STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALSTON BROOK	4748 OLD SALISBURY ROAD LEXINGTON, NC 27292

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		10/10/14

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

Electronically Signed | 10/30/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide Medicare non-coverage letters within the 2 day time requirement for 5 of 6 residents in the sampled reviewed. (Residents # 107, #161, #48, #77 and #129) The findings are: Record review revealed a minimum (2) two day notice of Medicare non-coverage was not provided as follows: a. Review of the Medicare non-coverage letter for Resident #107 stated Medicare covered services were ending on 6/27/14 for speech therapy. There was no acknowledgement of notification until a signed signature on 6/30/14. b. Review of the Medicare non-coverage letter for Resident #161 stated Medicare covered services were ending on 10/27/13 for physical therapy. There was no acknowledgement of notification until a signed signature on 10/27 (no year). c. Review of the Medicare non-coverage letter for Resident #48 stated Medicare covered services were ending on 4/21/14 for physical therapy. There was no acknowledgement of notification until a signed signature on 4/24/14. d. Review of the Medicare non-coverage letter for Resident #77 stated Medicare covered services were ending on 6/16/14 for physical therapy. There was no acknowledgement of notification until a signed signature on 6/30/14.	F 156	THIS FACILITY□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The correct ABN and NOMNC forms to be used for informing both Medicare Part A residents and Medicare Part B residents of their pending discharge date from Therapy/s. 1. The correct forms to use for notifying Medicare Part A residents are: a. CMS-10055 □ ABN b. CMS 10095 □ NOMNC 2. The correct forms to use for notifying Medicare Part B residents are: a. CMS-R-131 - ABN b. CMS 10095 □ NOMNC The forms are to be sent based on regulation of a two (2) day notice. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME	

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F 156	Continued From page 3 Interview on 10/8/14 at 4:15 pm with the business office manager revealed Resident # 129 would have non coverage of Medicare for participation in Medicare as of 5/15/14 but the facility did not provide the resident or with the responsible party the Notice of Medicare Non coverage. The business office manager indicated she did not know that the facility was required to provide the notice. Interview on 10/8/14 at 3:45 pm with the business office manager and the business office assistant (who was responsible for the non-coverage letters) was held. The assistant business office manager indicated that if a resident was coherent he would have the resident sign the notice letter and if unable he would mail the notice to the responsible party providing at least a 48 hour notice. At 4:15 pm the business office manager indicated she was not aware of the time frame required to provide residents with notice of Medicare non coverage. Interview on 10/09/14 at 3:30 PM with the administrator and VP of operations was conducted. The VP of operations indicated the expectation of the facility was to provide a minimal of 48 hours prior notice of non-coverage of Medicare benefits.	F 156	DEFICIENT PRACTICE: The correct ABN and NOMNC forms to be used for informing both Medicare Part A residents and Medicare Part B residents of their pending discharge date from Therapy/s. 3. The correct forms to use for notifying Medicare Part A residents are: a. CMS-10055 □ ABN b. CMS 10095 □ NOMNC 4. The correct forms to use for notifying Medicare Part B residents are: a. CMS-R-131 - ABN b. CMS 10095 □ NOMNC The forms are to be sent based on regulation of a two (2) day notice. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The new protocol for ensuring the correct ABN Forms is used and sent in a timely manner is as follows: 1. Therapy will give their five (5) days notice of therapies being discontinued to the Business Office Assistant who will then obtain the signature from the Resident, if own Responsible Party. 2. If not own Responsible Party it will be given to the Receptionist, who then calls the resident's POA or Responsible Party to inform of need to come to facility to sign the ABN Form as soon as possible. If the POA or Responsible Party is not able to come into the facility the form/s will be	

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F 156	Continued From page 4	F 156	mailed to them. 3. The Receptionist will be responsible to write on the form: a. Name of POA or Responsible Party she spoke with; b. Date and time; c. Date a POA or Responsible Party will be able to come to facility to sign the form or if requests the form to be mailed; d. If unable to speak to someone they will leave a voicemail, along with the information concerning notification forms. e. The Receptionist will record her signature on the form along with the date. 4. On a weekly basis the Business Office Manager will review the ABN's that are to be kept in a notebook to ensure correct forms are used and that new procedure is being followed. The Business Office Manager will sign and date that she has reviewed that accurate and timely notices are being sent. 5. If the procedure is not being followed as established, the Business Office Manager will re-educate the staff involved in this process on correct protocol and procedures. The ABN's will be reviewed on a monthly basis during our Triple Check Meeting to ensure they have been completed correctly according to the new protocol. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE	

