

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345477	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/30/2014
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NAME OF PROVIDER OR SUPPLIER THE OAKS AT SWEETEN CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704
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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigations as part of the annual survey. Event ID #RXM611.	F 000		
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,	F 156		11/26/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/24/2014
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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	<p>Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>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.</p> <p>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.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to post the correct complaint intake phone number of the State agency for residents and families to reference if they wanted to file a complaint.</p> <p>The findings included:</p> <p>During the initial tour of the facility on 10/27/14 at 9:30 AM contact information for residents and families was observed posted in a locked glass bulletin board at the entrance of the facility. The phone number posted of the complaint intake unit of the State agency to call to file a complaint was an incorrect number.</p> <p>The number posted for the State agency was called on 10/27/14 at 9:41 AM and the number was noted to be disconnected.</p> <p>On 10/30/14 at 10:46 AM the facility Social Worker stated the contact information posted at the front of the facility behind the glass bulletin board had last been reviewed about a year ago. The Social Worker stated she was not aware the complaint intake number posted was incorrect. On 10/30/14 at 10:50 AM the Administrator stated she was not aware the complaint intake phone</p>	F 156	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.</p> <ol style="list-style-type: none"> No resident was injured related to this citation. The Executive Director posted the correct complaint intake number on 10/30/2014. All residents have the potential to be affected by this citation. Residents will be educated on admission and during monthly resident council meetings the proper location of central intake number. The Executive Director was in serviced by the Regional Director of Operations on 11/24/2014 on posting of correct numbers for the complaint intake line. The Executive Director will perform Quality Improvement Monitoring of the posting of the complaint intake number 1 time a week for 4 weeks then monthly for 		

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F 156	Continued From page 3 number for the State agency was incorrect and immediately posted the correct phone number.	F 156	5 months and/or substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interviews, the facility failed to promote dignity by waking a resident for a blood sugar check and not checking her for incontinence care (Resident #29), waking residents early for morning care and leaving them partially dressed (Resident #109 and #125) and not responding to a resident's call light (Resident #45).	F 241	1. Resident #29 had peri care provided 10/29/2014 by certified nurse assistant. Resident #109 was dressed and gotten up 10/29/2014 by certified nurse assistant. Resident #125 was dressed and gotten up 10/29/2014 by the certified nurse assistant. Resident #45 was not injured related to this citation. NA# 2 was in serviced by the Director of	11/26/14	

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F 241	<p>Continued From page 4</p> <p>The findings included:</p> <p>1. Resident #29 was admitted to the facility on 08/13/14 with diagnoses including congestive heart failure and depressive disorder. The most recent annual Minimum Data Set (MDS) dated 08/20/14 coded Resident #29 as cognitively intact and requiring extensive assistance from staff with transfers, bed mobility, toileting, bathing and personal hygiene. The MDS documented that personal preferences were very important to the resident, she preferred to be toileted and that the resident was occasionally incontinent of bladder.</p> <p>Review of Resident #29's care plan dated 08/20/14 indicated she was unable to participate in her usual daily routine, at risk for side effects related to antidepressant medication, had a potential for skin breakdown due to incontinence of bladder and bowel and had chronic pain. Approaches included sponge baths only, monitoring resident's mood state, daily observation of skin with routine care, assess for signs/symptoms of depression, crying, isolation, decrease appetite, and to promote dignity.</p> <p>A review of Resident #29's physician note dated 10/20/14 noted a concern with rash on lower back and buttocks, not related to medication and that the physician would continue to monitor.</p> <p>An interview on 10/29/14 at 5:20 AM with Nurse Aide (NA) #1 revealed Resident #29 was a sensitive lady who liked to go to bed around 10:00 PM and would put her light on if she needed anything. She further stated that Resident #29 became sad and depressed when she had occasional accidents on herself.</p>	F 241	<p>Clinical Services on proper get up procedures 10/29/2014.</p> <p>NA# 3 was in serviced by the Director of Clinical Services on proper get up procedures 10/29/2014.</p> <p>NA# 1 was in serviced by the Director of Clinical Services on proper get up procedures 10/29/2014.</p> <p>2. All residents have the potential to be affected by this citation. Interviews with Residents and/or responsible party to determine their preferred get up times was completed 11/21/2014-11/25/2014 by the Interdisciplinary team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) Observations of the answering of call bells was performed by the Interdisciplinary team 11/21/2014-11/25/2014.</p> <p>3. Licensed Nurses, Certified Nurse assistants were in serviced 11/21/2014-11/25/2015 on residents right to choose when getting up and honoring that preference, the proper way to get residents up out of bed and answering call lights timely. The Director of Clinical Services and/or Nursing Supervisor will conduct Quality Improvement monitoring of 10 residents choice of when to get up and how residents are gotten up 3 times a week for 8 weeks, 2 times a week for 8 weeks and 1 time a week for 8 weeks</p>		

