STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING ______ B. WING ______	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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 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, 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	F 157		7/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/21/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 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 record review, resident, staff and family interview, the facility failed to notify a resident who was his own responsible party and a family member who the resident preferred to be notified of medication or treatment changes for 1 of 2 residents reviewed (Resident #138). Findings included: Record review revealed Resident #138 was admitted to the facility on 1/23/2017 with cumulative diagnoses which included Hypertension and Atrial Flutter (abnormal beating of the heart). Review of the Annual Minimum Data Set (MDS) assessment dated 12/5/2016 indicated Resident #138 was cognitively intact. The MDS also indicated it was very important to have family involved in discussion about his care. A review of the physician orders revealed the following orders with no documentation of resident or family member notification: 5/26/2017-Podiatry consult 5/26/2017-Regular diet with no fried foods 5/29/2017-Discontinue Physical Therapy services 6/2/2107-Discontinue Occupational Therapy services	F 157	F157 A care plan meeting was scheduled on 07/13/2017 for resident #138 and the resident□s spouse which he prefers to be present however the resident□s spouse did not show to discuss the resident□s current medications and treatments and any order changes. The Social Worker will continue to reach out to resident # 138□s spouse to reschedule the care plan meeting. On 06/26/2017 all residents to include resident #138 Physician orders from 5/26/2017-07/04/2017 were reviewed to ensure all residents if own responsible party, family members who residents preferred to be notified, and resident representative for non-alert and oriented residents had been notified of all new orders and medications or treatment changes and to verify that the notification was documented in the Medical Record by a facility Nurse. All identified areas of concern will be addressed by the Director of Nursing and Assistant Director of NURSING (ADON) by 07/30/2017 with	

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F 157	Continued From page 2 6/2/2017-Decrease Ativan to 0.5 milligrams every 6 hours for anxiety/agitation An interview was conducted with Resident #138 on 6/19/2017 at 3:01PM. The resident stated the facility staff did not tell him when medication changes or treatment changes were made. The resident further stated the staff did not inform his family member of the changes. An interview was conducted with Resident #138's family member on 6/21/2917 at 11:31AM. The family member stated the facility staff did not inform her of the resident's medication changes. The family member further stated they did not notify her about any changes and she asked if she needed to know something. An interview was conducted with Nurse #6 on 6/21/2017 at 4:00PM. Nurse #6 revealed she worked with the resident almost every day. Nurse #6 stated the resident's family member visited almost daily. Nurse #6 indicated she informed the resident and family member when changes were made. Nurse #6 further indicated since the family member was at the facility so often, she just didn't think to document the notification. An interview was conducted with the Director of Nursing (DON) on 6/21/2017 at 4:18 PM. The DON stated the expectation was for the facility staff to notify the resident if appropriate and the family member of any medication changes, treatment or any other changes in services provided.	F 157	notification to the resident, family member, and/or resident representative as appropriate with document in the medical record. 100% In-servicing of all license Nurses to include nurse #8 was initiated on 06/17/2017 by the Unit Manager and re-presented on 06/23/2017 by ADON and will be completed by 07/20/2017regarding notification of the resident if own responsible party, family members who residents preferred to be notified, and/or resident representative for non-alert and oriented residents immediately upon receipt of ALL new orders or changes in medication and treatment orders. All newly hired Nurses will be in-serviced regarding notification of the resident if own responsible party, family members who residents preferred to be notified, and/or resident representative for non-alert and oriented residents immediately upon receipt of ALL new or changes in medication and treatment orders. When a license nurse receives a verbal or written physician order, the license nurse is responsible for processing the order to include order transcription and immediately notifying the resident, family member, and/or resident representative as appropriate upon receipt of the order and documenting the notification in the medical record. Physician orders will be reviewed for all Residents to include Resident #138, 3 x a week for 4 weeks then weekly for 4 weeks, then monthly x 1	

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F 157	Continued From page 3	F 157	month to ensure that the residents if own responsible party, family members who residents preferred to be notified, and/or resident representative for non-alert and oriented residents were notified of new orders and changes to medication and treatment orders with documentation in the medical record utilizing a Notification QI Audit Tool by the ADON and Quality Improvement (QI) Nurses. The ADON will immediately retrain the license nurse and ensure the notification is completed with documentation in the medical record during the audit, for any identified areas of concern. The Director of Nursing will review and initial the Notification QI Audit Tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern are addressed. The Director of Nursing will forward the results of the Notification QI Audit Tool to the Executive QI Committee monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The	F 272		7/20/17

