3/30/15

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

PRINTED: 03/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	C 03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF FOREST GLENN	1101 HARTWELL STREET GARNER, NC 27529

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to accurately assess residents in the areas of urostomy (surgical opening through which urine passes) and swallowing (Resident #209), pressure ulcers (Resident #57), diagnosis of mood disorder	F 278	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is April 02, 2015. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F Tag 278: Resident #'s 209, #57, #25 and #158's assessments were corrected by the MDS Coordinator on 3/24/2015. Current residents have the potential to be affected.	4-2-15

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

Administrator 3-30-15

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 d 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 disclos days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to program participation.

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F 278	Continued From page 1 (Resident #25) and preadmission screening and resident review (Resident #158) for four of 24 residents. The findings included: 1. Resident #209 was admitted to the facility 5/13/14. Diagnoses included urostomy. A review of the Admission Minimum Data Set (MDS) dated 5/20/14 revealed ostomy was not coded on the MDS. On 3/5/15 at 8:07AM, Administrative staff #4 stated she failed to code the urostomy and indicated it was an oversight and it should have been coded on the MDS. 2. Resident #209 was admitted to the facility on 5/13/14. Cumulative diagnoses included dysphagia (difficulty swallowing). A speech therapy progress note dated 5/15/14 was reviewed and revealed Resident #209 had increased difficulty masticating (chewing) soft textures with two coughing episodes. A review of the Admission Minimum Data Set (MDS) dated 5/20/14 indicated Resident #209 had no difficulty with swallowing. On 3/5/14 at 8:07AM, Administrative staff # 4 stated she was not aware that Resident #209 had difficulty choking or coughing during meals and it should have been coded on the MDS. 3. Resident #158 was admitted 12/30/14 and had a Preadmission Screening and Resident Review Level II (PASRR Level II) number.	F 278	The Regional Clinical Resource Specialist will in-service current MDS nurses on accurate resident assessments and coding of assessments per the RAI manual by 4/2/2015. The Regional MDS Specialist will conduct an audit of 20 MDS to ensure accuracy by 04-02-15. Variances will be corrected if appropriate. All other residents' MDS will be audited for accuracy during the MDS schedule and RAI process. Corrections will be made if indicated at the time of the assessment. Medical Records will ensure all cumulative diagnosis sheets are completed upon admission and are updated as new diagnoses are identified.	

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F 278	Continued From page 2 Review of the Admission Minimum Data Set (MDS) dated 1/6/15 revealed the section of the MDS regarding PASRR " Has the resident been evaluated by Level II PASRR " was coded as " No ". On 3/5/15 at 9 AM interview with Administrative Staff #4 revealed that the resident ' s PASRR information was available to her at the time of the MDS assessment. She stated that she incorrectly coded the section regarding PASRR and should have coded it as " yes ". She also said that she did not know why she had coded the section incorrectly other than it was an oversight. 4. Resident #25 was admitted to the facility 1/24/14. Cumulative diagnoses included diabetes, anxiety, hypertension, mood disorder and dementia with behaviors. Review of the Annual Minimum Data Set (MDS) dated 1/14/15 revealed that no mood disorders such as depression or manic depression were coded and dementia was not coded on the MDS. On 3/5/15 at 9:35 AM during an interview with Administrative Staff #5 she stated that since the resident was on a medication for Mood Disorder at the time of the assessment, as indicated by the Physician ' s Order summary for 1/1/15 through 1/31/15, she should have coded the mood disorder on the MDS. However, she stated that the diagnoses of dementia was not supposed to be coded because the resident was not receiving any medications for the diagnoses of dementia. She added that she only coded diagnoses on the Active Diagnoses section of the MDS if residents were on medication for that diagnoses. On 3/5/15 at 4 PM interview with Administrative Staff #2 indicated the diagnoses of dementia should have been coded on the MDS even though the resident was not receiving a medication for dementia.	F 278	The DON will audit (2) MDS assessments weekly for (3) months to ensure proper coding of the MDS. All variances will be corrected at the time of observation. The DON will report auditing results to the QA meeting for the next (3) months. Continued compliance will be monitored through routine Regional MDS reviews during facility visits, record reviews and through the facility's Quality Assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 278	Continued From page 3 5. Resident # 57 was admitted to the facility 3/31/14. Review of the Quarterly Minimum Data Set (MDS) dated 12/3/14 revealed that " the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment " was coded as 4, stage 4 pressure ulcers. Review of the Wound Doctors Assessment Notes dated 12/3/14 revealed 1 stage 4 pressure ulcer and two other wounds. On 3/5/15 at 9:44 AM during an interview with Administrative Staff #5 she indicated that the resident did not have 4, stage 4 pressure ulcers at the time of the assessment and that the number of " current pressures that were not present or were at a lesser stage on a prior assessment " was incorrectly coded.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	F Tag 279: Resident 209 was discharged from the facility on 06/02/2014. Current residents with ostomies have the potential to be affected. An audit of all residents with ostomies was completed on 03/24/2015 by the DON. Care plans were updated as identified.	4-2-15