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F 241	<p>Continued From page 5</p> <p>An interview on 10/29/14 at 5:46 AM with Nurse #3, who cared for Resident #29, revealed the resident was alert and oriented, she did not exhibit any cognitive impairment and she was able to verbalize her needs. The Nurse stated if the resident was awake she would turn on her light and let staff know she needed to go to the bathroom. She reported when Resident #29 took her pain medication at night she usually slept through the night. Nurse #3 stated checked the resident ' s blood sugar around 6:00 AM and many times she would fall back to sleep.</p> <p>NA #5 who cared for Resident #29 on the night of 10/30/14 was not available by phone for interview during the survey.</p> <p>An interview on 10/30/14 at 10:53 AM with NA #2, who cared for Resident #29, revealed if the previous shift did not have enough staff they would take short cuts in order to get things done. NA#2 was asked for an example of this and NA #2 revealed Resident #29's room was an example of a short cut. NA #2 stated when she entered Resident #29's room prior to her morning care, Resident #29 was in bed with a urine-soaked brief and bed linens. She stated the residents who were on the facility get-up list for breakfast were the priority and the other residents were left for the day shift.</p> <p>An interview on 10/30/14 at 1:52 PM with Resident #29 revealed that when NA #2 came in to wake her up a little after 7:00 AM she was in a soaked brief and her bed was also soaked with urine. Resident #29 held her head down and stated it made her feel bad when she was left wet because she was dependent on the staff to assist her to the bathroom as she required a</p>	F 241	<p>and/or until substantial compliance is obtained.</p> <p>The Interdisciplinary Team will perform Quality Control monitoring for timely answering of 5 call lights each shift 5 times a week for 4 weeks, 3 times a week for 8 weeks, 2 times a week for 8 weeks and 1 time a week for 4 weeks and/or until substantial compliance is obtained.</p> <p>4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing, Activities, Medical Director, Social Services, Maintenance Director, and Minimum Data Assessment Nurse.</p>		

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F 241	<p>Continued From page 6</p> <p>mechanical lift to get up. Resident #29 stated her preference was to be toileted.</p> <p>An interview on 10/30/14 at 8:15 PM with the Director of Clinical Services (DCS) and the Administrator revealed the condition in which Resident #29 was in at the beginning of first shift was not acceptable. The DCS stated her expectation was for staff to ensure residents were clean and dry and their environment was in order. She stated that other residents who do not get up for breakfast should have be clean, dry and well groomed before staff ended their shift. The Administrator agreed with the DCS and reported her expectation was that all residents should have been well cared for and in good condition before the staff ended their shift.</p> <p>2. Resident #109 was admitted to the facility on 06/17/13 and readmitted on 04/27/14 with diagnoses including cognitive communication deficit and dementia. Review of the most recent Minimum Data Set (MDS) dated 09/10/14 revealed the resident to be severely cognitively impaired. Resident #109 was coded as requiring extensive 1 to 2 person assistance for most activities of daily living including dressing, toileting and personal hygiene. Review of her most recent care plan updated on 09/27/14 revealed the problem of a self-care deficit with interventions including care that promoted dignity.</p> <p>On 10/29/14 at 5:34 AM, an interview with nurse aide (NA) #3 revealed night shift staff were expected to start getting residents up. She stated on this particular shift she was told to get residents up at 6:00 AM but on past shifts it was 4:30 AM. She stated she was aware of families complaining that their loved ones were getting up</p>	F 241			

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F 241	<p>Continued From page 7</p> <p>too early. She stated she was told to "pre-dress" residents which meant leaving their pants down at their ankles while in bed to keep their pants dry in case of incontinence. During a tour of residents who were identified as pre-dressed, Resident #109 was observed sleeping in bed with the lights off. The NA was asked to pull the resident's blanket back to reveal the resident's pants were not pull up all the way over the resident's hips, exposing their incontinence brief.</p> <p>On 10/29/14 at 5:57 AM, an interview with NA #1 revealed that NAs had been told to put pants on residents but to leave them down. She stated NAs were getting residents up by 4:30 AM if there were 2 NAs, by 5:00 AM if 3 NAs and if more than 3 NAs by 6 AM. She stated getting residents up meant providing grooming, dressing and washing with some staying in bed and other getting into their wheelchairs.</p> <p>On 10/29/14 at 6:14 AM an interview with Nurse #4, with the interim director of clinical services (DCS) present, revealed staff used a get-up list to identify residents needing to get up and that no one got residents up before 5 AM. She stated NAs woke residents up, washed them up with a "mini" bed bath, dressed them and got them into their wheelchairs or assisted them with their walkers if they were ambulatory. She stated residents were never dressed and put back to bed. During a tour of residents with Nurse #4 and the interim DCS, Resident #109 was observed sleeping in bed with the lights off. Nurse #4 was asked to pull the resident's blanket back to reveal the resident's pants were not pull up all the way over the resident's hips, exposing their incontinence brief.</p>	F 241			

