STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 12/18/14. Event ID# Y7N611.	F 000	Resident # 10 offered an alternative to the food she dislikes.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff interviews and record review, the facility failed to honor food preferences not to serve items on their dislikes for 2 of 2 sampled residents (Residents #10 and 57). The findings included: 1 .Resident #10 was admitted to the facility on 1/10/08. The diagnoses included diabetes, depressive disorder .and colon cancer. The Minimum Data Set (MDS) dated 11/13/14, indicated that Resident #10 had decision making skills and only required set up assistance with meals and on a regular no concentrated sweet diet. Review of the care plan dated 11/13/14, identified the problem as: the potential for nutritional	F 242	All interview able residents have ben re surveyed for food preferences. Interested family members for residents who were not able to be interviewed have been interviewed for their recommendations for food that the resident would enjoy. The updates have been entered into the tray card system to allow for the preferences to be printed on the daily tray card. Newly admitted residents will be visited by a Dietary Aide to be interviewed for food preferences within two days of admission. Dietary leads and supervisor have been reeducated concerning the process of updating tray card information as needed. Dietary staff has also been reeducated concerning the process of communication of the serving line to ensure that these preferences listed on the tray card are followed. Any flex/prn Dietary staff unavailable for reeducation prior to 1/15/2015 will be reeducated prior to taking their next assignment. Nursing staff has been reeducated to check the tray card against the tray contents removing any listed dislikes and offering a replacement immediately to the resident. Any flex/prn nursing staff unavailable for reeducation prior to 1/15/2015 will be reeducated prior to taking their next assignment.	1/15/15 1/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ima Bullock LNHA | TITLE: Administrator | (X6) DATE: 01-20-2015

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 242	Continued From page 1 problems. The goal included Resident #10 needed to have a dietary consult for nutritional regimen and ongoing monitoring. The approaches included encourage Resident #10 to follow any diet restrictions and explanation and importance of the maintaining the diet and risk with refusal. RD(registered dietician) to evaluate and make diet change recommendations. During an observation on 12/17/14 at 12:20PM, the meal tray observation staff were preparing resident meals. The dietary staff plated stewed tomatoes on the plate, even after the dietary card was called out that no stew tomatoes were on the dislike. Review of the meal card under dislikes lasagna, beets, no sugar/muffin, squash/cabbage, stew tomatoes, rice and sweet potatoes. During an observation on 12/17/14 at 1:00PM, Resident#10 was seated at the table and she did not eat the stew tomatoes. She stated I have told them several times that I did not like stewed tomatoes and I keep getting I ' m so sick of it, they should have gotten it right by now. Resident pointed to her meal card and stated it was printed on the card. I just leave it there. During an interview on 12/17/14 at 4:09PM, the registered dietician (RD)indicated that when a resident dislike is identified they should not be given the item of dislike. The tray line staff should be checking the meal cards closely and the checker should cross check to ensure the meal was plated correctly in accordance to meal card.	F 242	During the tray line process in the kitchen, an additional final checker will inspect the contents of the all the trays coming to the Extended Care Unit against the tray card after the final processing of the trays have been completed in the kitchen. This will be documented on the Final Tray Check monitoring tool every meal daily x 7 days, every meal daily x 5 days x 1 week, every meal three days a week x 2 weeks, one meal a day three days a week x 4 weeks, one meal a week weekly x 2 months. The information about preferences gathered from residents newly admitted will be placed into the tray card system the day gathered by a Dietary Lead or the Dietary Supervisor. This data gathering and entry will be documented on the New Resident Food Preferences monitoring tool for every newly admitted resident x 7 days, every newly admitted resident x 5 days a week x 1 week, every newly admitted resident x 3 days a week x 2 weeks, weekly x 2 months. Assigned Extended Care Unit staff will check 4 trays a meal service of residents who have dislikes listed on their tray cards. The results of these checks will be documented on the Tray Contents/Tray Cards monitoring tool every meal for 1 week, one meal a day for 3 weeks, one meal 5 days a week for 4 weeks, and then one meal a week x 4 weeks.	

