STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING _____ B. WING _____	C 01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #CZ4X11.	F 000		
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 record review and staff interview, the	F 278	The Laurels of Chatham wishes to have	1/27/16

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

Electronically Signed | 01/21/2016

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F 278	Continued From page 1 facility failed to accurately code the Minimum Data Set (MDS) assessments for 1 of 3 sampled residents (Resident #204) with level II Preadmission Screening and Resident Reviews (PASRR). The findings included: On 1/4/16 the Director of Nursing (DON) completed an entrance conference worksheet that listed PASRR level II residents. Resident #204 was listed as PASRR level II. Resident #204's admission MDS, dated 12/24/15 indicated a "No" to question A1500 which asked if Resident #204 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Record review indicated that Resident #204 was a level II PASRR. Resident #204's level II PASRR was initially received 12/14/15. An interview was conducted on 1/6/16 at 10:00 AM with the MDS Coordinator. She stated that she was responsible for answering question A1500 on the MDS for all residents. She stated that she obtained the information on level II PASRR's from the medical records. The MDS Coordinator stated that the Admissions staff placed the level II PASRR documentation in the medical records. She revealed that this documentation must have been overlooked for Resident #204.	F 278	this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is January 22, 2016. 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. Corrective Action The MDS for resident #204 has been corrected to accurately reflect the residents status. Corrective action for those who have the potential to be affected: All residents with a level 2 PASRR were identified at the time of survey and MDS reviewed by the DON for accurate coding of the MDS. No further issues were noted. Systemic changes The MDS/Care Plan nurse has been re-educated on 1-25-16 by our regional MDS consultant regarding the correct coding for a level 2 PASRR. Monitoring The Director of Nurses will review all new admissions with a level 2 PASRR to	

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F 278	Continued From page 2	F 278	ensure proper coding on the MDS, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly Quality Assurance meeting (QAPI) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from committee with further education and/or training as indicated.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 280	Corrective Action	1/27/16

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F 280	Continued From page 3 resident and staff interviews, the facility failed to review and revise the care plan for one of one resident reviewed for dialysis to indicate Resident #25 had a vascular access catheter and failed to revise the care plan for one of two residents reviewed for splints (Resident #18). The findings included: 1. Resident #25 was readmitted to the facility 7/19/15. Cumulative diagnoses included end stage renal disease and left subclavian dialysis catheter (catheter in the left upper chest area that was used for hemodialysis). An Annual Minimum Data Set (MDS) dated 11/12/15 indicated Resident #25 was cognitively intact. Dialysis was noted as having been received while a resident at the facility. A care plan dated 11/20/15 indicated Resident #25 had end stage renal disease and was on HD (hemodialysis). Approaches included, in part, observe dialysis site for signs of infection such as redness, swelling, edema or drainage and report to physician. Check bruit and/or thrill in arm every shift; notify nephrologist/ doctor if bruit/ thrill not detected (Thrill and bruit are sounds noted when a shunt/ fistula is present and used for dialysis and are not present if a vascular access catheter is used for hemodialysis). The care plan did not reflect that Resident #25 had a vascular access catheter. On1/6/16 at 11:30AM, an observation of Resident #25 revealed a vascular access catheter was present/ visible in the upper left chest area. On 1/6/16 at 11:30AM, an interview was conducted with Resident #25 who stated she	F 280	The care plan for resident #25 has been corrected by the MDS nurse, to reflect the vascular access. The care plan for resident #18 has been revised by the MDS nurse for the use of washcloths and towels. Corrective action for those who have the potential to be affected: Residents that receive dialysis or are utilizing splinting have been identified. At the time of survey the DON reviewed the care plans for those who are receiving dialysis and those with a splint. No other care plan issues were found. Systemic changes The MDS/Care Plan nurse and unit managers have been re-educated on 1-11-16 by the DON regarding the accuracy of care plans for dialysis and patients with splints. Monitoring New orders will be reviewed in the morning clinical meeting for any new orders or changes in orders for splinting residents and for residents receiving dialysis by the MDS nurse and unit managers who will then review and update the care plans of those residents as indicated. A monitoring tool will be utilized by the DON/administrative nurse to ensure care plans have been revised and updated as	

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F 280	Continued From page 4	F 280		

went to dialysis three times weekly. Resident #25 stated she had a catheter in her left upper chest area that was used for dialysis.

On 1/6/16 at 4:14PM, Administrative staff #3 stated she was not aware that Resident #25 had a vascular access catheter and the care [;an should have been revised and updated to reflect that Resident #25 had a vascular access catheter. The reference to the thrill/ bruit should have been discontinued.

2. Resident #18 was admitted to the facility 8/19/14. Cumulative diagnoses included: bilateral upper extremity spasticity and multi-site contractures.

A Quarterly MDS dated 11/10/15 indicated Resident #18 was in a persistent vegetative state. Functional limitation in range of motion was noted bilateral for both upper and lower extremities.

A care plan dated 7/10/15 stated Resident #18 had contractures and the potential for further contractures related to non-functional mobility and quadriplegia. Approaches included, in part, splints as ordered. The approaches were updated 8/11/15 that restorative nursing had been ordered.

A Nursing Care Card (undated) and posted in Resident #18's closet indicated Resident #18 was to have right and left palm guards on at all times except for hygiene.

A restorative program therapy to nursing communication sheet dated 8/12/15 stated, in part, after
gentle range of motion, position bilateral elbows

appropriate, on a weekly basis bor 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from committee with additional education or training as indicated.

