STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(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 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 record review, observation and staff interview, the facility failed to review the continued need for the use of psychotropic medications at least quarterly and failed to document the rationale/target symptoms for continuing the medications for 2 (Residents #111 & # 124) of 5 sampled residents reviewed for unnecessary medications. Findings included:	F 329	F 329 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).	1/28/15

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

Electronically Signed | 01/27/2015

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F 329	Continued From page 1 1. Resident #111 was admitted to the facility on 8/2/14 and was readmitted 8/12/14 with multiple diagnoses including dementia with behaviors, hypertension, hypothyroidism, esophageal stricture, atrial fibrillation and chronic obstructive pulmonary disease (COPD). The facility's policy on antipsychotic medication (undated) was reviewed. The policy indicated that resident's on antipsychotic medication should have a behavior monitoring record/form to document the resident's behavior. The form was placed in the Medication Administration Record (MAR) book. The target behaviors and frequency of behaviors should be documented in the specific behavior section. The Minimum Data Set (MDS) assessments dated 9/18/14 (significant change in status assessment) and 12/13/14 (quarterly assessment) indicated that Resident #111 had memory and decision making problems, had no psychosis and had no behavioral symptoms. The assessments also indicated that Resident #111 had received antianxiety, antidepressant and antipsychotic medications. The admission physician's orders (8/2/14) and the current physician's orders (January, 2015) were reviewed. The orders included Lexapro (antidepressant drug) 10 milligrams (mgs) by mouth daily for depression, ativan (antianxiety drug) 0.5 mgs by mouth three time a day for agitation and seroquel (antipsychotic drug) 25 mgs ½ tablet by mouth twice a day for dementia with behavior. The care plan dated 12/17/14 was reviewed.	F 329	For residents 111 & 124 that were affected by the alleged deficiency, both residents charts have been reviewed for A GDR (Gradual Dose Reduction) on 1-12-15. Both residents received Behavior Monitoring Record sheets on 1-12-15. Resident 124 has been rescheduled to see her personal psychiatrist on 1-27-15. Resident 111 had a recommended gradual dose reduction on 1-21-15 by the Consultant Pharmacist which was denied by the Medical Director do to detrimental effects to the resident. All resident charts have been audited by Clinical Supervisors on 1-12-15. Any residents found through the audit receiving antipsychotics, anxiolytic and hypnotics now have a Behavior Monitoring Record sheet with target behaviors identified. All licensed staff, PRN, Weekend and regular staff have been inserviced on 1-28-15 by Director of Nursing, Pharmacy Consultant and/or Clinical Supervisors. This inservice included how to and when to document behaviors and to ensure that all residents receiving antipsychotics, anxiolytic and hypnotics are receiving Behavior Monitoring Record Sheets and routine Gradual dose reductions. For the residents that have the potential to be affected by this alleged deficiency, Clinical Supervisors will ensure that all residents requiring Behavior Monitoring Record Sheets by auditing telephone physician orders Monday through Friday in morning clinical meeting, have targeted behaviors identified on Behavior Monitoring Record Sheet. The Clinical Supervisors will	

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F 329	Continued From page 2 One of the care plan problems was " (name of resident) is at risk for side effects from seroquel, ativan, trazodone and lexapro use. " The goal was " (name of resident) has no injury related to medication usage/side effects through next review. " The approaches included " administer medications as ordered, observe resident for adverse side effects, document and report to physician, and monitor resident behavior/mood changes. " The nurse's notes were reviewed from August 2, 2014 through January 7, 2015. There was no documentation of behaviors. The social worker progress notes dated 9/18/14 and 12/12/14 indicated that Resident #111 had no mood or behavioral issues noted. The doctor's progress notes were reviewed. There was no documentation about the rationale for the use of the psychotropic medications. The care plan conference notes dated 12/17/14 were reviewed. The notes indicated that Resident #111 was on lexapro, ativan and seroquel. There was no documentation of rationale/target symptoms for the continued use of the medications. On 1/7/15 at 10:33 AM, Nurse #1 was interviewed. Nurse #1 stated that Resident #111 had no mood or behavioral issues since she was readmitted in August, 2014. She stated that behaviors were documented in the nurse's notes if any. Nurse #1 also stated that the facility had no monitoring sheet to document target behavior if a resident was on psychotropic medications.	F 329	monitor weekly for 3 months, then monthly thereafter using a Behavior Monitoring audit log. Clinical Supervisors and/or Director of Nursing will bring results of Behavior Monitoring Record Sheets to our monthly QA meeting. QA committee will review results and make recommendations as needed	