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F 279	Continued From page 4 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a care plan with goal and approaches for one of one residents who had a urostomy (Resident #209). The findings included: Resident #209 was admitted to the facility on 5/13/14 and discharged on 6/2/14. Admission diagnoses included a diagnosis of urostomy (a surgical opening through which urine passes). A transfer summary from (name) hospital dated 5/13/14 indicated Resident #209 had a urostomy and urostomy care was to be done. A review of the admission care plan dated 5/13/14 revealed no care plan/ approaches had been developed for the care of the urostomy. A review of the care plan dated 5/21/14 revealed no care plan/ approaches had been developed for Resident #209 regarding the care of the urostomy. On 3/5/15 at 8:07AM, Administrative staff #4 stated she did not create a care plan for the urostomy. She indicated it was an oversight and a care plan should have been written.	F 279	The Regional Clinical Resource Specialist educated all MDS staff on ensuring residents with ostomies needs are individually addressed in the plan of care on 4/2/2015. The DON will continue to monitor using audit tool for the care plans of new admissions with ostomies and/or residents with new orders for ostomies to ensure ostomy needs are identified in the plan of care for (1) x weekly for (2) months then randomly thereafter. Variances will be corrected as identified. The DON will report auditing results and concerns to the QA Committee during the monthly meeting for the next (3) months. Admission comprehensive care plans will be reviewed by the IDT team (DON, ADON, Unit Managers, MDS Coordinators, Dietary Manager, Activities director, Rehab Director, Social Worker) during the admission care conference as scheduled	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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F 314	Continued From page 5 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete weekly skin checks for a resident at risk for pressure ulcers resulting in an unstageable pressure ulcer (Resident # 159) for one of three residents reviewed for pressure ulcers. The findings included: Resident #159 was admitted to the facility on 11/25/14 with multiple diagnoses including a history of a cerebral vascular accident, diabetes mellitus, anemia, weakness, urinary retention, and chronic kidney disease. A review of the Wound and Skin Management Program revised June 2011 was conducted. The program included " identification of those at risk and for early detection/identification of signs of problems. This can be accomplished by: Weekly Skin Assessment-completed by the licensed nurse. " A review of the Minimum Data Set dated 12/2/14 indicated resident #159 was assessed as being moderately cognitively impaired and at risk for pressure ulcers. The resident was not assessed with an unhealed pressure ulcer.	F 314	through the requirement of the MDS RAI assessment requirements. Any variances will be corrected at the time. Continued compliance will be monitored through routine care plan and record reviews, care conferences through the MDS RAI assessment process and schedule and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. F Tag 314: Resident #159 was discharged from the facility on 03/07/15. Current residents identified to be at risk for pressure sores and/or currently exhibit a pressure sore have the potential to be affected.	

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F 314	Continued From page 6 The Plan of Care revised on 1/13/15 indicated the resident had the potential for impaired skin integrity related to limited mobility, frequent incontinence and requiring assistance with bed mobility. The interventions included to perform weekly skin assessments. A review of the Weekly Skin Assessment for resident #159 revealed a weekly skin assessment was performed on 11/25/14, 12/4/14 and 1/8/15. The review revealed weekly skin assessments were not documented as performed on 12/11/14, 12/18/14 and 12/25/14. The weekly skin assessment dated 12/4/14 contained no information pertaining to wound description. The weekly skin assessment dated 1/8/15 stated the resident had an existing pressure ulcer. The weekly skin assessment contained a diagram of the human body with the sacral area circled. A review of the Pressure Ulcer Record for resident # 159 revealed an unstageable sacral pressure ulcer was identified on 12/26/14. The pressure ulcer was measured with a length equal to 9.0 centimeters (cm) and a width equal to 7.0 cm. The pressure ulcer was assessed with having a " foul " odor, " bloody " drainage and with a color of white and dark. On 3/4/15 at 10:39 AM resident #159 refused to allow the Wound Care Specialist to assess and measure the sacral pressure ulcer. The resident also refused to allow the nurse to administer treatment and perform a dressing change to the sacral pressure ulcer. The sacral pressure ulcer was not observed due to the resident ' s refusal of care. An interview was conducted with Nurse #4 on	F 314	The DON, ADON, and Unit managers will complete skin observation assessments for all residents with a Braden score of 17 or below by 4/2/15. Any variances will be reported to the physician, treatment orders obtained, interventions implemented and the care plan updated. The ADON will conduct in-servicing relating to the facility's policy for admission and weekly skin assessments and documentation of the assessment and findings for all Licensed Nurses (which includes weekend and PRN staff) by 4/2/2015. The Unit Managers, ADON, and DON will monitor 20 skin assessments per week for (8) weeks then randomly thereafter to ensure compliance. Monitoring will include direct observation of skin assessment completion weekly on varying shifts for the next (8) weeks. Direct observations will be compared to written documentation to	

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F 314	Continued From page 7 3/4/15 at 3:45 PM. Nurse #4 stated she was unable to locate documentation showing a weekly skin assessment was performed for resident #159 on 12/11/14, 12/18/14 or 12/25/14. Nurse #4 stated she expected the nurses to do a weekly skin check for every resident and to document the assessment on the weekly skin assessment form. An interview was conducted with Nurse #5 on 3/4/15 at 5:13 PM. Nurse #5 stated she was assigned to care for resident #159 on 12/18/14. She stated she performed the weekly skin check on the resident and did not find any skin abnormalities. She also stated she did not know why she failed to document the assessment on the weekly skin assessment form. Nurse #5 stated the nurses were expected to perform weekly skin assessments and to document the assessment on the weekly skin assessment form. An interview was conducted with Nurse #6 on 3/5/15 at 9:37 AM. Nurse #6 stated she did not remember if she performed a weekly skin assessment for resident #159 on 12/11/14. Nurse #6 stated the nurses were expected to perform weekly skin assessments and to document the assessment on the weekly skin assessment form. On 3/5/15 at 9:57 AM resident #159 refused to allow the nurse to administer treatment and perform a dressing change to the sacral pressure ulcer. The sacral pressure ulcer was not observed due to the resident ' s refusal of care.	F 314	verify accuracy of skin assessments via audit tool. Variances will be corrected at the time of observation. Monitoring results will be reported to the DON weekly for the next (8) weeks and concerns will be reported to the quality assurance committee by the DON during the monthly meeting for the next (3) three months. Continued compliance will be monitored through review of the weekly skin assessments 5x/week during the morning clinical operations meeting, routine record and documentation reviews during the MDS assessment and care conference process and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328	F Tag 328: Resident #209 discharged from the facility on 6/2/2014.	4-2-15

