STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	C 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 survey of 12/15/16. Event ID ZGIY11. On 1/5/17, the 2567 was amended to correct errors in tag F520. On 01/23/17, the 2567 was amended to reflect the deletion of F315 and citing the facility at a new tag of F281 at D. On 1/23/17 management discussed F 157 with the surveyor - while surveyor was onsite the facility presented information to show PNC and therefore the tag is deleted.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and nurse practioner ' s interviews the facility failed to obtain physician ordered urine tests to diagnose an infection for one of three residents (Resident #172) with urine incontinence. The findings included: Resident #172 was admitted to the facility on 12/1/16 with diagnoses including atrial fibrillation, cervical disc degeneration and hypertension. Review of the admission Minimum Data Set (MDS) dated 12/8/16 revealed Resident #172 had mild memory impairment, required extensive assistance of one to two staff for most activities of daily living (adls) and was incontinent of bladder.	F 281	1. Corrective action for the resident affected by the alleged deficient practice: For Res #172: a. UA ordered immediately on 12/15/16 when need was identified. b. Antibiotic started per new order. No negative outcome was identified by this alleged deficient practice. Resident discharged to home 1/3/17. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: On 12/6/17, all resident's MAR's reviewed	1/12/17

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

Electronically Signed | 01/13/2017

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F 281	Continued From page 1 This MDS indicated the resident had received an antibiotic during the assessment timeframe. Review of the care plan dated 12/1/16 included a problem of incontinence due to mobility impairment, dependence on staff for adls. He was at risk for further decline in continence/associated complications. The approaches included observe and document frequency of voiding and identify any abnormal urine characteristics indicative of UTI (urinary tract infections), request UA (urine analysis) for signs and symptoms and report abnormal results to the physician. Other approaches included to encourage fluids, identify acute behavioral changes that may indicate UTI...increased confusion, agitation, and restlessness. Review of lab results for a complete blood count dated12/5/16 indicated an elevated white blood count of 14.4 (normal high would be 10). The physician gave an order to repeat the lab test on 12/7/16. The lab results of 12/7/16 revealed a white blood count of 14.8. The physician gave an order for Rocephin intramuscular (IM) and to check the urine for possible infection. A telephone order dated 12/8/16 indicated Resident #172 was to receive an antibiotic intramuscular (IM) every day for five days, intravenous fluids were to be administered for two days and a complete blood count (CBC) and basic metabolic panel (BMP) were to be obtained the following Monday (12/12/16). A telephone order dated 12/14/16 indicated the physician had written an order to " get the labs from Monday to the chart for review, pls (please) get urine c/s (culture/sensitivity).. "	F 281	for lab orders for continued monitoring. Any missing labs were obtained. 3. Measures/Systemic changes put into place to assure the alleged deficient practice does not re occur: On 12/29/2016 Licensed Nursing Staff in-serviced by the DON/designee on the revised Laboratory Management Protocol. Licensed nursing staff in-serviced by DON/Designee on Procedures for Laboratory and Radiology tests. Any licensed nursing staff that was not available during training will be trained before next scheduled shift. All new licensed nursing staff will be trained during orientation, by the DON/Designee. The DON/designee will review Laboratory Logs 5 times weekly at daily clinical meeting for 6 weeks. 4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur: Laboratory Logs will be audited weekly for 4 weeks, followed by 2 times per week for 3 months, then twice monthly for 8 months. The results of the weekly and monthly audits will be presented to the QMT at the monthly QAPI Meeting for 12 months. The QMT will modify the plan and/or system if the audits show non-compliance.	

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F 281	Continued From page 2	F 281		

Review of the clinical record revealed results of the urine analysis with culture, the CBC and BMP were not available for review. Review of the lab books for the nursing unit and for the lab services revealed there was no documentation the ua c&s had been requested or obtained. The BMP and the CBC had been obtained on 12/12/16.

Interview with Nurse #2 on 12/15/16 at 9:23 AM revealed the lab work was ordered for Resident #172 due to recent change in behavior to rule out a UTI and treatment of intravenous fluids and an antibiotic was started. Further interview revealed she would look for the lab results. Nurse #2 explained the process for handling lab results included receiving the faxed lab results from the lab, the physician would be notified by fax or put in their folder for review. She further explained her process for handling the lab results included writing " fax " at the top of the lab results and keeping confirmation it was faxed to the physician.

