STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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 A recertification and complaint investigation survey was conducted from 01/03/2017 through 01/06/2017. Immediate jeopardy was identified at: CFR 483.55 Tag F 371 at a scope and severity of (J) Immediate jeopardy began on 01/03/17 when the facility began to deliver a turkey breast that was not thoroughly cooked. The Administrator was informed of the immediate jeopardy on 01/04/2017 at 12:20 PM. The immediate jeopardy was removed on 01/05/2017 when the facility implemented a credible allegation of compliance.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157		2/8/17

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

Electronically Signed | 01/27/2017

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F 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff and nurse practitioner interviews, and record review, the facility failed to notify an interested family member of an order for a psychiatric consultation and failed to notify the nurse practitioner of a delay to obtain a psychiatric consultation for 1 of 3 sampled residents who required mental health services (Resident #14).	F 157	F 157 SS=D Notify of Changes 1. On 1/6/17, the registered nurse notified the nurse practitioner and Responsible Party for Resident #14 of the delay in obtaining the ordered psychiatric consultation and the newly scheduled consult appointment. The resident no longer resides at the facility. 2. By 1/27/17, licensed nurses	

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F 157	Continued From page 2 The findings included: Resident #14 was admitted to the facility on 11/22/16 with diagnoses which included Alzheimer's Disease with behavioral disturbances. Review of Resident #14's admission medication orders dated 11/22/16 revealed medications included Seroquel (an antipsychotic) 12.5 milligrams (mg.) in the morning with 25 mg. at bedtime and Risperdone (an antipsychotic) 0.50 mg. at bedtime for dementia with behaviors. Review of Resident #14's admission Minimum Data Set (MDS) dated 11/29/16 revealed an assessment of moderately impaired cognition with physical behavioral symptoms directed toward others that significantly intruded on the privacy or activity of others. Review of nurse practitioner's (NP) orders dated 12/05/16 revealed Resident #14 required a psychiatric consultation for dementia with behaviors. Review of Resident #14's record revealed there was no documentation of a psychiatric consultation. Interview with Nurse #1 on 01/05/17 at 12:43 PM revealed she did not know if Resident #14 received the psychiatric consultation and the Unit Manager made arrangements for the referrals. Nurse #1 explained the Unit Manager would be responsible to notify Resident #14 ' s family member. Nurse #1 reported Resident #14's family member visited frequently and was very involved with the care of Resident #14.	F 157	completed a quality monitoring of current residents physicians orders from 12/26/16-1/25/17 for psychiatric consultation orders to validate timely scheduling and Responsible Party/Nurse Practitioner and Physician notification as appropriate. No discrepancies were identified. 3. By 1/30/17, the Director of Clinical Services (DCS)will reeducate licensed nurses on regulation 483.10(g)(14) and the notification to resident, RP and MD/NP of any changes to residents care, condition, treatment or orders including; notification of psychiatric consultations and/or delays in scheduling. Newly hired licensed nurses will be educated upon hire. The licensed nurse to notify resident, RP, MD/NP when there are changes to residents care, condition, treatment or orders; including notification of psychiatric consultations and/or delays in scheduling. 4. A quality monitoring of residents physicians orders will be completed by the DCS/RN designee for three(3) residents at a frequency of three (3) times weekly for four (4) weeks, then one (1) time weekly for eight (8) weeks, then monthly to ensure that the resident, RP, MD/NP are immediately notified of changes . The ED to report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting monthly for (12) months. The QAPI committee will recommend and implement revisions to the plan as necessary to sustain substantial compliance.	

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F 157	Continued From page 3 Interview with Unit Manager #1 on 01/05/17 at 12:46 PM revealed he did not know if Resident #14 received a psychiatric consultation. A second interview with Unit Manager #1 on 01/05/17 at 3:00 PM revealed Resident #14's psychiatric consultation was delayed until Resident #14's family member consented. Unit Manager #1 explained he informed Resident #14's family member "several weeks ago" and did not receive a response. Unit Manager #1 reported he did not document the telephone call with Resident #14's family member and did not follow-up. Telephone interview with Resident #14's family member on 01/05/17 at 3:21 PM revealed he was not aware of the order for a psychiatric consultation or requirement for consent. Resident #14's family member reported he would agreed to the psychiatric consultation. Interview with the Director of Nursing (DON) on 01/05/17 at 5:45 PM revealed the delay in psychiatric referral was caused by the abrupt departure of the facility's social worker who was responsible for psychiatric referrals. The DON reported he expected nursing staff to notify the NP when the psychiatric consultation did not occur. The DON reported he was not aware of the delay and Resident #14 should receive the psychiatric consultation. Interview with the NP on 01/06/17 at 9:29 AM revealed she expected to be notified of any delay in obtaining Resident #14's psychiatric consultation. The NP explained Resident #14 required the psychiatric consultation due to	F 157	5. AOC- 2/08/17	

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F 157	Continued From page 4 severe depression, agitated behaviors and use of antipsychotic medication.	F 157		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident council president and staff interviews, and record review, the facility failed to post the notice of location and availability of the facility's survey results.	F 167	F167 SS=C 1. On 1/6/17, the ED posted Survey Results signage in prominent, accessible locations within the facility. The facility will	2/8/17

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F 167	Continued From page 5 The findings included: Observations on 01/03/17 at 9:45 AM, on 01/04/17 at 8:00 AM and at 6:00 PM, and on 01/05/17 at 8:00 AM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. Interview with the resident council president, Resident #32, on 01/05/17 at 11:42 AM revealed a desire to read the facility's most recent survey results. Resident #32 explained she did not know the location of the survey results. Observation on 01/05/17 at 11:47 AM revealed the facility's survey results were in a binder on the bottom shelf of a wall unit across from the receptionist's desk in the lobby. Interview with the Administrator on 01/05/17 at 4:10 PM revealed the facility did not have a notice of survey results availability and location posted. The Administrator reported a notice would be immediately posted and was not able to provide a reason for the omission of posted notice.	F 167	continue to post the availability and location of the facility□s survey results for examination. 2. By date 1/30/2017, the Interdisciplinary Team (IDT) completed a quality monitoring of interview-able residents to ensure that they are informed of the location and availability of the facilities survey results. On date 1/9/2017 during the Resident Council meeting, the Activity Director also reeducated residents of the facilities survey results location and availability 3. On 1/6/17, the Regional Director of Clinical Services (RDCS) reeducated the ED on regulation 483.10(g)(10)(i)(11) regarding the residents right to examine the results of the facilities most recent Federal and State survey results and posting notices of the availability of such reports in areas of the facility that are prominent and accessible to the public. Newly hired EDs will be educated upon hire. The ED will maintain a copy of the facilities most recent State and Federal survey results in a prominent, accessible location in the front lobby. The reports will be within a binder labeled Survey Results and additional signage will be posted in prominent physical locations to inform residents of its location. The Activities Director will also remind residents of the location of the facilities survey results during Resident Council meetings. 4. A quality monitoring of residents knowledge of the location of the facilities most recent survey results will be completed by the Activities Director for	