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F 328	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the necessary care and treatment for one of one residents reviewed who had a urostomy (resident #209). The findings included: Facility policy titled "Urostomy/ Ileal Conduit Appliance Change" undated stated, in part, "Urostomy appliance changes will be done by the licensed nurse every three to seven (3-7) days per manufacturer's recommendations and/or physician's instructions to permit visualization of the stoma and the surrounding skin, to prevent urine leakage and skin excoriation and to control odor." Resident #209 was admitted to the facility 5/13/14 and discharged 6/2/14. Cumulative diagnoses included CVA (cerebrovascular accident), chronic kidney disease and urostomy (surgical opening through which urine passes). A transfer summary from (name) hospital dated 5/13/14 indicated discharge diagnoses indicated Resident #209 had a urostomy. Urostomy care	F 328	No negative outcome resulted from this observation. Current residents with ostomies/special needs have the potential to be affected. All residents with ostomies/special needs were reviewed by the DON, ADON and Unit Mangers to ensure special needs have been identified, included in the plan of care and documented. Variances were corrected as identified on 3/25/15. The ADON will conduct in-service training with all licensed nurses on care of residents with special needs and appropriate documentation of the care provided by 3/27/2015. A monitoring tool will be utilized and completed by the DON/ADON/Unit Managers on 3/24/2014 of all residents with special needs to ensure orders are received and care provided is documented. Variances will be corrected as identified.	

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F 328	Continued From page 9 was noted on the discharge summary. A physician assistant's progress note dated 5/15/14 indicated Resident #209 had a urostomy. An Admission Minimum Data Set (MDS) dated 5/20/14 indicated Resident #209 was cognitively intact. He required extensive assistance with personal hygiene, toileting and bathing. Urostomy was not coded on the MDS. A review of the care plan dated 5/21/14 revealed there was not a care plan for urostomy care. Nursing notes from 5/13/14 through discharge date 6/2/14 were reviewed. Only one nursing note dated 5/17/14 at 7:16PM by Nurse #11 indicated urostomy was changed and stoma cleaned well. No nursing notes documented that family performed urostomy care. A review of physician orders from 5/13/14 through discharge 6/2/14 were reviewed and revealed no order was obtained for urostomy care/ treatment. A review of the Medication Administration Records for May 2014 and June 2014 were reviewed and revealed no documentation that urostomy care was performed by nursing staff or family during Resident #209's stay at the facility. Treatment records for May 2014 and June 2014 were reviewed and revealed no documentation that urostomy care was performed by nursing staff or family during Resident #209's stay at the facility. On 3/4/15 at 4:20PM, Nurse #10 stated she provided care for Resident #209 but could not	F 328	The DON/ADON/Unit Managers will monitor new admissions, new orders and special needs documentation (3) times per week for 3 months using audit tool thereafter to ensure appropriate orders have been obtained and care is documented. Variances will be corrected as identified. Monitoring results will be reported to the DON weekly for the next (3) months and the DON will report concerns to the quality assurance committee during the monthly meetings for the next 3 months. Continued compliance will be monitored by the DON/Unit Managers through review of new admissions and new orders during the morning clinical meeting, record reviews during care conferences and through the facility's quality assurance	

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F 328	Continued From page 10 recall if he had a urostomy. She stated if Resident #209 had a urostomy, urostomy care would be done every three to five days and as needed. Documentation of changing the wafer/ bag would be in the computer on the skilled nursing assessment under the GI (gastrointestinal) area or on the treatment sheet. Nurse #10 stated orders for urostomy care would be obtained from the physician on resident admission. On 3/4/15 at 4:37 PM, Nurse #11 stated she provided care for Resident #209 during his stay. She stated she did not remember if she provided care/ changed the urostomy bag during his stay at the facility. On 3/4/15 at 6:08PM, Administrative staff #1 stated there were no urostomy supplies billed to Resident #209 during his stay at the facility. He stated Resident #209's family brought in the urostomy supplies because they did not want to be charged for the supplies. On 3/4/15 at 5:15PM, Administrative staff #2 stated she expected nursing staff to have a physician's order for care/ treatment of a urostomy/ ostomy. Documentation of the care/ treatment of the urostomy should be on the Medication Administration Record/ Treatment record.	F 328	program. Additional education and monitoring will be initiated for any identified concerns.	
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.	F 332	F Tag 332: Resident #147 received the omitted medications from Nurse #1 upon identification of	4-2-15