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assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with the resident, as well as communication with licensed and
non-licensed direct care staff members on all shifts.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

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F 272	Continued From page 5 This REQUIREMENT is not met as evidenced by: The facility failed to include a side rail assessment for side rail safety for 1 of 1 residents which resulted in lack of a completed accurate comprehensive assessment (Resident #46). Findings included: Record review revealed Resident #46 was admitted to the facility on 12/11/2015 with diagnoses which included Hypertension, Osteoarthritis and a history of a stroke with right sided hemiparesis. The Annual Minimum Data Set (MDS) dated 11/11/2016 revealed the resident was cognitively intact, required extensive to total assistance with Activities of Daily Living (ADLs) and was non ambulatory. The MDS Assessment also indicated bed rails were not used for the resident. The Care Area Assessment (CAA) dated 11/11/2016 indicated the resident needed extensive to total assistance with her ADLs due to the right sided hemiparesis. The CAA further indicated the area went to care plan. The Care Plan initiated on 11/11/2016 and revised on 4/27/2017 revealed the resident required assistance for transferring from one position to another related to right hemiparesis. The goal was the resident would receive the necessary physical assistance through the next review. An observation and interview with Resident #46 was conducted on 6/19/2017 at 2:58 PM. The resident was observed to be well kempt lying in an electric bed and ½ side rails were observed on both sides of the bed. The side rails were securely attached to the bed with no space	F 272	3) F272 483.20(b) (1) COMPREHENSIVE ASSESSMENTS A side rail safety assessment was completed for resident #46 by the Minimum Data Set Nurse (MDS) on 06/21/2017 and documented in the resident□s medical record. The side rail assessment for resident #46 completed on 06/21/2017 by MDS Nurse, revealed that the side rails were safe, securely attached to the bed with no space between the rails and the mattress and used to assist resident to turn and reposition. A progress note was entered into resident #46 medical record and the resident care plan and care guide will be updated to address the use of the side rails by MDS Nurse by 07/20/2017. A 100% side rail safety assessments were completed for all residents□ to include resident #46 by Assistant Director of Nursing (ADON), Unit Manager, Quality Improvement (QI) Nurse LPN, & QI Lab Nurse on 06/21/2017 to ensure safety of the side rails, ensure side rails were not a restraint, and to identify use for side rails with documentation in the medical records. There were no side rails that were found to be unsafe or used as restraints during the audit. A 100% audit will be completed of all resident□s last comprehensive assessments utilizing a census sheet to include resident #46 by the Director of Nursing (DON) by 07/19/2017 to ensure assessments were accurate to include side rail assessments	

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between the rails and the mattress observed. The resident was observed during the interview repositioning herself several times with the assistance of the side rails. The resident stated she used the rails to reposition in bed.

An interview was conducted with the MDS nurse on 6/21/2017 at 11:08 AM. The MDS nurse stated she was aware Resident #46 had side rails on both sides of her bed which she used for positioning. The MDS nurse stated the side rails were not included in the assessment because they were not used as restraints. The MDS nurse further stated she was unaware of any side rail safety assessment completed for the resident.

An interview was conducted with the Director of Nursing (DON) on 6/21/2017 at 2:44 PM. The DON stated she was aware Resident #46 had side rails on her bed. The DON reported there was not a safety assessment tool for side rails used by the facility. The DON further reported she was unaware of any side rail safety assessment conducted for Resident #46. The DON stated the expectation was for side rails to be accurately assessed for safety.

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for side rail safety. A progress note will be entered into the resident medical record and the resident care plan and care guide will be updated for all comprehensive assessments that did not include the use of side rails by the MDS Coordinator and MDS Nurses by the 07/20/2017 with oversight of the DON.

All MDS nurses were re-educated on the requirement of completing an accurate comprehensive assessment to include ensuring a side rail assessment is completed for side rail safety and documented in the medical record and factors impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary to include the use of side rails are addressed by the DON on 06/28/2017.