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F 241	<p>Continued From page 8</p> <p>On 10/29/14 at 6:30 AM the interim DCS, with Nurse #4 present, stated her expectation was residents were not woken up early for AM care and that if pants were put on residents they were pulled up all the way. She stated residents should not have been woken up and dressed for AM care only to be put back to bed as this was not complete AM care. Nurse #4 stated the directive from the previous DCS was to get residents up on night shift and some staff had used this strategy of putting pants on but leaving them at their ankles and this was not right.</p> <p>3. Resident #125 was admitted to the facility on 04/28/14 with diagnoses including history of metabolic encephalopathy and advanced dementia. Review of the most recent Minimum Data Set (MDS) dated 07/28/14 revealed the resident to be severely cognitively impaired. Resident #125 was coded as requiring extensive 1 person assistance for most activities of daily living including dressing, toileting and personal hygiene. Review of his most recent care plan updated on 08/13/14 revealed the problem of a self-care deficit with interventions including care that promoted dignity.</p> <p>On 10/29/14 at 5:34 AM, an interview with nurse aide (NA) #3 revealed night shift staff were expected to start getting residents up. She stated on this particular shift she was told to get residents up at 6:00 AM but on past shifts it was 4:30 AM. She stated she was aware of families complaining that their loved ones were getting up too early. She stated she was told to "pre-dress" residents which meant leaving their pants down at their ankles while in bed to keep their pants dry in case of incontinence. During a tour of residents who were identified as pre-dressed,</p>	F 241			

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F 241	<p>Continued From page 9</p> <p>Resident #125 was observed sleeping in bed with the lights off. The NA was asked to pull the resident's blanket back to reveal the resident's pants were not pull up all the way over the resident's hips, exposing their incontinence brief.</p> <p>On 10/29/14 at 5:57 AM, an interview with NA #1 revealed that NAs had been told to put pants on residents but to leave them down. She stated NAs were getting residents up by 4:30 AM if there were 2 NAs, by 5:00 AM if 3 NAs and if more than 3 NAs by 6 AM. She stated getting residents up meant providing grooming, dressing and washing with some staying in bed and other getting into their wheelchairs.</p> <p>On 10/29/14 at 6:14 AM an interview with Nurse #4, with the interim director of clinical services (DCS) present, revealed staff used a get-up list to identify residents needing to get up and that no one got residents up before 5 AM. She stated NAs woke residents up, washed them up with a "mini" bed bath, dressed them and got them into their wheelchairs or assisted them with their walkers if they were ambulatory. She stated residents were never dressed and put back to bed. During a tour of residents with Nurse #4 and the interim DCS, Resident #125 was observed sleeping in bed with the lights off. Nurse #4 was asked to pull the resident's blanket back to reveal the resident's pants were not pull up all the way over the resident's hips, exposing their incontinence brief.</p> <p>4. Resident #45 was originally admitted to the facility on 05/29/07 with diagnoses including history of a spinal cord injury, muscular atrophy and depressive disorder. Her most recent Minimum Data Set (MDS) dated 08/19/14</p>	F 241			

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F 241	<p>Continued From page 10</p> <p>revealed the resident to be cognitively intact with no behaviors or rejection of care. Resident #45 was coded as requiring extensive 2 person assistance with bed mobility and toileting and having impaired range of motion on both sides of her body and in upper and lower extremities. She was coded as always incontinent of bowel and bladder. Review of the most recent care plan dated 09/21/14 included a self-care deficit for total dependency related to a spinal cord injury. An intervention of this problem was for staff to anticipate resident needs and wants and provide necessary care.</p> <p>On 10/30/14 at 2:30 PM, an interview with Resident #45 revealed she sometimes had to wait over an hour for a nurse aide (NA) to answer a call light. She stated she normally went to bed at 10:00 PM and required staff to position her in bed and that 2 weeks previous to the interview she hit the call light and no one responded. Resident #45 stated that at 10:30 PM she called a family member and around 11:00 PM a nurse and NA from another hall came to assist positioning her in bed. She stated she was disappointed but the resident stated she was concerned that in the event of a real emergency, like a fall, staff would not have been around to assist her. She stated she could not remember the name of the staff involved in this incident but a named family member could be called for more details and she provided the first name of the nurse who finally came and helped her. She stated she later learned that the NA left at 10:00 PM due to a second job.</p> <p>On 10/30/14 at 3:03 PM an interview with the family member of Resident #45 revealed the resident did call her at home and the family</p>	F 241			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345477	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/30/2014
NAME OF PROVIDER OR SUPPLIER THE OAKS AT SWEETEN CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
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F 241	<p>Continued From page 11</p> <p>member called the nursing station twice. She stated she could not remember the exact date but that it was in the recent past, perhaps during a weekday evening. The family member stated when the resident had needs or concerns she usually took care of them as she was in her right mind, but that particular night the resident was so frustrated she called the family member. The family member stated she thought she spoke to a particular nurse, mentioning the same first name as that mentioned by the resident. She stated when she called and spoke to this nurse the second time the nurse replied she would help the resident herself.</p> <p>On 10/30/14 at 3:38 PM an interview with Nurse #5 revealed she answered call lights if NAs were not around. She stated she recalled receiving a phone call from a family member of Resident #45 regarding the resident was not taken care of for the night and in response went to find the resident's NA. The nurse stated the family member called a second time at which point the nurse went with another NA to care for the resident. The nurse stated she found out later that the resident's NA left work early and the next day asked that NA what happened, who stated she offered to assist the resident with positioning but it would have been earlier than what the resident wanted. Nurse #5 stated she could not remember the name of the NA. She stated on the night the family member called no one covered the NA who left work early. The nurse provided the first name of the NA whom she found to assist her with Resident #45.</p> <p>On 10/30/14 at 4:29 PM an interview with the scheduling nurse (Nurse #6) revealed the name of the NA who left work early. She stated this NA</p>	F 241			