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F 329	Continued From page 3 On 1/7/15 at 4:40 PM, administrative staff #1 was interviewed. She stated that nurses had to document behaviors in the nurse's notes if any. She also stated that she had read the policy on antipsychotic medications and was not aware of any behavior monitoring form being used at the facility. Administrative staff #1 did not comment when questioned about the indication/rationale or target symptom for the continued use of the psychotropic medications for Resident #111. On 1/8/15 at 9:40 AM, administrative staff #2 was interviewed. She stated that she agreed that Resident #111 had no behavioral issues that warrant the use of the antianxiety, antidepressant and antipsychotic medications. She added that the facility had to depend on the pharmacist for gradual dose reduction for psychotropic medications. 2. Resident #124 was admitted to the facility on 6/11/14 with diagnoses including diabetes, cerebral vascular accident and depression. The Quarterly Minimum Data Set (MDS) Assessment dated 12/17/14 revealed resident #124 was cognitively intact, had no symptoms of a depressed mood according to her responses to questions about her mood, had no behaviors or refusals of care and had received antidepressant medications. The admission Physician ' s Orders dated 6/11/14 and the current orders dated January 2015 revealed an order for Paroxetine (Paxil) 40 mg (milligrams) twice a day for depression.	F 329		

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F 329	Continued From page 4	F 329		

The nursing notes were reviewed from admission (6/11/14) through January 7, 2015. There was no documentation of behaviors or depressed mood symptoms.

Nurse Practitioner #1 ' s (NP #1) Progress Note dated 8/14/14 revealed that Resident #124 had been followed by a psychiatrist for many years and that NP #1 did not want to make any changes to the dosage of Paxil the resident was receiving, unless it was approved by her psychiatrist. She suggested that the resident be referred for a follow-up visit with her psychiatrist.

Further review of the Nursing Notes and Physician ' s Orders from 8/14/14 through 1/7/15 revealed no notations regarding a referral or follow-up appointment with the resident ' s psychiatrist.

A Physician note dated 12/5/14 revealed " depression stable - continue paroxetine " .

A Pharmacist Communication to Physician Note dated 12/21/14 revealed " on Paxil bid (twice a day) since admission 6 months ago, please review for GDR (Gradual Dose Reduction) to 20 (mg) BID or 40 (mg) q AM (every morning) in effort to find lowest effective dose - typically given once daily in the AM " . Further review of this form revealed that the physician put a check to indicate that he did not agree with the recommendation. In the section where the rationale and risk benefit of not following the recommendation was to be documented, the following was hand written " no change at this time. "

On 1/7/15 at 8:30 AM interview with the Physician

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F 329	Continued From page 5	F 329		

revealed that since the resident had a psychiatrist, it made sense for her Paxil to be managed by him. He stated he was unaware that Resident #124 had not yet been to see her psychiatrist since admission 7 months ago and acknowledged that " no change at this time " was not a rationale for not pursuing a GDR.

On 1/7/15 at 9:30 AM Administrative Staff #1 stated that if a resident had behaviors supporting the need for psychotropic medications such as antidepressants they would be documented in the Nursing Notes.

On 1/7/15, interview with Nurse #2 at 11 AM revealed that the Nursing staff chart by exception and if behaviors and symptoms were not documented it meant that that they were not present. She also stated that she had worked with Resident #124 on a regular basis since her admission. She added that while the resident was reluctant to come out of her room much when she was first admitted, Nurse #2 had not observed any signs of depressed mood and the resident had never expressed any feelings of a depressed mood since admission. Nurse #2 had not been aware that NP#1 had suggested a follow-up appointment with the resident ' s psychiatrist and did not know whether an appointment had occurred.