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F 242	Continued From page 2 During an interview on 12/18/14 at 8:00AM, the dietary staff indicated that expectation was for the tray line caller to call out the diet consistency and the dislike. The server would plated the food and recheck the card for accuracy and the last person would recheck to ensure everything was right on the tray. She indicated that she was unaware that she had put a dislike on the resident plate. During an interview on 12/18/14 at 1:30PM, NA#4, that had Resident #10 had complained often about getting foods she did not like, so we have to call down to the kitchen to get a substitute or alternate. Resident #10 would get upset and would refuse the meal. During an interview on 12/18/14 at 3:00PM, the director of nursing (DON) indicated that the residents should not get food items that they dislike. Don indicated that the kitchen staff was responsible for checking the cards prior to meal delivery and nursing staff should be reviewing the cards as well.to ensure residents were receiving desired foods. She indicated that she was aware of the concern that residents had been receiving food dislikes. #2 Resident #57 was admitted on 11/7/14, with the diagnosis of Diabetes Mellitus, Chronic Kidney Disease Stage III, Coronary Artery Disease and Atrial Fibrillation. The Minimum Data Set dated 11/21/14, revealed Resident #57 had some memory problems and was independent with decisions of daily care. Review of the tray card faxed to the dietary	F 242	During each monthly Resident Council meeting for the next 6 months the residents will be asked if they are receiving their meals according to their preferences. This will be documented on the Resident Counsel Meal Preferences monitoring tool monthly x 6 months. Any stated concerns will be placed on a concern form and will be sent thru the concern process. The results of the Tray Contents/Tray Card monitoring will be presented to the Quality Assurance/Performance Improvement committee by the Administrator. The results of the Final Tray Check will be presented by the Dietary Manager. The results of the Resident Counsel Meal Preferences monitoring will be presented by the Director of Activities. These results will be presented monthly for the duration of the documentation of each monitoring process for the committee to review and make any recommendations it deems necessary. The allegation of compliance for this plan of correction is 1/15/2015.	

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F 242	Continued From page 3 department and dated 12/11/14, revealed hand written food dislikes included which green beans, turnip salad and pork chops During an interview on 12/16/14 at 3:46PM, with a family member indicated Resident #57 disliked turnip salad, green beans and peas but he continued to get these items on his tray. Observation during the evening meal on 12/16/14, revealed turnip salad was served to Resident #57. During an interview on 12/17/14 at 12:55PM, Dietitian indicated the tray ticket with changes had been faxed down to the kitchen on 12/11/14. An inquiry was made about turnip salad served at dinner on 12/16/14 to Resident #57. She said, " There was a systems problem. "	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to follow Physician orders to administer doses of a diuretic and daily weight for 1 of 1 sampled resident (Resident #57). Findings Included: Resident #57 was admitted on 11/7/14, with the diagnosis of Chronic Kidney Disease Stage III, leg swelling.	F 281	Resident # 57 no longer has an order for daily weights to determine Lasix dosage. No other resident has an order for daily weights to determine Lasix dosage.	1/15/15