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F 280	Continued From page 5 in extension with rolled towels and place rolled washcloth in both hands (between palms and digit). A physician's order dated 8/12/15 stated to place rolled washcloth/towel at both elbows and both hands every shift. Skin checks every shift before and after placing cloth/ towels. On 1/6/16 at 4:25PM, Administrative staff #2 stated Resident #18 was being seen by restorative nursing. She stated the current order for management of his hand/ arm contractures was to place rolled washcloth/towel at bilateral elbows and bilateral hands every shift. Skin checks should be done before and after placing cloth/ towels. Restorative aides performed the care three to five times a week and nursing assistants and nurses check to make sure splints/ rolls were in place. Administrative staff #2 stated Resident #18 should have towels/ washcloths bilaterally for his elbows and hands at all times except for range of motion and skin checks. On 1/6/16 at 5:05PM, Administrative staff #1 stated the care plan should have been revised to indicate the use of the washcloths/ towels for Resident #18's hands and elbows.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		1/27/16

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F 282	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow the care plan interventions for pain management for one of one resident (Resident#71), failed to follow the care plan interventions for contracture management for one of two sampled residents (Resident #142) and failed to obtain a referral for psychiatric services for one of three residents reviewed for PASRR (Preadmission Screening and Resident Review) level 2 (Resident #17). The findings included: 1. Resident # 71 was admitted to the facility 9/25/15. Cumulative diagnoses included osteonecrosis (breakdown of bone due to decreased or loss of blood supply), right sided hemiparesis and hip pain. An Admission Minimum Data Set (MDS) dated 10/2/15 indicated Resident #71 was cognitively intact. Pain assessment revealed the following: received scheduled pain medication regime, received PRN (as needed) pain medication or was offered and was declined. No presence of pain as noted at the time of the assessment. A care plan dated 10/7/15 stated Resident #71 had a potential for pain related to left hip pain. Approaches/ interventions included, in part, administer medications for pain and observe for effectiveness/ side effects and report ineffectiveness to physician. Assess characteristics of pain on scale 0-10. Physician orders were reviewed and revealed the following order for PRN (as needed) pain medication:	F 282	Corrective Action Resident #71 was interviewed at the time of survey and stated his pain was effectively managed. The facility is following the care plan interventions for pain management. Resident #142's splints are being applied as according to the care plan interventions for contracture management. Resident #17 has had the psych consult on January 12th, 2016. Corrective action for those who have the potential to be affected: All residents that require pain management were identified and care plans were reviewed by the DON to ensure interventions were being carried out according to the care plan interventions. No other variances were noted. All residents that require splinting for contracture management were identified and care plans reviewed by the DON to ensure interventions were being carried out according to the care plan interventions. No other issues with splinting were noted. Residents with Level 2 PASRR care plans were reviewed for referral for psychiatric services as interventions on the care plan. No issues were noted. Systemic changes	

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F 282	Continued From page 7 10/1/15 Percocet (narcotic used for pain) 5/325 milligrams one by mouth every four hours prn for pain A review of the November 2015 Medication Administration Record (MAR) revealed Percocet was recorded as having been administered on 11/9, 11/11, 11/12, 11/17, 11/21. 11/22, 11/23, 11/28, 11/29 and 11/30/15. The assessment of pain on a scale of 1-10 was not documented on the MAR or in the nursing notes. The effectiveness of the pain medication administration was documented on 11/11, 11/21. 11/22 and 11/28/15. A review of the December 2015 MAR revealed Percocet was recorded as having been administered on 12/ 5, 12/6, 12/7, 12/9, 12/12, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/22, 12/23, 12/24, 12.26, 12/27, 12/28, 12/29, 12/30 and 12/31/15. The assessment of pain on a scale of 1-10 was not documented on the MAR or in the nursing notes. The effectiveness of the pain medication was documented on 12/2, 12/12, 12/13, 12/19. 12/27 and 12/28/15. A review of the January 2016 MAR revealed Percocet was recorded as having been administered on 1/1, 1/2, 1/3, 1/5 and 1/6/16. The assessment of pain on a scale of 1-10 was not documented on the MAR or in the nursing notes. The effectiveness of the pain medication was documented for 1/5/16. On 1/07/16 at 11:09AM, an interview was conducted with Resident #71 who stated he requested prn (as needed) pain medication when he needed it and the medication was effective in relieving his pain.	F 282	Licensed staff has been inserviced between January 8th and 16th 2016 by the DON and/or assistant DON regarding pain management and splinting according to the plan of care. Licensed staff and the Director of Social Services has been inserviced between January 8th and 16th 2016 by the DON on proper follow-up on consult orders and/or interventions of psychiatric referrals according to the care plan interventions. Monitoring Administrative nurses will daily monitor for 1 week that the care plan interventions are in place for residents receiving pain management and splinting , then weekly for 3 weeks and then monthly for 2 months to ensure ongoing compliance. All findings will be reviewed by the Director of Nurses and reported to the monthly QAPI meeting for review and/or recommendations. The DON will be responsible to follow-up on any recommendation from the committee with further education or training as indicated.	

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On 1/7/16 at 9:45AM, Nurse #2 stated the process regarding pain management was to assess the pain using the pain scale 0-10, administer the pain medication and follow up with the resident to determine the effectiveness of the pain medication. Nurse #2 stated documentation of administration of the pain medication would be done on the front of MAR. Also, she would document on the back of the MAR alo9ng with the level of pain and document the effectiveness of the medication on the back of the MAR. She stated a nursing note should be written but the minimum would be documentation on the front and back of MAR (effectiveness).

On 1/07/2016 at 11:21AM, Administrative staff #1 stated she expected nursing staff to administer prn pain medication on request and evaluate the effectiveness of the pain medication within 1-2 hours of administration. She stated the nursing staff should document the administration, level of pain and effectiveness of the pain medication on the Medication Administration Record.

2. Resident #142 was admitted to the facility on 9/17/14 with multiple diagnoses including contractures. The quarterly Minimum Data Set (MDS) assessment dated 11/23/15 indicated that Resident #142 had memory and decision making problems and had limitation in range of motion on one side of the upper extremities.
The care plan dated 11/29/15 was reviewed. One of the care plan problems was "splint and brace program." The goal was guest will be able to maintain skin integrity under the splint and maintain circulation to the affected limbs." The approaches included left upper extremity splint.

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The wearing schedule were "on 8 AM and off 10 AM, on 1 PM and off 3 PM, on 6 PM and off 9 PM and on 12 MN and off 6 AM."
The December, 2015 physician's orders were reviewed. The orders included "splint to LUE (left upper extremity) on at 12 AM and off at 6 AM, on at 8 AM and off at 10 AM, on at 1 PM and off at 3 PM and on at 6 PM and off at 9 PM and to do gentle range of motion after each removal." The date of the order was 11/1/15.
On 1/5/16 at 1:41 PM, 1/6/16 at 8:30 AM, 9:34 AM and 1:50 PM. Resident #142 was observed. He was not wearing a splint on his LUE.
On 1/6/16 at 1:50 PM, NA # 2, assigned to the resident, was interviewed. She stated that she normally applied the LUE splint when the resident was out of bed and not when he was in bed.
On 1/6/16 at 3:10 PM, Nurse # 4, assigned to the resident, was interviewed. He stated that the nursing aide assigned to the resident was responsible for applying the splints.
On 1/7/16 at 2:35 PM, administrative staff #1 was interviewed. She indicated that she expected the staff to follow the care plan for the application of the splints.