The ADON, QI Nurse LPN & QI Lab Nurse LPN or her designee will audit 10% of all comprehensive assessments completed during the previous week to include any assessments for resident #46 3 times a week, weekly x 8 weeks, then monthly x 1 month to ensure the assessment is accurate and complete to include side rail assessment for side rail safety with documentation in the medical record and factors impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary to include use of side rails were addressed utilizing a Comprehensive Assessment QI Audit tool. The ADON, QI Nurse LPN, & QI Lab Nurse LPN will reeducate the MDS nurse and significant corrections to the

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F 272	Continued From page 7	F 272	MDS assessment will be completed as necessary for any identified areas of concerns during the audit. The Director of Nursing will review and initial the a Comprehensive Assessment QI Audit tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern are addressed. The Director of Nursing will forward the results of the Comprehensive Assessment QI Audit tool to the Executive Quality Improvement Committee monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 315		7/20/17

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F 315	Continued From page 8 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview the facility failed to provide scheduled or prompted toileting for a resident identified as appropriate for a scheduled toileting program, which resulted in a risk for increased urinary incontinent episodes for 1 of 1 residents (Resident #138). Findings included: Record review revealed Resident #138 was admitted to the facility on 1/23/2017 with cumulative diagnoses which included Hypertension and Atrial Flutter (abnormal beating of the heart). Review of the Quarterly Minimum Data Set (MDS) dated 3/1/2017 indicated Resident #138 was cognitively intact. The MDS revealed the	F 315	483.25(e)(1)-(3) No Catheter, Prevent UTI, Restore Bladder F315 Resident #138 will be reviewed for the appropriateness of the scheduled toileting program by the Minimum Data Set (MDS) Nurse on 06/23/2017. The care plan and the care guide will be updated as needed based on the review by MDS Nurses on or before 06/30/2017. Resident #138 will continue to be toileted by the facility as appropriate. 100% audit was completed of all current resident□s to include resident #138 documentation for the last 30 days, who are on a toileting program to include schedule or prompted toileting, to ensure	

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resident required one person assistance with toileting, was occasionally incontinent of urine and was on a toileting program.

Review of the most recent MDS 14 day readmission assessment dated 4/30/2017 indicated Resident #138 was cognitively intact, required one person assistance with toileting, was frequently incontinent of urine and was on a toileting program.

Care Area Assessment dated 5/10/2017 revealed resident was frequently incontinent of bladder, required assistance with toileting and was on a scheduled toileting program. The Care Area of urinary incontinence proceeded to care plan.

Review of the Care Plan updated 5/10/2017 included a focus for the potential to restore or maintain maximum function for the physical process of toileting. The interventions included a scheduled toileting program for the resident to be toileted before meals, after meals, at bedtime and as needed. The goal was the resident would remain dry of urine at least 75% of the time.

Review of the nursing notes revealed a note on 5/11/2017 at 6:22 PM by the MDS nurse. The note indicated Resident #138 continued on the scheduled toileting program. The note further indicated the MDS nurse informed the resident's nurse to continue with the toileting program. The note specified the nurse or nursing assistant (NA) were to offer the urinal before and after meals, at bedtime and frequently in between.

Review of the nursing notes revealed a note on 5/16/2017 at 5:12 PM by the MDS nurse. The note reported the resident remained on the

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the resident is being toileted per the identified program by the MDS Coordinator on or before 06/30/2017. 100% of all residents currently on a toileting program, to include resident #138, was reviewed to determine that the program is appropriate by the MDS Nurses and will be completed by 06/30/2017. Once the appropriate toileting program was determined, the care plan and care guide was updated as needed based on the review by MDS Nurses on or before 06/30/2017.

100% of all nursing staff, licensed nurses and nursing assistants(NA), to include Nurse #6 & NA: #5 ,will be in-serviced by the Staff Facilitator and will be completed by 7/20/17, regarding what a toileting program is to include schedule toileting with examples to include toilet before meals, after meals, at HS and/or as needed, how to identify residents who are on a schedule toileting program by reviewing the resident care guide prior to starting care, following the resident care guide, documenting the toileting program in the electronic medical record, and notifying the assigned hall nurse and MDS nurse of any changes in a resident□s ability to toilet and/or changes in bowel and bladder continence. All newly hired licensed nurses and NA□s will be in-serviced during orientation by the staff facilitator regarding what a toileting program is to include schedule toileting with examples to include toilet before meals, after meals, at HS and/or as needed, how to identify residents who are