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F 156	Continued From page 5	F 156	IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Business Office Manager will review the ABN's on a weekly basis that are to be kept in a notebook to ensure correct forms are used and that new procedure is being followed. The Business Office Manager will sign and date that she has reviewed that accurate and timely notices are being sent. If the procedure is not being followed as established, the Business Office Manager will re-educate the staff involved in this process on correct protocol and procedures. The Business Office Manager will bring the current ABN's to the Quality Assurance Committee on a weekly basis for the committee to review for one month. If after one (1) month the new procedure for ABN's is being completed correctly then the review by the QA Committee will be complete. The QA Committee will review on a weekly basis for one (1) month to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance, to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that	

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F 156	Continued From page 6	F 156	corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff the facility failed to maintain clean enteral feeding pumps, poles and bases. This was evident in 5 of 5 enteral feeding systems in use. (Rooms # 115B, 222B, 207A, 200A, 214A) Observations on 10/8/2014 revealed: In room 115B at 8:55 AM the pole attached to the enteral pump had a dried beige colored splattered substance which resembled tube feeding formula on the surfaces. In room 222B at 9:04 AM the pole attached to the enteral pump had a dried beige colored splattered substance which resembled tube feeding formula on the surfaces. In room 207A at 9:06 AM the pole attached to the enteral pump had a dried beige colored splattered substance which resembled tube feeding formula on the surfaces. In room 200A at 9:10 AM the enteral feeding pump, base and pole had a dried beige colored	F 253	THIS FACILITY□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Immediately after it was shared with the Administrator by the Survey Team of a dried beige colored substance splattered on the enteral pumps, poles and bases they were cleaned making sure the dried substance was removed for all residents having a enteral feeding pump.	10/24/14

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F 253	Continued From page 7 splattered substance resembling tube feeding formula on the surfaces. In room 214A at 9:15 AM the enteral feeding pump, base and pole had a dried beige colored splattered substance resembling tube feeding formula on the surfaces. Additional observations on 10/9/2014 revealed the dried beige colored splattered substance which resembled tube feeding formula remained as noted: In room 115B at 12:43PM the pole attached to the enteral pump had a dried beige colored splattered substance which resembled tube feeding formula on the surfaces. In room 200A at 12:44 PM the enteral feeding pump, base and pole had a dried beige colored splattered substance resembling tube feeding formula on the surfaces. In room 207A at 12:52 PM the pole attached to the enteral pump had a dried beige colored splattered substance which resembled tube feeding formula on the surfaces. In room 214A at 12:55PM the enteral feeding pump, base and pole had a dried beige colored splattered substance resembling tube feeding formula on the surfaces. In room 222B at 12:56PM the pole attached to the enteral pump had a dried beige colored splattered substance which resembled tube feeding formula on the surfaces. Interview with Nurse #4 on 10/9/14 at 9:12 AM revealed the treatment nurse would clean the enteral feeding equipment every Saturday, but	F 253	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Immediately after it was shared with the Administrator by the Survey Team of a dried beige colored substance splattered on the enteral pumps, poles and bases they were cleaned making sure the dried substance was removed for all residents having a enteral feeding pump. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The nurses were in-serviced on 10/23/2014 by the Staff Development Nurse and the DON regarding the procedure that is to be followed each time they change the feeding tube formula. They are to inspect the enteral feeding pump, pole, and base to ensure it is free of any substance or matter. An email was also sent to the Nurses instructing them of the above information by the Director of Nursing on October 24, 2014. This procedure has been added to the Electronic Medication Administration Records (eMAR) of all residents utilizing this equipment. The nurse signs off each shift that the equipment was inspected and cleaned. Any new admissions with an enteral feeding tube will have these inspection and cleaning instructions added to their eMAR.	