On 1/7/15 at 2:03 PM interview with the Receptionist/Transportation Clerk revealed that she had booked transportation for Resident #124 to go to an appointment on September 5, 2014 at 2:15 PM with her psychiatrist. The appointment was written in her appointment book. She added that she just found out today that the resident had refused to go to the appointment and it was not

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F 329	Continued From page 6 rescheduled because she (the Receptionist) was unaware the resident had not gone to the appointment. The Receptionist stated that the Van Driver told her today that the resident refused to go because she had a bruise on her face and did not want to go out like that. On 1/7/15 at 2:13 PM NP #1 was interviewed. She stated that the psychiatrist who followed Resident #124 did not want his patient ' s medications changed by anyone but himself. She acknowledged that she was unaware that the follow-up appointment Resident #124 had with her psychiatrist in September 2014 did not occur and was not rescheduled, that the resident had no documented signs of depression while at the facility, and that the facility did not have any documentation of a previous unsuccessful GDR. She further acknowledged that the facility should have already followed-up to determine the ongoing need for the resident to receive her current dose of Paxil.	F 329		
F 332 SS=D	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 observation, record review and staff interviews, the facility failed to maintain a medication error rate of 5% or below by not flushing the gastrostomy tube (GT) with water before and after medication administration and between medications for one of one residents	F 332	F 332 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and	2/5/15

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F 332	Continued From page 7 observed receiving medications (Resident #5) via GT. There were two errors of 25 opportunities for error resulting in an 8% error rate. The findings included: A facility policy titled "Administration of oral medications through a nasogastric or gastrostomy tube" undated stated, in part, "Water for flushing tube--minimum 30 ml (milliliters) before and after medications and at least 5 ml between each medication. 8. Each medication must be administered separately, flushing with water between each medication. 12. a. Flush tube with a minimum of 30 ml of water, unless otherwise ordered by the physician. 14. As the last of the medication flows out of the syringe, begin to irrigate the tube by adding at least 30 ml of water, unless otherwise ordered by the physician." 1a. Resident #5 was admitted to the facility 10/19/2000 with last readmission on 11/26/14. Cumulative diagnoses included, aspiration pneumonia, dysphagia (swallowing difficulty) with aspiration risk and gastrostomy tube. On 1/7/15 at 8:15AM, Nurse #1 was observed administering the following medications to Resident #5 via gastrostomy tube: Aspirin 81 milligrams (mg) 1 tablet, calcium antacid 500 mg 1 tablet, Carvedilol (cardiac medication) 6.25 mg 1 tablet, Centamin liquid (vitamin supplement) 15 milliliters (ml), Allegra (allergy medication) 180 mg 1 tablet, Extra Strength Tylenol 500 mg 1 tablet, Valproic acid (seizure medication) 250 mg/ 5 ml--15 ml. and Valsartan (hypertension medication) 40 mg 1 tablet. Nurse #1 did not flush before and after medication administration. On 1/7/15 at 8:30AM, Nurse #1 stated she was	F 332	does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Nurse #1 was inserviced on policy and procedure for medication administration via G-tube including proper flushing technique by the Director of Nursing on 1-7-15. Physician was contacted and notified by the Director of Nursing of the medication errors on 1-7-15, orders were received to administer 30cc water before and at least 5 cc water between each medication and 30 cc water after medication administration. Resident #5 was monitored for adverse reaction to medication errors and none were noted. Nurse # 1 was observed administering medications via G-Tube on 1-7-15 by the Director of Nursing and all medications were administered correctly. All residents with a G-tube, have the potential to be affected by the same alleged deficient practice. All G-tube residents were identified through chart audit by the Director of Nursing on 1-7-15, each resident receiving G-Tube medications received orders from Medical Director for appropriate flushing with medication administration. All licensed nurses will receive inservice education on G-tube medication administration by the Consultant Pharmacist, Director of Nursing, Clinical Supervisors and/or Nurse Consultants by 2-5-15. Any nurse not able to attend the mandatory inservise will be removed from schedules until inservice is completed. All licensed	

