STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	R-C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

(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 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff and family interviews the facility failed to keep carpeted and tiled floor clean for 5 of 6 halls and failed to address a foul smell on 1 of 6 halls. The findings included: 1. On 06/22/16 at 8:20 AM a tour was made of the facility that revealed the 100 and 200 halls were carpeted. The carpet was noted to have black splattered stains throughout the length of the hallway. One stained area on the 200 hall was noted to cover an area approximately 18 inches by 12 inches. During the tour the 300 hall's tiled floor was dingy in appearance and had debris, scuff marks and dried spills scattered along the length of the hallway. The 400 and 500 halls were toured on 06/22/16 at 8:30 AM and the tiled flooring was noted to dingy in appearance with dried stains and debris. On 06/22/16 at 9:05 AM the housekeeping supervisor was interviewed and reported housekeeping staff started at 7 AM but were not able to start cleaning hallways until later in the morning. She explained that the carpeted area on the 100 and 200 halls was vacuumed only. She added that her company's manager had visited the facility last week sometime and identified that the carpeted areas were stained and the carpet needed to be deep cleaned. The housekeeping supervisor stated she had not	F 253	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F253 HOUSEKEEPING & MAINTENANCE SERVICES Corrective Action: Carpets were cleaned, hallway floors were stripped and waxed, and 400 hall was deep cleaned to address the foul smell. Contract was terminated with contracted housekeeping company. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All hallway floors were observed to need attention. Systemic Changes: Nursing Home Administrator called upon the owner of the Environmental Services Company, Stanton Environmental, on	7/6/16

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

Electronically Signed

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F 253	Continued From page 1 scheduled a time to have that done. On 06/22/16 at 9:30 AM a second tour was conducted with the Administrator present. The Administrator reported that she had identified concerns with the facility's cleanliness and was trying to work with the housekeeping department to make the facility cleaner. The Administrator explained that the housekeeping department was a contracted service. The Administrator observed the stained carpet and stated the carpet needed to be deep cleaned. The Administrator also observed the tiled hallways on 300, 400 and 500 halls stating they appeared that they had not been mopped the day prior based on their condition and appearance. During the observations, the Administrator noted a black, dried sticky spill on the 500 hall that covered an area approximately 24 inches by 36 inches. Footprint and wheelchair tracks were noted to have spread the stain along the 500 hall. During this observation, the Administrator stated she would expect nursing to assist with cleaning simple spills and alert housekeeping. She stated she expected her facility to be cleaner. On 06/22/16 at 1:18 PM a family member was visiting and interviewed. She stated she visited daily and her only concern about the facility was the cleanliness. The family member described the floors as "horrendous" and pointed to the tiled floor outside her mother's room stating, "It doesn't look like they ever mopped. And it's always like this." The floor was noted to have dried debris and spills splattered on the floor. On 06/22/16 at 3:30 PM the housekeeping staff started mopping the 400 Hall and were able to remove the dried spills and stains. 2. On 06/22/16 at 8:33 AM the end of the 400 Hall was observed and noted to have a strong foul smell.	F 253	June 22, 2016 to inform him of how poor the floors looked and that the surveyors had addressed their concerns with the Administrator. Owner came into the facility on June 22, 2016 and in serviced housekeeping staff on policies and procedures. On June 23, 2016 all carpets were cleaned on the 100 and 200 halls. On June 29, 2016 the carpets were cleaned for the second time on 100 and 200 halls. Stanton Environmental also started the stripping and waxing of the floors. The 400 hall was completed on June 27, 2016. The 500 hall was completed on July 1, 2016. The 600 hall was completed on July 5, 2016. And the 300 hall was completed on July 6, 2016. There are schedules in place to make sure the hallways remain clean and the carpets continue to get cleaned. The 400 hall was also deep cleaned to address the foul smell. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by observing the hallway floors to insure cleanliness. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program	