Interview on 12/15/16 at 9:35 AM with Nurse #2 revealed the CBC results were not faxed to the nursing unit, and she had called the lab to send the results. Review of the CBC results revealed the white blood count was elevated with a value of 13. The normal high would be 10. Nurse #2 explained, if the lab result was a " critical " she would call the physician instead of faxing the results. The lab results were not " critical " and she had not called the physician. This nurse verified the CBC results were not requested from the lab until the surveyor asked about them. During the interview, the urinalysis and culture results had not been located.

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F 281	Continued From page 3 Interview on 12/15/16 at 10:01 AM with the Director of Nursing revealed she would expect the nurses to use the process in place for obtaining and tracking lab work. The nurse should requested the lab results and called the physician of the abnormal WBC ' s due to follow up would be needed, especially if other symptoms were present. Interview with the nurse practioner on 12/15/16 at 10:40 AM revealed the primary physician would typically treat fevers of unknown origin with Rocephin until labs or chest x-ray results returned. The physician and the nurse practioner would alternate visits. Lab results would be in a folder and initialed by them it was reviewed. If they had not seen the lab results, they would want to be called. The primary physician ordered labs to be drawn on a Monday, so he can review them on Tuesday when he visits the facility. On12/15/16 at11:25 AM a follow up interview with Nurse #2 revealed she looked for the urinalysis and culture lab requisition, checked the lab's book, and called the local hospital lab to locate the lab results. She was unable to locate the lab, or determine if it was obtained. She had placed the lab on the schedule to be obtained today. Interview with the primary physician on 12/15/16 at 2:23 PM revealed he was not aware of the CBC lab results. To his knowledge the urinalysis, culture and sensitivity had not been obtained, as he had not seen the results. He further explained the infection could have been a residual from the recent hospitalization.	F 281		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		1/12/17

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F 329	Continued From page 4 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor a resident ' s blood pressure as ordered by the physician for 1 of 5 sampled residents (Resident #6) receiving a medication for urinary retention. Findings included: Resident #6 was admitted to the facility on 8/5/2014 and diagnosis included: Alzheimer ' s	F 329	1. Corrective action for the resident affectected by alleged deficient practice: For Resident #6, blood pressure was checked immediately on 12/14/2016 and was within normal limits. A review of Res#6's blood pressures for the past 2 months reveal the lowest systolic blood pressure was 112mmHG. No negative outcome was identified by	

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F 329	Continued From page 5 disease, Coronary Artery Disease, Diabetes, Emphysema and Benign prostatic hyperplasia. A review of the Minimum Data Set (MDS) for Resident #6 dated 12/9/2016 revealed he required extensive assistance with dressing, toilet use and personal hygiene and that he was always incontinent of bladder. A review of the physician orders dated December 2016 for Resident #6 revealed an order for Flomax 0.4mg every hour of sleep (HS); hold if systolic blood pressure (SBP) is less than 100 was initiated on 7/4/2015. A review of the medication admission record (MAR) for Resident #6 for the months of October 2016, November 2016 and December 2016 revealed that Resident #6 had no blood pressure readings recorded. The Flomax 0.4mg was documented as being administered every HS. An interview on 12/14/2016 at 2:58 pm with Nurse #3 revealed that she routinely administered the medications for Resident #6. She stated that this was the first time she had seen the order to hold the Flomax if his SBP was less than 100. She further stated that the blood pressure should have been checked by the nurse prior to administering the Flomax and that the blood pressure results should have been recorded on the MAR. An interview on 12/15/16 at 9:00 am with Nurse #4 revealed that she had reviewed the medical record for Resident #6 and that blood pressure monitoring had not been completed as ordered by his physician prior to administration of his Flomax.	F 329	this alleged deficient practice. Resident discharged on 12/17/2016. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: On 1/6/2017, all resident's MARs reviewed for special requirements with medications and orders adjusted appropriately, as needed. 3. Measures/Systemic changes put into place to assure the alleged deficient practice does not re occur: The IDT will continue to review all new orders 5 times a week during clinical meeting. Process will include reviewing the order to ensure all guidelines are met, including special requirements. On 12/29/2016, licensed nursing staff in-serviced on guidelines for order entry which will require special requirements to be documented in system prior to medication administration documentation. Pharmacy consultant to perform monthly audits to help identify special requirements for medications. Pharmacy consultant to communicate findings to Director of Nursing and/or Administrator. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The DON/designee will audit 10 resident charts per week x 4 weeks for special	