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F 253	Continued From page 8 she would clean the equipment and poles with "Cavi-wipes" if she saw the equipment soiled. Interview with Nurse #5 on 10/9/14 at 9:17 AM revealed the equipment should be cleaned daily by the nurse and as needed if visibly soiled. Interview with Nurse #6 on 10/9/14 at 9:27 AM revealed any visibly soiled piece of equipment, poles, and bases should be cleaned. Interview with Nurse #7 on 10/9/14 at 9:50 AM, revealed it was each nurses responsibility to make sure that the equipment was cleaned not just the treatment nurse. Interview with housekeeping staff #1 on 10/9/14 at 9:52 AM reveals it was nursing staff ' s responsibility to clean pumps and poles.	F 253	Inspection of enteral feeding pumps, bases, and poles has been added to the Quality Assurance checks to be completed weekly by the Administrative Staff. The Director of Nursing will make twice weekly Quality Assurance checks on each enteral feeding pump, base, and pole for a month, weekly checks for one month, monthly checks for four months then re-evaluate for the need of continued monitoring. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.: Inspection of the enteral feeding pumps, bases, and poles has been added to the Quality Assurance Checklist that is completed weekly by the Administrative Staff. The Director of Nursing will make twice weekly Quality Assurance checks on each enteral feeding pump, base, and pole for a month, weekly checks for one month, monthly checks for four months then re-evaluate for the need of continued monitoring.	

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F 253	Continued From page 9	F 253	The Quality Assurance checks conducted by the Director of Nursing and the Administrative Staff will be discussed weekly at our weekly Quality Assurance Meetings to evaluate effectiveness of this POC procedure The QA Committee will review the Quality Assurance Checklist on a weekly basis to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide adaptive equipment for one (1) of one (1) sampled resident to promote independent feeding. (Resident #18) Findings included: Resident # 18 had cumulative diagnoses which included coronary artery disease and	F 369	THIS FACILITY□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	10/27/14

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F 369	Continued From page 10 hypertension. Review of the admission MDS (Minimum Data Set) assessment tool dated 7/27/14 revealed the resident was alert and oriented and required limited assistance from staff for eating. Review of the occupational therapist (OT) note dated 7/14/14 revealed a goal for self-feeding. Record review of the OT progress note dated 8/22/2014 revealed "Patient trialed with rocker knife due to difficulty cutting meat. Resident was able to cut theraputty in simulated task with stand by assistance with moderate to minimum cues. Record review of the OT progress note dated 8/22/14 revealed the resident is able to feed herself, and demonstrates "good use of knife with no assistance" after being seen using a rocker knife during a meal on 8/27/2014 Record review of the OT progress note dated 9/1/14 revealed "Pt [patient] demonstrates self feeding with good participation after set up with use of rocker knife. Pt patient states she likes using knife and inner lip plate at meals." Review of Dietary communications sheets revealed on 8/27/14 an order for adaptive equipment of "Rocker knife to use @ [at] all meals." Interview on 10/9/14 at 9:51 am with the occupational therapist revealed Resident #18 had poor upper extremity coordination and the rocker knife had a built -up handle to assist the resident with independence with cutting up food items. The therapist indicated that at the time of	F 369	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The resident identified as having been affected by the deficient practice was provided with the adaptive equipment ordered by the physician. The Dietary Department was in-serviced on October 27, 2014 by the Dietary Manager concerning the need to fully read the dietary tray cards and the importance thereof to insure that each resident identified as having a physician's order/or nursing communication receives the required adaptive eating utensils determined by their abilities and weaknesses. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The facility staff audited all resident's records to ensure all residents identified as having a physician's order for adaptive equipment are receiving the equipment as ordered at each meal. The Dietary Department was in-serviced on October 27, 2014 by the Dietary Manager concerning the need to fully read the dietary meal tickets and the	

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F 369	Continued From page 11 discharge from skilled therapy on 9/1/14, Resident #18 had the ability to use the rocker knife with success. During continuous observation in Main Dining room, from 5:00pm-5:17pm on 10/7/2014, Resident #18 was observed feeding herself without difficulty after staff set-up and cut her food items. There was no rocker knife. Continuous observation in the main dining room on 10/8/2014 at 11:30 AM during the lunch meal revealed Resident #18was served a meal of chicken pot pie, mixed vegetables, iced tea, and carrot cake. The tray also included a standard fork, standard knife and napkin. Review of the meal slip noted to include a rocker knife as an adaptive device. NO rocker knife was observed. Interview with the food service manager on 10/9/14 at approximately 10 am revealed she was not aware that the resident was not provided the adaptive device during the meal. No explanation was provided as to why the resident was not provided the rocker knife. Interview with nursing assistant #1 on 10/9/14 at 2:20 PM revealed it is dietary's responsibility to place special devices on tray and if they are not present the staff assisting in the dining room would inform dietary, or send the tray back to the kitchen to be corrected. Interview on 10/8/14 at 3:05 pm with a family member revealed she had never witness the adaptive knife on the resident ' s tray. Interview on 10/09/14 at 3:30 pm with the administrator and the VP revealed the	F 369	importance thereof to insure that each resident identified as having a physician's order/or nursing communication receives the required adaptive eating utensils determined by their abilities and weaknesses. The procedure for ensuring the correct procedure is as follows: a. The staff member at the beginning of the tray line is responsible for placing adaptive equipment on the tray. b. The staff member who places the trays in the carts is responsible to check that all adaptive equipment is on the tray prior to leaving the dietary department. c. Once in the dining room or on the units the Nursing Assistants are to check the diet tray card to verify that all equipment is on tray prior to delivering tray to the resident. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The Dietary Department was in-serviced on October 27, 2014 by the Dietary Manager concerning the need to fully read the dietary meal tickets and the importance thereof to insure that each resident identified as having a physician's order/or nursing communication receives the required adaptive eating utensils determined by their abilities and weaknesses.	