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F 315	Continued From page 10 scheduled toileting program and was more alert since medication changes. The note reported the resident showed some improvement in the scheduled toileting. An interview was conducted with Nurse #6 on 6/21/2017 at 3:00PM. Nurse #6 indicated she worked with Resident #138 almost daily on the day shift. Nurse #6 stated the resident was incontinent of urine and was not on a scheduled toileting program. Nurse #6 further stated the NAs were responsible for scheduled toileting. An interview was conducted with NA #5 on 6/21/2017 at 3:20 PM. NA #5 reported working with Resident #138 practically every day. NA #5 said the resident was incontinent all the time. NA #5 stated the computer system indicated the resident was on a scheduled toileting program. NA #5 stated the resident was alert and oriented and would report when he needed to be changed and the toileting program consisted of changing the resident when requested or when it was needed. NA #5 further stated the resident was not offered a urinal or assisted to the bathroom because he was incontinent. An interview was conducted with the MDS nurse on 6/21/2017 at 3:33 PM. The MDS nurse stated Resident #138 was initially placed on a toileting program because he attempted to get up and go to the bathroom unassisted. The MDS nurse indicated the resident had a recent hospitalization and returned much more alert and capable of letting the staff know when he needed to urinate. The MDS nurse stated a discussion was held with the resident's family member who agreed it would benefit the resident for the scheduled toileting to be continued. The MDS nurse said she	F 315	on a schedule toileting program by reviewing the resident care guide prior to starting care, following the resident care guide, documenting the toileting program in the electronic medical record, and notifying the assigned hall nurse and MDS nurse of any changes in a resident□s ability to toilet and/or changes in bowel and bladder continence. The Quality Improvement (QI) Nurse, LPN & QI Lab Nurse, LPN will monitor documentation and complete resident care observations on all of the residents on a toileting program to include a schedule toileting program to ensure the resident, to include resident #138, are toiled per the program to prevent increased incontinence episodes utilizing a Scheduled Toileting QI tool weekly times 8 weeks then monthly times one month utilizing the Scheduled toileting QI Tool. The licensed nurse or NA will be immediately re-trained during the audit by the ADON for any identified areas of concern. The DON will review and initial the Scheduled Toileting QI tool for completion and to ensure all areas of concerns were addressed weekly times 8 weeks then monthly times one month. The Director of Nursing will forward the results of the Scheduled Toileting QI tool to the Executive Quality Improvement Committee monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 315	Continued From page 11 personally spoke to the nursing staff and the NAs regarding the plan, included the toileting program on the resident's care guide which was located inside his closet door and included it in the care plan. The MDS nurse stated the toileting schedule was not new for the resident and was unaware the schedule was not followed. An interview was conducted with Resident #138 on 6/21/2017 at 3:55 PM. The resident was in his room resting in bed. The resident was alert and oriented to person, place and time. The resident stated he was unaware at times when he needed to urinate and he wore a brief at all times. The resident stated no one asked if he needed to use the urinal or go to the bathroom. The resident further stated he was unaware of a scheduled toileting program to prompt or remind him of the need to urinate. The resident said he would let the staff know when he needed to be changed. The resident's care guide was observed to be inside the closet door and the care guide included the instructions for the resident's scheduled toileting program. An interview was conducted with the Director of Nursing (DON) on 6/21/2017 at 4:21 PM. The DON stated the expectation was any resident identified as appropriate for a scheduled toileting program to be offered toileting before and after meals, at bedtime and frequently throughout the day to prevent an increase in incontinence.	F 315		
F 371 SS=D	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.	F 371		7/20/17

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F 371	Continued From page 12 (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 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 observation and staff interview, the facility failed to remove an expired protein supplement from one of seven medication carts reviewed for storage. Findings included: On 6/21/2017 at 11:41 AM, an inspection of the 600 hall medication cart revealed a canister of Beneprotein supplement with an expiration date of 1/11/2017. Nurse #2 stated in an interview on 6/21/2017 at 11:45 AM, the resident who received the protein supplement had been discharged. Nurse #2 stated all medications on the cart should be checked for expiration dates.	F 371	F371 483.60 (i)(1)-(3) Food Procure, Store/Prepare/Serve On 6/21/17 nurse# 2 removed the protein supplement, Beneprotein, from the 600 hall medication cart that was expired and discarded it with oversite by Director of Nursing (DON). 100% of all medication carts, to include the 600 hall cart, and all medication rooms were audited for expired medications/protein supplements, to include Beneprotein and discharged residents medications/protein supplements by the Unit Manager, Quality Improvement (QI) Nurse LPN, QI Lab	