3. Resident #17 was admitted to the facility on 10/27/15 with diagnoses that included dementia, depression, bipolar disorder, and schizophrenia. The admission Minimum Data Set (MDS) dated 10/31/15 indicated she had severe cognitive impairment.
A care plan dated 11/13/15 indicated that Resident #17 had depression and bipolar illness with a history of mood cycles. The interventions included referring to psychiatric services as

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F 282	Continued From page 10 needed. The physician's orders were reviewed for Resident #17. On 10/29/15 there was a physician's order for a psychiatric consultation. A review of the medical record revealed no documentation that Resident #17 received a psychiatric consultation as ordered. An interview was conducted on 1/6/16 at 1:37 PM with the Social Worker (SW). She stated that she was responsible for coordinating psychiatric services. The SW reviewed the medical record for Resident #17. She revealed that Resident #17 did not receive a psychiatric consultation as ordered. The SW reviewed the normal procedure for coordinating a psychiatric consultation. She stated that she or a nurse wrote the resident's name in a binder that was kept at the nurses' station. The psychiatric provider looked at the binder when they came into the facility and provided services to the residents that were listed. The SW revealed that Resident #17 was not listed in the binder. She stated that this step was missed for Resident #17. She stated that she usually followed up on residents to verify that they received psychiatric services. She stated that she did not follow up on Resident #17.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		1/27/16

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interviews, the facility failed to monitor the effectiveness of pain medication for one of one resident reviewed for pain management (Resident #71). The findings included: Resident # 71 was admitted to the facility 9/25/15. Cumulative diagnoses included osteonecrosis (breakdown of bone due to decreased or loss of blood supply), right sided hemiparesis and hip pain. An Admission Minimum Data Set (MDS) dated 10/2/15 indicated Resident #71 was cognitively intact. Pain assessment revealed the following: received scheduled pain medication regime, received PRN (as needed) pain medication or was offered and was declined. No presence of pain as noted at the time of the assessment. A care plan dated 10/7/15 stated Resident #71 had a potential for pain related to left hip pain. Approaches/ interventions included, in part, administer medications for pain and observe for effectiveness/ side effects and report ineffectiveness to physician. Assess characteristics of pain on scale 0-10. On 1/5/16 at 9:54AM, an interview was conducted with Resident #71. He stated he was having pain in his left hip. He stated he had a "boil" on his left hip and had been seen by a doctor for the area. Resident #71 stated he received pain medication when he requested it and the pain medication helped for a little while but did not totally relieve the pain.	F 309	Corrective Action Resident #71 was interviewed at the time of survey and stated his pain was effectively managed. The facility is documenting effectiveness of PRN pain medication on the back of the MAR. Corrective action for those who have the potential to be affected: All residents requiring PRN pain medication were identified. Documentation was reviewed by the Director of Nurses and/or the ADON, and both Unit Managers to ensure effectiveness of pain medication was documented on the back of the MAR. No other issues or variances were noted. Systemic changes The licensed staff has been inserviced by the DON between January 8th and January 16th regarding proper monitoring and documentation of effectiveness of PRN pain medication. Monitoring The Director of Nurses and/or the ADON, and both Unit Managers will review the MAR for all residents that receive pain medication for effectiveness, daily for 4 weeks and then weekly for 2 months to ensure ongoing compliance. This will include weekend reviews as well. Results will be reported by the DON to the monthly	

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F 309	Continued From page 12 Physician orders were reviewed and revealed the following order for PRN (as needed) pain medication: 10/1/15 Percocet (narcotic used for pain) 5/325 milligrams one by mouth every four hours prn for pain A review of the November 2015 Medication Administration Record (MAR) revealed Percocet was recorded as having been administered on 11/9, 11/11, 11/12, 11/17, 11/21. 11/22, 11/23, 11/28, 11/29 and 11/30/15. The effectiveness of the pain medication administration was documented on 11/11, 11/21. 11/22 and 11/28/15. A review of the December 2015 MAR revealed Percocet was recorded as having been administered on 12/ 5, 12/6, 12/7, 12/9, 12/12, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/22, 12/23, 12/24, 12.26, 12/27, 12/28, 12/29, 12/30 and 12/31/15. The effectiveness of the pain medication was documented on 12/2, 12/12, 12/13, 12/19. 12/27 and 12/28/15. A review of the January 2016 MAR revealed Percocet was recorded as having been administered on 1/1, 1/2, 1/3, 1/5 and 1/6/16. The effectiveness of the pain medication was documented for 1/5/16. On 1/7/16 at 9:45AM, Nurse #2 stated the process regarding pain management was to assess the pain using the pain scale 0-10, administer the pain medication and follow up with the resident to determine the effectiveness of the pain medication. Nurse #2 stated documentation of administration of the pain medication would be done on the front of MAR. Also, she would	F 309	QAPI meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from committee with additional education or training as necessary.	

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F 309	Continued From page 13 document on the back of the MAR alo9ng with the level of pain and document the effectiveness of the medication on the back of the MAR. She stated a nursing note should be written but the minimum would be documentation on the front and back of MAR (effectiveness). On 1/07/2016 at 11:21AM, Administrative staff #1 stated she expected nursing staff to administer prn pain medication on request and evaluate the effectiveness of the pain medication within 1-2 hours of administration. She stated the nursing staff should document the administration, level of pain and effectiveness of the pain medication on the Medication Administration Record.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to apply splints and provide range of motion (ROM) as ordered for 2 (Residents #142 & # 18) of 2 sampled residents with limited range of motion. Findings included: 1a. Resident #142 was admitted to the facility on 9/17/14 with multiple diagnoses including contractures. The quarterly Minimum Data Set	F 318	Corrective Action Splints are being applied and range of motion provided for residents #18 and #142 as ordered. Corrective action for those who have the potential to be affected:	1/27/16