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F 329	Continued From page 6 An interview on 12/15/2016 9:13 am with the Director of Nursing (DON) revealed she had been the DON at the facility since October of 2016. She stated that Resident #6 ' s blood pressure should have been checked prior to the administration of his Flomax per the physician ' s order. An interview on 12/15/16 at 4:28 pm with the facility Pharmacy Consultant revealed that he had identified on 12/2/16 that the blood pressure monitoring associated with the Flomax administration for Resident #6 had not been completed and he notified the facility of this through a pharmacy recommendation. An interview on 12/15/16 at 5:07 pm with the physician for Resident #6 revealed that the nurse should have checked the blood pressure before giving the medication.	F 329	requirements attached to medication orders. Then random audits of 10 resident records per month will continue x 11 months. The results of the weekly and monthly audits will be presented to the QMT at the monthly QAPI Meeting for 12 months. The QMT will modify the plan and/or system if the audits show non-compliance.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure expired foods were	F 371	1. Corrective action for the resident affected by the alleged deficient practice:	1/12/17

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F 371	Continued From page 7 discarded in the walk-in refrigerator, opened food items were sealed, labeled and dated in the dry storage room, walk-in refrigerator and freezer, dishware were clean, in good repair and not stacked together wet and hair restraints were worn by staff while working in the kitchen. This had the potential to affect 101 of the 101 residents who resided in the facility. Findings Included: 1. An observation of the kitchen on 12/12/16 at 11:55 am revealed the following: · 3 - five pound containers of cottage cheese that had expired on 12/10/16 were in the walk-in cooler · A bag of hamburger patties and sausage patties were not sealed and exposed to the air in the walk-in freezer · 2 packages of waffles and pancakes were not labeled and dated in the walk-in freezer · An open box of black-eyed peas, an open box of pinto beans and a 50 pound case of thickener were not sealed and exposed to the air in the dry storage room · 2 male employees (Cook #1 and Cook #2) with facial hair did not have on beard guards while preparing meals in the kitchen. An interview on 12/12/16 at 12:00 pm with Cook #1 revealed that he was told if he kept his facial hair trimmed that he did not need to wear a beard guard while working in the kitchen. An interview on 12/12/16 at 12:00 pm with Cook #2 revealed that he was not aware that he needed to wear a beard guard while working in the kitchen. 2. An observation of the kitchen on 12/14/16 at	F 371	There were no residents affected by the deficient practice since non-compliance issues were corrected at time of identification. All effected food that was not properly labelled and dated was immediately discarded. All food that had expired was discarded immediately. Defective plate bases were immediately removed from service. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: The facility will maintain all dishware in accordance with state and local health department guidelines. The facility will maintain sanitary conditions in kitchen areas by ensuring all staff wear proper hair and beard restraints. All food items will be properly labelled and dated in all food storage areas, ensuring all foods are is within "use by" date. 3. Measures/Systemic changes put into place to assure the alleged deficient practice does not re occur: On 12/14/2016, dietary staff in-serviced on proper procedure for air-drying dishes and assuringcleanliness before storage and/or use. On 12/14/2016, dietary staff in-serviced on proper operation of dish machine. Brainstorming session held on 1/10/2017 with dietary staff to identify reasons for non-compliance and complete Root Cause	