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F 281	Continued From page 4 Review of the admission discharge orders dated 11/7/14, included Furosemide (a diuretic) 20 MG (milligrams) 2 tablets (40 MG total) by mouth daily then 20 MG if weight gain of more then 2 pounds in one day. The focused care plan dated 11/13/14 addressing renal disease included, · Daily weights per physician ' s orders · Give medication as ordered by physician Review of the medication administration record (MAR) revealed, the following weights had no diuretic administered per physicians orders: · 11/18/14 166.5lbs, · 11/19/14 183.9 lbs. 17.4 pound weight gain · 11/20/14 no weight · 11/21/14 170lbs · 11/22/14 189 lbs 19 pound weight gain · 12/07/14 172.3lbs · 12/08/14 176.5 lbs, 4.2 pound weight gain · 12/15/14 165.5lbs · 12/16/14 170.5lbs 5pound weight gain During interview on 12/17/14 at 11:48AM, Nurse #5 indicated the orders intent was to give the resident additional 20 MG of Lasix with greater then 2 pounds of weight gain. During interview on 12/18/14 at 8:36 AM, Nurse #3 indicated her interpretation was to give the resident additional 20 MG of Lasix with greater then 2 pounds of weight. She indicated she would also report it to the supervisor and put it on the 24 hour report.	F 281	All nurses have completed the online medication pass instructional course entitled Medication Pass Fundamentals, which is offered by the pharmacy providing service to the facility, by 1/15/2015 or will complete course prior to taking an assignment past that date. All nurses will sign a statement of understanding that it is the responsibility of each nurse to acquire accurate vital signs, including weights, if the physician order states this information as a condition of the order. Any vital signs or weights that are at a significant variance or are outside the parameters from the previous findings must be confirmed before continuing to carry out the medication or treatment portion of the order. New nurses coming onto the unit will complete the course and sign the statement of understanding before being allowed to be independent in passing medications. This completion of the course work for new nurses will be documented on the Medication Administration Course Completion monitoring tool with each new nurse for the next 6 months. The Director of Nursing will validate the completion of the course work for the existing nurses and will report that completion to the Quality Assurance/Performance Improvement Committee at the next monthly committee meeting. The Director of Nursing will report the ongoing monitoring of new nurses monthly x 6 months to the committee for review and recommendations. Allegation of Compliance for this plan of correction is 1/15/2015.	1/15/15 1/15/15

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F 281	Continued From page 5 During interview on 12/18/14 at 2:15PM, Director of Nursing had no comment regarding the physicians order.	F 281		
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 observation, staff and family interviews, the facility failed to assess 1 of 1 residents with swallowing and chewing concerns (Resident #107). The findings included Resident #107 was admitted to the facility on 12/9/14. The diagnoses included stage IV lung cancer, acute renal failure with hypoxia. The Minimum Data Set (MDS) had not been completed. Resident #107 required total assistance with activities of daily living. He had short and long term and decision making problems. During an observation on 12/16/14 at 8:52AM, Resident #107 regular meal tray of eggs, bacon, waffles, grits uneaten.	F 309	Resident # 107 is no longer in the facility. All new residents will be screened by Speech Therapy within 3 business days of their admission onto the unit. All new residents will have a care plan meeting with the resident and family invited within 3 business days of admission to allow for information about the resident to be shared in formulating the plan of care of the resident. All medication administration records have been reviewed to ensure how the resident takes medication safely and effectively. The Director of Rehabilitation has reeducated the speech therapy staff of the expectation that all new admissions will be screened by Speech Therapy. The nursing staff has been reeducated concerning the ability of the nurses to downgrade a diet if there is concern about swallowing difficulties until there can be following up by evaluation and testing by Speech Therapy as well as updating the medication administration record with the change in how the resident takes medication effectively. The Director of Admissions has been reeducated to schedule the initial care plan meeting with the family and resident invited when admitting the resident.	1/15/15 1/15/15