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F 253	Continued From page 2 On 06/22/16 at 9:15 AM a family member was interviewed on the telephone and described the facility as "filthy" and "reeked of urine." The family member stated she dreaded visiting because the smell at the end of the 400 Hall and described the odor as being a combination of urine and mold. She stated she had complained to the nurses about the facility's cleanliness. On 06/22/16 at 9:30 AM a second tour was conducted with the Administrator present. The Administrator reported that she had identified concerns with the facility's cleanliness and was trying to work with the housekeeping department to make the facility cleaner. The Administrator toured the 400 hall and noted that the end of the hall had a foul odor. She stated she expected her facility to be cleaner. On 06/22/16 at 11:23 AM the end of the 400 hall was observed again and noted to still have a foul smell. On 06/22/16 at 1:13 PM the end of the 400 hall was observed and noted that air freshener had been sprayed to mask the foul odor but the odor was still detected. On 06/23/16 at 9:52 AM the end of the 400 hall was observed and noted to have clean floors and the odor was not noticeable. The housekeeping aide was interviewed and reported that the odor at the end of the hall "was bad." She explained she had to "really mop hard" to try to get rid of the smell in the resident's rooms.	F 253	reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 7/6/2016	
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		7/6/16

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F 282	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow a care plan that specified the resident was to have hand rolls for her hand contractures for 1 of 1 sampled resident (Resident #36). The findings included: Resident #36 was admitted to the facility on 04/20/15 with diagnoses that included contracture of hands, Alzheimer's disease and others. The most recent Minimum Data Set (MDS) dated 03/14/16 specified the resident's cognition was intact, she had no behaviors, did not reject care but required extensive 2 person assistance with bed mobility, personal hygiene, eating and had impaired range of motion on both sides of her upper and lower extremities. A care plan revised on 05/16/16 specified Resident #36 was to have hand rolls (wash cloths) placed in both hands. On 06/22/16 at 11:00 AM observations were made of Resident #36's hands. Nurse Aide (NA) #1 was present for the observations and uncurled Resident #36's contracted fingers that revealed indentions in the Resident's palm from her fingernails. The NA was interviewed and explained that she was routinely assigned to care for Resident #36 but not today. There were no hand rolls placed in the Resident's hands and there were no cloths laying in the bed to suggest they had fallen out. On 06/22/16 at 11:10 AM an attempt to interview Resident #36 was made but she was unable to answer questions. On 06/22/16 at 11:37 AM NA #1 was interviewed again and reported that she had gotten confused	F 282	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Corrective Action: Hand rolls were placed in resident #36 hands. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All Care Plans were reviewed by MDS Coordinator on July 6, 2016 to insure all contracture managing devices were care planned and implemented. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) that they must review Care Plans of their residents on their assignment to insure they know what items they need in place for contractures. This in service was completed by 6/22/2016. Any nursing staff member	

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F 282	Continued From page 4 and was assigned to Resident #36 today but had not provided care since starting her shift at 7 AM. The NA stated she was unaware Resident #36 was to have hand rolls or cloths in her hands. On 06/23/16 at 8:38 AM the MDS Coordinator was interviewed and stated nurse aides were expected to follow care plans.	F 282	(RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance the MDS Nurse, DON or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by observing 5 residents to insure any newly ordered device for contracture management is being implemented. This will be done on weekly basis M-F for 4 weeks then monthly for 3 months by the MDS Nurse, DON or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 7/6/2016	
{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	{F 312}		7/6/16

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{F 312}	Continued From page 5 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to trim a dependent resident's nails for 1 of 3 sampled residents (Resident #36). The findings included: Resident #36 was admitted to the facility on 04/20/15 with diagnoses that included contracture of hands, Alzheimer's disease and others. The most recent Minimum Data Set (MDS) dated 03/14/16 specified the resident's cognition was intact, she had no behaviors, did not reject care but required extensive 2 person assistance with bed mobility, personal hygiene, eating and had impaired range of motion on both sides of her upper and lower extremities. A care plan revised on 05/16/16 specified Resident #36 had an activity of daily living (ADL) deficit related to impaired cognition and staff were to check nail length and trim as necessary. On 06/22/16 at 11:00 AM observations were made of Resident #36's hands. Nurse Aide (NA) #1 was present for the observations and uncurled Resident #36's contracted fingers on the left and right hand revealing 1/8 inch to ¼ inch long nails. The NA was interviewed and explained that she was routinely assigned to care for Resident #36 but not today. The NA stated the resident's nails were long and should be trimmed on shower days and as needed. On 06/22/16 at 11:10 AM an attempt to interview	{F 312}	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Corrective Action: Resident #36, were trimmed. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All resident's nails (fingers and toes) were assessed on July 5, 2016 by DON, Unit Manager, and Wound Nurse for cleanliness to provide comfort, to meet their physical and mental needs, to prevent spread of infection, to provide cleanliness and to prevent skin problems. All long and dirty finger nails were trimmed and cleaned. Systemic Changes:	

