| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345420 | A. BUILDING _____ B. WING _____ | C 08/11/2016 |

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| ALAMANCE HEALTH CARE CENTER | 1987 HILTON STREET BURLINGTON, NC 27217 |

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| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the psychotropic medications received for 1 of 5 residents (Resident #228) reviewed for unnecessary medications. | F 278 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain | 9/3/16 |

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

Electronically Signed | 09/02/2016

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| F 278 | Continued From page 1<br><br>The findings included:<br><br>Resident #228 was admitted to the facility on 12/18/15 from a hospital. His cumulative diagnoses included anxiety, depression, and psychotic disorder.<br><br>A review of Resident #228 ' s medical record revealed his 12/18/15 admission medication orders included, in part: 100 milligrams (mg) quetiapine (an antipsychotic medication) to be given as one tablet by mouth once daily. A review of Resident #228 ' s Order Summary for December 2015 revealed no orders were received for an antianxiety medication.<br><br>A review of Resident #228 ' s admission Minimum Data Set (MDS) assessment dated 12/24/15 was completed. Section N of the MDS assessment indicated the resident received both an antipsychotic and an antianxiety medication on 7 out of 7 days during the look back period.<br><br>Further review of Resident #228 ' s medical record revealed a Care Area Assessment (CAA) Worksheet for Psychotropic Drug Use was completed on 12/28/15. The CAA indicated Resident #228 was taking both an antipsychotic and antianxiety medication.<br><br>An interview was conducted with MDS Nurse #1 on 8/11/16 at 2:50 PM. During the interview, the inclusion of an antianxiety medication on Resident #228 ' s MDS assessment (Section N) dated 12/24/15 and the CAA Worksheet was discussed. Upon review of Resident #228 ' s records, the MDS nurse reported she was unable to find information to indicate the resident actually | F 278 | in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice<br>On August 30, 2016, the MDSC modified residents□ #228 12/24/15 Admission MDS to remove anti-anxiety medication in section N, as the resident did not receive this medication class.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All medical records for current residents receiving an anti-psychotropic medication will be audited by September 3, 2016 to ensure that their anti-psychotropic medication was coded correctly on their most recent MDS. The MDSs were modified by the MDSC for any coding errors identified in the audit, and completed by September 3, 2016.<br><br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>On 8/29/16, the MDSC Consultant provided education to the MDSC that any anti-psychotropic medication that a | |

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| F 278 | Continued From page 2<br>received an antianxiety medication during the MDS 7-day look back period.<br><br>An interview was conducted with the facility ' s Director of Nursing (DON) on 8/11/16 at 3:58 PM. During the interview, the inclusion of an antianxiety medication in Section N of Resident #228 ' s MDS assessment was discussed. Upon inquiry, the DON stated, "No, he didn't get any (antianxiety medication). It was a mistake." | F 278 | resident receives during the 7 day look back period of the ARD of the MDS must be accurately coded in section N of the MDS.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>The MDS Consultant will audit 5 current residents□ MDS who are receiving anti-psychotropic medication to ensure the medication was correctly coded on their MDS for the schedule listed below. This will be done 1 week for 4 weeks, twice a month for 1 month, and monthly for 4 month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. The issue will be presented to completion or revision as needed within the QA program. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and | F 279 | | 9/3/16 |