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F 318	Continued From page 14 (MDS) assessment dated 11/23/15 indicated that Resident #142 had memory and decision making problems and had limitation in range of motion on one side of the upper extremities. The care plan dated 11/29/15 was reviewed. One of the care plan problems was "splint and brace program." The goal was guest will be able to maintain skin integrity under the splint and maintain circulation to the affected limbs." The approaches included left upper extremity splint. The wearing schedule was "on 8 AM and off 10 AM, on 1 PM and off 3 PM, on 6 PM and off 9 PM and on 12 MN and off 6 AM." The December 2015 physician's orders were reviewed. The orders included "splint to LUE (left upper extremity) on at 12 AM and off at 6 AM, on at 8 AM and off at 10 AM, on at 1 PM and off at 3 PM and on at 6 PM and off at 9 PM and to do gentle range of motion after each removal." The date of the order was 11/1/15. On 1/5/16 at 12:21 PM, a family member of Resident #142 was interviewed. The family member indicated that the resident had contractures and staff were not applying the splints as scheduled. Resident #142 was observed on 1/5/16 at 1:41 PM, 1/6/16 at 8:30 AM, 9:34 AM and 1:50 PM. He was not wearing a splint on his LUE. On 1/6/16 at 1:50 PM, NA #2, assigned to the resident, was interviewed. She stated that she normally applied the LUE splint when the resident was out of bed and not when he was in bed. On 1/6/16 at 3:10 PM, Nurse # 4, assigned to the resident, was interviewed. He stated that the nurse aide assigned to the resident was responsible for applying the splints. On 1/7/16 at 2:35 PM, administrative staff #1 was interviewed. She indicated that she expected the staff to follow the care plan and the doctor's	F 318	Residents that wear splints and/or require range of motion were identified. Orders and care plans of the identified residents were reviewed by the DON, to determine if splints and range of motion were occurring as ordered. No further issues were found. Systemic changes Licensed staff and nursing assistants, which included prn and weekend staff, have been inserviced by the DON between January 8th and 16th, 2016 regarding carrying out range of motion and for splinting according to orders and care plan interventions. Monitoring The DON or ADON or unit managers will use an audit tool to review all residents that require splints and/or range of motion daily for 2 weeks, to include weekends, and then weekly for 2 weeks, and then monthly for 2 months to determine if the splinting and range of motion is occurring as ordered to ensure compliance. Results will be reported by the DON to the monthly QAPI meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from committee with additional training or education as necessary.	

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orders for the application of the splints.

1b. Resident #142 was admitted to the facility on 9/17/14 with multiple diagnoses including contractures. The quarterly Minimum Data Set (MDS) assessment dated 11/23/15 indicated that Resident #142 had memory and decision making problems and had limitation in range of motion on one side of the upper extremities and both lower extremities.
The Restorative Program Therapy to Nursing Communication form was reviewed. The form included restorative problems, goals and interventions for Resident #142. The restorative program was referred by the physical therapist (PT) and occupational therapist (OT) which included passive range of motion (PROM) to the right wrist and right hand/digits and assisted active range of motion (AAROM) and PROM to both lower extremities. The form indicated that the restorative aides were instructed by the PT and OT of the restorative interventions on 11/17 - 11/20/15.
On 11/24/15, there was a doctor's order "restorative nursing has been requested by therapy due to decrease range of motion in right hand/wrist and bilateral lower extremities 3 - 5 times weekly."
The Restorative Passive Range of Motion Program Daily Records for Resident #142 were reviewed. The restorative aide had worked with Resident #142 on passive and active ROM from November 24 through December 16, 2015.
There were no records to indicate that the AAROM and PROM were provided to the resident from December 17 2015 through January 6, 2016.
On 1/6/16 at 2:00 PM, administrative staff #3 was interviewed. She stated that the facility had 2

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restorative aides. These 2 aides were out at this time, one was on vacation and the other one was sick. The rehabilitation technician had helped with the restorative program when the restorative aides were out.
On 1/6/16 at 2:20 PM, the rehabilitation technician was interviewed. She stated that she worked with the therapy department. She indicated that at times she helped with the restorative program when the restoratives aides were out but mainly helped with the restorative dining and not restorative ROM and splint application.
On 1/6/16 at 2:30 PM, administrative staff #2, responsible for the restorative nursing program, was interviewed. She indicated that the 2 restorative aides were out and the nurses and nurse aides assigned to the residents were supposed to provide the ROM. Administrative staff #2 was not able to give an explanation as to why the restorative program was not provided from December 17 through December 31, 2015 to Resident #142.
On 1/7/16 at 2:35 PM, administrative staff #1 was interviewed. She indicated that she expected the staff to provide the restorative nursing program as ordered.

1c. Resident #142 was admitted to the facility on 9/17/14 with multiple diagnoses including contractures. The quarterly Minimum Data Set (MDS) assessment dated 11/23/15 indicated that Resident #142 had memory and decision making problems and had limitation in range of motion on one side of the upper extremities.

Resident #142 was screened by the occupational therapist (OT) and the OT had recommended PROM to right wrist and right hand/digits due to

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limitation in range of motion. Instructions on PROM were given to the restorative aides on 11/17 through 11/20/15.

On 12/13/15, there was a doctor's order to "apply splint to right hand on same schedule as LUE due to contractures."
The January 2016 Medication Administration Record (MAR) was reviewed. There was no documentation that the right hand splint was applied to the resident from January 1-6, 2016.
Resident #142 was observed on 1/5/16 at 1:41 PM, 1/6/16 at 8:30 AM, 9:34 AM and 1:50 PM. He was not wearing a splint on his RUE.
On 1/6/16 at 1:50 PM, NA # 2, assigned to the resident, was interviewed. She stated that the resident did not have a splint ordered for his right hand.
On 1/6/16 at 3:10 PM, Nurse # 4, assigned to the resident, was interviewed. He stated that he was not aware that the resident had an order for the right hand splint. He further indicated that the order for the right hand splint was not carried over to the January, 2016 MAR.
On 1/6/16 at 2:30 PM, administrative staff #2, responsible for the restorative nursing program, was interviewed. She stated that the nurses and nurse's aides were responsible for the splint application. She added that the order for the right hand splint was not carried over to the January 2016 MAR.

On 1/7/16 at 2:35 PM, administrative staff #1 was interviewed. She stated that she expected the staff to follow the splint application as ordered.

