerators (200/400 hall

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BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 520	Continued From page 45 refrigerator), failed to store medications within the temperature range required for medications needing refrigeration (36 - 46 degrees Fahrenheit) for 1 of 2 medication refrigerators (100/300 hall refrigerator),failed to discard Tuberculin Purified Protein Derivative (PPD) within 30 days after opening in 1 of 2 medication refrigerators (200/400 hall refrigerator), and failed to identify logged medication refrigerator temperature readings of 34 degrees Fahrenheit as under the safe medication storage range. During the recertification survey conducted 6/27/13, the facility was cited at F 431 for failure to discard expired medications in two of six medication carts and one of two medication refrigerators. On the current follow up/ recertification survey/complaint investigation, the facility was again cited for failure to discard expired medications. On 9/11/14 at 4:46 PM, Administrative staff #3 stated the issue had been resolved and there was a process in place where the unit managers checked the medication rooms and medication carts weekly. She indicated the monitoring would be ongoing.	F 520		