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F 332	Continued From page 8 not aware of facility policy regarding flushing before and after medications or flushing between medications On 1/7/15 at 9:00AM, Administrative staff #1 stated she expected nursing staff to follow the policy and flush before and after medication administration with 30 cubic centimeters (cc) of water and flush with 5 cc of water between medications. 1b. Resident #5 was admitted to the facility 10/19/2000 with last readmission on 11/26/14. Cumulative diagnoses included, aspiration pneumonia, dysphagia (swallowing difficulty) with aspiration risk and gastrostomy tube. On 1/7/15 at 8:15AM, Nurse #1 was observed administering medications via gastrostomy tube. Resident #5 was observed to receive the following medications via gastrostomy tube: Aspirin 81 mg 1 tablet, calcium antacid 500 mg 1 tablet, Carvedilol 6.25 mg 1 tablet, Centamin liquid 15 ml, Allegra 180 mg 1 tablet, Extra Strength Tylenol 500 mg 1 tablet, Valproic acid 250 mg/ 5 ml-- 15 ml. and Valsartan 40 mg 1 tablet. Nurse #1 did not flush between medications. On 1/7/15 at 8:30AM, Nurse #1 stated she was not aware of facility policy regarding flushing before and after medications or flushing between medications On 1/7/15 at 9:00AM, Administrative staff #1 stated she expected nursing staff to follow the policy and flush before and after medication administration with 30 cubic centimeters (cc) of water and flush with 5 cc of water between medications.	F 332	nursing staff will complete a competency for medication administration via G-tube by 2-5-15. Newly employed nursing staff will complete a competency for medication administration via G-tube during the orientation Period. To ensure compliance, Clinical supervisors, Nurses Consultants and/or Consultant Pharmacist shall complete 5 random medication pass observations via G-Tube on licensed nursing staff weekly for 3 months, 5 observations monthly for 3 months and one observation monthly for 6 months, this will include all three shifts of PRN, weekend and regular schedule nursing staff. All results will be given to the Director of Nursing and/or Administrator within 48 hours. The Director of Nursing and/or Administrator shall bring all results of medication observations to the monthly QA meeting. QA committee will review results and make recommendations as needed.	

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F 371	Continued From page 9	F 371		
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: Based on observation and staff interview the facility failed to discard food items by their expiration date, failed to discard opened food items their use by date, failed to date opened food items, failed to cover opened food items and failed to use beard guards to contain facial hair. The findings included: 1. On 1/5/15 at 10:25 AM observation of the reach in refrigerator revealed an opened carton of salad fresh with an expiration date of 1/4/15, an opened carton of coleslaw with an expiration date of 12/30/14, an opened but undated container of sauerkraut and a package of sausage patties opened and exposed to the air. The Dietary Manager (DM) stated he did not know when the box of sausage patties was opened and discarded it. On 1/5/15 at 10:30 AM observation of the walk in refrigerator revealed 48 single serving containers of nutrition shakes that were unthawed. Review of the information on the carton revealed that the shakes were to be used within 14 days of unthawing. There were no dates on the	F 371	F 371 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No individual residents were identified as having been affected by the alleged deficient practice. All residents having the potential to be affected by the same alleged deficient practice, Items that were identified during the survey as having been mislabeled, expired or improperly labeled were discarded immediately. The Dietary Manager will be using a generic labeling system that will record date opened, Use by date, Employee that filled out the label,	1/12/15

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F 371	Continued From page 10 containers to indicate when unthawing started and the DM stated at this time that he did not know when they were removed from the freezer. Also observed in the walk in refrigerator were 61 one ounce packets of sour cream with an expiration date of 12/28/14 and an 8 ounce carton supplement with an expiration date of 11/19/14. Observation of the walk in freezer on 1/5/15 at 10:35 AM revealed the following items opened and undated: 6 beef steak fritters 1/2 bag stewed vegetables 4 pound bag corn chowder 1 bag of sliced potatoes The DM stated at this time that all items in the freezer should have been labeled and dated when opened. On 1/5/15 at 10:40 AM the Dietary Manager stated that all opened items should have been dated and all expired items should have been discarded. He said that it was the Lead Cook ' s responsibility to check for expired foods when they came in first thing in the morning and that the afternoon cook was also supposed to check when they came in. On 1/5/14 at 10:45 AM the Lead Cook was interviewed. He stated that he had not checked for undated or expired food items yet that day but had been planning to do it before he left for the day. On 1/8/15 at 10:30 AM a second observation of the reach in refrigerator revealed an opened container of pimento cheese that had been dated as opened on 12/4/14 that expired in 2016. The DM said that he thought that opened items could	F 371	Item label and shelf life. Dietary manager has created a policy and procedure for labeling and when food must be discarded. This policy and procedure is based on county health department rules. All employees received in-service education on proper storage of food - perishable and non-perishable, labeling items when opened, new expiration date guidelines on 1-12-15 by the Dietary Supervisor. New expiration date guidelines are that all RDE (Ready to Eat) food will be discarded in 7 days from the opening date, Items that are made by the dietary department which includes mixed foods and leftovers will be discarded within 72 hours from creation date. All employees have been inserviced on policy and procedure for facial hair by the Dietary Manager on 1-12-15. Per this policy all employees prepping food must be clean cut or wearing a beard guard. . To ensure that this alleged deficiency does not occur again, the dietary department will be conducting daily inspections three times a day by am cook for the morning, dietary manager or assistant manager at lunch and the PM cook for nights. This auditing tool will include all food items labeled, dated, initialed and properly sealed, all open perishable food items have been discarded within the 5 day time frame, spills in refrigerator has been cleaned, Thermometer is visible and working, raw meat products are on the bottom shelf and properly sealed and/or covered, no	