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F 167	Continued From page 6	F 167	three(3) interviewable residents at a frequency of three (3) times weekly for four (4) weeks, then one (1) time weekly for eight (8) weeks, then monthly. to ensure that the residents rights are being honored. The ED to report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting monthly for (12) months. The QAPI committee will recommend and implement revisions to the plan as necessary to sustain substantial compliance. 5. AOC- 2/08/17	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to give a choice in bath type and frequency to 2 of 3 residents	F 242	F242 SS=D 1. On date 1/13/2017, the licensed nurse completed a Bathing Preference	2/8/17

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F 242	Continued From page 7 sampled for choices (Residents #5 and #46). The findings included: 1. Resident #46 was admitted to the facility on 10/19/16 with diagnoses which included end stage renal disease. Review of Resident #46's admission Minimum Data Set (MDS) dated 10/26/16 revealed an assessment of intact cognition. The MDS indicated it was very important to Resident #46 to choose between a tub bath, shower, bed bath or sponge bath. Resident #46 required the physical assistance of one person with bathing. Review of Resident #46's care plan dated 10/26/16 revealed interventions for a self-care deficit included assistance with showers as scheduled. Interview with Resident #46 on 01/04/17 at 10:35 AM revealed staff provided assistance with a shower twice weekly. Resident #46 reported she would prefer a tub bath. Resident #46 explained staff informed her the tub did not work when she requested a tub bath. Interview with Nurse Aide (NA) #3 on 01/05/17 at 10:51 AM revealed the tub next to the hall did not work and she could not offer a tub bath. Interview with NA #2 on 01/05/17 at 3:05 PM revealed she assisted Resident #46 with showers on the evening shift twice weekly. NA #2 explained the tub next to the hall did not work. NA #2 reported Resident #46 inquired if the tub worked so she informed Resident #46 of the tub's unavailability.	F 242	questionnaire for Resident #5 and #46 to obtain residents choice of bath type and frequency. Residents continue to receive baths/showers as desired. 2. By date 1/30/2017, licensed nurses will complete a quality monitoring of current residents choice of bath type and frequency. Residents bathing preferences will continue to be honored. 3. By date 1/30/2017, the DCS will reeducate nursing staff on regulation 483.10(f)(1)(3) regarding residents right to have self determination and the right to make choices including; the right to have a choice in bath type and frequency. Nurses were also reeducated on the policy and procedure of obtaining residents bathing preferences upon admission, quarterly and as requested by the resident. Newly hired nursing staff will be educated upon hire. In addition staff educated on availability of new lift for use with tubs available in shower rooms. The licensed nurse will complete a Bathing Preference questionnaire with interviewable residents or their RP upon admission, quarterly and as requested. The residents bath type and frequency will then be updated onto the Bathing Schedule and provided per resident choice with nursing assistance as appropriate. 4. A quality monitoring of residents bath type and frequency will be completed by the RN Unit Manager for three(3) interviewable residents or their RP at a frequency of three (3) times weekly for four (4) weeks, then one (1) time weekly for eight (8) weeks, then monthly for 9	

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F 242	Continued From page 8 Interview with Unit Manager #1 on 01/05/17 at 3:12 PM revealed a resident could ask for a tub bath but he did not know if the tub worked. Interview with the Director of Nursing (DON) on 01/05/17 at 4:13 PM revealed the bathtubs on other units worked and Resident #46 could have a tub bath if requested. The DON reported residents were not given a choice of tub baths but tub baths would be provided if the resident requested. 2. Resident #5 was admitted to the facility on 11/18/16 with diagnoses which included chronic obstructive pulmonary disease. Review of Resident #5's admission Minimum Data Set (MDS) dated 11/25/16 revealed an assessment of intact cognition. The MDS indicated Resident #5 required set-up help with bathing. Review of Resident #5's care plan dated 11/30/16 revealed interventions for a self-care deficit included provision of assistance with showers according to the shower schedule. Interview with Resident #5 on 01/03/17 at 12:26 PM revealed staff assisted with showers twice weekly on Wednesday and Friday. Resident #5 reported he would prefer a daily shower but did not have a choice. Interview with Nurse Aide (NA) #3 on 01/05/17 at 10:50 AM revealed showers are scheduled twice weekly and by room number. NA #3 explained the shower schedule dictated the frequency of showers.	F 242	months that the residents right to make choices are being honored. The ED to report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting monthly for (12) months. The QAPI committee will recommend and implement revisions to the plan as necessary to sustain substantial compliance. 5. AOC- 2/08/17	

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F 242	Continued From page 9 Interview with Unit Manager #1 on 01/05/17 at 10:56 AM revealed residents received assistance with showers twice weekly and the shower schedule went by room number. Unit Manager #1 explained Resident #5 would need to request daily showers in order to change the schedule. Unit Manager #1 reported the Director of Nursing (DON) was in charge of the shower schedule. Interview with the DON on 01/05/17 at 4:17 PM revealed residents could receive more frequent showers if requested. The DON explained nurse aides and nurses should ask residents if showers were preferred more frequently. The DON reported Resident #5 should receive daily showers if desired.	F 242		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide medically related social services regarding assessment and interventions for resident behavior for 1 of 3 sampled residents who exhibited behavioral symptoms (Resident #14). The findings included: Resident #14 was admitted to the facility on 11/22/16 with diagnoses which included Alzheimer's Disease with behavioral	F 250	F250 SS=D 1. Resident #14 no longer resides at the facility. 2. By 1/27/17, registered nurses completed a quality monitoring of current residents who have exhibited behavioral symptoms between 12/26/16-1/25/17, to ensure medically related social services have been provided by the facility regarding assessment and interventions. No discrepancies were identified. 3. By 2/7/17, the DCS reeducated	2/8/17