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F 369	Continued From page 12 expectation was to have the devices available and be used.	F 369	The procedure for ensuring the correct procedure is as follows: a. The staff member at the beginning of the tray line is responsible for placing adaptive equipment on the tray. b. The staff member who places the trays in the carts is responsible to check that all adaptive equipment is on the tray prior to leaving the dietary department. c. Once in the dining room or on the units the Nursing Assistants are to check the diet tray card to verify that all equipment is on tray prior to delivering tray to the resident. Once the nurses have given the Diet Change/Order Slip to the Dietary Manger or Kitchen Supervisor, the Dietary Manager/Kitchen Supervisor will be responsible for placing the information onto the tray card. The dietary staff reviews the tray cards each meal and highlights in yellow dislikes and will begin highlighting any adaptive devices in pink on the tray cards. This will include any and all special equipment deemed necessary by the nurses or therapy department. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS	

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F 369	Continued From page 13	F 369	EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.: The Dietary Manager will make a list from the data on the tray cards indicating the residents who require special adaptive equipment. The Dietary Manager or the Kitchen Supervisor will do a QA Check of the residents meals to ensure the residents have their adaptive equipment. They will check all meals for a period of a week, then one rotating meal per day for a period of a week, and then spot check a meal on a weekly basis. The weekly checks will continue and will be documented on QA Form and kept in a note book on file as part of an ongoing QA plan. The QA Committee will review the Quality Assurance Checklist on a weekly basis to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		10/27/14

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F 431	Continued From page 14 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 observations and staff interviews, the facility failed to label medications with an expiration date in 1 of 3 medication store rooms	F 431	THIS FACILITY□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE	

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F 431	Continued From page 15 (Green ' s Commons); and failed to follow the manufacturer ' s instructions to determine expiration dating for medications in 1 of 5 medication carts (Lillian ' s Way medication cart). The findings included: 1) An observation made on 10/9/14 at 10:40 AM revealed a box of levalbuterol 1.25 milligrams (mg) / 3 milliliters (ml) solution for oral inhalation labeled for Resident #24 was stored on the Lillian ' s Way medication cart. A review of Resident #24 ' s October 2014 Physician ' s Orders revealed there was a current medication order for levalbuterol 1.25 mg / 3 ml solution with the following instructions: Use 1 vial by inhalation every 4 hours as needed. Levalbuterol is a medication used to prevent or relieve the wheezing, shortness of breath, coughing, and chest tightness caused by lung disease such as asthma and chronic obstructive pulmonary disease (COPD). A handwritten date on the box of levalbuterol indicated the box was opened on 7/18/14. The opened box of levalbuterol contained two foil pouches: one foil pouch was unopened; the second foil pouch was opened (not dated) and contained 6 vials of levalbuterol solution. An auxiliary notation included on the pharmacy label placed on the box of levalbuterol read: " Do not use after: **Refer to Package.** " Manufacturer storage instructions printed on the outside of the box and on each foil pouch of the levalbuterol included the following information: Unit dose vials should remain stored in the protective foil pouch at all times. Once the foil	F 431	STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Upon notification by the Surveyor of the expired medications, the Nursing Staff removed and properly discarded the solution for oral inhalation and the vial of medication used as a screening test for tuberculosis. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The medication carts and med storage rooms were checked by the Nurse Managers on October 8, 2014 to ensure there were no more drugs that had expired. No others were noted. All nurses were in-serviced on October 27, 2014 by the Staff Development Nurse and the Director of Nursing regarding the requirements of properly dating any medications with an expiration date once the package is opened. They also are required to read any external packaging for further instructions as to the length of	