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F 371	Continued From page 11 be kept until the expiration date on the container even after opening. A policy and procedure for discarding opened prepared foods, with the time frame for discarding opened food items, was requested but the DM indicated he did not have one. 2. On 1/7/15 at 11:30 AM the tray line for the lunch service was observed. Dietary Aide (DA) # 1, # 2 and #3 were observed to have facial hair that was not contained by a beard guard. Interview with the DM at this time revealed that he was unaware facial hair needed to be covered in the kitchen but would ensure it was if it was a requirement. On 1/8/15 at 10:35 AM Dietary Aide # 3 and Dietary Aide #4 were observed to be preparing food and had facial hair that was not covered by a beard guard. The DM stated he would let his staff with facial hair know that facial hair must be covered by beard guards.	F 371	personal food or drink items in both refrigerators and any outdated food item have been discarded immediately. Both Refrigerators will have open and discarded control sheets posted on the outside of the refrigerator which will be a safe guard to make sure all items have been labeled and all expired items have been discarded. This auditing will continue for 90days after 90 days the dietary manager will decrease lunch inspection to twice a week for 6 months and then weekly their after. AM and PM cook will continue to audit in the morning and night daily for a year. They will be using three different audit sheets, Refrigerator open and discard control sheet, Walk in Cooler open and discard control sheet and three point inspection. These audit sheets will be used in conjunction with the inspection check list which will be completed daily by the am cook. Personnel manager will be completing a Dietary Sanitation QA audit sheet monthly for a year. Dietary manager and/or Assistant Dietary Manager will bring all results to QA monthly. All results will be reviewed by QA and the QA committee will determine if new auditing, education or disciplinary action is needed.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		1/30/15

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F 431	Continued From page 12 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date multi dose medications and supplements on 3 (400/500 hall, 400/600 hall and 300 hall medication carts) of 4 medication carts and 1 (400/500/600 hall medication room) of 2 medication rooms.	F 431	F 431 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid	

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F 431	Continued From page 13 Findings included: 1. On 1/7/15 at 1:10 PM, the medication cart on 400/600 hall was observed with Nurse # 2. There were 8 vials of levalbuterol solution (drug used to treat asthma and chronic obstructive pulmonary disease) observed in an opened foil pouch. The foil pouch had no date of opening. The storage instruction written on the foil pouch read in part " store unused vial in the foil pouch and discard all unused vials in two weeks after you open the pouch. " On 1/7/15 at 1:15 PM, Nurse #2 was interviewed. He stated that the levalbuterol should have been dated when the foil pouch was opened. Nurse #2 was observed to discard the 8 vials of levalbuterol. On 1/7/15 at 4:45 PM, administrative staff #1 was interviewed. She stated that nurses were expected to date the medications/supplements when opened. She added that the unit managers were responsible for checking the medication carts and the medication rooms for expired medications and opened dates monthly. 2. On 1/7/15 at 1:10 PM, the medication cart on 400/600 hall was observed with Nurse # 2. A used bottle of UTI stat (a supplement) was observed with no open date. The instruction on the bottle read in part " discard 3 months after opening. "	F 431	programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). There were no residents directly affected by the alleged deficiency. All residents have the potential to be affected by the alleged deficient practice, all expired medications were removed from medication carts and medication rooms by clinical supervisors and cart nurse on 1-7-15. (Levalbuterol solution, UTI Stat, Prostat, PPD (purified protein derivative), and Fiberstat). All licensed nursing staff will be inserviced by the Director of Nursing and/or Consultant Pharmacist by 1-30-15, regarding proper labeling, dating, storage of drugs, and proper discarding of expiring drugs and/or biologicals. To ensure that the alleged deficiency does not recur, the third shift licensed nursing staff will perform daily medication storage checks and document findings on Medication storage daily check form. The Clinical Supervisors will review these daily medication storage checks for compliance and also will perform weekly medication storage checks for 3 months, twice monthly storage checks for 3 months, then monthly storage checks thereafter. The Consultant Pharmacist will also review med storage monthly for 3 months, then quarterly per policy. Director of Nursing and/or Clinical Supervisors will bring all results of	