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F 371	Continued From page 13 On 6/21/2017 at 3:00 PM, the Director of Nursing (DON) stated she expected the nurses to check all medications for expiration, including supplements.	F 371	Nurse LPN, and QI Nurse RN on 06/23/2017 utilizing a Medication carts and Med rooms/Expired medications QI Tool to ensure no expired medications/protein supplement and discharge residents/protein supplements were on the medication carts/medication rooms. Any items found to be expired or for discharged residents were discarded and/or returned to pharmacy appropriately per policy during the audit by the Unit Manager, QI Nurse LPN, QI Lab Nurse LPN, and QI Nurse RN. There were no negative findings from the audit. 100% in-service to all licensed nurses to include nurse# 2 and medication aides was initiated on 6/21/17 by the Director of Nursing (DON) regarding checking medication rooms and medication carts for expired meds and protein supplements, to include Beneprotein, prior to administration; immediately removing all medications and protein supplements for discharged residents; discarding expired items and/or returning to pharmacy discharged residents medications/protein supplements appropriately per policy and to date medications that require dating when opened. This inserivce will be completed by 7/20/17. All newly hired licensed nurses and medication aide□s will be in-serviced during orientation by the staff facilitator regarding checking medication rooms and medication carts for expired meds and protein supplements, to include Beneprotein, prior to administration, immediately removing all medications and	

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F 371	Continued From page 14	F 371	protein supplements for discharged residents, discarding expired items and/or returning discharged residents appropriately per policy and to date medications that require dating when opened. A list of Medication Discard dates from the Pharmacy will be placed in front of every Medication Administration Record on all medication carts in the facility as a reference to be utilized by the licensed nurse and medication aides, by the Unit Manager, QI Nurse LPN & QI Lab Nurse LPN and was completed on 06/23/2017. All Medication Carts and medication rooms will be monitored using a Medication carts and Med rooms/Expired medications QI Tool to ensure all medication rooms and medication carts do not have expired medications and/or protein supplements, to include Beneprotein, and all discharged residents medications and supplements have been removed, discarded, and/or returned per policy by the Unit Manager, QI Nurse LPN, & QI Lab Nurse LPN, weekly times 8 weeks then monthly times 1 month. The licensed nurses and medication aides will be immediately re-trained during the audit by the Unit Manager for any identified areas of concern. The DON will review and initial the Medication cart/Expired medications QI Tool for completion and to ensure all areas of concerns were addressed weekly X�s 8 weeks then monthly X�s 1 month. The Director of Nursing will forward the	

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F 371	Continued From page 15	F 371	results of the Medication carts and Med rooms/Expired medications QI Tool to the Executive Quality Improvement Committee monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
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.	F 431		7/20/17

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F 431	Continued From page 16 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (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 observation, staff interview and record review, the facility failed to ensure medication storage was free of expired vaccine and biologicals for 2 of 4 med rooms (Station 1 and Station 4). Findings included: On 6/21/2017 at 10:00 AM, Station 1 medication storage room refrigerator contained 4 prefilled, single dose, 0.5 milliliter (ml) syringes of Flu AD. The lot numbers were the same: 165902. Expiration date of 4/2017 was on all 4 syringes. Tubersol (for tuberculosis testing) vial #1 opened and undated with the Lot # C5036AA. Expiration	F 431	F 431 483.45 (b)(2)(3)(g)(h) Drug Records, Label/Store Drugs and Biologicals The 4 pre-filled syringes of Flu AD that were expired and Tubersol vial #1 and vial #2 that were opened and not dated, were discarded per policy from Station 1 on 6/21/17 by the Quality Improvement Nurse (QI). The 4 pre-filled syringes of Flu AD that were expired and 4 vials of Tubersol that were opened and not dated, were discarded per policy from Station 4 on 6/21/17 by the Staff LPN Nurse for 900 &	

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F 431	Continued From page 17 21 Oct 2018.Tubersol vial #2 opened and undated with the Lot # C4904AA. Expiration 21 Oct 2018. On 6/21/2017 at 10:15 AM, in an interview, Nurse #1 stated all meds should be checked for expiration and any multi - dose vial should be dated when opened. On 6/21/2017 at 12:15 PM, Station 4 medication storage room refrigerator had 4 prefilled syringes of 0.5 ml Flu AD with the same lot # of 165902 and expiration dated 4/2017. Tubersol multi dose vials #4 with the same Lot # C5036AA and expiration dated 21 Oct 2018, all 4 were opened and undated. The Director of Nursing (DON) was present during this observation and stated her expectation was the flu vaccines would have been sent back and the Tubersol would have been dated when opened.	F 431	1100 Hall with over sight of the Director of Nursing (DON). 100% audit was completed on all medication carts and medication rooms to include Station 1 and station 4 med rooms to ensure all med rooms and medication carts, did not have any medications to include vaccines and biologicals that were expired and/or any medications that were opened and required an open date were dated as appropriate by the Director of nurses (DON), Assistant Director of nurse, (ADON) Unit Manager and the LPN Quality Improvement (QI) nurses (2) on 6/23/17. Any areas of concerns were addressed at that time by the Director of nurse (DON), Assistant Director of nurses (ADON) Unit Manager and the LPN Quality Improvement (QI) nurses (2) by discarding the medications per policy. 100% inservice to all licensed nurses to include nurse #1 and medication aides was initiated on 6/21/17 by the DON and will be completed by 7/20/17 regarding checking medication rooms and medication carts for expired meds, to include vaccines and biological to include prior to administration of the medication, discarding appropriately per policy and dating medications that require dating when opened. All newly hired licensed nurses and medication aides will be in-serviced during orientation by the staff facilitator regarding checking medication rooms and medication carts for expired meds, to include vaccines and biological to include prior to administration of the	