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F 309	Continued From page 6 During an observation/ on 12/16/14 at 9:21AM, the responsible person and another family member came to feed Resident #107 breakfast. The included bacon eggs, waffles, grits, orange juice, coffee. The family reported that on admission the nursing staff were informed that Resident #107 had difficulty chewing/swallowing food and medications. Family members reported that Resident #107 did not chew or swallow properly the foods and medications needed to be chopped/ground because Resident #107 would pocket both in his mouth. The family reported that when they reported the concern to the nursing staff on admission, they were told that the information would be documented on the chart and a swallowing evaluation would be done. Nurse #2 had entered into the room to administer medications. The medications were in whole form and when Nurse #2 attempted to give Resident #107 medication the family member stopped the process. Family upset that information had not been conveyed across all shifts. Resident #107 required coaching to consume the medication and the meal. Resident #107 did pocket the small out of food and medication in his mouth. Family concern that Resident #107 could choke on the diet/medication if a proper evaluation was not done soon. During an interview on 12/16/14 at 4:00PM, rehab director indicated that since Resident#107 was a hospice resident services for speech therapy evaluation for swallowing would not be done until hospice either agree to pay for the services or hospice team provided the services themselves. During an observation on 12/17/14 at 9:01AM, Resident#107 in bed and meal tray (regular diet)	F 309	The Administrator will verify in the morning meeting following a new admission of a resident that the care plan meeting with the resident and family invited has been scheduled with in the 3 business days of the admission. This will be documented on the Initial Care Plan Meeting monitoring tool with each new resident admission for 4 weeks, the first two resident admissions of the week for 4 weeks, and then a monthly review of resident admissions compared to the care plan calendar for 12 weeks. The Administrator will report the results of the monitoring to the Quality Assurance/Performance Improvement committee monthly for 6 months. The Director of Nursing will review the medication administration record for each resident admission and the change of condition of existing residents documented on the 24 hour report to ensure the method of medication administration is clearly stated. This will be documented on the Medication Administration Method monitoring tools with each new admission and change of condition for 4 weeks, then the first two admissions and all residents with a change of condition for 4 weeks, and then monthly with change over to the new medication administration records until the initiation of the electronic medical records for medication administration has begun.	1/15/15 1/15/15

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F 309	Continued From page 7 of eggs, bacon, waffles and grits on tray uneaten, orange juice and milk not drank. During an interview on 12/17/14 at 9:08AM, NA#3 indicated that she delivered Resident #107 tray around 8:15AM- 8:30AM. During an interview /observation on 12/17/14 at 9:09AM, NA#4 indicated that she was feeding in the dining room and on the other end of the hall and did not come to feed the resident. She observed the resident meal and identified that the meal was cold and ordered a new tray. During an interview on 12/17/14 at 9:21AM, Nurse#4 indicated that a full care plan had not been developed only a 7 day and it was generated from the orders. She did not have a meeting or discussion with the family. She added that since the resident was under hospice care they would need to be involved in the team meeting process and another staff was assigned to set the meeting up. She added that if the family had concerns about diet/ dental etc, hospice services would have to approve the cared needed and or swallowing evaluation. She added that the 14 day MDS assessment had not been completed at this time and the care plan meeting not been done as well. She confirmed a discussion /assessment should have been done to determine the need for a swallowing assessment due to the concerns with swallowing and chewing of medication and meals. During an observation on 12/17/14 at 9:25AM, NA#4 was assisting Resident#107 with the meal. Resident#107 was demonstrating some pocketing of foods in right corner of the mouth. He required constant cueing and coaching. When	F 309	The Director of Nursing will report the results of the monitoring to the Quality Assurance/Performance Improvement committee monthly until the initiation of the electronic medical records for medication administration has begun. The committee will review the results of this monitoring for review and recommendations during the documented monitoring duration. The allegation of compliance date for this plan of correction is 1/15/2015.	1/15/15

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F 309	Continued From page 8	F 309		

offered the bacon he stated he could not chew the bacon or eat it every day. He appeared to need reminders just to eat or drink. NA#4 indicated that she was uncertain when the hospice aides came in to work with Resident #107. Resident #107 did not eat but a few spoonful of eggs and what he had in his mouth NA#4 had to remove because it had not been chewed or swallowed and Resident #107 only drank several sips of juice and coffee.

During an interview on 12/17/14 at 9:51AM, the director of nursing (DON) indicated the expectation would be when family brought the concern to nursing staff regarding Resident #107 ' s chewing/swallowing on admission, the information should have been relayed directly to the director of nursing. The DON acknowledged she became was aware of Resident #107 concerns with swallowing and chewing on 12/15/14. DON confirmed that an assessment/evaluation should have been done to down grade Resident #107 diet consistency. In addition, the concern should have been address and follow-up done with the family when the concern was brought to her attention. In addition, a swallowing screen/study could have been done at any time.