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F 241	<p>Continued From page 12</p> <p>was an as needed (PRN) NA who worked until 10:00 PM so she could leave in time for a second job at another facility. This nurse stated she was aware of Resident #45 and her care needs and her waiting an hour for a call light response was too long.</p> <p>On 10/30/14 at 5:00 PM an interview with NA #4 revealed she was the NA who assisted Nurse #5 with Resident #45 which included changing her, incontinence care, cleaning her up, positioning her in bed and placing a cup in position for the resident to drink from at night. She stated this care occurred on a second shift as that was her normal shift and the care occurred after 10:30 PM. She stated she did not remember the actual day, but the NA assigned to the resident had to leave at 10:00 PM and that NA was not aware that she had to do other preparations with the resident to get her ready for bed. NA #4 stated staff were supposed to be told or asked to answer call lights until relief staff came in, that staff leaving early was not all that usual but it was unexpected that night, and she did not realize the NA was gone until Nurse #5 grabbed her to assist with resident care. NA #4 stated she was not aware of any staff being on Resident #45's hallway from 10:00 PM to 11:00 PM. NA #4 stated she recalled the resident being soiled with bowel movement running out of her brief, but she did not think it was due to being there for a long time. NA #4 stated the following day that she was told by the NA who left early that all her assigned residents were clean and dry, but that NA did not realize Resident #45 required preparation for bed as she did not normally work that schedule. NA #4 stated Resident #45 was really verbally upset and the NA could tell it in the resident's talking that the resident could not believe the NA left</p>	F 241			

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F 241	Continued From page 13 before making sure she was ready for bed. She stated Resident #45 was glad to see her as she was a familiar face and she knew what to do for her. On 10/30/14 at 8:25 PM an interview with the interim DCS revealed her expectation of a reasonable amount of time to answer a call light was 3 to 4 minutes, that any staff member could respond and it did not have to be the nurse or NA assigned to that resident. She stated waiting an hour for a call light to be answered was too long and she would have expected staff to respond to the resident sooner.	F 241			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews the facility failed to remove a water pitcher from a resident's room that was to have nothing by mouth (Resident #95) and failed to administer vitamin B12 injections to a resident as ordered by the physician (Resident #64). The findings included: 1. Resident #95 was admitted to the facility	F 309	1. The water pitcher was removed from resident #95 room on 10/30/2014 by licensed nurse. Resident #64 was not injured related to this citation. Physician of record for resident #64 was notified of the missed does of B12 on 10/29/2014 by the Director of Clinical Services. 2. Residents that are NPO and receive	11/26/14	