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F 250	Continued From page 10 disturbances. Review of Resident #14's admission medication orders dated 11/22/16 revealed medications included Seroquel (an antipsychotic) 12.5 milligrams (mg.) in the morning with 25 mg. at bedtime and Risperdone (an antipsychotic) 0.50 mg. at bedtime for dementia with behaviors. Review of Resident #14's admission Minimum Data Set (MDS) dated 11/29/16 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #14 felt down, depressed or hopeless with little pleasure in doing things. The MDS indicated Resident #14 demonstrated physical behavioral symptoms toward others which significantly intruded on the privacy or activity of others. Review of Resident #14's care plan dated 11/29/16 revealed interventions for behavior management included redirection and monitoring. Review of nursing notes revealed the following documented behaviors: · 12/09/16: Resident #14 accused family and staff of stealing and became agitated. · 12/10/16: Resident #14 cried uncontrollably and voiced delusions. · 12/12/16: Resident #14 shouted at other residents and demonstrated exit seeking behaviors. · 01/03/17: Resident #14 was combative and disrobed. · 01/05/17: Resident #14 screamed and refused care. Review of Resident #14's social worker notes revealed there was no documentation regarding	F 250	nursing and social services staff on regulation 483.40(d) related to providing medically-related social services to attain and maintain the highest practical physical, mental and psychosocial well-being of each resident. Education was also provided on the policy and procedure of assessing residents who exhibit behavioral symptoms and implementing interventions to meet residents□ needs and documentation requirements in the medical record. Newly hired nursing and social services staff will be educated upon hire. Nursing and social service staff who observe residents exhibiting behavioral symptoms will report findings to the appropriate licensed nurse. The licensed nurse to ensure an evaluation is completed and appropriate interventions are implemented and documented per the residents□ plan of care. Newly exhibited or unmanaged behavioral symptoms to be reported to MD/NP and new orders implemented as indicated. Social services staff will also provide medically related social services to residents exhibiting behavioral symptoms to maintain their highest practicable physical, mental and psychosocial well-being and documented in the medical record. A newly hired Social Services Coordinator begins employment effective 2/7/17. 4. A quality monitoring of the residents medical record will be completed by the ED or Registered Nurse Designee for three(3) random residents at a frequency of three (3) times weekly for four (4) weeks, then one (1) time weekly for eight	

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F 250	Continued From page 11 Resident #14's behaviors and need for psychoactive medication use. During an interview on 01/04/17 at 9:32 AM, Resident #14 cried. Resident #14 reported abandonment and persecution. Observation on 01/04/17 at 3:30 PM revealed Resident #14 shouted at other residents to leave and take her with them. Resident #14 shook her fist at the other residents. Observation on 01/05/16 at 9:39 AM revealed Resident #14 yelled and attempted to stand up in front of the wheelchair. Nurse Aide (NA) #1 redirected Resident #14 and assisted her back into the wheelchair. Interview with NA #1 on 01/05/17 at 11:33 AM revealed Resident #14 required frequent checks for safety. NA #1 explained Resident #14 frequently became angry and confused. NA #1 reported Resident #14 could be redirected when given food items, taken to an activity, and provided with one to one conversations. Interview with Nurse #1 on 01/05/17 at 12:43 PM revealed Resident #14 cried frequently. Nurse #1 reported Resident #14's family member visited frequently but Resident #14 did not remember the visits so would become sad and angry. Observation on 01/05/17 at 3:46 PM revealed Resident #14 crying. Nurse Aide (NA) #2 engaged Resident #14 in conversation and Resident #14 calmed. At 3:51 PM, Resident #14 began to curse and stood up in front of the wheelchair. NA #2 assisted Resident #14 into the wheelchair and transported Resident #14 to the	F 250	(8) weeks, then monthly for 9 months to ensure that medically related social services related to assessment and interventions are being provided and documented for residents exhibiting behavioral symptoms. The ED will report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting monthly. The QAPI committee will recommend and implement revisions to the plan as necessary to sustain substantial compliance. 5. AOC- 2/08/2017	

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F 250	Continued From page 12 resident room. NA #2 assisted Resident #14 with a choice of a television show and Resident #14 calmed. Interview with NA #2 on 01/05/17 at 3:52 PM revealed Resident #14 frequently became agitated during the evening shift. NA #2 explained Resident #14 cried, shouted and became resistant to care. NA #2 reported Resident #14 required frequent checks and redirection. Interview with the Director of Nursing (DON) on 01/05/17 at 5:45 PM revealed the facility's social worker ended employment at the facility abruptly on 12/23/16. The DON could not provide information regarding the social worker's involvement with Resident #14. The social worker was not able to be interviewed.	F 250		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309		2/8/17

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F 309	Continued From page 13 the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff and nurse practitioner interviews, and record review, the facility failed to provide a psychiatric referral for 1 of 3 sampled residents who required mental health services (Resident #14). The findings included: Resident #14 was admitted to the facility on 11/22/16 with diagnoses which included Alzheimer's Disease with behavioral disturbances. Review of Resident #14's admission medication orders dated 11/22/16 revealed medications included Seroquel (an antipsychotic) 12.5 milligrams (mg.) in the morning with 25 mg. at bedtime and Risperdone (an antipsychotic) 0.50 mg. at bedtime for dementia with behaviors. Review of Resident #14's admission Minimum Data Set (MDS) dated 11/29/16 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #14 felt down, depressed or hopeless with little pleasure in doing things. The MDS indicated Resident #14 demonstrated physical behavioral symptoms toward others which significantly intruded on the	F 309	F309 SS=D 1. Resident #14 no longer resides at the facility. 2. By 1/27/17, registered nurses completed a quality monitoring of current residents physician orders between 12/26/16-1/25/17 to ensure psychiatric referrals were completed as ordered to provide care and services for the residents highest well being. No discrepancies were identified. 3. By 2/7/17, the DCS will have educated/reeducated licensed nurses and social services staff on regulation 483.24(k)(l) related to providing care and services to obtain and maintain the highest physical, mental and psychosocial well-being consistent with the residents comprehensive assessment and plan of care. Education was also provided on the policy and procedure of obtaining and implementing psychiatric referral orders and documentation requirements in the medical record. Newly hired licensed nurses and social services staff will be educated upon hire. Upon obtaining a physician order for psychiatric services, the licensed nurse or	

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F 309	Continued From page 14 privacy or activity of others. Review of Resident #14's care plan dated 11/29/16 revealed interventions for behavior management included a psychologist consult as needed. Review of nurse practitioner's orders dated 12/05/16 revealed an order for Resident #14 to receive a psychiatric consultation for dementia with behaviors. Review of nursing notes revealed the following documented behaviors: · 12/09/16: Resident #14 accused family and staff of stealing and became agitated. · 12/10/16: Resident #14 cried uncontrollably and voiced delusions. · 12/12/16: Resident #14 shouted at other residents and demonstrated exit seeking behaviors. · 01/03/17: Resident #14 was combative and disrobed. · 01/05/17: Resident #14 screamed and refused care. During an interview on 01/04/17 at 9:32 AM, Resident #14 cried. Resident #14 reported abandonment and persecution. Observation on 01/04/17 at 3:30 PM revealed Resident #14 shouted at other residents to leave and take her with them. Resident #14 shook her fist at the other residents. Observation on 01/05/16 at 9:39 AM revealed Resident #14 yelled and attempted to stand up in front of the wheelchair. Nurse Aide (NA) #1 redirected Resident #14 and assisted her back	F 309	social services designee will notify the RP, obtain completed consent, and schedule psychiatric evaluation and document in the medical record. The RN Unit Manager is responsible for reviewing physician orders and documenting new psychiatric referral orders on the Psychiatric Referral Log to monitor compliance and ensure care and services are being provided for residents who require mental health services. 4. A quality monitoring of the residents medical record will be completed by the ED or DCS for three(3) random residents at a frequency of three (3) times weekly for four (4) weeks, then one (1) time weekly for eight (8) weeks, then monthly for 9 months to ensure that psychiatric referrals are provided as necessary. The ED to report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting monthly. The QAPI committee will recommend and implement revisions to the plan as necessary to sustain substantial compliance. 5. AOC- 2/08/17	

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F 309	Continued From page 15	F 309		

into the wheelchair.