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| F 279 | Continued From page 3<br>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop a care plan to address the use of psychotropic medications for 1 of 5 residents (Resident #228) reviewed for unnecessary medications.<br><br>The findings included:<br><br>Resident #228 was admitted to the facility on 12/18/15 from a hospital. His cumulative diagnoses included anxiety, depression, and psychotic disorder.<br><br>A review of Resident #228 ' s medical record revealed his 12/18/15 admission medication orders included, in part: 100 milligrams (mg) quetiapine (an antipsychotic medication) to be given as one tablet by mouth once daily.<br><br>A review of Resident #228 ' s admission Minimum Data Set (MDS) assessment dated 12/24/15 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He required extensive assistance for his Activities of Daily Living (ADLs). Section N of the MDS assessment indicated, in part, that the resident received an antipsychotic medication on 7 out of 7 days during the look back period. | F 279 | How corrective action will be accomplished for each resident found to have been affected by the deficient practice<br>On August 10, 2016, the MDSC updated residents #228 care plan for the use of antipsychotic medication.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All medical records for current residents receiving an anti-psychotropic medication will be audited September 3, 2016 to ensure that their anti-psychotropic medication was coded correctly on their most recent comprehensive MDS and care planned as indicated in the CAA. The MDSs were modified by the MDSC for any coding errors identified in the audit, and completed by September 3, 2016.<br><br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>On 8/29/16, the MDSC Consultant provided education to the MDSC that any | |

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| F 279 | Continued From page 4<br><br>A review of Resident #228 ' s medical record revealed a Care Area Assessment (CAA) Worksheet for Psychotropic Drug Use was completed on 12/28/15. The analysis of findings included in the CAA Worksheet described the nature of the problem/condition as follows: "Resident has a Dx (diagnosis) of Mood Disorder, Depressive Psychosis ...Resident is on antipsychotics meds..." Further review of the CAA Worksheet revealed Psychotropic Drug Use would be addressed in Resident #228 ' s care plan. The overall objective for care planning this problem was noted as: " Avoid complications. "<br><br>A review of Resident #228 ' s care plan (initiated 12/21/16) revealed the topic of Psychotropic Drug Use was not addressed as a focus area.<br><br>On 1/11/16, a physician ' s order was received to change Resident #228 ' s antipsychotic medication from quetiapine to risperidone (another antipsychotic medication).<br><br>A review of Resident #228 ' s medical record included the June 2016 Medication Administration Record (MAR). According to his June 2016 MAR, the resident received 1 mg risperidone twice daily as ordered for psychosis.<br><br>A review of Resident #228 ' s most recent quarterly MDS assessment dated 6/10/16 was completed. Section N of the MDS indicated the resident received an antipsychotic medication on 7 out of 7 days during the look back period. Resident #228 ' s care plan did not address the use of a psychotropic medication.<br><br>An interview was conducted with MDS Nurse #1 | F 279 | Care Area Assessment, including Anti-psychotropic medication, indicated as needing care planning, is to be addressed in the resident□s care plan.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>The MDS Consultant will audit 5 current residents□ comprehensive MDS who are receiving anti-psychotropic medication to ensure the item was care planned if the CAA addressed that the item would need to be care planned, for the schedule as follows: 1 week for 4 weeks, twice a month for 1 month, and monthly for 4 months<br>Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. The issue will be presented to completion or revision as needed within the QA program. | |

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| F 279 | Continued From page 5<br>on 8/10/16 at 2:14 PM. Upon inquiry, MDS Nurse #1 reported a resident ' s care plan typically needed to address the use of an antipsychotic medication if one was prescribed for the resident.<br><br>An interview was conducted with the facility ' s Director of Nursing (DON) on 8/10/16 at 2:55 PM. Upon inquiry, the DON reported her expectation would be for psychotropic drugs (including antipsychotic medications) to be care planned for a resident receiving such a medication. The DON stated Resident #228 ' s care plan was reviewed and she acknowledged an antipsychotic medication had not been care planned for the resident. The DON reported a focus area related to psychotropic medications was added to Resident #228 ' s care plan on the date of the interview. | F 279 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to keep walk in cooler from standing water on the floor, failed to label plastic bags of sliced cheese and cookie dough, | F 371 | How corrective action will be accomplished for each resident found to have been affected by the deficient practice. | 9/3/16 |