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{F 312}	Continued From page 6 Resident #36 was made but she was unable to answer questions. On 06/22/16 at 11:37 AM NA #1 was interviewed again and reported that she had gotten confused and was assigned to Resident #36 today but had not provided care since starting her shift at 7 AM. On 06/22/16 at 11:40 AM Nurse #1 was interviewed and reported that she had cleaned Resident #36's nails that morning around 9:30 AM but did not trim the nails because they didn't seem long to her. On 06/23/16 at 10:32 AM the Director of Nursing (DON) was interviewed and explained that fingernail length was resident specific. The DON stated if Resident #36's nails were not trimmed short, the length could break the skin due to the severity of her hand contractures. The DON was unable to observe Resident #36's nail length.	{F 312}	Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) that a resident who is unable to carry out activities of daily living must receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Nail care of fingers and toes has to be provided to residents to provide comfort, to meet their physical and mental needs, to prevent spread of infection, to provide cleanliness and to prevent skin problems. This in service was completed by 7/1//2016. Any nursing staff member (RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by observing all residents requiring assistance with ADLs. This will be done on weekly M-F basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of	

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{F 312}	Continued From page 7	{F 312}	Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 7/6/2016	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a 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 observations, staff interviews and record review the facility failed to implement hand rolls to prevent a pressure ulcer for a resident with a history of a pressure ulcer on her finger for 1 of 1 sampled resident (Resident #36). The findings included: Resident #36 was admitted to the facility on 04/20/15 with diagnoses that included contracture of hands, Alzheimer's disease and others. The most recent Minimum Data Set (MDS) dated 03/14/16 specified the resident's cognition was intact, she had no behaviors, did not reject care	F 314	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	7/6/16

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F 314	Continued From page 8 but required extensive 2 person assistance with bed mobility, personal hygiene, eating and had impaired range of motion on both sides of her upper and lower extremities and she had no pressure ulcers or skin breakdown. On 04/27/16 a physician's order was written to place wash cloths in bilateral hands daily for wound care to a stage 3 pressure ulcer between the 3rd and 4th right fingers. On 05/02/16 the MDS Coordinator documented Resident #36 was receiving treatment to her right 4th finger and had contractures to fingers on both hands and hand rolls were placed in them. On 05/11/16 Resident #36's pressure ulcer to her finger resolved. A care plan revised on 05/16/16 specified Resident #36 was to have hand rolls (wash cloths) in place to both hands. On 06/22/16 at 11:00 AM observations were made of Resident #36's hands. Nurse Aide (NA) #1 was present for the observations and uncurled Resident #36's contracted fingers that revealed indentions in the Resident's palm from her fingernails. The NA was interviewed and explained that she was routinely assigned to care for Resident #36 but not today. There were no hand rolls placed in the Resident's hands and there were no cloths laying in the bed to suggest they had fallen out. On 06/22/16 at 11:10 AM an attempt to interview Resident #36 was made but she was unable to answer questions. On 06/22/16 at 11:37 AM NA #1 was interviewed again and reported that she had gotten confused and was assigned to Resident #36 today but had not provided care since starting her shift at 7 AM. The NA stated she was unaware Resident #36 was to have hand rolls or was cloths in her hands.	F 314	F314 Treatment /SVCS To Prevent/Heal Pressure Sores Corrective Action: Resident #36 pressure ulcer was healed on 5/11/2016. Hand rolls placed to hands as ordered. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All residents who have hand rolls ordered to meet their physical and mental needs and prevent/heal pressure areas were audited by DON on 7/5/2016. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, CNAs full time, part time, and PRN) that 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 infections and prevent new sores from developing on 6/22/2016. Any nursing staff member (RNs, LPNs, CNAs full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring:	