Interview with NA#1 on 01/05/17 at 11:33 AM revealed Resident #14 required frequent checks for safety. NA #1 explained Resident #14 frequently became angry and confused. NA #1 reported Resident #14 could be redirected when given food items, taken to an activity, and provided with one to one conversations.

Interview with Nurse #1 on 01/05/17 at 12:43 PM revealed Resident #14 cried frequently. Nurse #1 reported Resident #14 ' s family member visited frequently but Resident #14 did not remember the visits so would become sad and angry. Nurse #1 reported she did not know if Resident #14 received the psychiatric consultation and the unit manager made arrangements for the referrals.

Interview with Unit Manager #1 on 01/05/17 at 12:46 PM revealed he did not know if Resident #14 received a psychiatric consultation.

A second interview with Unit Manager #1 on 01/05/17 at 3:00 PM revealed Resident #14 could not receive a psychiatric consultation until Resident #14's family member consented. Unit Manager #1 explained he informed Resident #14's family member "several weeks ago" and did not receive a response. Unit Manager #1 reported he did not follow-up with the family member and did not notify the nurse practitioner of the delay.

Telephone interview with Resident #14's family member on 01/05/17 at 3:21 PM revealed he was not aware of the order for a psychiatric consultation or requirement for consent. Resident #14's family member reported he would

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F 309	Continued From page 16 agree to the psychiatric referral and come to the facility to sign the consent. Observation on 01/05/17 at 3:46 PM revealed Resident #14 crying. Nurse Aide (NA) #2 engaged Resident #14 in conversation and Resident #14 calmed. At 3:51 PM, Resident #14 began to curse and stood up in front of the wheelchair. NA #2 assisted Resident #14 into the wheelchair and transported Resident #14 to the resident room. NA #2 assisted Resident #14 with a choice of a television show and Resident #14 calmed. Interview with NA #2 on 01/05/17 at 3:52 PM revealed Resident #14 frequently became agitated during the evening shift. NA #2 explained Resident #14 cried, shouted and became resistant to care. NA #2 reported Resident #14 required frequent checks and redirection. Interview with the Director of Nursing (DON) on 01/05/17 at 5:45 PM revealed the delay in psychiatric referral was caused by the abrupt departure of the facility's social worker and lack of follow -up by the nursing staff. The DON reported he was not aware of the delay and Resident #14 should receive the psychiatric consultation. Interview with the nurse practitioner (NP) on 01/06/17 at 9:29 AM revealed she expected Resident #14 to receive the psychiatric consultation. The NP explained Resident #14 required the psychiatric consultation due to severe depression, agitated behaviors and use of antipsychotic medication.	F 309		
F 356	483.35(g)(1)-(4) POSTED NURSE STAFFING	F 356		2/8/17

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INFORMATION

483.35
(g) Nurse Staffing Information
(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)

(C) Certified nurse aides.

(iv) Resident census.

(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

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F 356	Continued From page 18 (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to post daily staffing that included night shift on 3 of 4 days during the survey and the six weeks prior to the survey. Findings included: Observation on 01/03/2017 at 05:45 PM revealed staffing posted in the front lobby of the facility did not have night shift staffing posted. Observation on 01/04/2017 at 08:00 AM revealed staffing posted in the front lobby of the facility did not have night shift staffing posted. Observation on 01/05/2017 at 08:00 AM revealed staffing posted in the front lobby of the facility did not have night shift staffing posted. Interview on 01/05/2017 at 03:59 PM with the Human Resources Coordinator revealed she was not aware of why the night shift staffing was not completed. She was not aware of which night shift should be posted for the current day since the night shift started at 11 PM the night before the staffing was posted in the morning. Interview on 01/05/2017 at 03:59 PM with the Director of Nursing revealed he was not aware the night shift staffing was not being posted. Review of the staff postings from 11/17/2016-01/05/2017 revealed that night shift staffing was not completed on the postings.	F 356	F356 SS=C 1. The facility continues to post daily nurse staffing including day, evening and night shifts and will maintain records for eighteen (18) months. 2. n/a 3. On date 1/6/2017, the ED reeducated the staffing coordinator and nurse supervisors on regulation 483.35(g)(1)-(4) regarding the daily nurse staffing posting requirements. Education was also provided on ensuring the day, evening and night shifts are included and posted in a prominent place that is readily accessible to residents and visitors, as well as, maintaining daily nurse staffing data for a minimum of 18 months. Newly hired staffing coordinators and nurse supervisors will be educated upon hire. The staffing coordinator will be responsible for posting the daily nurse staffing including day, evening and night shifts and maintaining records for a minimum of eighteen (18) months. The nurse supervisor will serve as a back-up in the staffing coordinators absence. 4. A quality monitoring of the daily	

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F 356	Continued From page 19 Interview on 01/06/2016 at 09:15 AM with the Administrator revealed he expected the staffing to be completed and posted for all shifts daily. Interview on 01/06/2017 at 09:55 AM with the Receptionist revealed she has recently started in that position and was not aware she was required complete the night shift staffing on the staff posting sheet.	F 356	nurse staffing posting, as well as, retention of records will be completed by the ED at a frequency of three (3) times weekly for four (4) weeks, then one (1) time weekly for eight (8) weeks, then monthly for 9 months. The ED will report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting monthly. The QAPI committee will recommend and implement revisions to the plan as necessary to sustain substantial compliance. 5. AOC- 2/08/17	
F 371 SS=J	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of	F 371		2/8/17