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F 309	<p>Continued From page 14</p> <p>10/02/14 after hospitalization for a fall and cervical spine fracture with additional diagnoses which included dysphagia and dementia. Physician orders on admission included nutrition via tube feeding with strict orders for "nothing by mouth" (NPO).</p> <p>The initial care plan dated 10/09/14 for Resident #95 included the problem area, Resident receives Osmolite (a tube feeding formula) 1.5, 240 bolus every four hours with water flushes as ordered. An approach to this problem area included, the resident is to remain NPO.</p> <p>Resident #95 was seen by the speech therapist with services initiated on admission. The initial evaluation and assessment dated 10/07/14 by the speech therapist noted Resident #95 had mild-moderate dementia with severe dysphagia.</p> <p>On 10/29/14 at 6:00 AM and 8:07 AM a water pitcher with a straw in the lid was observed on the overbed table in the room of Resident #95. The water pitcher was in arms reach of where Resident #95 was seated in a wheelchair.</p> <p>On 10/29/2014 at 8:40 AM the speech therapist was observed in the room with Resident #95. The water pitcher and straw remained on the overbed table in the room.</p> <p>On 10/30/14 at 9:00 AM the water pitcher with a straw in place was observed on the overbed table in the room of Resident #95. At the time of the observation the speech therapist was asked about the water pitcher and she reported that Resident #95 was a strict NPO and should not have anything by mouth except in her presence. The speech therapist reported she was not aware</p>	F 309	<p>B-12 injections have the potential to be affected by this citation.</p> <p>Review of current residents orders for how or if they should receive liquids was completed 11/10/2014 with care plans and kardex updated if needed by the Director of Clinical Services and/or Nursing Supervisor.</p> <p>Review of current residents receiving B-12 injections was completed 11/21/2014-11/25/2014 by the Director of Clinical Services and/or Nursing Supervisor.</p> <p>3. The Director of Nursing and/or Nursing Supervisor in serviced licensed nurses on following physician orders for administering medications 11/21/2014-11/25/2014.</p> <p>The Director of Nursing and/or Nursing Supervisor in serviced licensed nurses, certified nurse assistants on ensuring that residents only have liquids at bedside if they are suppose to and to check kardex to determine if resident is to be NPO.</p> <p>The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) will perform Quality Improvement Monitoring of liquids provided at the bedside to residents to make sure that NPO residents do not have liquids 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks and 1 time a week for 4 weeks and/or until substantial compliance obtained.</p> <p>The Director of Clinical Services and/or</p>		

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F 309	<p>Continued From page 15</p> <p>a water pitcher had been placed in the room of Resident #95 and she immediately removed it from the room.</p> <p>On 10/30/14 at 9:10 AM the Director of Clinical Services (DCS) stated third shift nursing assistants placed new water pitchers in resident rooms every night. The DCS stated a water pitcher should not have been left in the room of Resident #95 due to strict NPO orders. The DCS stated nursing assistants would know a resident was NPO by review of information in their individual kardex. The kardex of Resident #95 was reviewed with the DCS and though it noted Resident #95 was fed by tube feeding, it did not indicate any restrictions under the headings "fluids" or "restrictions". The DCS could not explain why the kardex information did not include the NPO information or why a water pitcher was placed in the room of Resident #95.</p> <p>2. Resident #64 was admitted to the facility 09/12/14 with diagnoses which included behavioral disturbances, Parkinsons, chronic pain and diabetes. Review of admission physician orders in the medical record of Resident #64 included an order for an injection of 1000 micrograms (mcg) of vitamin B12 every 14 days.</p> <p>Review of the September and October Medication Administration Records (MARs) for Resident #64 noted the following:</p> <p>September 2014 MAR 09/15/14-the initial block on the MAR was noted with a circled initial 09/16/14-the initial block was blank 09/17/14-09/21/14-the initial blocks were noted with initials</p>	F 309	<p>Nursing Supervisor will perform Quality Improvement Monitoring of the administration of B12 injections 2 times a week for 12 weeks, 2 times a week for 8 weeks and 1 time a week for 4 weeks and/or until substantial compliance is obtained.</p> <p>4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.</p>		

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F 309	<p>Continued From page 16</p> <p>09/21/14-09/26/14-the initial blocks had an "x" 09/26/14-09/30/14-the initial block was blank</p> <p>October 2014 MAR 10/01/14-the initial block on the MAR was outlined in pen with no initial noted in the block 10/02/14-10/13/14-the initial blocks were noted with an "X" 10/14/14-the initial block had an initial signature 10/15/14-10/27/14-the initial blocks were noted with an "X" 10/28/14-the initial block had an initial signature</p> <p>On 10/29/14 at 10:14 AM Nurse #7 verified the circled initial signature on 09/15/14 was hers and that she recalled administering the vitamin B12 injection to Resident #64. Nurse #7 reviewed the remainder of the September MAR for Resident #64 and could not explain what it meant in relation to the B12 for Resident #64. At the time of the interview Nurse #7 removed from the medication cart the B12 vials sent from the pharmacy for Resident #64. One bag had 2 individual vials of 1000 mcg of B12 of the 2 vials that were labeled as dispensed by the pharmacy on 09/11/14. The other bag had one of two individual vials of 1000 mcg of B12 remaining that were labeled as dispensed by the pharmacy on 10/14/14.</p> <p>On 10/29/14 at 11:10 AM the Assistant Director of Clinical Services (ADCS) reviewed the September MAR for Resident #64 and could not explain what happened with the administration of the Vitamin B12. The ADCS looked at the medication error reports and noted there were two they were aware of involving Resident #64 but they did not include the vitamin B12. The ADCS called the dispensing pharmacy and</p>	F 309			