Review of record revealed Resident #107 was admitted to the facility from the hospital on a cardiac diet. The registered dietician who had seen Resident #107 on the hospital unit indicated that the clinical treatment was to address poor oral intake and dental concerns. On 12/16/14 at 5:00PM, meal arrived to Resident #107 room as regular diet. The diet consistency had not

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F 309	Continued From page 9 changed on the meal card or the meal texture itself. Resident #107 did not eat the meal due to chewing/swallowing difficulties. During an interview on 12/17/14 at 10:43AM, the registered dietician (RD) indicated that when Rresident#107 was seen by her on the hospital side he was on s soft diet with supplements. She indicated the diet consistency should have transferred to the skilled nursing home. She added that when the diet was changed on 12/16/14 to mechanical soft all of the meals should have been prepared with the new consistency. RD indicated that she was unaware Resident #107 did not get the correct diet after the change had been made. During a follow-up interview on 12/17/14 at 4:09PM, the RD indicated that when Resident #107 was on the hospital side, she had spoken with a relative who was not was really aware of Resident #107 ' s diet/swallowing issues. She indicated the hospital diet should have been carried over to the SNF (skilled nursing facility). She further stated when the new order was done on 12/16/14, the information was faxed down to the dietary staff. The meal card was printed the night before and the new changes were not done on the meal card therefore Resident#107 received the previous regular diet as opposed to the changed mechanical chopped diet. The tray line staff should check the meal card and ensure the resident received the correct diet. Nursing should report any concerns with the diet. ST was responsible for the MBBS(modified barium swallow study) to determine any swallowing concerns.	F 309		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to discontinue an antimicrobial agent, Nystatin, and bring to the attention of the providing physician the necessity of Nystatin's ongoing use since September 2014 for 1 of 5 residents reviewed for unnecessary medications (Resident #51). Findings included: Resident #51 was admitted to the facility on	F 329	The nystatin order for Resident #51 was discontinued on 12/16/2014. All new resident physicians' orders will be reviewed to ensure that they are properly transferred according to the original order. Nurse # 2 has been reeducated concerning her responsibility to understand the use for each medication she will be administering and to notify the physician if the medication appears to her as no longer needed. Upon admission, the unit secretary or staff nurse transcribes the admission orders and the orders are then verified by a second nurse prior to sending the orders to the pharmacy. All nurses have been reeducated to complete the third check of all new admissions orders nightly when working at that time to ensure accurate transcription from the discharge orders that arrived with the resident onto the medication administration record. Every order in the chart will be initialed by the nurse checking at the completion of the review. The Director of Nursing or the Nurse Manager will monitor for completion of the chart check the day after each new admission and document this monitoring on the Accurate Transcription of Admission Orders monitoring tool daily x 1 week, 5 days a week x3 weeks, one day a week x 8 weeks, and then 1 day a month x 3 months. The Director of Nursing will present the results of the documentation monthly for 6 months to the Quality Assurance/Performance Improvement Committee for their review and recommendations. The allegation of compliance date for this plan of correction is 1/15/2015.	1/15/15 1/15/15 1/15/15

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F 329	Continued From page 11 9/27/14 with pertinent diagnoses of thrush and dementia. The resident had severely impaired cognition. Upon admission, the resident had orders from the hospital to take Nystatin 500,000 units by mouth four times daily. The end date on the hospital discharge orders for the Nystatin was 10/07/14. This stop date was not transcribed onto the facility's medication administration record nor acknowledged by the staff and/or physician. Record review revealed the Nystatin remained on the medication administration record for September, October, November and December 2014 and was being given four times daily. Nurse #2 was interviewed on 12/16/14 at 10:00 AM. She indicated that the resident did not currently have an issue with thrush, nor had he had issues with thrush since he was initially admitted. She stated that she thought that the Nystatin was being continued for "dry mouth" and therefore indicated that the nursing staff continued to administer Nystatin four times daily. She was not aware of the plan to have discontinued the medication on 10/7/14. She also indicated that she had not brought to the attention of the provider the need to continue or discontinue Nystatin. The Nurse Manager was interviewed on 12/16/14 at 4:00 PM. She indicated that the resident was admitted with Nystatin for "raging thrush." She confirmed that the thrush had resolved and further stated that "I really don't know why he is still on it. I guess it was an oversight." She later confirmed, at 4:15 PM, that she had discussed the medication with a physician and had received an order to discontinue its use.	F 329		