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F 431	Continued From page 16 pouch is opened, the vials should be used within 2 weeks. Once removed from the foil pouch, the individual vials should be used within 1 week. An interview was conducted with Nurse #3 on 10/9/14 at 10:45 AM. Nurse #3 was assigned as the hall nurse on Lillian ' s Way. Upon inquiry, the nurse indicated that she was not aware of the manufacturer ' s storage instructions indicating that levalbuterol vials needed to be used within two weeks once the foil pouch was opened. The nurse reviewed the Resident #24 ' s Medication Administration Record (MAR) and reported that the last dose of levalbuterol had been administered to the resident on 8/16/14. Nurse #3 then indicated that the 6 vials of levalbuterol remaining in the opened pouch were expired and needed to be returned to the pharmacy for disposal. An interview was conducted with the DON on 10/9/14 at 11:35 AM. Upon inquiry, the DON indicated that she was not aware of the manufacturer ' s storage and expiration dating instructions for levalbuterol. When asked what her expectation was in regards to storing the levalbuterol inhalation solution, the DON stated, "We would have to date the foil package and discard any remaining vials within 2 weeks (after opening the foil pouch)." 2) An observation of the Green ' s Commons medication store room on 10/9/14 at 10:07 AM revealed an opened vial of Aplisol Tuberculin PPD (an injectable medication used as a screening test for tuberculosis) was stored in the refrigerator. The vial was not labeled with the date it had been opened. The manufacturer ' s product information indicated opened vials of	F 431	time a particular medication may be kept and how it must be stored and discarded. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The facility and the pharmacy have developed a new protocol on the nebulizer medications to prevent future issues with expired medications. The following is the new protocol: 1. Upon receiving a package of nebulizer medication the nurse should note that a Date Opened Sticker is on the outside of each foil package containing the nebulizer vials. Each foil package should have a sticker on the outside that reads: " Date Opened: _____ " Expires in _____ (this blank is to be completed by the pharmacy) days after opening. " Discard After: _____ 2. When the foil package is opened the nurse is to document the date opened in the appropriate blank and then the discard after date based upon prefilled information from the pharmacy stating how many days the package expires after opening. 3. If the nurse receives a foil package that does not have a Date Opened Sticker or the days until expiration date is not completed, then the pharmacy is to be notified. If it is after pharmacy hours and	

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F 431	Continued From page 17 Aplisol should be discarded after 30 days. During an interview with Nurse #2 on 10/9/14 at 10:10 AM, the nurse indicated the opened vial should have been labeled with the date it was opened. Nurse #2 stated this vial would need to be discarded since it was not known when it had been opened. During an interview with the Director of Nursing (DON) on 10/9/14 at 11:35 AM, the DON addressed the normal procedure for dating and storing medications such as Aplisol. The DON reported the Aplisol vial should have been dated when opened. She indicated that the undated, opened vial of Aplisol would need to be discarded since it was not known as to when it had been opened.	F 431	the foil package must be opened, the nurse should date the package upon opening and then follow up with the pharmacy the next day to verify expiration date and obtain stickers for the foil packages. 4. Dates are to be monitored with weekly QA checks completed by the Nurse Managers/Administrative Nurses. The storage of medications in the six (6) medication carts will be audited by the Clinical Service Coordinator/Nurse Manager twice weekly for one month then weekly thereafter and will document on a QA Checklist. The storage of medications in the medication rooms on each of the three (3) units will be inspected by the third shift nurse assigned to the unit twice weekly. The First Shift Nurse in Charge will also check the medication rooms weekly. Any medications with a expiration date within the month will be used or returned to pharmacy or discarded. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.:	

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F 431	Continued From page 18	F 431	The Director of Nursing will review the results of the QA rounds on a weekly basis for one month. The DON will conduct an audit of the Med Carts and Med Rooms twice monthly for three months. She will document on a Quality Assurance Checklist the results of her audit. If expired medications are found she will re-educate the Nurses that would have been assigned to the unit with the deficient practice. After three (3) months if found to be in compliance the DON will conduct random audits thereafter. The DON will bring the results of the audits to the weekly QA Committee meeting for three (3) months or until compliance is achieved. The QA Committee will review the Quality Assurance Checklist on a weekly basis to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	