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F 309	Continued From page 17 reported that since admission, two separate doses of two vials of 1000 mcg B12 were sent for Resident #64 on 09/11/14 and 10/14/14. When the ADCS saw that three of the four vials of 1000 mcg of B12 remained in the medication cart for Resident #64 she could not explain what happened. The ADCS stated staff would typically outline the initial block on the MAR for the day when a medication was due. She stated if it was not administered on a daily basis the initial blocks for those days would be "X'd" off. In a follow-up interview on 10/29/14 at 2:09 PM Nurse #7 stated she had worked with Resident #64 on 09/17/14, 09/18/14, 09/19/14 and 10/01/14. Nurse #7 stated that typically the nurse that received admission orders would block off on the MAR specific dates to administer medications that were not given on a routine basis. Nurse #7 stated dates not to administer a medication would be "X" off on the MAR. Nurse #7 stated her initials on 09/17/14, 09/18/14 and 09/19/14 were done so the MAR would not have been left blank. Nurse #7 could not explain how 3 of 4 vials of the 1000 mcg of B12 remained in the medication cart or what happened on 10/01/14 that the 1000 mcg of B12 was not administered to Resident #64. On 10/30/14 at 6:30 PM the facility nurse consultant reviewed the September and October MARs for Resident #64 and could not explain why only one of four doses of the 1000 mcg of vitamin B12 had been administered to Resident #64 since admission.	F 309			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328		11/26/14	

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F 328	<p>Continued From page 18</p> <p>proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, family interview, staff interview and manufacturer technical support representative interview, the facility failed to provide ordered continuous oxygen therapy to a resident (Resident #13) while in her wheelchair and failed to provide manufacturer recommended periodic oxygen concentrator preventive maintenance.</p> <p>The findings included:</p> <p>Review of the user manual for the oxygen (O2) concentrator used by the facility and revised 08/13 revealed a preventive maintenance (PM) record listing the following items be checked every 4,380 hours of use for a concentrator without an O2 sensor: O2 concentration, clean/replace cabin filter(s), check outlet high efficiency particulate air (HEPA) filter, check compressor inlet filter and check power loss alarm. Review of a frequently asked question (FAQ) sheet, provided by the manufacturer's Technical Support representative, revealed providers were still required to check O2 purity on concentrators without O2 sensors every 4,380</p>	F 328	<ol style="list-style-type: none"> 1. Resident #13 was not injured related to this citation. Resident #13 was assessed by the physician on 11/3/2014 with new orders noted. 2. Residents with orders for continuous oxygen have the potential to be affected by this citation. A review of residents with oxygen orders was completed on 11/17/2014 by the Director of Clinical Services. Concentrator's filters were changed by Central Supply on 11/17/2014. The Maintenance Director provided manufacturer recommendations servicing of the oxygen purity 11/17/2014. 3. Licensed Nurses were in-serviced by the Director of Clinical Services and/or Nursing Supervisor on providing oxygen as ordered, transporting and change out of oxygen cylinders. The Director of Clinical Services and/or Nursing Supervisor will conduct Quality Control Monitoring of residents that require continuous oxygen to ensure they are 		

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F 328	<p>Continued From page 19</p> <p>hours, the hourly equivalent to six months. The sheet noted the time interval was stated in hours as most patients did not use their concentrators 24/7, giving providers more flexibility in performing PM. This FAQ sheet recommended concentrator filters be checked during PM and replaced as needed, with no specific timeframe due to varying environmental conditions.</p> <p>Resident #13 was admitted to the facility on 01/29/14 and readmitted after a hospitalization on 05/21/14 with diagnoses including history of acute hypoxic respiratory failure. Review of her care area assessment dated 05/28/14 revealed Resident #13 received O2 at 2 liters/minute (l/min) due to respiratory failure and aspiration.</p> <p>Record review revealed a nursing note dated 08/05/14 documenting the resident as continuing on antibiotics for a right leg cellulitis, anticoagulants for a right leg deep vein thrombosis and oxygen at 2 l/min via nasal cannula (NC) at hour of sleep.</p> <p>Resident #13's most recent Minimum Data Set (MDS) dated 08/13/14 revealed her to have severely impaired cognition and showing no rejection of care. Shortness of breath (SOB) was checked on the MDS.</p> <p>Review of a provider order dated 08/16/14 revealed Resident #13 be given O2 at 2 l/min by NC and to check O2 saturation levels every shift. Review of another nursing note, unsigned and dated 08/16/14, revealed clarification of the order, the resident with a history of hypoxemia and showing no signs or symptoms of respiratory distress or SOB.</p>	F 328	<p>using 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 1 month and 1 time a week for 1 month and/or until substantial compliance is obtained.</p> <p>Central Supply Clerk will change and/or clean the oxygen concentrator's filter when in use by residents 1 time a week for 6 months and/or substantial compliance is obtained.</p> <p>The Maintenance Director will perform oxygen purity testing and preventive maintenance on oxygen concentrators 1 time a month for 6 months and/or substantial compliance is obtained.</p> <p>4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services and Maintenance Director for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.</p>		