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| F 371 | Continued From page 6<br>plastic and metal containers with salad, to discard expired plastic bag of cheese in the walk in cooler, failed to label eleven plastic bags of vanilla cookies and discard one dented can in the dry storage room.<br><br>The findings included:<br><br>On 8/8/16 at 6:00 AM, during the observation of the walk-in cooler in the kitchen, there was approximately two inches of standing water on the floor.<br><br>On 8/8/16 at 6:00 AM, during an interview, the kitchen cook stated that the floor in the walk in cooler needed to be dry at any time.<br><br>On 8/8/16 at 6:05 AM, during the observation of the walk-in cooler in the kitchen, there were one plastic bag of sliced cheese, one plastic bag of cookie dough, two plastic and metal containers with salad observed with no labels on it.<br><br>On 8/8/16 at 6:05 AM, during an interview, the kitchen cook stated that all the food in walk in cooler needed to be labeled with expiration date and the date of opening.<br><br>On 8/8/16 at 6:10 AM, during the observation of the walk-in cooler in the kitchen, there was one plastic bag of Parmesan cheese, labeled with expiration data 8/7/16.<br><br>On 8/8/16 at 6:10 AM, during an interview, the kitchen cook stated that all the expired food needed to be removed from the walk in cooler.<br><br>On 8/8/16 at 6:15 AM, during the dry food storage room observation, there was one dented can of | F 371 | At the time of observation all unlabeled/dated items were immediately discarded (8/8/16). At the time of observation all cans were evaluated for dents and discarded appropriately (8/8/16). Standing water in walk-in-refrigerator was corrected on 8/8/16.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.<br>All dining services employees were in-serviced regarding sanitation standards including proper labeling and dating procedures by dining services manager.<br>Dining services manager and employees were in-serviced on the dented can procedure (8/10/16).<br>Position job responsibilities regarding sanitation standards, dating and labeling procedures were reviewed with each dining services employee by dining services manager (8/10/16).<br>Dining services manager discussed problem of standing water left after cleaning with outside vendor, reviewed correct process for ensuring water does not seep into unwanted areas during cleaning on (8/8/16).<br><br>Measures to be put in place or systemic changes made to ensure practice will not re-occur.<br>A sanitation inspection audit will be conducted weekly x 4 weeks and at least monthly thereafter by Regional Dietitian to ensure compliance with corrective actions | |

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| F 371 | Continued From page 7<br>Spaghetti Marinara Sauce on the shelf.<br><br>On 8/8/16 at 6:15 AM, during an interview, the kitchen cook stated that all the dented cans could not be use and needed to be removed from the shelves.<br><br>On 8/10/16 at 9:50 AM, during an interview, the kitchen cook stated that all the kitchen employees who restocked the shelves, were responsible for food labeling. He was not aware that some food was not labeled in the dry storage room and walk in cooler.<br><br>On 8/10/16 at 9:55 AM, during an interview, the dietary manager stated that all the staff responsible to keep the food in boxes and plastic bags labeled with correct expiration date and date of opening. All the expired food and dented cans needed to be removed from the kitchen. She was not aware about the standing water in the walk in cooler and indicated that the floor cleaning company had to leave the floor dry after the cleaning.<br><br>Record review of the kitchen cleaning schedule revealed the daily, weekly and monthly kitchen cleaning assignments with AM and PM schedule for cleaning per kitchen areas per shift. All of the assignments were posted and marked as done by the kitchen staff but the kitchen equipment and storage areas, mentioned above, were not clean at the time of observation.<br><br>Record review revealed the Dining Service Department Cleaning Schedule, indicated the last time kitchen cleaning was performed on 8/7/16.<br><br>Record review revealed the letter from the | F 371 | and sanitation standards.<br>A sanitation audit will also be conducted by dining services manager at start of business operations following vendor cleaning to ensure proper sanitation prior to start of daily food service operations.<br>All new hires will receive in-service education regarding proper sanitation standards including dating, labeling and discarding dented cans by dining services manager.<br>Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated by dining services manager.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur.<br>Findings will be reviewed at the Quarterly Quality Assurance meeting x 1 for tracking and trending for further problem resolution is needed. | |

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| F 371 | Continued From page 8<br>contracted cleaning company, indicated that the last steam cleaning of floors in the kitchen was performed on 8/7/16 and the water absorbent snakes had being used to prevent water from seeping into unwanted areas. | F 371 | | |