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F 329	Continued From page 12 The Director of Nursing was interviewed at 4:20 PM on 12/16/14. She suggested that the physician may have been using the medication prophylactically but she did not believe that the resident had any medical issues that would necessitate long-term prophylactic use. She stated that "I would expect the physician to have documented his plan for prophylactic use in his notes. Regardless, we definitely would not have used Nystatin for dry mouth." The physician was interviewed at 10:05 AM on 12/17/14. He stated that "Because we (physicians) rotate so often so I cannot say for certain what the plan for use of the Nystatin was. In general professional practice, we would never use Nystatin for prophylaxis, it is a drug used for acute infections only. I am not sure why it was on his profile for three months but I discontinued it when they brought it to my attention."	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility's medication error rate was greater than 5 percent as evidenced by 2 medication errors in 33 opportunities, resulting in a medication error rate of 6.1 percent. (Resident #14). Findings included:	F 332	Resident #14 was transferred out of the facility on 12/17/14 and returned on 12/23/14. She was readmitted with no Flonase ordered. The Miralax order for has been clarified. No ill effects were noted by the dosage of either medication given.	1/15/15

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F 332	Continued From page 13 1. Resident #14 was admitted to the facility on 10/21/14 with diagnoses that included allergic rhinitis. A review of Resident #14's medical record revealed a physician's order for Flonase nasal spray one spray into each nostril twice daily. On 12/17/14 at 8:00 AM, Nurse #1 was observed to hand a Flonase spray bottle to Resident #14 who then proceeded to spray 2 sprays in each nostril. Resident #14 was interviewed at 8:08 AM on 12/17/14. She indicated that she had thought that the directions were to spray 2 sprays in each nostril twice daily. She indicated that no facility staff member had told her that it was only 1 spray per nostril twice daily. Nurse #1 was interviewed at 8:10 AM on 12/17/14. She stated that she only worked occasionally and she did not anticipate that the resident would administer 2 sprays per each nostril. She confirmed that the order stated to administer 1 spray per each nostril and indicated that she should have provided instructions to Resident #14 prior to handing her the medication. The Director of Nursing was interviewed on 12/17/14 at 10:30 AM. She confirmed that a medication error was made and stated that her expectations are that medications are administered without errors and as prescribed. 2. Resident #14 was admitted to the facility on 10/21/14 with diagnoses that included constipation. A review of Resident #14's medical record revealed a physician's order for Miralax 1 teaspoonful in 8 ounces of water daily.	F 332	All residents who prefer to self-administer nasal sprays have been educated concerning the proper administration of their respected medications based on the physician orders. All nurses have been reeducated to repeat the instructions of the physician order to the resident that is self-administering any nasal spray. All nurses will sign the statement of understanding prior to taking the next assignment that specifies that all self-administered medication require the nurse to repeat the instructions of the physician order to the resident when the medication is handed to the resident. It will also include the statement that any orders that are at variance with the standard use of the medication in quantity or frequency will be verified by the staff nurse with the MD before transcription. The nightly chart checks will verify that new orders have been properly transcribed. Nurse #1 has completed the assigned course Medication Pass Fundamentals. The Director of Nursing will report the completion of the assigned course Medication Pass Fundamentals to the Quality Assurance/Performance Improvement committee for their review and recommendations at the next meeting. The allegation of compliance for this plan of correction is 1/15/2015.	1/15/15 1/15/15 1/15/15