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F 332	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, the facility failed to maintain a medication error rate of 5% or below and failed to administer the medications as ordered by the physician. There were 7 errors of 29 opportunities for error, resulting in an error rate of 24.13793% (Resident #147). The findings included: Resident #147 was admitted to the facility on 11/18/14 with multiple diagnoses including hypertension, gout, depression and failure to thrive. Example 1) A review of the Physician ' s Orders revealed an order dated 11/19/14 which stated " Allopurinol 100 milligrams (mg) 1 tablet via tube every day to be given at 9:00 AM. " Nurse #1 was observed administering medication to resident #147 via a gastrostomy tube (GT) on 3/4/15 at 8:45 AM. Nurse #1 failed to administer Allopurinol 100 mg 1 tablet via GT. An interview was conducted with Nurse #1 on 3/4/15 at 9:47 AM. Nurse #1 stated she overlooked the medication on the Medication Administration Record. An interview was conducted with Nurse #2 on 3/4/15 at 9:52 AM. Nurse #2 stated she expected the nursing staff to administer all of the medications scheduled to be given during the morning medication pass. Example 2)	F 332	the omission on 3/4/15. These medications were administered within the appropriate time frame of 2 hours, (1 hour before to 1 hour after) the ordered time. There were no negative outcomes identified. Current residents receiving medications have the potential to be affected. Nurse #1 as provided additional education by the DON relating to medication pass procedures on 3/04/15. The ADON will in service all licensed nurses which includes weekend and PRN prior to scheduled shift on the 5 rights of medication administration and documentation by 4/2/2015.	

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F 332	Continued From page 12 A review of the Physician ' s Orders revealed an order dated 11/19/14 which stated " Amlodipine Besylate 10 mg 1 tablet via tube every day to be given at 9:00 AM. " Nurse #1 was observed administering medication to resident #147 via a gastrostomy tube (GT) on 3/4/15 at 8:45 AM. Nurse #1 failed to administer Amlodipine Besylate 10 mg 1 tablet via GT. An interview was conducted with Nurse #1 on 3/4/15 at 9:47 AM. Nurse #1 stated she overlooked the medication on the Medication Administration Record. An interview was conducted with Nurse #2 on 3/4/15 at 9:52 AM. Nurse #2 stated she expected the nursing staff to administer all of the medications scheduled to be given during the morning medication pass. Example 3) A review of the Physician ' s Orders revealed an order dated 11/19/14 which stated " Furosemide 20 mg 1 tablet via tube every day to be given at 9:00 AM. " Nurse #1 was observed administering medication to resident #147 via a gastrostomy tube (GT) on 3/4/15 at 8:45 AM. Nurse #1 failed to administer Furosemide 20 mg 1 tablet via GT. An interview was conducted with Nurse #1 on 3/4/15 at 9:47 AM. Nurse #1 stated she overlooked the medication on the Medication Administration Record. An interview was conducted with Nurse #2 on 3/4/15 at 9:52 AM. Nurse #2 stated she expected	F 332	The DON, ADON and Unit Managers will conduct med pass observations (to include a minimum of 25 opportunities observed) on random licensed nurses and Nurse #1 will be observed during her next scheduled shift utilizing a med pass observation tool then randomly 1 x per week on varying shifts (to include weekend staff) for the next 2 months. Variances will be corrected at the time of observation and additional education provided. Monitoring results will be reported to the DON weekly for the next 2 months. The DON will report results to the quality assurance committee during the monthly meetings. Continued compliance will be monitored through routine random med pass observations and through the facility's quality assurance program. The DON will report any concerns to the quality assurance committee during the monthly meetings.	

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F 332	Continued From page 13 the nursing staff to administer all of the medications scheduled to be given during the morning medication pass. Example 4) A review of the Physician ' s Orders revealed an order dated 11/19/14 which stated " Multi-Delyn Liquid take 15 milliliters (ml) via tube every day to be given at 9:00 AM. " Nurse #1 was observed administering medication to resident #147 via a gastrostomy tube (GT) on 3/4/15 at 8:45 AM. Nurse #1 failed to administer Multi-Delyn Liquid 15 ml via GT. An interview was conducted with Nurse #1 on 3/4/15 at 9:47 AM. Nurse #1 stated she overlooked the medication on the Medication Administration Record. An interview was conducted with Nurse #2 on 3/4/15 at 9:52 AM. Nurse #2 stated she expected the nursing staff to administer all of the medications scheduled to be given during the morning medication pass. Example 5) A review of the Physician ' s Orders revealed an order dated 12/12/14 which stated " Oxybutynin ER 5 mg 1 tablet by mouth every day to be given at 9:00 AM. " Nurse #1 was observed administering medication to resident #147 on 3/4/15 at 8:45 AM. Nurse #1 failed to administer Oxybutynin ER 5 mg 1 tablet by mouth. An interview was conducted with Nurse #1 on	F 332	Additional education and monitoring will be initiated when indicated.	

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F 332	Continued From page 14 3/4/15 at 9:47 AM. Nurse #1 stated she overlooked the medication on the Medication Administration Record. An interview was conducted with Nurse #2 on 3/4/15 at 9:52 AM. Nurse #2 stated she expected the nursing staff to administer all of the medications scheduled to be given during the morning medication pass. Example 6) A review of the Physician ' s Orders revealed an order dated 11/19/14 which stated " Sertraline HCL 100 mg 1 tablet via tube every day to be given at 9:00 AM. " Nurse #1 was observed administering medication to resident #147 via a gastrostomy tube (GT) on 3/4/15 at 8:45 AM. Nurse #1 failed to administer Sertraline HCL 100 mg 1 tablet via GT. An interview was conducted with Nurse #1 on 3/4/15 at 9:47 AM. Nurse #1 stated she overlooked the medication on the Medication Administration Record. An interview was conducted with Nurse #2 on 3/4/15 at 9:52 AM. Nurse #2 stated she expected the nursing staff to administer all of the medications scheduled to be given during the morning medication pass. Example 7) A review of the Physician ' s Orders revealed an order dated 11/19/14 which stated " Florastor 250 mg 1 capsule via tube twice daily to be given at 9:00 AM and at 5:00 PM. " Nurse #1 was observed administering medication	F 332		