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F 371	Continued From page 8 11:00 am revealed the following: · An open box of instant mashed potatoes and an open box of kosher salt were not sealed and exposed to the air · A dietary aide (Dietary Aide #2) did not have her hair fully covered with a hair net while working on the lunch serving line. · 9 of 12 plates had food particles on them and stacked together wet were stored at the steam table ready for service · 7 of 7 divided plates had food particles on them and heavily stained were stored at the steam table ready for service · 10 of 26 bowls had food particles on and stacked together wet were stored at the steam table ready for service · 22 of 35 plate bases were cracked with rust and rust colored water seeping out of the cracks An interview on 12/14/16 at 11:20 am with Dietary Aide #1 revealed that the staff was supposed to check the dishes for cleanliness and allow them to air dry before they put them away. She also stated that when she placed the plate bases on the heating unit it would " spit out " the water that was up inside the base through the cracks. An interview on 12/15/16 at 3:01 pm with the Dietary Manager revealed that food items taken out of their original container should be labeled and dated, leftover food items should be labeled with the production and expiration dates and all foods should be in sealed containers. He stated all dishware should be clean and allowed to air dry. He stated that the plate bases that were cracked and rusted should be replaced. He stated that all employees with facial hair should have on beard guards while working in the kitchen and that hairnets should be fully covering their hair. An interview on 12/15/16 at 3:34 pm with the	F 371	Analysis. Root causes identified were used to develop training and system modifications. Opening and closing checklist to be utilized to ensure items are stored properly and procedures are followed. Signs placed at entrances to kitchen to remind staff of hair and beard net use. Hair/beard net stations placed at each entrance to kitchen area. New plate bases received on 1/6/2017. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: Food service manager/designee will perform random checks for sanitation and food storage compliance 3 times per day, 5 days a week, for 4 weeks. Food Service Manager/designee will monitor use of daily opening and closing checklists 5 days a week for 4 weeks, followed by 2 times a week for 2 weeks.Area Manager will perform unannounced audits weekly for 4 weeks and 2 times for 1 month. Random monthly audits will continue, indefinitely, by Food Service Manager/designee to ensure ongoing compliance. Administrator/Designee will review weekly auditing tools presented by Food Service Manager/Designee. The results of the weekly and monthly audits will be presented to the QMT at the monthly QAPI Meeting for 12 months. The QMT will modify the plan and/or system if the audits show non-compliance.	

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F 371	Continued From page 9 facility Administrator revealed that he expected all food containers should be closed and all food items should be labeled and dated. He stated that all dishware should be clean without stains and air dried before being used. He stated that the plate bases should be in good repair and fully functional and that he expected all dietary staff to wear hair restraints as required.	F 371		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and nurse practioner ' s interviews the facility failed to notify the physician of abnormal lab results during treatment of an infection for one of three residents (Resident #172) with urine incontinence. The findings included: Resident #172 was admitted to the facility on 12/1/16 with diagnoses including atrial fibrillation, cervical disc degeneration and hypertension. Review of lab results for a complete blood count dated12/5/16 indicated an elevated white blood count of 14.4 (normal high would be 10). The physician gave an order to repeat the lab test on 12/7/16. The lab results of 12/7/16 revealed a white blood count of 14.8. The physician gave an order for Rocephin intramuscular (IM) and to check the urine for possible infection. A telephone order dated 12/8/16 indicated	F 505	1. Corrective action for the resident affected by the alleged deficient practice: For Res #172: a. UA ordered immediately on 12/15/2016 when need was identified. b. Antibiotic started per new order on 12/15/2016 c. Lab results obtained on 12/16/2016 showed no infection. No negative outcome was identified by this alleged deficient practice. Resident discharged to home 1/3/2017. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: On 1/6/2017, all resident's MAR's	1/12/17

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F 505	Continued From page 10 Resident #172 was to receive an antibiotic intramuscular (IM) every day for five days, intravenous fluids were to be administered for two days and a complete blood count (CBC) and basic metabolic panel (BMP) were to be obtained the following Monday (12/12/16). A telephone order dated 12/14/16 indicated the physician had written an order to " get the labs from Monday to the chart for review, pls (please) get urine c/s (culture/sensitivity).. " Review of the clinical record revealed results of the urine analysis with culture, the CBC and BMP were not available for review. Review of the lab books for the nursing unit and for the lab services revealed there was no documentation the ua c&s had been requested or obtained. The CBC had been obtained on 12/12/16. Interview with Nurse #2 on 12/15/16 at 9:23 AM revealed the lab work was ordered for Resident #172 due to recent change in behavior to rule out a UTI and treatment of intravenous fluids and an antibiotic was started. Further interview revealed she would look for the lab results. Nurse #2 explained the process for handling lab results included receiving the faxed lab results from the lab, the physician would be notified by fax or put in their folder for review. She further explained her process for handling the lab results included writing " fax " at the top of the lab results and keeping confirmation it was faxed to the physician. The BMP had been reviewed by the physician as evidenced by his initials. Nurse #2 did not know if the physician had reviewed the CBC and she could not locate the lab results. Interview on 12/15/16 at 9:35 AM with Nurse #2	F 505	reviewed for lab orders for continued monitoring.Any missing labs were obtained. 3. Measures/Systemic changes put into place to assure the alleged deficient practice does not re occur: On 12/29/2016, licensed nursing staff in-serviced by the DON/Designee on procedures for laboratory and radiology testing, which includes physician notification. Any licensed nursing staff that was not available during training will be trained before next scheduled shift. All new licensed nursing staff will be trained during orientation, by the DON/Designee. The DON/designee will review Laboratory Logs 5 times weekly at daily clinical meeting for 6 weeks. 4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur: Laboratory Logs will be audited 2 times weekly for 4 weeks, followed by weekly for 3 months, then twice monthly for 8 months. The results of the weekly and monthly audits will be presented to the QMT at the monthly QAPI Meeting for 12 months. The QMT will modify the plan and/or system if the audits show non-compliance.	