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F 371	Continued From page 20 foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of facility recipes/manufacturer's instructions, the facility failed to 1) thaw and thoroughly cook a raw frozen turkey breast, prepared for 27 residents, to prevent the growth of bacteria and potential food borne illness as evidenced by a minimum internal temperature of 165 degrees Fahrenheit (F) for 15 seconds and 2) failed to obtain a temperature of the turkey breast on the tray line. The undercooked turkey breast was sliced, plated and put on a delivery cart for delivery to 2 of 27 residents on a regular diet (Residents #68 and #98). Immediate jeopardy began on 01/03/17 when the facility began to deliver a turkey breast that was not thoroughly cooked to 2 of 27 residents (Residents #68 and #98), after it was sliced and plated, as evidenced by turkey juices that were pink/red in color and internal temperatures that reached 142.7 degrees F and 155.5 degrees F in the center of the turkey breast. Immediate jeopardy was removed on 01/05/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) for monitoring of the revised systems put in place related to food preparation and temperature monitoring of time/temperature control for safety (TCS) food items.	F 371	F371 SS=E On 1/3/17, Resident #68 and #98 did not receive the undercooked turkey. All turkey was immediately reheated in the streamer by the cook to the internal temperature of >165 degrees and lunch delivery by dietary staff continued. On 1/3/17 at 2:00pm, the secondary District Dietary Manager (DDM) provided 1:1 reeducation to identified cook on sanitary food preparation and safe serve temperatures. Identified cook verbalized and documented by signature understanding. On 1/3/17 by 4:00pm, the Unit Managers completed quality assurance monitoring on facility residents for gastrointestinal signs and symptoms during past and future 72 hours. No issues identified. Meal temperatures monitored for correct internal cooking temperatures for each meal for 72 hours post 1/3/17, and random on going to ensure appropriate internal cooking temperatures. On 1/3/17, the facility Dietary Manager and secondary DDM reeducated dietary staff on site regarding sanitary food preparation to include thawing procedures as appropriate and serve safe temperatures. Emphasized was cooking and serving temperatures. Additional HSG cooks/dietary staff were educated prior to	

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F 371	Continued From page 21 The findings included: The facility policy "Food Preparation", revised May 2014, recorded the following, in part: · The cook would prepare all cooked food items in a fashion that permits rapid heating to appropriate minimum internal temperatures. · TCS hot food items would be heated according to these guidelines ...Poultry - 165 degrees F. · Temperature for TCS foods would be obtained/recorded at the point of service (on tray line) and monitored periodically during meal service. The facility policy "Food Storage: Cold", revised May 2014, recorded the following, in part: · The cook was responsible to thaw frozen items requiring defrosting, before preparation, under refrigeration, in a microwave for immediate use, or in a sealed container immersed in cold running water. On 01/03/17 at 10:51 AM, an 8 - 10 pound turkey breast was observed covered with foil wrap and in a conventional oven at 350 degrees F. Interview with dietary staff (DS) #1 (morning cook) revealed the turkey breast was for the lunch meal that day (01/03/17). On 01/03/17 at 11:50 AM, DS #1 was observed to remove the turkey breast from the oven, removed a thermometer from a cup of ice water and inserted the thermometer (twice) into the center of the turkey breast (thickest part of the breast). The turkey juices were observed with a pink/red color. DS #1 obtained the following temperatures in the center of the turkey breast where the juices were observed with a pink/red color:	F 371	their next shift. On 1/4/17, the primary DDM provided detailed reeducation to onsite dietary staff to include; 1.) thawing frozen items requiring defrosting before preparation under refrigeration in the microwave for immediate use or in a sealed container immersed in cold running water per HCSG Policy 022 Food Storage: Cold, 2.) preparing menu items according to standardized recipes achieving minimum internal temperatures within guidelines provided by printed meal tracker recipes per HCSG Policy 014 Food Quality and Palatability, and 3.) ensuring safe serve minimum temperatures by using a thermometer placed in the thickest portion of the meat away from the bone, fat or gristle and in alternate meat depths, then allowing the thermometer to stop moving for at least 15 seconds and finally sanitizing probe using food sanitizer or wipes per HCSG Thermometer Use Guidelines. To ensure meat is cooked to proper temperatures before serving, the cook will use a thermometer probe to insert into the center of the meat when removing from oven/cooking source to ensure internal temperature is within required guidelines and per facility (Health Care Services Group) policies and procedures. Once meat is within guidelines from the oven/cooking source, the cook will record on temperature log and place meat in warming tray to maintain safe serve temperatures. Prior to plating meat, the cook will again monitor and record line temperature of meat from heating tray to be within requirements for safe food	

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F 371	Continued From page 22 · 142.7 degrees F · 155.5 degrees F Additionally, DS #1 conducted temperature monitoring to the right/left outer portions of the turkey breast (thinnest part of the breast) and obtained the following temperatures: · 164.7 degrees F (right) · 171.4 degrees F (left) DS #1 was interviewed during the observation of temperature monitoring and stated that she calibrated the thermometer prior to use. DS #1 also stated that she was trained to cook the turkey until the internal temperature reached above 140 degrees F, but that the turkey was still frozen in some places when she started cooking it. She further stated "I was trying to get it done for lunch." On 01/03/17 from 11:52 AM until 12:03 PM, DS #1 was observed to remove the turkey breast from the pan it was cooked in, placed the turkey breast on a cutting board and cut the turkey breast in half. The juices coming from the center of the turkey were observed pink/red in color and made contact with other parts of the turkey. Then DS #1 sliced and weighed each turkey slice using a kitchen scale. DS #1 returned the sliced turkey breast to the pan it was cooked in, and at 12:03 PM placed the sliced turkey (uncovered) on the steam table for the lunch tray line. The sliced turkey breast remained uncovered on the steam table until the lunch tray line meal service began. DS #1 stated at the time of the observation that she obtained 30 servings of turkey, 3 ounce portions each for lunch to be served to residents who received a regular consistency diet with the exception of 2 residents who received regular consistency diets, but ordered a salad instead. DS #1 further stated that she used a pre-cooked	F 371	holding temperatures of at least 140 degrees. The cook will also utilize the Cooks Log which includes printed recipes, temperature logs for each meal and HCSGs policies and procedures for reference. Newly hired dietary staff will be educated upon hire and quarterly thereafter. 4. A quality monitoring of time/temperature control for safety (TCS) food items will be completed by the ED at a frequency of five (5) times weekly for four (4) weeks, then one (1) time weekly for eight (8) weeks, then one (1) time monthly to ensure food is properly thawed and served at the required temperature to prevent harm to residents. The ED will report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting monthly. The QAPI committee will recommend and implement revisions to the plan as necessary to sustain substantial compliance. 5. AOC- 2/08/17	

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turkey product to prepare turkey for residents who received mechanical soft or pureed consistency diets.

On 01/03/17 from 12:07 PM to 12:24 PM DS #1 conducted temperature monitoring of the lunch food items, but did not monitor the temperature of the sliced undercooked turkey that remained uncovered on the steam table.