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F 431	Continued From page 14 On 1/7/15 at 1:15 PM, Nurse #2 was interviewed. He stated that the bottle should have been dated when opened. Nurse #2 was observed to discard the opened bottle of UTI stat. On 1/7/15 at 4:45 PM, administrative staff #1 was interviewed. She stated that nurses were expected to date the medications/supplements when opened. She added that the unit managers were responsible for checking the medication carts and medication room for expired medications and open dates monthly. 3. On 1/7/15 at 1:45 PM, medication cart on 400/500 hall was observed with Nurse #3. A used bottle of prostat (a protein supplement) was observed with no open date. The instruction on the bottle read in part " discard 3 months after opening. " On 1/7/15 at 2:00 PM, Nurse #3 was interviewed. He stated that he didn't know that prostat has to be dated when opened. On 1/7/15 at 4:45 PM, administrative staff #1 was interviewed. She stated that nurses were expected to date the medications/supplements when opened. She added that the unit managers were responsible for checking the medication carts and the medication rooms for expired medications and opened dates monthly. 4. On 1/7/15 at 3:15 PM, the medication room on 400/500/600 halls was observed. There was an opened bottle of purified protein derivatives	F 431	medication storage checks to our monthly QA meeting. QA committee will review results and make recommendations as needed.	

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F 431	Continued From page 15 (PPD) observed inside the refrigerator with no date of opening. PPD is a skin test used to diagnose tuberculosis. On 1/7/15 at 3:18 PM, Nurse #2 was interviewed. He stated that the PPD bottle should have been dated when opened. The manufacturer's instruction for PPD indicated that vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. On 1/7/15 at 4:45 PM, administrative staff #1 was interviewed. She stated that nurses were expected to date the medications/supplements when opened. She added that the unit managers were responsible for checking the medication carts and the medication rooms for expired medications and opened dates monthly. 5. Manufacturer's instructions for Fiberstat (fiber supplement) stated, in part, " Discard three months after opening. Record date opened in bottom of container. " On 1/7/15 at 1:10PM, an observation of the 300 hall medication cart was conducted. There was one bottle of Fiber-Stat opened and undated. On 1/7/15 at 1:10PM, Nurse #1 stated it should have been dated when opened. On 1/7/15 at 3:00PM, Administrative staff #1 stated she expected staff to date the Fiber-Stat when opened.	F 431		
F 520	483.75(o)(1) QAA	F 520		1/30/15

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F 520 SS=E	Continued From page 16 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility's Quality Assessment and Assurance Committee failed to implement, monitor and revised as needed the action plan developed for the 9/12/13 and 7/12/12 recertification surveys in order to achieve and sustain compliance. The facility had a repeat deficiency on medication administration (F332) on 1/8/15 and 9/12/13 recertification surveys. The	F 520	F520 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). For residents affected by this alleged	