2. Resident #18 was admitted to the facility 8/19/14. Cumulative diagnoses included bilateral

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upper extremity spasticity and multi-site contractures.

A Quarterly Minimum Data Set (MDS) dated 11/10/15 indicated resident #18 was in a persistent vegetative state. Functional limitation in range of motion was documented bilaterally for both upper and lower extremities.

A care plan dated 7/10/15 stated Resident #18 had contractures and had potential for further contractures related to non-functional mobility and quadriplegia (paralysis of all extremities). Approaches included, in part, splints as ordered.

A review of the medical record revealed a physician's order dated 8/12/15 to place rolled washcloth/towel at both elbows and both hands every shift. Skin checks every shift before and after placing cloth/ towels.

On 1/5/16 at 12:17PM, Resident #18 was observed lying in bed with both arms held up to chest. His fingers, hands and arms were in a contracted position. There were no rolled washcloths/ towels noted at the elbows or in the hands.

On 1/5/16 at 4:00PM, Resident #18 was observed lying in bed with both arms held up to chest. His fingers, hands and arms were in a contracted position. There were no rolled washcloths/ towels noted at the elbows or in the hands.

On 1/6/16 at 7:50AM, Resident #18 was observed lying in bed with both arms held up to chest. His fingers, hands and arms were in a contracted position. There were no rolled

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washcloths/ towels noted at the elbows or in the hands.

On 1/6/16 at 2:37PM, Nurse #1 stated Resident #18 used rolled washcloths in both hands. She stated either the nurse or nursing assistant put the washcloths in his hands and removed them. She stated he was on a scheduled time to have them in and out and Resident #18 was resting at this time. She stated she had not seen Resident #18 with washcloths in his hands during her shift.

On 1/06/2016 at 2:56PM, Nursing assistant (NA) #1 stated she provided care for Resident #18 on 1/6/16. She stated Resident #18 did not have any washcloths or splints on his hands when she came on shift that morning and she had not applied any washcloths/ splints that day.

On 1/6/16 at 4:25PM, Administrative staff #2 stated she wrote a physician ' s order on 8/12/15 for Resident #18 to have rolled washcloths/towels placed at bilateral elbows and bilateral hands every shift. Skin check were to be done every shift before and after placing the washcloths/ towels. Restorative aides performed the care three to five times a week and nursing assistants and nurses should check to make sure splints/ rolls are in place. He should have towels/ washcloths bilaterally for his elbows and hands all the time except for range of motion and the skin checks.

On 1/6/16 at 5:05PM, Administrative staff #1 stated she expected nursing staff to follow the physician ' s orders and Resident #18 should have had the washcloths/ towels applied bilaterally to his hands/ elbows as ordered by the physician.

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews and observation, the facility failed to monitor behaviors for a resident on an anti-psychotic medication for one of five residents (Resident # 124) reviewed for unnecessary medications. The findings included: Resident # 124 was admitted to the facility on 3/13/13 with multiple diagnoses including	F 329	Corrective Action Behaviors for resident #124 are being monitored every shift on a behavior monitoring form in the Medication Administration Record. Corrective action for those who have the potential to be affected:	1/27/16

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F 329	Continued From page 21 psychotic disorder, Alzheimer ' s disease, dementia and depression. The quarterly Minimum Data Set dated 11/19/15 stated the resident was severely impaired for cognitive skills for daily decision making. The resident was assessed with the use of anti-psychotic medication. The Plan of Care dated 11/19/15 indicated the resident was assessed with behavior problems evidenced by inappropriate crying, screaming at night and the repeating of words related to psychosis. The interventions included to observe and record the resident ' s behaviors. A review of the Physician ' s Orders revealed an order dated 8/11/15 for Seroquel 50 milligrams 1 tablet by mouth three times a day and to hold if drowsy. A review of the Behavior Documentation Record for Resident #124 revealed there was no documentation of behaviors occurring on 1/4/16 or 1/5/15. Behaviors including yelling and agitation were documented occurring on 1/6/16. A review of the Nurses ' Notes from 1/4/16 to 1/6/16 revealed no documentation of the observation of behaviors. Resident # 124 was observed lying in bed, rocking up and down and yelling on 1/5/16 at 12:13 PM. An interview was conducted with Nurse #4 on 1/6/16 at 2:44 PM. Nurse #4 stated the resident was exhibiting an increase in behaviors, including yelling, on 1/4/16, 1/5/16 and 1/6/16. She stated	F 329	All residents requiring antipsychotic medications have been identified and documentation reviewed by the DON and ADON on January 8th to determine if behaviors were being monitored using the behavior monitoring tool. No issues were noted. Systemic changes Licensed staff, including weekend and PRN has been inserviced by the DON the week of January 8th through the 16th, regarding the proper monitoring of behavior with the behavior monitoring tool. Monitoring Administrative nurses will audit each behavior monitoring tool daily, to include weekends, to ensure behavior documentation is occurring for each shift as appropriate weekly for 4 weeks and then monthly for 2 months to ensure ongoing compliance. The Director of Nurses will report results of audits to the monthly QAPI meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from committee with additional training or education as indicated.	

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F 329	Continued From page 22 the nursing staff was expected to document resident behaviors on the behavior documentation record or to send a fax informing the attending physician of an increase of behaviors. She stated she had not documented the resident ' s behaviors on the behavior documentation record on 1/4/16, 1/5/16 or 1/6/16. Nurse #4 stated the behavior documentation record for Resident #124 was kept in the behavior book at Station 2. She was unable to locate a behavior documentation record for Resident # 124. She stated she had not documented the increased behaviors in the nurses ' notes. Nurse #4 stated she had not sent a fax to the physician on 1/4/16, 1/5/16 or 1/6/16 to inform him of the increased behaviors. She stated it was her intention to send a fax on 1/6/16 to the physician regarding the change in the resident ' s behaviors. An interview was conducted with Nurse #4 on 1/6/16 at 3:00 PM. She stated she had located the behavior documentation record for Resident # 124 in the behavior book located on the 900 Hall. She stated she then documented the increased behaviors on 1/6/16. An interview was conducted with Nurse #3 on 1/7/16 at 2:00 PM. Nurse #3 stated the nursing staff was expected to document increased or new behaviors on the behavior documentation record or in the nurses ' notes.	F 329		
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	F 371		1/27/16