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F 332	Continued From page 14 Observations on 12/17/14 at 8:00 AM revealed Nurse #1 mixed 1 cupful of Miralax with 8 ounces of water and gave it to the resident to drink. Nurse #1 was interviewed at 10:10 AM on 12/17/14. She stated that typical instructions for Miralax are to mix 1 cupful (17 grams) of medication with 8 ounces of water for administration. She stated that she had not noticed that the order said to administer 1 teaspoonful in 8 ounces of water; she indicated that she should have read the order closely prior to administering the cupful of Miralax. She also acknowledged that 1 cupful was roughly equivalent to 1 tablespoon of Miralax powder. The Director of Nursing was interviewed on 12/17/14 at 10:30 AM. She confirmed that a medication error was made and stated that her expectations are that medications are administered without errors and as prescribed.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 15 Based on observations, staff interviews and record review, the facility failed to maintain sanitary conditions in the kitchen by 1) ensuring that fresh produce was removed from spoiled/rotten produce in 1 of 1 walk in vegetable cooler, 2) discard expired bread products from 1 of 1 walk in refrigerator, 3) discard opened unlabeled/undated yogurt in 1 of 1 walk in refrigerator, 4) clean the steamer box and hot plate cart, 5)clean dry storage bins and, 6) clean shelves of the steam table where clean plates/cups were stored . The findings included: 1.During an observation of the kitchen on 12/15/14 at 10:40AM, the walk in vegetable cooler had the following items: 1 bag of rotten/spoiled brown celery, 2 containers of molded/ rotten pans of cucumbers, 1 box of rotten/molded peppers. During an interview on 12/115/14 at 10:45AM AM, the dietary supervisor (DS) indicated the fresh produced should be checked when delivered and the spoiled/rotten produce should be discarded. Dietary supervisor indicated that he was responsible for restocking the produce and removal of spoil items to be returned to the vendor and when he was not available the utility person would take care of the produce. 2. During an observation on 12/15/14 at 10:40AM, there were 4 packages pita breads and 4 packages of tortilla wraps that had expired on 7/14/14 and 8/9/14 stored in 1 of 1 walk in refrigerator.	F 371	All spoiled, outdated, and opened and unlabeled food was disposed of. All the areas of the kitchen listed have been cleaned. All residents are at risk from the stated citation. The Dietary Staff have been reeducated concerning their responsibility in the kitchen. This included cleaning all surfaces of the kitchen, following the checklist for cleaning, and documenting completion on the checklist when they have completed each task; labeling all opened foods with the date opened; throwing out any spoiled, unlabeled, or out of date food; and removing any dented cans from the kitchen. Dietary Leads and the Dietary Supervisor have been reeducated concerning their role in inspecting the work of the dietary staff for all work required in the kitchen and reeducating as is needed. The Dietary Manager or designee will document monitoring of completion of these processes on the Food Storage/Kitchen Sanitation monitoring tool daily x 14 days, 5 days a week x 4 weeks, 3 days a week x 6 weeks, and then weekly x 12 weeks.	1/15/15 1/15/15

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F 371	Continued From page 16 During an interview on 12/10/14 at 11:10AM, the DS indicated that products should be checked upon delivery and the expired breads/wraps should be reported to vendor. DS indicated that expired foods should be discarded when staff use the product, there was no system in place for checking expired foods. 3. During an observation on 12/10/14 at 10:40AM, 2 boxes prepackaged yogurts were opened unlabeled/undated. During an interview on 12/10/14 at 11:20AM, the DS indicated that all foods opened should be labeled and dated once it was opened. DS confirmed several of the yogurts were opened and should have been discard. 4. During an observation on 12/10/14 at 10:40AM, the steamer box and hot plate cart had large volumes of dried food and grease build up on the inside and outside. During an interview on 12/10/14 at 11:20AM, the DS indicated that the kitchen staff was responsible for ensuring that all kitchen equipment was clean daily in accordance to the kitchen checklist. 5. During an observation on 12/10/14 at 10:40AM, the dry storage bins where the flour/sugar was contained had large volumes of dry foods/liquids on the inside and outside of the containers. During an interview on 12/10/14 at 11:20AM, the DS indicated that the kitchen staff was responsible for ensuring the storage bins were cleaned daily in accordance to the kitchen	F 371	The Dietary Manager will report the findings of this documented monitoring to the Quality Assurance/Performance Improvement committee monthly for the duration of the documented monitoring timeframe for review and recommendation. The allegation of compliance for this plan of correction is 1/15/2015.	1/15/15