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F 332	Continued From page 15 to resident #147 via a gastrostomy tube (GT) on 3/4/15 at 8:45 AM. Nurse #1 failed to administer Florastor 250 mg 1 capsule via GT. An interview was conducted with Nurse #1 on 3/4/15 at 9:47 AM. Nurse #1 stated she overlooked the medication on the Medication Administration Record. An interview was conducted with Nurse #2 on 3/4/15 at 9:52 AM. Nurse #2 stated she expected the nursing staff to administer all of the medications scheduled to be given during the morning medication pass.	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: Based on record reviews, staff interviews and observations, the facility failed to contain facial hair for 1 of 1 (staff #1), failed to include the include the dates on unopened food items for 6 of 6 items, failed to include the dates on opened food items for 7 of 7 items, failed to label and date refrigerated food items for 5 of 5 items, failed to store, label and date refrigerated meat	F 371	F Tag 371: All identified food not labeled/dated was discarded by the Dietary Manager at the time of observation on 3/2/2015. Staff #1 has shaved his facial hair. Current residents in the facility have the potential to be affected. The Dietary Manager will in service all dietary staff on the policies and procedures for storage of food, labeling and dating, and the use of beard guards on 3/27/2015.	4-2-15

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F 371	Continued From page 16 for 1 of 1 item, failed to discard expired packets of oatmeal, pancake mix and milk for 27 of 27 items. Findings included: Review of the facility policy dated April 2010, Storage of Potentially Hazardous Foods, revealed under sub-heading Procedure, item #2, Food shall be dated, labeled, and properly covered or wrapped tightly. 1. A. Observation on 3/2/15 at 10:25 AM of the dry storage room with the Dietary Manager revealed: - 4 unopened (5 lb) bag of fudge brownie mix, partially dated 10/16 - no year - 1 unopened bag of chocolate cake mix, partially dated 12/29 - no year - 1 unopened (5 lb) bag of basic muffin mix, partially dated 11/26 - no year - 1 opened bag of original cheesecake filling wrapped in clear plastic wrap, not dated - 1 opened (5 lb) box of graham cracker crumbs wrapped in clear plastic wrap, not dated - 1 opened box of carnival sprinkles wrapped in clear plastic wrap, partially dated 12/20- no year recorded - 1 opened bag lemon pie crust mix wrapped in clear plastic wrap, partially dated 12/15 - no year - 1 opened bag lemon pie crust mix wrapped in clear plastic wrap, partially dated 12/18 - no year - 1 opened bag of Roseli spiral noodles opened end twisted, unclamped/sealed, not dated - 1 opened bag of Roseli egg noodles open end twisted, unclamped/sealed, not dated - 1 box of buttermilk pancake mix wrapped in clear plastic wrap, expired on 2/17/15 - 25 packs of dry oatmeal in two separate clear zip lock bags, expired on 12/1/14	F 371	The Dietary Manager will conduct observations of beard guards, labeling and dating of food items utilizing an audit tool on random shifts and weekends (3) times a week for (4) weeks then weekly times 2 months. Variances will be corrected at the time observation. The Dietary Manager will report observation results to the Administrator weekly for the next (3) months and to the quality assurance committee during the monthly meeting x3 months. The ADON and Unit Managers will monitor the nourishment rooms to ensure all food items are labeled, dated within expiration dates (2) two times a week x 4 weeks then weekly x 2 months then randomly thereafter. Variances will be corrected at the time of observation. Monitoring results will be reported to the DON weekly for the next 3 months. The	

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F 371	Continued From page 17 b. Observation on 3/2/15 at 10:30 AM with the Dietary Manager revealed dietary staff #1 had a beard who was not wearing a beard guard. c. Observation on 3/2/15 at 10:45 AM of kitchen refrigerator #1 with the Dietary Manager revealed: - 1 cucumber, with one end cut off, wrapped in clear plastic wrap, not labeled or dated - 1 head of lettuce wrapped in clear plastic wrap, not dated - 1 clear zip lock bag, unsealed, that contained an undetermined processed meat, not labeled or dated. d. Observation on 3/5/15 at 12:10 PM of the nurse ' s station #1 nourishment room refrigerator revealed: - 1 gallon container of milk that had an expiration date of February 19, 2015, - 2 one-half sandwiches wrapped in clear plastic wrap that were not labeled or dated - 1 paper plate containing salad (egg, ham, cucumber, lettuce and cheese) wrapped with clear plastic wrap that was not labeled or dated. Interview on 3/2/15 at 10:40 AM with Dietary Manager revealed he acknowledged that the stored food should be dated and include the year. He also acknowledged that expired foods should be discarded and that staff that had beards should wear beard guards. Interview on 3/2/15 at 11:00 AM with Dietary Manager revealed he acknowledged that the refrigerated food items should be sealed, labeled and dated.	F 371	DON will report findings to the quality assurance committee x 3 months. Continued compliance will be monitored through routine kitchen and nourishment room observations and through the facility's quality assurance' program. Additional education and monitoring will be initiated for any identified concerns.	