On 01/03/17 at 12:25 PM, DS #1 began the lunch meal tray line. The undercooked sliced turkey was plated for Residents #68 and #98 and their plates were placed on a delivery cart. On 01/03/17 at 12:35 PM the delivery cart was taken out of the kitchen by dietary staff at which time the surveyor intervened and stopped the delivery of the undercooked turkey to these residents. Temperature monitoring by district dietary manager (DDM) #1 conducted on 01/03/17 at 12:36 PM at the request of the surveyor revealed the sliced undercooked turkey on the steam table was 121.7 degrees F. DDM #1 stated that he would place the sliced turkey in the steamer and reheat it to at least 165 degrees F. DDM #1 further stated that he did not see DS #1's process of temperature monitoring for the turkey breast, because he was making gravy, but that he did see her slice and weigh the turkey. DDM #1 further stated that due to his vantage point, he could not see the color of the turkey juices because the pan was blocking his view.

On 01/03/17 at 12:37 PM, the facility policy "Food Preparation" revised May 2014, was reviewed with DS #1 and district dietary manager (DDM) #1. In review of the policy, DS #1 stated she was not aware of the expectation to cook poultry to an internal temperature of at least 165 degrees F.

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DDM #1 stated he was aware of the safe food handling practice to cook poultry to a minimum internal temperature of 165 degrees F and expected this practice to be followed.

On 01/03/2017 at 12:48 PM, during an interview with the dietary manager (DM) and DS #1, the DM was asked to provide recipes for the 01/03/17 lunch meal for review. The DM stated that she was off the previous weekend and had just returned to work on Monday, 01/02/17. The DM stated she had not previously printed the recipes for DS #1's use and would have to print the recipes from the computer. The DM further stated "I usually print out recipes and keep them in a book for the cook, but I did not today, I am hands on, I work along with them (cooks), but today my delivery from (named vendor) was late and I was trying to get those items put away." The DM provided the turkey recipe for review and during review of the recipe the DM stated DS #1 should have known to cook the turkey breast to an internal temperature of at least 165 for 15 seconds. The DM also stated that she was not present while DS #1 conducted temperature monitoring of the turkey, but was putting her stock away. DS #1 confirmed that she did not refer to a recipe when she prepared the raw frozen turkey breast for lunch on 01/03/17. Review of the recipe Turkey, Roast 3 ounce portion, revealed the following instructions:

· Roast raw frozen turkey in the oven at 350 degrees F for 2 - 4 hours or until done.
· Let stand 20 minutes before slicing.
· Cook to a minimum internal temperature of 165 degrees F for 15 seconds.

On 01/03/17 at 1:41 PM, during a follow up interview, DS #1 stated the turkey breast she

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prepared for lunch that day was frozen when she arrived to work at 5:30 AM. DS #1 stated she removed the turkey breast from the freezer, placed it in a pan under cold running water, uncovered, to thaw. DS #1 further stated that there was a frozen turkey breast in the freezer just like the one she cooked that morning. Review of the manufacturer's instructions on the box of the frozen turkey breast revealed the following:

· The case contained 2, raw, ready to cook, in a bag, boneless turkey breasts, 8 - 10 pounds each.

· Cooking instructions included to "cook in bag".

· Safe handling instructions recorded in part "Some food products may contain bacteria that could cause illness if the product is mishandled or cooked improperly. For your protection follow these safe handling instructions, keep refrigerated or frozen, thaw in refrigerator or microwave, cook thoroughly in the bag."

DS #1 stated she did not cook the turkey in the safe oven plastic bag, but rather removed the plastic bag prior to cooking, nor did she review the box for cooking/safe food handling instructions.

On 01/03/17 at 1:56 PM, a follow up interview with the DM and review of the vendor invoice revealed the DM received the frozen turkey breast from the vendor on Tuesday, 12/27/16 and placed it in the freezer. The DM stated her usual practice was to remove frozen foods that required cooking, from the freezer, 3 days in advance and put them in the refrigerator to thaw, but that she forgot. The DM stated that she should have put the turkey in the refrigerator on Friday, 12/30/16 to thaw before taking the weekend off.

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F 371	Continued From page 26 On 01/03/17 at 1:58 PM, DS #1 stated in a follow up interview that she started cooking the turkey breast on 01/03/17 at 8:30 AM. DS #1 stated that she had never cooked a turkey that was frozen before because in the past the turkey breast was either thawed or already cooked for her by another cook. DS #1 also stated that she was not familiar with cooking meats in a plastic bag and had not seen this particular turkey product before. DS #1 stated she did not know internal temperature of the turkey breast had to reach 165 degrees or higher. DS #1 stated when she arrived to work at 5:30 AM and saw that the turkey was still frozen she started thawing it, in the plastic bag, uncovered, under cold running water, but that the turkey was still frozen in the middle when she put in the oven at 8:30 AM to cook at 350 degrees F. On 01/03/17 at 3:55 PM, during an interview with the administrator, director of nursing (DON), and the regional director of clinical services, the administrator stated that once he was made aware of the concern with the turkey breast prepared for the lunch meal that day, he re-educated the DM and DDM #1 on dietary services regarding sanitary conditions and safe food handling practices of raw frozen poultry. The administrator stated that it was his expectation that the dietary staff utilize and follow the facility's policies/recipes regarding food preparation and thawing foods to ensure safe food handling practices were followed and that these practices were monitored by the DM/DDM. On 01/04/17 at 11:25 AM, a follow up interview with the DM revealed she arrived to the facility on 01/03/17 after 8:00 AM. When the DM arrived, she stated she was informed by DS #1 that she	F 371		

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was thawing a turkey breast in the sink under cold running water to cook for lunch that day. The DM stated she did not observe the thawing process DS #1 used, but told DS #1 to make sure the turkey was submerged in water. The DM reviewed the facility policy "Food Storage: Cold", during the interview and stated she did not instruct DS #1 to thaw the turkey breast per the facility policy, but to make sure the turkey was submerged in water. The DM stated she did not discuss plans for cooking the turkey or what the final cooking temperature of the turkey should be with DS #1. DM stated she did not observe the full process of temperature monitoring by DS #1, but rather "I was putting stock away. I did not see that the (turkey) juices still had blood in it." The DM stated that she ordered a raw/frozen turkey product for delivery on 12/27/16 that she was familiar with and it usually came in a foil pouch, but the facility received an unfamiliar raw/frozen turkey product that was in a plastic bag. The DM stated that she had been the DM for the facility for 3 months and that this was the first time that she forgot to take a frozen turkey breast out ahead of time to thaw. The DM stated she did not provide more oversight regarding the cooking process of the raw/frozen turkey to DS #1 because DS #1 had been trained and knew the cooking process. A review of the facility resident diet list with the DM revealed 34 residents received a regular consistency diet, but that 7 residents were either out of the facility or requested an alternate meal on 01/03/17 which left a total of 27 residents who could have received the undercooked turkey breast for lunch.