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F 314	Continued From page 9 On 06/22/16 at 11:40 AM Nurse #1 was interviewed and reported that she had cleaned Resident #36's nails that morning around 9:30 AM and Resident #36 did not have hand rolls placed in her hands. The Nurse also stated she did not put hand rolls in the Resident's hands after she finished cleaning her nails because she was not aware the resident had an order to keep hand rolls in place. On 06/23/16 at 9:57 AM the wound nurse was interviewed and stated that on 04/27/16 Resident #36 was noted to have a stage 3 pressure ulcer on her right 4th digit between the knuckles of the 3rd and 4th finger. The wound nurse stated she obtained orders for treatment and implemented the use of hand rolls to open the hands to assist with wound healing. She added the hand rolls were to be in place all day, every day to relieve the pressure to the fingers and absorb moisture. The wound nurse reported that the stage 3 pressure ulcer resolved but she would expect the hand rolls to remain in place.	F 314	To ensure compliance the Unit Manager, Wound Nurse, Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor 5 residents weekly for prevention/healing pressure sores. This will be done weekly M-F basis for 4 weeks then weekly for 3 months by the Unit Manager, Wound Nurse, DON or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 7/6/2016	
{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	{F 431}		7/6/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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{F 431}	Continued From page 10 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 observations and staff interviews the facility failed to secure a medication cart when left unattended for 1 of 1 observed medication carts and left medications unattended at the nurses' station at 1 of 2 nurses' stations. The findings included: 1. On 06/22/16 at 10:00 AM observations were made of the nurses' station located at the intersection of the 400, 500 and 600 Halls. On the desk were three bottles of medications. The medications were positioned at the corner of the desk less than an arm's reach from the hallway. There was no one attending the nurses' station during the observation. Residents were in the hallway next to the nurses' station during the	{F 431}	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS	

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{F 431}	Continued From page 11 observation. On 06/22/16 at 12:04 PM observations of the nurses' station at the intersection of 400, 500 and 600 Halls were made with the Director of Nursing (DON). The 3 bottles of medications were unattended at the nurses' station. The DON picked up the medication bottles that revealed: - 1 bottle of acetaminophen unopened - 1 bottle of acetaminophen empty - 1 bottle of acidophilus opened and contained pills The DON removed the bottles from the nurses' station. On 06/23/16 at 10:32 AM the DON was interviewed and stated the medications should not have been left unattended at the nurses' station. 2. On 06/22/16 at 11:39 AM observations were made of the 500 Hall medication cart. The cart was positioned halfway down the hall, unlocked and unattended. After approximately 5 minutes, Nurse #2 exited a resident's room and approached the medication cart. Nurse #2 was interviewed and stated her medication cart was unlocked, stating, she had left it unlocked "long enough to administer medications and apply cream to a resident's buttocks." Nurse #2 reported she was aware her medication cart was to be locked when left unattended. On 06/23/16 at 10:32 AM the Director of Nursing (DON) was interviewed and stated all nurses had been educated to lock medication carts when left unattended.	{F 431}	Corrective Action: Medication and Treatment carts where locked and secured while the nurse was not in attendance. Medication removed from nurses desk and stored in secured location. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Audits were done 7/1/ 2016 by DON and all medication and treatment carts were locked and secured when the nurse was not in attendance. All medications were stored and secured. All medication and treatment carts are locked at all times when not in immediate use by Nurse. All Medication and treatment carts and also any area that medication was securely stored were checked to ensure that there was, no expired, undated or not initialed meds. No medication was unsecured at nurses station. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, full time, part time, and PRN) that 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 also separately lock, and have permanently affixed compartments for storage of controlled drugs. 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	

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{F 431}	Continued From page 12	{F 431}	expiration date when applicable. This in service was completed by 7/1/2016. Any nursing staff member (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Unit Manager, DON or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by auditing each medication cart, and treatment cart and any other areas that medication is stored to ensure that they are secured properly at all times. Facility will also observe all medication and treatment carts for expired, undated and not initialed, by the nurse. This will be done on daily M-F basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary	

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{F 431}	Continued From page 13	{F 431}	Manager, Wound Nurse. Date of Compliance: 7/6/2016	
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 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 observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in May	F 520	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State	7/6/16