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(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 371	Continued From page 23 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard outdated food in the refrigerator, to date and label food in the refrigerator, to clean the ice maker machine and to date the mighty shakes (dietary supplement) when thawed. Findings included: The facility's policy on food storage and date marking dated 4/11 was reviewed. The policy indicated " any ready to eat and potentially hazardous food prepared and held in refrigerator for over 24 hours shall be date marked to ensure food safety. Food maintained at a temperature of 41 degrees Fahrenheit (F) or less shall be marked to be used within 7 calendar days. Leftovers shall be used within 3 days and marked accordingly. " The manufacturer's instruction written on the box of mighty shakes read " use thawed product within 14 days. " 1. On 1/4/16 at 10:30 AM, initial tour of the kitchen was conducted with dietary staff #1. The following were observed inside refrigerator #1: 1 bag with slices of bologna dated 12/1/15 1 container of Pimiento cheese with used by date	F 371	Corrective Action The ice machine was cleaned, outdated food was discarded, the mighty shakes were discarded and new ones dated when thawed, the ice bucket and scoop were sanitized by the dietary department and put back into use. Corrective action for those who have the potential to be affected: At the time of survey, the assistant dietary manager reviewed the other ice chest for proper scoop storage, the ice maker in the kitchen was checked for cleanliness, all thawed mighty shakes were checked for dates, and all other food in the refrigerator was checked for expiration dates. No other issues were found Systemic changes The cooks have been inserviced by the Dietary Manager on January 11th, 2016, regarding proper labeling and storage of food and dating of mighty shakes when pulled from freezer. The Maintenance Director has been educated on January	

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	345421	A. BUILDING _____ B. WING _____	C 01/07/2016

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F 371	Continued From page 24 12/29/15 1 container of chicken salad dated 12/31/15 1 container of cottage cheese with used by date 12/19/15 2 bags of hard boiled eggs undated. On 1/4/16 at 10:45 AM, the following were observed inside refrigerator #2: 1 bowl of chicken salad undated/unlabeled 12 cartoons of thawed mighty shakes undated On 1/4/16 at 10:45 AM, dietary staff #1 was interviewed. She stated that it was the responsibility of the dietary staff to label and date food and to check the refrigerator for outdated food. She revealed that the leftover food were good for 3 days. She also stated that the bologna, pimiento cheese, chicken salad and cottage cheese were outdated and should have been discarded. Dietary staff #1 was observed to discard these products. She indicated that she did not know how long the hard boiled eggs were good but it should have been dated. On 1/7/16 at 10:05 AM, administrative staff #4 was interviewed. She stated that the dietary manager was responsible for checking the refrigerator/freezer for outdated food and to make sure food were dated and labeled. She added that the mighty shakes should have been dated when pulled from the freezer. Administrative staff #4 revealed that she made the chicken salad and the pimiento cheese and they should be good for 3 days. She added that they used hard boiled eggs a lot everyday but it should have been dated when placed in the refrigerator. 2. On 1/6/16 at 11:15 AM, the nourishment room	F 371	11th by the administrator to review in more detail the ice machine when performing cleaning procedures. The Assistant Dietary Manager has been re-educated on January 11th, by the administrator for reviewing the refrigerators daily for proper dating and storage of food items, thawing and dating of mighty shakes, and for reviewing the ice machine on a weekly basis. The nursing staff has been inserviced by the DON regarding proper storage of the ice scoop. Monitoring The Assistant Dietary Manager will review each refrigerator on an daily basis, in both the kitchen and the nourishment rooms for compliance. The dietary manager will review/audit the refrigerators in the nourishment rooms and kitchen, reviewing for dates, labels, cleanliness and improper stored scoops, daily for 4 weeks and then twice weekly thereafter. Results of the audits will be reported to the monthly QAPI meeting, with the Dietary Manager responsible to carry out any further recommendations from the committee with additional training or education as necessary.	

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F 371	Continued From page 25 on station 2 was observed. Inside the ice maker machine, there were brown/black matter observed. The machine had ice and ice scoop in it. On 1/6/16 at 11:16 AM, Nurse #3 was interviewed. She stated that it was the responsibility of the nursing staff to defrost the ice maker machine. She stated that the machine was defrosted 2 weeks ago. Nurse #3 was not sure who was responsible for cleaning the machine. At 11:54 AM, Nurse #3 indicated that the maintenance director was responsible for cleaning the ice maker machine. On 1/7/16 at 11:50 AM, administrative staff #5 was interviewed. He stated that he was responsible for cleaning the ice maker machine and he cleaned it monthly. He indicated that he did not keep a record as to when he cleaned it. He added that he might have missed to clean the ice maker machine thoroughly. 3. On 1/6/16 at 11:25 AM, the nourishment room on station 1 was observed. Inside the cooler, an ice scoop was observed lying on top of the ice. On 1/6/17 at 11:50 AM, Nurse # 2 was interviewed. She stated that the ice scoop should be kept in the holder and not inside the cooler.	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness	F 406		1/27/16

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F 406	Continued From page 26 and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide specialized services as required by the Preadmission Screening Resident Review (PASRR) Level II for 1 of 3 residents (Resident #17) reviewed for PASRR Level II. The findings included: Resident #17 was admitted to the facility on 10/27/15 with diagnoses that included dementia, depression, bipolar disorder, and schizophrenia. The admission Minimum Data Set (MDS) dated 10/31/15 indicated she had severe cognitive impairment. The physician's orders were reviewed for Resident #17. On 10/29/15 there was a physician's order for a psychiatric consultation. Record review indicated that Resident #17 received a PASRR Level II determination notification on 11/02/15. The Level II had no expiration date. The determination notification read, in part: Specialized Service Determination: Follow Up Psychiatric Services Record review revealed no documentation that Resident #17 received psychiatric services as ordered and as required by the PASRR Level II. An interview was conducted on 1/6/16 at 1:37 PM with the Social Worker (SW). She stated that she was responsible for coordinating psychiatric services. The SW reviewed the medical record	F 406	Corrective Action The specialized services, psych consult, for resident number 17 has been completed on January 12th. Corrective action for those who have the potential to be affected: At the time of survey, the Director of Nurses (DON) reviewed all residents with a level 2 PASRR to determine if necessary services were being provided. No other issue was found. Systemic changes All orders necessary to provide services for level 2 PASRRs will be obtained by the social worker and carried out as ordered. The Social Worker and all licensed staff have been re-educated by the DON between January 8th and 16th, 2016, in the procedure of obtaining and carrying out consult orders. Monitoring The DON will review all residents with a	