On 01/04/17 at 12:01 PM, DDM #2 was interviewed and stated he visited the facility bi-monthly, but that he had not observed a

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problem with temperature monitoring or cooking raw poultry to safe final internal temperatures. DDM #2 further stated that on Tuesday, 01/03/17 there was sufficient management oversight to ensure safe food handling practices were being followed. DDM #2 stated that he expected and trained dietary staff to thoroughly cook TCS food items to the correct internal temperatures, conduct temperature monitoring on the tray line and to serve TCS foods at the correct temperature/per facility policy. DDM #2 stated dietary staff should take temperatures of all foods on the tray line and follow menus/recipes, "had we done that for the turkey this would not have happened."

On 01/04/17 at 3:36 PM, an interview with the consultant registered dietitian (RD) revealed she primarily provided the facility with weekly clinical support, but that she was available for dietary support when needed. The RD stated when she visited the facility she observed some of the meal preparation in the kitchen, but that routine observations for dietary support/operations was conducted by the district manager. The RD stated that the facility missed the step of obtaining a temperature of the turkey breast on the tray line, she stated "that should have been done." The RD confirmed that there were currently 34 residents who received a regular consistency diet, but that 7 residents who were either out of the facility for lunch or requested an alternate meal did not receive turkey for lunch that day and that the remaining 27 residents could have received the undercooked turkey. The RD stated that she expected/trained dietary staff that raw poultry should be cooked to an internal temperature of at least 165 degrees F for 15 seconds per facility policy, and served at least

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140 degrees F. The RD stated that she expected dietary staff to use/follow facility policies/menus/recipes for preparing raw/frozen poultry.

On 01/05/17 at 12:32 PM, a follow up interview with DDM #1 was conducted via phone. DDM #1 stated he arrived to the facility at 11:30 AM on Tuesday, 01/03/17. The DDM #1 stated he was the routine DDM for the facility from August 2015 to May 2016, but that on Tuesday, 01/03/17 he was filling in for DDM #2. DDM #1 stated he was responsible for monitoring dietary practices/operations and served the facility in a dietary operations support role. DDM #1 stated he had worked with DS #1 during previous visits to the facility, but that it was his first time meeting the current DM. DDM #1 stated he was not aware that turkey was being served for lunch on Tuesday, 01/03/17 until the turkey breast was removed from the oven. DDM #1 also stated he was accustomed to seeing the facility cook a turkey breast in a foil package, not a plastic bag and that the turkey product prepared on Tuesday, 01/03/17 was a new product to him. DDM #1 stated he was not aware that the manufacturer for the turkey product the facility received recommended to cook the turkey breast in an oven safe plastic bag. DDM #1 also stated that since he did not know that the turkey breast was not cooked to an internal temperature of at least 165 degrees F for 15 seconds or that the juices still contained blood, he did not intervene, but had he known he would have placed the turkey back in the steamer/oven to obtain a temperature of at least 165 degrees F. DDM #1 stated "We should have obtained another temperature of the turkey before the tray line started, I did not notice that

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we did not." DDM #1 stated that he attributed the drop in temperature of the turkey breast to 121.7 degrees F to not reaching an initial internal minimum temperature of at least 165 degrees F and that the turkey was not covered on the tray line.

On 01/05/17 at 1:14 PM, DDM #2 provided a copy of the vendor's cooking instructions dated 01/05/17 at 8:41 AM that he received via electronic mail for the raw/frozen turkey breast. Review of the instructions revealed to bake the thawed turkey breast in the oven at 350 degrees for 2-3 hours or 20 mins per pound, bake in the original bag to an internal temperature of 160 degrees F; let the turkey breast rest for 30 minutes before slicing.

The immediate jeopardy was identified on 01/04/17. The facility administrator was notified of the immediate jeopardy on 01/04/17 at 12:20 PM.

The facility provided an acceptable credible allegation of compliance which included:

· On 1/3/17 at approximately 11:45am, the line cook recorded an internal temperature of turkey breast <165 degrees coming from the oven and dietary staff immediately stopped plate delivery when indicated by state surveyor.
· The turkey was immediately reheated in the streamer by the cook to the internal temperature of >165 degrees and lunch delivery by dietary staff continued. No harm resulted.
· On 1/3/17 at 2:00pm, the secondary District Dietary Manager (DDM) provided 1:1 reeducation to identified cook on sanitary food preparation and safe serve temperatures. Identified cook verbalized and documented by signature

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understanding.

· On 1/3/17 by 3:00pm, the facility Dietary Manager and secondary DDM reeducated dietary staff on site regarding sanitary food preparation to include thawing procedures as appropriate and serve safe temperatures. Emphasized was cooking and serving temperatures. Additional cooks/dietary staff will be educated prior to next shift.

· On 1/3/17 from 2:30-3:00pm, Impromptu QAPI meeting held with the Executive Director, Director of Clinical Services, Dietary Manager, District Dietary Manager, Regional Director of Clinical Services, District VP of Operations and District VP of Clinical Services to discuss and develop immediate plan of correction.

· On 1/4/17 by 7:00pm, the primary DDM provided detailed re-education to onsite dietary staff to include; 1.) thawing frozen items requiring defrosting before preparation under refrigeration in the microwave for immediate use or in a sealed container immersed in cold running water per policy 022 Food Storage: Cold, 2.) preparing menu items according to standardized recipes achieving minimum internal temperatures within guidelines provided by printed meal tracker recipes per Policy 014 Food Quality and Palatability, and 3.) ensuring safe serve minimum temperatures by using a calibrated thermometer placed in the thickest portion of the meat away from the bone, fat or gristle and in alternate meat depths, then allowing the thermometer to stop moving for at least 15 seconds and finally sanitizing probe using quaternary food sanitizer or wipes per Thermometer Use Guidelines. Dietary staff not attending initial training will receive education prior to starting next worked shift. Dietary Manager and dietary staff will be educated by the Primary District Dietary Manager

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upon hire and quarterly thereafter to ensure understanding of sanitary food practices for resident safety.

· To ensure meat is cooked to proper temperatures before serving, the cook will use a calibrated thermometer probe to insert into the center of the meat when removing from oven/cooking source to ensure internal temperature is within required guidelines and per policy and procedures. Once meat is within guidelines from the oven/cooking source, the cook will record on temperature log and place meat in warming tray to maintain safe serve temperatures. Prior to plating meat, the cook will again monitor and record line temperature of meat from heating tray to be within requirements for safe food holding temperatures of at least 140 degrees Fahrenheit. The cook will also utilize the "Cooks Log" which includes printed recipes, temperature logs for each meal and policies and procedures for reference.

· The Dietary Manager and cook are responsible for food preparation per policies and the DM will be responsible for randomly observing the cooks meal preparations to ensure proper procedures are being followed. Reeducation and/or disciplinary action will be implemented as appropriate to maintain compliance for the safety of the residents.