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F 328	<p>Continued From page 20</p> <p>Review of the monthly order review sheet for October, 2014 and checked by the assistance director of nursing (ADON), revealed a current order for O2 to continue at 2l/min and to check O2 saturation levels every shift due to a history of hypoxemia.</p> <p>On 10/27/14 at 11:32 AM, Resident #13 was observed in the hallway, seated in her wheelchair (WC) and not wearing her NC, which was attached to a portable O2 tank on the back of her WC. The tank's gauge was reading empty with the needle in the red zone of the gauge. The resident did not show any signs of respiratory distress.</p> <p>On 10/27/14 at 12:09 PM Resident #13 was observed in the dining room, seated in her WC and not wearing NC, which was attached to a portable O2 tank on the back of her WC. The portable O2 tank's gauge was reading empty with the needle in the red zone of the gauge. The resident did not show any signs of respiratory distress.</p> <p>On 10/28/14 at 8:43 AM Resident #13 was observed in her room, seated in her wheelchair (WC) and not wearing her NC, which was attached to a portable O2 tank on the back of her WC. The tank's gauge was reading empty with the needle in the red zone of the gauge. An O2 concentrator was observed at her bedside and was off. The resident did not show any signs of respiratory distress.</p> <p>On 10/29/14 at 7:33 AM Resident #13 was observed in the dining room, seated in her WC and not wearing NC, which was attached to a portable O2 tank on the back of her WC. The</p>	F 328			

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F 328	<p>Continued From page 21</p> <p>portable O2 tank's gauge was reading empty with the needle in the red zone of the gauge. The resident did not show any signs of respiratory distress.</p> <p>On 10/29/14 at 8:17 AM Resident #13 was observed leaving the assisted dining room, seated and self-propelling in her WC and not wearing NC, which was attached to a portable O2 tank on the back of her WC. The portable O2 tank's gauge was reading empty with the needle in the red zone of the gauge. The resident did not show any signs of respiratory distress.</p> <p>On 10/29/14 at 9:38 AM Resident #13 was observed in her room, seated in her wheelchair (WC) and not wearing her NC, which was attached to a portable O2 tank on the back of her WC. The tank's gauge was reading empty with the needle in the red zone of the gauge. Observation of the O2 concentrator at her bedside revealed a PM sticker affixed to the top of the concentrator. The PM sticker noted a PM check was done on 6/10/13 and due on 12/10/13. Observation of the filter on the back of the concentrator revealed it to be covered in dust. On the handle of the concentrator was a sticker printed with "Property of the [facility name]."</p> <p>On 10/29/14 at 9:53 AM, a phone interview with a family member revealed he visited Resident #13 up to twice a week and was familiar with her care needs. He stated the resident did not wear O2 when first admitted in January 2014, he had seen her with it on sometimes, but he was not sure if she required it all the time. He stated it had been a couple weeks when he last saw her wearing O2 and at that time she was in bed.</p>	F 328			

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NAME OF PROVIDER OR SUPPLIER THE OAKS AT SWEETEN CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
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F 328	<p>Continued From page 22</p> <p>On 10/29/14 at 10:45 AM, an interview with a medical supply company representative revealed his company provided the facility O2 tanks and respiratory equipment if required. He stated he made routine pick-ups of empty tanks and deliveries of full tanks on Mondays, Wednesdays and Fridays. He stated his company could make an immediate delivery if required, but he was not aware of the facility running out of tanks. He stated if his company provided the facility O2 concentrators, he checked them once a month to include changing filters, cleaning, and placing an analyzer on them to determine if the concentrators were delivering O2 accurately. He stated the facility would not keep records of this as his company was performing the monthly checks, his company's name was clearly noted on stickers placed on the equipment and that no PM stickers were necessary for his company-owned equipment.</p> <p>On 10/30/14 at 8:35 AM Resident #13 was observed in the hallway at the nursing station, seated in her WC and not wearing her NC. The assitant director of clinical services (ADCS) was observed approaching the resident, starting to unravel the NC tubing and noting the portable O2 tank on the back of her WC was reading as empty. The ADCS stated Resident #13 had an order for continuous O2 therapy and was care planned as being non-compliant with wearing it. She stated she was not sure who was responsible for making sure there was a full O2 tank on her WC when AM care was provided and assisted to her WC to go to breakfast. The ADCS was observed taking Resident #13 via her WC to the O2 closet where, with assistance from a nurse aide, the empty O2 tank was removed and replaced with a full O2 tank.</p>	F 328			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 328	<p>Continued From page 23</p> <p>On 10/30/14 at 8:45 AM, the ADCS was interviewed in Resident #13's room. She stated that until the resident was assessed by a provider, the current order for O2 therapy was valid and nursing staff had a responsibility to carry it out. She stated the facility's Central Supply representative was responsible for the concentrators owned by the facility which included delivery to rooms, set up, checking the filters and changing out the tubing. The ADCS was observed inspecting the filter on the concentrator, found it to be covered in dust and stated this was not acceptable. The ADCS was observed inspecting the PM sticker and stated she was not sure what that sticker meant or who might be responsible for any PM on the concentrator.</p> <p>On 10/30/14 at 9:00 AM, an interview with the Central Supply representative, with the ADCS present and in the resident's room, revealed that the medical supply company representative provided concentrators only when the facility ran out of their own and did rounds on their own concentrators. He stated he was responsible for checking facility-owned concentrators every week, which included changing out the tubing. He stated at one time housekeepers were responsible for checking the filters on the concentrators, but it was passed to him and he did not always get to check the filters. He stated he did no PM on the concentrators and that Maintenance addressed any PM concerns. He stated at one time an outside entity may have done PM on the concentrators, but that this had not occurred for some time.</p> <p>On 10/30/14 at 9:10 AM an interview with the</p>	F 328			