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F 520	Continued From page 17 facility had also a pattern of repeat deficiencies on kitchen sanitation (F371) and on proper labeling of drugs and biological (F431) on 1/8/15, 9/12/13 and 7/12/12 recertification surveys. Findings included: This tag is cross referred to: F332 - Medication Administration - Based on observation, record review and staff interview, the facility failed to maintain a medication error rate of 5% or below by not flushing the gastrostomy tube (GT) with water before and after medication administration and between medications for one of one resident observed receiving medications (Resident #5) via GT. There were two errors of 25 opportunities for error resulting in an 8% error rate. During the recertification 9/12/13, the facility was cited F332 for having 6.45% error rate on the medication administration. F371 - Kitchen Sanitation - Based on observation, staff interview and record review, the facility failed to discard food items by their expiration date, failed to discard opened food items by a used by date, failed to date opened food items, failed to cover opened food items and failed to use beard guards to contain facial hair. During the recertification surveys 9/12/13 and 7/12/12, the facility was cited F371 for not labeling foods when opened, not discarding foods by their discard by date and not washing or sanitizing hands or changing gloves when handling dirty and then clean dishes during the dish washing process. The facility also failed to change gloves after handling contaminated items	F 520	deficiency. F332, the nurse involved was inserviced on policy and procedure and following physician□s orders by the Director of Nursing 1-7-15. For F371, No individual residents were identified as having been affected by the alleged deficient practice and F431 No individual residents were identified as having been affected by the alleged deficient practice. Since all residents have the potential to be affected by the same alleged deficient practice the QA auditing team revised our QA process. All members recognize certain areas that need to be addressed. The Administrator QA president will make the following corrections to prevent this alleged deficiency from reoccurring again. For F332, the MDS Department will be observing 10% of all current G-Tube residents with monthly Medication Pass Observation sheet. This will include medication administration, proper flushing technique and following physician orders. This will be done random throughout the month which will include PRN, weekend and all three shifts of regular schedule nursing staff. MDS Department will bring this sheet to our monthly QA meeting to compare this audit with other ongoing auditing sheets from our POC for the same alleged deficiency practice. The QA team will examine results and make recommendations. For F371, the Personnel Manager will be assigned to complete the Dietary Sanitation Observations audit sheet weekly for four weeks and monthly thereafter. The Personnel manager will bring this audit sheet to our monthly QA	

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F 520	Continued From page 18 while serving food from the steam table. F431 - Proper labeling of drugs and biological - Based on record review, observation and staff interview, the facility failed to date multi dose medications and supplements on 3 (400/500 hall, 400/600 hall and 300 hall medication carts) of 4 medication carts and 1 (400/500/600 hall medication room) of 2 medication rooms During the recertification surveys 9/12/13 and 7/12/12, the facility was cited F431 for not dating multi dose medications, not discarding expired medications and not locking the medication cart when not attended. On 1/8/15 at 11:15 AM, the administrator was interviewed. He stated that the facility had a quality assurance committee consisted of the medical director and all the department heads including the administrator and the director of nursing. The committee had met monthly and quarterly. He indicated that he was aware that medication administration was a repeat deficiency from the previous recertification survey. He stated that the nursing administrative staff had been observing medication passes two to three times per week and had provided education for nurses on how to administer medications via tube. He further indicated that the reason might be that Nurse #1 has not been observed passing medications via tube. The administrator also was aware of the pattern of repeat deficiencies in kitchen sanitation and proper labeling of drugs and biological. He indicated that issues in the kitchen might be due to dietary staff turnover and they needed more education. He further indicated that he had told his nursing administrative staff to check the medication carts and the medication rooms once a week on	F 520	meeting. The QA team will compare this audit sheet with other ongoing auditing sheets from our POC for the same alleged deficiency practice. The QA team will examine results and make recommendations. For F431, Director of Nursing will monitor with Medication/Biologicals & Medication Cart Observation(s) Worksheets to ensure that any medications are not out of date and that our process is working, this will be completed for one wing of the facility each month, alternating wings. This sheet will be brought to our QA meeting monthly to compare this audit sheet with other ongoing auditing sheets from our POC for the same alleged deficient practice. The QA team will examine results and make recommendations. All audits will be conducted monthly and will continue throughout the year. Any new audit tools that are added to our QA process will be conducted monthly and will continue throughout the year. All audit sheets and results will be brought to our QA committee monthly and reviewed. The QA Committee will be responsible for making recommendations and following up on those recommendations. If auditing tools and process are not producing results desired, the QA committee will modify the process for better results.	

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F 520	Continued From page 19 Fridays and he didn't think that they had been checking them weekly.	F 520		