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F 520	Continued From page 14 2016. This was for two recited deficiencies that were originally cited in May 2016 and subsequently cited in June 2016 on the current follow up survey. The repeated deficiencies were in the areas of quality of care and pharmacy services. 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 Assurance Program. The tags were cross referred to: 1 a. F 312: Provide Assistance with Activities of Daily Living: Based on record review, observations, staff interviews and record review the facility failed to trim a dependent resident's nails for 1 of 3 sampled residents (Resident #36). The facility was recited for failing to provide nail care for a resident. F 312 was previously cited during the May 2016 recertification survey for failing to provide nail care for 4 of 4 sampled residents. b. F 431: Labeling and Storage of Pharmaceuticals: Based on observations and staff interviews the facility failed to secure a medication cart when left unattended for 1 of 1 medication carts observed and left medications unattended at 1 of 2 nurses' station. The facility was recited on the current survey for failing to secure a medication cart that was unattended and leaving medications unattended at the nurses' station. F 431was previously cited during the May 2016 recertification survey for failing to secure a medication cart when unattended and failing to discard expired insulin. On 06/23/16 at 10:49 AM the Administrator was	F 520	Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Corrective Action: Quality Committee consisting of the Administrator, Director of nursing, Unit Manager, Staff Development coordinator, MDS coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse and Medical Director reviewed implemented procedures and monitored interventions the committee put in place on July 5, 2016 on areas of quality of care and pharmacy services. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Quality Committee consisting of the Administrator, Director of nursing, Unit Manager, Staff Development coordinator, MDS coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse and Medical Director reviewed implemented procedures and monitored interventions the committee put in place on July 5, 2016 on areas of quality of care and pharmacy services All resident's nails (fingers and toes) were assessed on July 5, 2016 by Director of nursing, unit manager and wound nurse for cleanliness to provide comfort, to meet their physical	

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F 520	Continued From page 15 interviewed and explained that following the facility's recertification survey that ended on 05/02/16 the Quality Assurance (QA) Committee had implemented new systems to correct and prevent repeat deficient practice in the areas of F 312 and F 431. The Administrator added that the facility had not been able to hold a formal QA meeting but had worked to in-service and audit the new systems. The Administrator stated that through the audits she felt the facility was in compliance.	F 520	and mental needs, to prevent spread of infection, to provide cleanliness and to prevent skin problems. All long and dirty finger nails were trimmed and cleaned. Audits were done 7/1/ 2016 by Director of nursing and all medication and treatment carts were locked and secured when the nurse was not in attendance. All medications were stored and secured. All medication and treatment carts are locked at all times when not in immediate use by Nurse. All Medication and treatment carts and also any area that medication was securely stored were checked to ensure that there was, no expired, undated or not initialed, open insulin by the nurse. Systemic Changes: The Administrator in serviced the Quality Committee on July 5, 2016 consisting of the, Director of nursing, Unit Manager, Staff Development coordinator, MDS coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse and Medical Director that the 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 3other 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 actions to correct identified quality deficiencies. The Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, Medication Aides, CNAs full time, part	

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F 520	Continued From page 16	F 520	time, and PRN) that a resident who is unable to carry out activities of daily living must receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Nail care of fingers and toes has to be provided to residents to provide comfort, to meet their physical and mental needs, to prevent spread of infection, to provide cleanliness and to prevent skin problems. This in service was completed by 7/1//2016. Director of Nursing and /or Designee also in serviced all nursing staff (RNs, LPNs, full time, part time, and PRN) that 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 also separately lock, and have permanently affixed compartments for storage of controlled drugs. 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. This in service was completed by 7/1/2016. Any nursing staff member (RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 520	Continued From page 17	F 520	Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by auditing the QA Survey tools for F253, QA Survey Tool for F282, QA Survey Tool for F312, QA Survey Tool for F314, and QA Survey Tool for F431 at the weekly QOL meeting. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Quality Committee consisting of the Administrator, Director of nursing, Unit Manager, Staff Development coordinator, MDS coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse and Medical Director will meet quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of actions to correct identified quality deficiencies. Date of Compliance: 7/6/2016	