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F 371	Continued From page 18 Interview on 3/5/15 at 12:21 PM with nurse #8 revealed the nourishments for the resident refrigerator are usually brought to unit #1 around 3 AM and placed in the resident nourishment refrigerator. Nurse # 8 obtained her applesauce and med pass from the kitchen in the morning when she arrived. Nurse #8 reported that she didn ' t know of any staff member being assigned the duty of checking for expired foods in the resident nourishment refrigerator but, she usually saw Administrative Staff #3 cleaning out the expired refrigerated items and added that any staff that saw a refrigerated item had expired should get it out. Interview on 3/5/15 at 12:45 PM with Administrative Staff #3 revealed the supervisor on unit I usually checks the resident nourishment refrigerator for daily temperature readings and the dietary staff cleans it out once a week. Administrative Staff #3 reported that no one person was assigned the duty of checking for expired refrigerated items and that the duty was shared by management.	F 371		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on staff interviews and observations, the facility failed to contain waste in 3 of 3 outside dumpsters and the facility failed to close the doors on 2 of 3 outside dumpsters.	F 372	F Tag 372: The dumpster area was cleaned by the Environmental Service Director on 3/5/2015. Current residents and employees have the potential to be affected.	

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F 372	Continued From page 19 Findings included: Observation on 3/4/15 at 2:40 PM of outside dumpsters with the Dietary Manager revealed approximately 25 pieces of trash on ground inside the fenced area around the three outside dumpsters, 2 pair of gloves and the metal doors were open on 2 of the 3 outside dumpsters. Interview on 3/4/15 at 2:45 PM with Dietary Manager revealed the trash dumpsters were picked up by the trash company on Thursdays. He reported that the trash should not be on the ground around the dumpsters that it should be inside the trash dumpsters. He acknowledged the two opened metal dumpster doors. The Dietary Manager reported the duty falls under the housekeeping department, however, since the Housekeeping Supervisor had just started work on Monday 3/2/15, he would take responsibility and have his staff clean it up. Observation on 3/4/15 at 3:15 PM of outside dumpsters revealed the trash on the ground in closest proximity to the dumpsters had been removed. Approximately 18 pieces of trash remained on the ground inside the fenced area around the dumpsters. Interview 0n 3/4/15 at 3:30 PM with House Keeping Supervisor revealed that his first day of employment with this facility was on Monday 3/2/15. He reported that he wasn ' t sure which department was responsible for making sure the area around the outside dumpsters was free of trash but, he would discuss making it his department ' s responsibility with the administrator.	F 372	All staff will be in serviced on the policy and procedures for keeping the doors to the dumpster area closed by the ADON, Environmental Service Director, and Dietary Manager on 3/27/2015. The Environmental Service Director will use an audit tool while conducting random dumpster area observations (3) times per week for (2) weeks including weekends for (3) months to observe that the dumpster doors are closed. Variances will be corrected at the time of observation. The Environmental Service Director will report all variances to the quality assurance committee during the monthly meeting for the next (3) months. Continued compliance will be monitored through routine daily dumpster area observations and through the facility's quality assurance program. Additional education	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=D	Continued From page 20 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 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 431	and monitoring will be initiated for any identified concerns. F Tag 431: The identified medications were discarded by the nurse on 3/5/2015. The replacement medications were dated by the charge nurse when opened and stored appropriately. No negative outcome resulted from the observation. Current residents receiving nebulizer medications have the potential to be affected. The ADON will in service all (which includes weekend and PRN) licensed nurses on the facility's policy regarding labeling/dating, and storage of ipratropium/albuterol vials along with manufacturer's recommendations on 3/27/2015. The Unit Managers and charge nurses will conduct med room	4-2-15

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F 431	Continued From page 21 facility failed to date six ipratropium bromide and albuterol sulfate vials (drug used to treat asthma and chronic obstructive pulmonary disease) after they had been removed from the foil pouch in one of five medication carts (cart for upper 100 hall). The findings included: On 3/5/15 at 1:03PM, the medication cart for the upper 100 hall was observed with Nurse # 9. There were six ipratropium bromide and albuterol sulfate vials observed lying in the medication box. They had been removed from the foil pouch and the foil pouch had been discarded. Manufacturer's instructions for the medication read, in part, "Once removed from the foil pouch, the individual vials should be used within one week." On 3/5/15 at 1:03PM, Nurse #9 stated she was not aware that the medication should be dated when removed from the foil pouch. On 3/5/15 at 1:10PM, the pharmacist stated the ipratropium bromide and albuterol sulfate vials should remain in the foil pouch. If they were removed from the foil pouch, they should have been dated and discarded within 7 days as per manufacturer's instructions.	F 431	and med cart audits utilizing an audit tool 2x/week for 3 months to ensure labeling/dating, and storage of ipratropium/albuterol vials per policy and manufacturer's recommendations. Variances will be corrected at the time of observation and additional education and/or administrative action provided when necessary. Monitoring results will be reported to the DON weekly for the next (3) months. The DON will report concerns to the quality assurance committee during the monthly meeting x (3) months. Continued compliance will be monitored through weekly medication cart and med room observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 22 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to prevent a staff member with signs of a potential infection from continuing to work on the unit for 1 of 5 Licensed Nursing Staff on 200 hall and failed to have the required signage for droplet isolation	F 441	F Tag 441: Resident #192 no longer resides in the facility. The identified nurse did not return to the facility until medically cleared. Proper signage was obtained by the DON for droplet precautions on 3/5/15. No negative outcome resulted from the observations. Current residents and employees have the potential to be affected. The ADON will in-service all licensed nursing staff (which includes weekend and PRN) on the policy and procedures for infection control for both residents and employee health which includes proper use of signage by 4/2/2015. The Unit Mangers will report residents and employees with signs and symptoms of infection daily in the clinical operations meeting. Employees with signs and symptoms of	4-2-15