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F 431	Continued From page 18	F 431	medication, discarding appropriately per policy and dating medications that require dating when opened. A list of Medication Discard dates from the Pharmacy will be placed in front of every Medication Administration Record on all medication carts in the facility as a reference to be utilized by the licensed nurse and medication aides, by the Staff Development Coordinator and completed on 06/23/2017. All Medication Carts and medication rooms will be monitored using a Medication carts and Med rooms/Expired medications QI Tool to ensure all medication rooms and medication carts do not have expired medications to include vaccines and biologicals, and medications that require a date when open are dated as appropriate, by the ADON, Unit Manager, and the LPN QI nurses (2), weekly x 8 weeks then monthly x 1 month. The licensed nurse or medication aide will be immediately re-trained during the audit and medication discarded per policy by the ADON for any identified areas of concern. The DON will review and initial the Medication cart/Expired medications QI Tool for completion and to ensure all areas of concerns were addressed weekly X□s 8 weeks then monthly X□s 1 month. The Director of Nursing will forward the results of the Medication carts and Med rooms/Expired medications QI Tool to the Executive Quality Improvement	

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F 431	Continued From page 19	F 431	Committee monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the	F 520		7/20/17

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F 520	Continued From page 20 records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 observation, staff and resident interviews and record review, the facility Quality Assessment and Assurance (QA) Committee failed to maintain and monitor interventions that were put into place 8/26/16. These interventions were originally cited in the recertification and complaint investigation survey of 7/14/16 and recited in the recertification and complaint survey of 6/22/17. The deficiencies were in the areas of services to provide scheduled toileting programs for identified residents with urinary incontinence. The failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings include: This citation is cross referenced to: 1. F315. Based on record review, observation and staff and resident interview the facility failed to provide scheduled or prompted toileting for a resident identified as appropriate for a scheduled toileting program, which resulted in a risk for increased urinary incontinent episodes for 1 of 1 residents (Resident #138). The facility was cited at F315 during the recertification / complaint survey of 7/14/16 for failure to evaluate a resident for participation in a toileting program.	F 520	F 520 The Administrator and Director of Nursing (DON), and Quality Improvement Nurses will be educated by the corporate consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include for providing scheduled toileting programs for identified residents with urinary incontinence on 07/20/2017. The Administrator, DON, & QI Nurse Times 2 will be educated by corporate consultant on the QA process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on 07/20/2017. The Facility Consultant, Administrator, DON will completed 100% audit by 07/20/2017 of previous citations and action plans within the past year to include providing scheduled toileting programs for	

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F 520	Continued From page 21 During an interview with the Director of Nursing (DON) on 6/21/2017 at 4:21 PM. The DON stated the expectation was any resident identified as appropriate for a scheduled toileting program to be offered toileting before and after meals, at bedtime and frequently throughout the day to prevent an increase in incontinence. During an interview on 6/22/17 at 5:30 PM, the DON stated the Quality Assurance Committee met monthly to identify any issues that required interventions and follow-up.	F 520	identified residents with urinary incontinence to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans will be revised and updated and presented to the QI Committee by the DON & QI Nurses by 07/20/2017 for any concerns identified. All data collected for identified areas of concerns to include providing scheduled toileting programs for identified residents with urinary incontinence will be taken to the Quality Assurance committee for review monthly x 4 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by QI Nurses. The corporate consultant will ensure the facility is maintaining an effective QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include providing scheduled toileting programs for identified residents with urinary incontinence are followed and maintained Quarterly x2. The corporate consultant will immediately retrain the Administrator, DON, or QI Nurses for any identified areas of	

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F 520	Continued From page 22	F 520	concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	