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F 505	Continued From page 11	F 505		

revealed the CBC results were not faxed to the nursing unit, and she had called the lab to send the results. Review of the CBC results revealed the white blood count was elevated with a value of 13. The normal high would be 10. Nurse #2 explained, if the lab result was a " critical " she would call the physician instead of faxing the results. The lab results were not " critical " and she had not called the physician. This nurse verified the CBC results were not requested from the lab until the surveyor asked about them.

Interview on 12/15/16 at 10:01 AM with the Director of Nursing revealed she would expect the nurses to use the process in place for obtaining and tracking lab work. The nurse should requested the lab results and called the physician of the abnormal WBC ' s due to follow up would be needed, especially if other symptoms were present.

Interview with the nurse practioner on 12/15/16 at 10:40 AM revealed the primary physician would typically treat fevers of unknown origin with Rocephin until labs or chest x-ray results returned. The physician and the nurse practioner would alternate visits. Lab results would be in a folder and initialed by them it was reviewed. If they had not seen the lab results, they would want to be called. The primary physician ordered labs to be drawn on a Monday, so he can review them on Tuesday when he visits the facility.

Interview with the primary physician on 12/15/16 at 2:23 PM revealed he was not aware of the CBC lab results. To his knowledge the urinalysis, culture and sensitivity had not been obtained, as he had not seen the results. He further explained the infection could have been a residual from the

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F 505	Continued From page 12 recent hospitalization.	F 505		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document with accuracy regarding an indwelling catheter and medication administration for one of one residents (Resident # 173) The findings included: Resident #173 admitted to the facility on 11/23/16 with diagnosis of fracture of left arm and left femur. Resident #173 was readmitted on 12/1/16 after repair of left arm fracture. Other diagnosis included anxiety disorder. Review of a readmission MDS dated 12/8/16 indicated she was continent of bowel and bladder.	F 514	1. Corrective action for the resident affected by the alleged deficient practice: For Res #173, after interview with the nurse and med aide in this situation, it was determined that physician orders for medications and treatments were followed, however the charting was not completely accurately. No negative outcome was identified by this alleged deficient practice. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: On 1/6/2017, MAR audit completed. Any identified discrepencies were corrected.	1/12/17

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F 514	Continued From page 13 Review of the re-admission orders dated 12/1/16 included obtaining a post void residual for one week and replace the catheter if the residual was greater than 300 milliliters (ml) and to administer Levaquin (an antibiotic) 500 milligrams (mg) every day for seven days. Review of the Medication Administration Record (MAR) for the dates of December 2 through December 9, 2016 revealed documentation Foley catheter care had been provided on 12/2 and 12/4 through 12/9/16; the catheter bag (drainage bag) was changed on 12/6; and the post void residual on 12/6/16 was 500 ml. There was no further documentation indicating a Foley catheter had been replaced according to the order. The MAR documented Levaquin doses for the dates of 12/5 and 12/6 were not given as indicated by an " N " which meant " Not Administered " according to the MAR instructions. According to the MAR, Resident #173 had received the antibiotic for the first three doses and the last two doses. On 12/15/16 at 10:58 AM an interview by phone was conducted with Nurse #1, who was in charge on 12/5 and 12/6 when med aide #1 worked. Interview revealed she did not think Resident #173 had a Foley catheter on readmission. She was not sure why the med aide documented the resident had a Foley catheter and care had been provided. Further interview revealed Nurse #1 remembered someone needed the drug Levaquin, but she could not remember who or when that occurred. Nurse #1 explained if the documentation was wrong, that was on the part of the med aide #1 and she was not aware. Interview with the Director of Nursing on 12/15/16	F 514	3. Measures/Systemic changes put into place to assure the alleged deficient practice does not re occur: On 12/15/2016, Med Aide #1 was in-serviced by the DON on the importance of accurate and timely documentation. On 1/4/17, nursing staff in-serviced by DON/designee on the importance of accurate and timely documentation. Any licensed nursing staff not available for training will be trained before the beginning of the next scheduled shift. All new licensed nursing staff will be trained during orientation, by the DON/Designee. On 1/6/2017, DON/ Designee led training began for admission team members on accurate entry of orders. This training will continue for new nursing staff, during orienation. New orders reviewed 5 times per week during clinical meeting for proper entry into electronic medicical record for 6 weeks. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The DON/designee will audit 10 resident charts per week X 4 weeks for accurate order entry and accurate documentation. Then random audits of 10 resident records per month will continue X 11 months. The results of the weekly and monthly audits will be presented to the QMT at the monthly QAPI Meeting for 12 months. The QMT will modify the plan and/or system if the audits show non-compliance.	