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F 441	Continued From page 23 precautions for 1 of 1 residents (Resident #192) with influenza. The findings included: 1. Review of the facility document titled Infection Control Program and dated 03/05 revealed " The employee reports employee infections to his/her immediate supervisor. The DON (Director of Nursing)/designee completes the Employee infection log. " " The Employee Health Policy (undated) revealed " It is the policy of this facility to prohibit employees with communicable disease or with infected skin lesions from direct contact with guests or their food." On 3/2/15 at 4:30 PM Nurse #12 was observed at the Nursing Station for 200 hall. At that time she stated to other staff at the Nursing Station that she was told she could not work because she had a fever. She also said that she was just trying to get done so she could go home. Nurse #12 added that she did not know she had a fever until 1:00 (PM) and that they were trying to get someone to cover her for tomorrow. There was no reply from any of the staff members present at the Nursing Station. On 3/2/15 at 4:43 Nurse #12 was observed at the Nursing Station for 200 hall doing paperwork and interacting with staff. On 3/5/15 at 1:15 PM during a telephone interview with Nurse #12 she stated that she started feeling like she might be getting a cold on Sunday evening (3/1/15) but still came into work on Monday morning (3/2/15) because she still thought it was just a cold. She said that around noon she wasn ' t feeling very well and took her	F 441	infection will not be permitted to work per policy. New admissions and new orders are reviewed by the Unit Managers during the morning clinical meeting. The Unit Managers will ensure that new orders for isolation are in place and appropriate signage is posted. The ADON will track all reported resident and employee infections per facility policy. The ADON will monitor isolation orders and postings (2) times a week for (4) four weeks then weekly for (2) two months utilizing an audit tool. Audit results will be reported to the DON weekly for the next (3) three months. The DON will audit the infection tracking logs 2x/week for 4 weeks and monthly thereafter. All auditing results will be reported to the quality assurance committee by the	

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F 441	Continued From page 24 temperature and it was 100 degrees. Nurse #12 stated that she told her supervisor, Nurse #2, and then said that she actually said it in general to the staff at the desk but then Nurse #2 came to her and told her that she (Nurse #2) had informed Administrative Staff #2. Nurse #12 said that after this, Administrative Staff #2 came to talk to her and told her that they would try to cover her shift for tomorrow (3/3/15) in case she wasn ' t feeling any better. Nurse #12 indicated that she was not sure if she interacted with any residents after she noted her fever was 100 degrees and said that after 1 PM she mostly had paperwork to do and the last medications she passes are given around 1 PM. She added that after 1 PM she would only be out on the hall if a Nursing Assistant needed help with something. Nurse #2 stated that that evening her fever was 102 degrees so she went to the doctor the next day and was told she had a viral illness that needed to run its course. On 3/5/15 at 3:00 PM Administrative Staff #2 stated that Nurse #12 did not tell her until the end of her shift that she had a low grade fever. She added that Administrative Staff #12 should have known she needed to report her fever when she first became aware of it so a determination of whether or not it was appropriate for her to continue working on the unit could be made. Administrative Staff #2 also said she had not known that Nurse #12 was aware of her low grade fever earlier in the day, or that she had continued to work after the end of her shift (first shift, 7-3). She also stated that there was no specific facility policy requiring a staff member to be fever free for any period of time before returning to work. On 3/5/15 at 4:00 PM, interview with Nurse #2	F 441	DON during the monthly meeting for the next (3) three months then monthly thereafter. Continued compliance will be monitored through review of new admissions, new orders and changes in condition during the morning clinical meeting, round observations for appropriate signage when residents are identified to require isolation, monthly review of infection control tracking logs and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 441	Continued From page 25 revealed that on 3/2/15, Nurse #12 told her that she had a fever. Nurse #2 said that Nurse #12 reported this at the end of her shift and she (Nurse #2) was not aware that Nurse #12 had known about her fever earlier in her shift. Nurse #2 said that she told Nurse #12 that she needed to tell Administrative Staff #2. Nurse #2 also said that Nurse #12 should have been aware that staff should report signs and symptoms of an infection immediately. Nurse #2 acknowledged that she saw Nurse #12 finishing up at the nursing station after reporting her fever and after the end of her shift but said-" I was busy but before I knew it she was gone. "	F 441		
	2. Review of the facility policy titled " Second Tier: Transmission Based Precautions Droplet Precautions dated 01/13 revealed: " The facility will utilize Droplet Precaution (in addition to Standard Precautions), for specified guests known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the guest during coughing, sneezing, talking, or the performance of procedures such as suctioning or trach (tracheostomy) care. " The precautions included: " Wear a mask when working within three feet of the guest. " " If transport or movement is necessary, minimize guest dispersal of droplets by masking the guest. " " Visitors: Place a sign on the door of the guest ' s room and instruct visitors to report to the Nurses ' Station prior to entering the room. " Resident #192 was admitted on11/22/14 with diagnoses including dementia, diabetes, brain tumor and chronic kidney disease. He was readmitted on 12/22/15 with a new diagnosis of influenza.			