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F 328	Continued From page 24 Maintenance director, accompanied by his assistant and in the resident's room, revealed he made sure concentrators had air flow but otherwise he did not use any analyzing device on the concentrator. He stated he did not know what the PM sticker meant and that his department did not use stickers like this. The Maintenance director was observed inspecting the concentrator's filter, removed it, found it dusty, stated this was not acceptable and gave it to his assistant with cleaning instructions. On 10/30/14 at 9:49 AM, a phone interview with the concentrator manufacturer's Technical Support representative revealed the recommendation that nursing homes should check the filter, the O2 concentration, the psi and liter flow every 12 to 18 months, referring to the PM record in the owner's manual. On 10/30/14 at 10:17 AM, an interview with the interim director of clinical services (DCS) revealed that if the resident had an order for O2 therapy, she expected staff to make sure NC tubing was in place and that tanks were full. She stated the Central Supply representative was responsible for checking and changing the tubing every week and checking the filters on the concentrators, but she was not sure what the schedule was for checking the filters. She stated she had seen PM schedules, similar to the one in the owner's manual, at other facilities for PM record keeping but stated she was not aware of any records like this for this facility. She stated the facility should have been following manufacturer's recommendations for PM checks on concentrators.	F 328			
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		11/26/14	

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F 431 SS=D	<p>Continued From page 25</p> <p>LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff</p>	F 431	1. No residents were affected by this		

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F 431	<p>Continued From page 26</p> <p>interviews, the facility failed to discard expired medications in 1 of 5 (300 hall) medication carts and 1 of 1 medication storage rooms.</p> <p>Findings include:</p> <p>During an observation of the 300 hall medication cart on 10/29/14 at 1:56pm, one dose card of Zofran 8mg was noted with three tablets remaining in the pack. The attached preprinted pharmacy label had an expiration date 1/9/14. An interview was conducted with the nurse assigned to the 300 hall medication cart on 10/29/14 at 1:58pm. During the interview Nurse # 1 acknowledged the medication was expired. He stated the resident was no longer on the medication and it should have been removed from the medication cart and sent back to pharmacy when the medication had been discontinued.</p> <p>During an interview with the Director of Clinical Services (DCS) on 10/29/14 at 2:15pm, she indicated that the medication had been discontinued on 4/11/14 and that it was her expectation that the medication be removed from the medication cart at the time the medication was discontinued and returned to the pharmacy. She further stated the medication had not been used since the order was discontinued and provided the medication administration records for review.</p> <p>During an observation of the medication storage room on 10/29/14 at 3:45pm, one bottle of Omeprazole Suspension was noted to be in the refrigerator with an attached pharmacy label that read "discard after 10/16/14 ". The expiration had been circled in red. There was also one bottle of Dukes Magic Mouthwash noted in the refrigerator with an attached pharmacy label that read "expires 10/16/14 ".</p> <p>An interview was conducted with Nurse # 2 at the</p>	F 431	<p>citation.</p> <p>Expired medications were removed from the medication cart and medication room and sent back to pharmacy on 10/29/2014 by the licensed nurse.</p> <p>2. All residents have the potential to be affected by this citation. Observations of all medication carts and medication room for expired medications was completed on 10/29/2014.</p> <p>3. The Director of Clinical Services d/or Nursing Supervisor in serviced licensed nurses on removing expired medications from medication carts and medication room and returning to pharmacy 11/21/2014-11/24/2015. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication carts for expired medications 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication storage refrigerator for expired medications 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained.</p> <p>4. The results of these audits will be reported to the Quality Assurance</p>		

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F 431	Continued From page 27 time of the observation of the medication storage room. Nurse # 2 acknowledged that both medications were expired and should have been removed from the refrigerator and returned to the pharmacy once the medication expired. Another interview was conducted with the DCS on 10/29/14 at 4:15pm and she indicated both expired medications should have been removed from the refrigerator and returned to the pharmacy once the medications had expired.	F 431	Performance Improvement Committee by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.		