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F 406	Continued From page 27 for Resident #17. She revealed that Resident #17 did not receive psychiatric services as ordered and as required by the PASRR Level II. The SW reviewed the normal procedure for coordinating a psychiatric consultation and/or routine psychiatric visit. She stated that she or a nurse wrote the resident ' s name in a binder that was kept at the nurses' station. The psychiatric provider looked at the binder when they came into the facility and provided services to the residents that were listed. The SW revealed that Resident #17 was not listed in the binder. She stated that this step was missed for Resident #17. She stated that she usually followed up on residents to verify that they received psychiatric services. She stated that she did not follow up on Resident #17.	F 406	level 2 PASRR on a weekly basis for 4 weeks and then on a monthly basis for two months to determine if all necessary services have been carried out. Results of the audits will be reviewed in the monthly QAPI meeting. The DON will be responsible to act upon any further recommendations from the committee with additional training or education as indicated.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on resident interview, record review, and staff interview, the facility failed to schedule follow up treatment for dental services as recommended for 1 of 1 residents (Resident #27) reviewed for dental services. The findings	F 412	Corrective action Resident # 27 has had the dental appointment scheduled on January 8th and carried out on January 20th.	1/27/16

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F 412	Continued From page 28 included: Resident #27 was admitted to the facility on 1/16/15 with diagnoses that included multiple sclerosis and morbid obesity. The annual Minimum Data Set (MDS), dated 12/21/15 indicated her cognition was intact. The payor source for Resident #27 was indicated as Medicaid. An interview was conducted with Resident #27 on 1/4/16 at 4:30 PM. She revealed that she had mild pain in two of her top teeth. She stated that she saw a dentist several months ago for a routine exam. She stated that the dentist referred her to a different dental clinic. She stated that she had not attended an appointment for the referral. She stated that she asked a facility staff member about the appointment in November (2015), but she had not heard back. She stated she could not recall who she asked. Record review was conducted on 1/6/16 for Resident #27's electronic medical record and hard copy medical record from the 1/16/15 admission date through 1/6/16. The medical record revealed no documentation of Resident #27 having had a dental exam or of a referral for an additional dental exam. An interview with the Director of Nursing (DON) was conducted on 1/6/16 at 11:20 AM. The DON reviewed the record and was unable to locate records for Resident #27's dental care. She stated that she remembered that Resident #27 had a dental appointment and she also believed there was an upcoming appointment scheduled. The DON stated that they do not put all of the dental records in the chart. She stated that she needed to check with the business office and medical records to see if they had the information. A second interview with the DON was conducted	F 412	Corrective action for those who have the potential to be affected: At the time of survey, the Director of Nurses (DON) and/or her designee reviewed all active medical records going back 6 months to determine if any other dental consult orders were not carried out. No other orders were found to not be carried out. Systemic changes All licensed staff, which included the PRN and weekend staff has been inserviced between January 8th and 16th, 2016 by the DON, regarding the process of carrying out consultation orders. The DON and/or ADON will review all consultation orders in the morning clinical ops meeting to determine if the order has been carried out. Monitoring The DON and/or ADON will review all consultation orders that are written in the facility, and will review each resident that returns from an outside appointment on a weekly basis for 4 weeks and then on a monthly basis for two months to determine if all orders have been carried out. Results of the audits will be reviewed in the monthly QAPI meeting. The DON will be responsible to act upon any further recommendations from committee with additional training or education as indicated.	

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F 412	Continued From page 29	F 412		

on 1/6/16 at 11:40 AM. The DON stated that Resident #27 had a limited dental exam on 6/11/15. She revealed that this dentist was unable to complete a full exam due to accessibility issues with the size of the dentist ' s office and the space required for Resident #27's wheelchair. She indicated that a dental referral was completed for a comprehensive dental exam at a different dental clinic. She explained that Resident #27 did not turn her dental paperwork into facility staff when she returned to the facility. She clarified that facility staff were unaware of the referral to a different dental clinic. The DON stated that in November (2015), the facility's Nurse Practitioner realized the information from Resident #27's 6/11/15 dental exam had not been reviewed. The DON stated that the dentist that performed the 6/11/15 exam was then contacted by phone and asked to fax Resident #27's records to the facility. The DON revealed a dental referral form that indicated the referral was written on 6/11/15 for Resident #27. The referral had a fax receipt date of 12/14/15. She stated that after the facility received this fax a dental appointment was scheduled for Resident #27 for 3/1/16. She indicated that this was earliest date available at that clinic.

The process for retrieval of residents' paperwork from out of facility appointments was reviewed with the DON. She stated that residents that were their own responsible party turned their paperwork into the nurse or the unit manager when they returned from an appointment. If a follow up appointment needed to be scheduled for the resident, the facility scheduled the appointment. She stated that if a resident had not turned in their own paperwork that the nurse on duty should have requested it. She acknowledged that Resident #27's dental referral

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F 412	Continued From page 30 was missed. She stated that the nurse on duty should have asked Resident #27 for the dental paperwork when she returned to the facility on 6/11/15. A follow up interview with the DON was conducted at 12:00 PM on 1/6/16. She stated that she contacted the dental clinic and rescheduled Resident #27's appointment to an earlier date. The appointment was changed to 1/20/16 from 3/1/16.	F 412		
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 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	F 431		1/27/16