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F 441	Continued From page 26 The hospital Discharge Summary dated 12/21/14 indicated that Resident #192 had a positive influenza screen while in the hospital. The Discharge Summary also revealed the following under discharge instructions " Patient was treated for the flu while an inpatient and will need to have isolation for 1 week following initiation of symptoms. Patient should be in isolation until 12/23/14 (droplet precautions). " The Nursing Note (time and date not indicated however this was the first note after the resident was readmitted on 12/22/14) revealed Resident #194 had a respiratory infection and was on special care isolation and precautions for an active infections disease. The type of isolation precautions (Contact or Droplet) was not specified. Review of the Physician ' s Orders for 12/22/14 revealed no orders for isolation precautions or Droplet precautions. The Nursing Note dated 12/22/14 at 11:30 PM revealed " special care isolation precautions standard " and " maintain isolation precautions due to flu. " The Nursing Note dated 12/23/14 at 3:38 PM revealed " special care isolation precautions active infectious disease. " The Nursing Note dated 12/23/14 at 7:08 PM revealed " special care isolation precautions standard. " Review of the Physician ' s Orders for 12/23/14 through the resident ' s discharge on 1/21/15 revealed no orders for isolation precautions or	F 441		

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F 441	Continued From page 27 Droplet precautions. Review of the facility Infection Control Log for December 2014 revealed that the resident ' s influenza diagnoses and information regarding isolation precautions had not been recorded on the log. On 3/4/15 at 5:30 PM, interview with Administrative Staff #3 revealed that the facility only used contact precautions (used when transmission involves direct contact) signage for residents who were on any type of isolation precautions, even if the isolation required was something else like droplet precautions. Administrative Staff #3 also said that staff at the facility were trained to use all the items of personal protective equipment available in the isolation kit. She said the kit was placed next to the resident ' s door on the hall side of the room and for droplet precautions masks would be included in the kit so staff would know they needed to wear them. She also stated that influenza cases should be tracked on the Infection Control Log but said that she did not receive a tracking sheet and she had therefore been unaware Resident #194 had a diagnoses of influenza. Administrative Staff #2 was present and added that there was also a sign that would be posted on the door to the room of a resident on isolation precautions, which instructed people to contact staff at the nursing station before they entered the room. She indicated that facility practice was to place the contact precautions sign on the top of the isolation kit. Administrative Staff #2 stated that the facility only used contact precaution signs, even when droplet precautions were required, in order to protect the privacy of residents.	F 441		

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F 441	Continued From page 28 On 3/5/15 at 8:25 AM Administrative Staff #4 was interviewed and verified that in December, 2014 the facility had a resident who required droplet isolation precautions for 1 day. She added that a decision was made by facility staff, in consultation with the physician, to keep the resident on drop isolation precautions for 1 week as a preventative measure. She stated that nursing staff had been informed that the resident was on droplet precautions and were aware when masks were required but she did not recall what signage about the isolation precautions was used at the resident ' s door. She added that masks were placed in all isolation kits even when only contact precautions were required. On 3/5/15 at 3:00 PM Administrative Staff #2 stated that the facility previously only had contact precautions signage for use in the facility when residents contact or droplet precautions isolation. She added that on 3/5/15 she had taken steps to acquire the required signage to use when residents were on droplet isolation precautions.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520	F Tag 520: The facility will maintain a quality assurance committee made up of a multiple disciplinary team. Current residents have the potential to be affected. The Regional QA Manager will in service all department heads	4-2-15

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F 520	Continued From page 29 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 Assurance and Performance Improvement (QAPI) committee failed to implement, monitor and revise as needed the action plan developed for the 12/5/13, 11/28/12 and 10/6/11 recertification surveys in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies on proper labeling and dating of drugs and biological (F431) on the 12/5/13, 11/28/12 and 10/6/11 recertification surveys. The findings included: This tag is cross referenced to: F 431- Proper labeling and dating of drugs and biological- Based on record review, observation and staff interviews, the facility failed to date six ipratropium bromide and albuterol sulfate vials after they had been removed from the foil pouch in one of five medication carts (cart for upper 100 hall).	F 520	on 3/27/2015 on the current policy, procedures and functions of the quality assurance committee and program. In-servicing will include the process for determining the root cause for identified concerns. The DON, ADON, and Unit Managers will complete weekly audits of medication carts and storage rooms for 3 months then randomly thereafter to ensure proper storage of drugs and biologicals. Variances will be corrected at the time of observation. The Regional QA Manager/ Regional Manager will review the QA meeting minutes for the next (3) months then randomly thereafter to ensure appropriate action plans have been identified and amended as needed. Variances will be corrected as identified. Continued compliance will be monitored through random	

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F 520	Continued From page 30 During the recertification surveys on 12/5/13, 11/28/12 and 10/6/11, the facility was cited F431 for not labeling medications with the date opened and for not discarding expired medications. An interview was conducted with Administrative Staff #1 on 3/5/15 at 3:34 PM. He stated the facility had a QAPI committee which consisted of the Director of Nursing, Social Worker, Maintenance Director, Medical Director, Pharmacist, Psychiatric Group, Rehabilitation Manager, Assistant Director of Nursing and the Administrator. He stated the QAPI committee had met on a monthly basis. He stated there were no corporate indicators regarding quality assurance issues with proper labeling and dating of drugs and biological.	F 520	review of QA meeting minutes during routine visits by the Regional Manager and Regional QA Manager.	