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F 371	Continued From page 17 checklist. 6. During an observation on 12/10/14 at 10:40AM, the shelves of the steam table where clean plates/cups were stored had large volumes of dried liquids and food debris stored inside the dishes and the shelving area. During an interview on 12/10/14 at 11:20AM, the DS the kitchen staff was responsible for ensuring that the kitchen area was clean in accordance to the kitchen checklist. During a follow-up observation on 12/17/14 at 12:10PM, the walk in refrigerator continued to have spoiled/rotten produce mixed with fresh produce (cucumbers). During an interview on 12/17/14 at 12:10PM, the DS indicated that the produce should have been returned to vender.	F 371		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews, the facility failed to identify and patch a 1.5 X 2 foot hole in the ceiling of a resident's room bathroom and electrically wire the bathroom for working lights in the bathroom for 1 of 6 rooms (Room 204 for Resident #38). Findings included:	F 465		

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F 465	Continued From page 18 During a room observation on 12/15/14 at 10:30 AM, a 1.5 X 2 foot square cut out in the ceiling of room 204's bathroom was observed. The area on the ceiling where the light fixture should have been was devoid of a fixture onto which to attach a light bulb. Resident #38 was interviewed at 4:00 PM on 12/16/14. She stated that she was does not use the bathroom in her room because she requires a lift and a space large enough to accommodate her and the lift. She stated that she used the hallway bathrooms. The resident indicated that the hole in the ceiling and light fixture issue had been present since she was admitted to that room, which was on 10/6/14. Maintenance employees #1 and #2 were interviewed on 12/17/14 at 9:30 AM. They stated that "we were aware of the hole in the ceiling since early this year, but have been busy with other projects. That bathroom is not used so we did not address the issues right away....There are only 3 of us and we can only work 8 hours a day. We stay busy, but the ceiling should have been fixed sooner." Regarding the light fixture, they indicated that an electrician needed to be called to appropriately route the wires so that they can attach a light fixture. The maintenance manager was interviewed on 12/17/14 at 10:00 AM. He stated that the hole in bathroom ceiling was made when the new sprinkler system was installed in January 2014. It was probably never caught during the "walk through inspection" before paying the sprinkler installation company. "We should have caught it and it should have been fixed before finalizing the	F 465	The hole in the ceiling of the bathroom in room 204 was repaired on 12-18-2014. The light fixture was replaced and working on 12-18-2014. All ceilings on the unit were inspected for holes and the light fixtures were inspected for function. No deficiency was found. Maintenance staff has been reeducated to repair any damage to ceilings or light fixtures as they are identified in a timely manner. This reeducation includes that the Administrator will be notified of any identified need for repair and the timeframe in which the work will be completed. Maintenance will inspect all ceilings and light fixtures for damage or loss of function. This inspection will be documented on the Maintenance Inspection of Ceilings and Light Fixtures monitoring tool weekly x 6 months. Maintenance will report the results of this monitoring to the Quality Assurance/ Performance Improvement committee monthly x 6 months for their review and recommendations. The allegation of compliance for this plan of correction is 1/15/2015.	1/15/15 1/15/15 1/15/15 1/15/15

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F 465	Continued From page 19 bill." He further stated that he had begun working at the facility in April 2014 and since that time he was not made aware of any holes in the ceiling. "It should not have been there; it was missed and should not have been missed." Regarding the light issue, he indicated that the probably reason was that the hole needed to be fixed first and then an electrician could complete wiring the light fixture. The Director of Nursing was interviewed at 10:30 AM on 12/17/14. She stated "I was not aware of a hole in the ceiling or that there was no light in there. It is definitely a problem."	F 465		