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F 514	Continued From page 14 at1:08 PM revealed the resident did not have a Foley catheter upon readmission. The documentation was in error. She would expect staff to document correctly. On 12/15/16 at 1:56 PM an interview by phone with Med Aide #1 revealed her documentation regarding the Foley catheter was inaccurate. Med Aide #1 explained she had not provided catheter care, had not changed a drainage bag (a nurse had to do that) and the 500 ml of post void residual urine was not correct. Resident #173 did not return from the hospital with an indwelling Foley catheter in place. Med Aide #1 further explained the urine residual amount should have been 50 ml instead of 500 ml. She could not go back and change it once it was in the computer. Further interview revealed she had given the Levaquin, Med Aide #1 explained the drug was not in her cart, she informed the nurse and it was taken from " back up " medication.	F 514		
F 520 SS=F	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		1/12/17

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F 520	Continued From page 15 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 reviews, observations and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place 11/06/15. This was for one recited deficiency that was originally cited 11/06/15 on a recertification survey and subsequently recited in December 15, 2016 on the current recertification survey. The deficiencies were in the areas of kitchen sanitation and food storage (F371). The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is crossed referenced to F371: Based on observation and staff interviews the facility failed to clean and air dry 3 of 15 pans stored for use; maintain and clean 1 of 1 fan in operation in the kitchen area and maintain a temperature of 41 degrees Fahrenheit (F) or below in 1 of 3 nourishment refrigerators. During the annual recertification on 12/15/16,	F 520	1. Corrective action for the resident affected by the alleged deficient practice: No specific resident was cited. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. QMT re-educated by Quality Advisor for Alliant Quality to ensure the QMT functions using QAPI and PDSA tools to identify trends, investigating issues, and develop plans to improve and maintain an effective quality management program. 3. Measures/Systemic changes put into place to assure the alleged deficient practice does not re occur: IDT meets 5 days a week to review incidents, trends, and concerns. QAPI tools will be utilized to ensure proper interventions are identified and implemented to reduce potential for	

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F 520	Continued From page 16 F371 was cited due to expired food items were not discarded; that foods were not sealed, labeled and dated; service ware was not clean, free of stains and air dried and that hair restraints were not worn while working in the kitchen. Interview with the Administrator on 12/15/16 at 3:34 PM revealed the last QA of the kitchen was on 10/27/16. He explained he would expect the dietary manager to check for cleanliness every day.	F 520	deficient practices. QMT meets monthly for 12 months to review and discuss initiated action plans,incidents, trends, and effectiveness of plans of correction. At least 1 member of frontline staff to attend monthly QAPI meeting to help identify concerns and understand QAPI initiatives/goals. On 1/4/2017, nursing staff was inserviced by the DON/designee and Administrator on the procedures for reporting care concerns or possible deficient practices. Any nursing staff that was unable to attend the in-service will be inserviced before their next scheduled shift. All new nursing staff will be trained during orientation, by the DON/Designee. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: In order to prevent a recurrence of deficient practices identified in F-371,the QMT will discuss findings and trends at monthly QAPI Meeting. All audits and monitoring tools will be reviewed. A representative from the management company will attend monthly QMT meeting or review monthly QMT meeting minutes. As needed, modifications to plans will be completed to ensure desired outcomes.	