· QAPI team concluded root cause to be isolated human error. Identified cook has 1.) Serve Safe Certification, 2.) Education completed on 9/29/16 on safe food temperatures and preparation, 3.) Visual references posted in kitchen of sanitary food temperatures and 4.) Meal tickets specific to food product which indicates appropriate food temperatures. QAPI representative ED assured that cook involved in incident was educated and validated

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understanding of thawing, cooking and serve temperature requirements. QAPI representative ED also assured/will assure all staff educated or at oncoming shift and validate understanding of same. DDM and FSM were educated by District Registered Dietitian on 1/04/2016. DM has also been directed to randomly monitor staff and assist in temperature verification.

· On 1/3/17 by 4:00pm, the Unit Managers completed quality assurance monitoring on facility residents for gastrointestinal signs and symptoms during past 72 hours. No issues identified.

· On 1/3/17 during dinner preparation and on 1/4/17 during breakfast and lunch preparation, the staff cook tested and documented food temperatures within serve safe guidelines for protein as well as other items to assure reaching appropriate and safe internal temperature after cooking. The ED/DM/DDM visually validated compliance. The staff cook will continue to ensure appropriate food temperatures by testing food items per serve safe guidelines after cooking to ensure proper internal temperature for protein items is reached per recipe as well as on the service line. This will be monitored by the ED, FSM, DDM or other trained designated staff in their absence to assure continued compliance.

The immediate jeopardy was removed on 01/05/17 at 5:43 PM following observations of dietary staff thawing/cooking/monitoring temperatures of raw/frozen TCS food items according to recipes and interviews with dietary staff related to education received regarding thawing/cooking/monitoring temperatures of raw/frozen TCS food items. On 01/05/17 from 3:00 PM to 5:41 PM observations occurred of dietary staff thawing, cooking and monitoring temperatures of raw, frozen beef patties and raw, frozen pork chops per the recipe. Documentation

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F 371	Continued From page 34 was reviewed regarding staff in-services related to thawing/cooking/monitoring temperatures of TCS food items.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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	F 431		2/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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F 431	Continued From page 35 applicable. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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, record review, and staff interviews the facility failed to remove from use expired medication from 2 of 3 medication carts (100 hall and 400 hall medication carts). The findings included: Review of a facility policy titled "Storage and Expiration Dating of Medication, Biologicals, Syringes, and Needles" dated 12/01/07 and revised on 10/31/16 read in part, facility should ensure that medications and biologicals that 1) have an expired date on the label; 2) have been retained longer than recommended by manufacture or supplier guidelines; or 3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 1. Observation of the 100 hall medication cart on 01/05/17 at 12:44 PM revealed a card of 30 Metformin (anti-diabetic agent) 500 milligrams	F 431	F431 SS=D 1. On 1/5/17, the licensed nurse removed and properly disposed of expired medications from the 100 hall and 400 hall medication carts. 2. On 1/6/17, the Director of Clinical Services (DCS) completed a quality monitoring of medication carts and medication rooms and any expired medications were immediately removed for use and properly disposed. 3. By 1/27/17, the DCS reeducated licensed nurses on regulation 483.45(b)(2)(3)(g)(h) and the facility policy Storage and Expiration Dating of Medication, Biologicals, Syringes and Needles . Education included ensuring appropriate disposal of medications and biologicals that 1) have an expired date on the label;	

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F 431	Continued From page 36 (mg) tablets and an opened bottle of Sodium Chloride tablets 1 gram both of which expired on 12/31/16 and were on the medication cart available for use. Interview with the Director of Nursing (DON) on 01/06/17 at 2:24 PM revealed that the nurses were expected to perform daily checks of their medication carts and the medication rooms for expired medications. In addition to the daily checks by the nurses the unit managers were expected to check the medication carts and rooms 2 times a week and the pharmacy staff also checked the medications rooms and carts quarterly. The pharmacy staff last went through the medication carts and rooms in October or November 2016. The DON further stated that he expected the staff to check the medications carts and pull expired medication off the carts and return them to the pharmacy for destruction and that the expired medication should not have been on the medication cart available for use. Interview with Nurse #1 on 01/06/17 at 3:03 PM revealed that she was responsible for the 100 hall medication cart on 01/05/17 and that there were expected to check the medication carts each day for expired medications. Nurse #1 stated that she had not checked her cart yesterday because she had been off for 3 days and when she returned she was pulled in so many directions she just did not have the time. Nurse #1 stated that sodium chloride tablets had not been used in a while but they had kept them on the cart in case another resident needed them. Nurse #1 stated that the Metformin and Sodium Chloride tablets should have been pulled off the cart on 01/01/17 and should not have been on the medication cart available for use. 2. Observation of the 400 hall medication cart on 01/06/17 at 10:46 AM revealed 10 Lisinopril	F 431	2) have been retained longer than recommended by manufacture or supplier guidelines or 3) have been contaminated or deteriorated. Newly hired licensed nurses will be educated upon hire. The licensed nurse will perform daily monitoring of their medication cart and room for expired medications and remove them from the cart and store in designated location for pharmacy destruction. The Unit Manager will randomly monitor the medication carts and rooms weekly and the pharmacy nurse will monitor at least quarterly to ensure expired medications and biologicals are properly stored and destructed. 4. A quality monitoring of medication carts and rooms will be completed by the DCS or designated Unit Manager at a frequency of three (3) times weekly for four (4) weeks, then one (1) time weekly for eight (8) weeks, then one (1) time monthly for three (3) months to ensure expired medications are removed from use and stored for pharmacy destruction as appropriate. The ED will report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting monthly for (12) months. The QAPI committee will recommend and implement revisions to the plan as necessary to sustain substantial compliance. 5. AOC- 2/08/17	

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F 431	Continued From page 37 (antihypertensive) 5 mg tablets that contained an expiration date of 12/31/16. Interview with Nurse #2 on 01/06/17 at 10:46 AM revealed that the nurses were expected to check their medication carts on a daily basis. Nurse #2 stated she had gone through her medication cart earlier in her shift and had "just missed" the expired Lisinopril. Nurse #2 further stated she would pull it off the cart return it to the pharmacy for destruction. Interview with the Director of Nursing (DON) on 01/06/17 at 2:24 PM revealed that the nurses were expected to perform daily checks their medication carts and the medication rooms for expired medications. In addition to the daily checks by the nurses the unit managers were expected to check the medication carts and rooms 2 times a week and the pharmacy staff also checked the medications rooms and carts quarterly. The pharmacy staff last went through the medication carts and room in October or November 2016. The DON further stated that he expected the staff to check the medications carts and pull expired medication off the carts and return them to the pharmacy for destruction and that the expired medication should not be on the medication cart available for use.	F 431		