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F 431	Continued From page 31 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 review of manufacturer's instruction, observation and staff interview, the facility failed to date Prostat (protein supplement) and Budesonide (use to treat asthma) when opened in 1 (400 hall) of 7 medication carts. Findings included: 1. On 1/7/16 at 12:10 PM, the medication cart on 400 hall was observed. A used bottle of Prostat, less than half full, was observed with no date of opening. The instruction on the bottle of Prostat read " discard 3 months after opening. " On 1/7/15 at 12:20 PM Nurse # 6 was interviewed. She looked at the used bottle of Prostat and was unable to find the date of opening. She stated that the nurse who first opened the bottle should have dated it. On 1/7/16 at 2:35 PM, administrative staff #1 was interviewed. She stated that she expected the nurses to date the Prostat when first opened. 2. On 1/7/17 at 12:10 PM, the medication cart on 400 hall was observed. There was one opened aluminum foil envelope with ampoules of Budesonide with no date of opening. The instruction on the aluminum foil envelop read " discard if not used within 2 weeks of opening. "	F 431	Corrective action The medication and supplement that were found to not be dated were discarded and replaced. Corrective action for those who have the potential to be affected: All medication carts were again reviewed by the DON, and/or ADON at the time of survey. No other issues were found. Systemic changes All licensed staff, including weekend and PRN staff, has been re-educated by the DON between January 8th and 16th, 2016 regarding the proper dating of all medications and supplements when opened. New licensed staff will be educated during orientation regarding the dating of items. Monitoring The nurse assigned to the med cart will	

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F 431	Continued From page 32 On 1/7/16 at 12:20 PM, Nurse # 6 was interviewed. She stated that Budesonide was good until expiration date and didn't need to be dated. On 1/7/16 at 2:35 PM, administrative staff #1 was interviewed. She stated that she expected the nurses to date the Budesonide when opened.	F 431	be responsible to review the med cart each time the nurse receives the cart at shift change. The unit manager will review each med cart for undated or outdated items at least three times per week and document findings. The DON and/or the Assistant DON will randomly review each med cart weekly for 4 weeks and then each cart every other week for 4 weeks. Thereafter, the DON and/or the ADON will continue to spot check medication carts randomly on a monthly basis. All audits will be documented utilizing an audit tool. Results of the audits by the DON/ADON will be reviewed in the monthly QAPI meeting for any further recommendations, with the DON responsible to act upon any further recommendation from committee with additional training or education as indicated.	
F 520 SS=E	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 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		1/27/16

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F 520	Continued From page 33 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, observations, staff interviews, and review of manufacturer's instructions, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 03/05/15 recertification survey. This was for two recited deficiencies in the areas of food procurement/storage (F371) and medication storage (F431). These deficiencies were cited again on the current recertification survey of 01/07/16. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F371 - Food Procurement/Storage: Based on record review, observation, and staff interview, the facility failed to discard outdated food in the refrigerator, to date and label food in the refrigerator, to clean the ice maker machine, and to date mighty shakes (dietary supplement) when thawed. During the recertification survey of 03/05/15 the facility was cited F371 for failing to provide a	F 520	The facility will continue to ensure that 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. Corrective Action At the time of survey, out/un-dated food items were discarded, the ice machine was cleaned, mighty shakes discarded. In addition, the Prostat and Budesonide were discarded. Corrective action for those who have the potential to be affected: At the time of survey, all storage areas for medications and food were reviewed for compliance. No other issues were found. Systemic Changes	

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F 520	Continued From page 34 barrier between bare hands and ready to eat food. On the current recertification survey of 01/07/16, the facility failed to discard outdated food in the refrigerator, date and label food in the refrigerator, clean the ice maker machine, and to date thawed dietary supplements. 2. F431 - Medication Storage: Based on review of manufacturer's instructions, observation, and staff interview, the facility failed to date Prostat (protein supplement) and Budesonide (used to treat asthma) when opened in 1 (400 hall) of 7 medication carts. During the recertification survey of 03/05/15 the facility was cited F431 for failing to dispose of expired insulin medication. On the current recertification survey of 01/07/16, the facility failed to date Prostat and Budesonide when opened. On 01/07/16 at 3:05 PM an interview with the Administrator was conducted. He stated that he was the head of the facility's QAA Committee. He stated the QAA Committee consisted of the Medical Director, Director of Nursing, Social Worker, Pharmacist, Dietary Manager, Housekeeping Director, and Activity Director. The committee had met monthly without the pharmacist and quarterly with all participants. The Administrator indicated he was aware that food procurement/storage was a repeat deficiency from the previous recertification survey. He stated he was not working at the facility during the previous recertification survey and was unaware of the specific action plan that was put into place. He stated he believed the deficiency was the result of multiple staffing changes in the dietary department. The Administrator also indicated he was aware that medication storage was a repeat deficiency from the previous recertification survey. He	F 520	The monthly Quality Assurance Meeting was held January 20th. In attendance was the Medical Director, the Administrator, DON, and the following department directors: Dietary, Maintenance, Housekeeping, Social Services, Activities, unit managers for both nurses stations, and Marketing. A root cause analysis was completed by the QA team to determine the best course of action. As both areas from the previous survey had time-limited monitoring, it was decided after performing a root cause analysis, that both areas require ongoing, not time limited monitoring, as well as education for staff. Monitoring The Assistant Dietary Manager will review each refrigerator on an daily basis, in both the kitchen and the nourishment rooms for compliance. The dietary manager will review/audit the refrigerators in the nourishment rooms and kitchen, reviewing for dates, labels, cleanliness and improper stored scoops, daily for 4 weeks and then twice weekly thereafter. Results of the audits will be reported to the monthly QAPI meeting, with the Dietary Manager responsible to carry out any further recommendations from the committee with additional training or education as necessary. The nurse assigned to the med cart will be responsible to review the med cart	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING _____ B. WING _____	C 01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 35 stated he was not working at the facility during the previous recertification survey and was unaware of the specific action plan that was put into place. He stated he had implemented medication cart audits that were completed by himself, the pharmacist and the facility consultant.	F 520	each time the nurse receives the cart at shift change. The unit manager will review each med cart for undated or outdated items at least three times per week and document findings. The DON and/or the Assistant DON will randomly review each med cart weekly for 4 weeks and then each cart every other week for 4 weeks. Thereafter, the DON and/or the ADON will continue to spot check medication carts randomly on a monthly basis. All audits will be documented utilizing an audit tool. Results of the audits by the DON/ADON will be reviewed in the monthly QAPI meeting for any further recommendations, with the DON responsible to act upon any further education and/or training as indicate. The Regional QA Manager/Regional Manager will attend the facility's quality assurance meeting monthly for two months to ensure the committee is developing and implementing appropriate plans of action to correct quality concerns. Variances well be corrected and/or additional education provided when indicated. The Administrator will be responsible to act upon any further recommendation that may come out of the facility QA committee.	