STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING _____ B. WING _____	C 06/30/2017

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MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

(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 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to lock all medications, and biologicals, including treatment items. The facility had residents with severe cognitive impairment who had access to these items. (Residents #38, #49). Findings included: 1. Resident #38 was admitted 08/07/2009 with a diagnosis of dementia. The quarterly Minimum	F 323	How the corrective action will be accomplished for the resident(s) affected □ On 6/26/17, it was noted that the facility failed to lock the central supply medication storage room. On 6/29/17 the maintenance director removed the key lock and replaced it with a keypad entry lock to ensure that the door will remain locked at all times.	7/21/17

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

Electronically Signed | 07/18/2017

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F 323	Continued From page 1 Data Set (MDS) dated 06/01/2017 assessed the resident as severely cognitively impaired. It documented the resident used a wheelchair with limited assistance. An observation on 06/28/2017 at 10:00 AM revealed the central supply medication storage room on the main hallway was unlocked and Resident #38 (nonverbal) was seated in front of the unlocked door. This resident was observed self-propelling down the hallway attempting to open the bathroom and activity room doors which were in close proximity to the central supply room door where medications, sharps and treatment items were stored. An observation of the central supply storage room on 06/28/2017 at 11:15 AM stock medications including bottles of Aspirin 81 milligrams (mg), Ibuprofen 200mg tablets, Aspirin 325mg, eye drops artificial tears, bottles of Milk of Magnesia 16oz. bottles, Melatonin, Prevacid, Tussin DM 12oz bottles, guaifenesin expectorant 400mg tablets, Senna Lax tablets, and Mira lax were stored in this room and the door was unlocked. There were sharp items insulin syringes, needles and scissors in this room. There were treatment items including bottles of povidone iodine solution. An interview on 06/28/2017 at 11:51 AM with Nurse #2 the central supply medications storage area for stock medications was left unlocked so staff had access to the supplies. An interview on 06/28/2017 at 12:15 PM with Nurse # 3 stated central supply stocked the medication rooms on the floor but if there was something they needed and it was not in the	F 323	How corrective action will be accomplished for those residents with the potential to be affected by the same practice New keypad door lock was installed on central supply room door on 6/29/17. No residents were affected by deficient practice. Measure to be put in place or systemic changes made to ensure practice will not re-occur A keypad lock was placed on the door on 6/29/2017, the door is currently locked and residents do not have access to the supplies. A keypad lock will remain on the door at all times. Staff will be educated on making sure that the door remains closed and locked at all times. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur Maintenance Director will check the function of the door weekly x4 weeks. To ensure continuum of care, it will also be reviewed at the quarterly QA meeting for the next 3 months to ensure compliance. Maintenance Director will implement changes for F323.	

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medication room, they would get it from the central supply room. The central supply room door was not kept locked.

An observation on 06/28/2017 at 3:30 PM revealed Resident #38 a confused resident in a wheelchair was in front of the central supply room door. The resident was attempting to self-propel down the hallway. The central supply medication storage room door was unlocked.

An observation on 06/28/2017 at 4:59 PM the central supply/stock medication room with the Director of Nursing (DON) revealed the door to the room was unlocked and no staff were in the room.

An interview on 06/28/2017 at 6:23 PM with the DON revealed the central supply /stock medication storage room on the main hallway was unlocked during the day. It was locked at night by the receptionist when she left at 6 PM. She stated the receptionist must have left the central supply room door unlocked since they were still all there. She stated the door was left open until 6:00 PM so the department heads could have access to the printer that is in the room.

An interview on 06/29/2017 at 10:53 AM the receptionist stated the central supply staff person left at 4:30 PM each day and left the central supply room door unlocked. She would make sure at 6:00 PM before she left the door was locked to the central supply room. She stated the central supply person left the door open so staff could have access to the printer.

An observation on 06/29/2017 at 11:24 AM

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Resident #38 was self-propelling herself in her wheelchair and opened the door and let herself into the activity room across from the central supply room. She needed to be redirected by staff.

An observation on 06/29/2017 at 12:00 PM revealed the central supply room with medications, sharps and treatment supplies was unlocked.

An observation on 06/29/2017 at 1:11 PM revealed Resident #38 again opened the door and rolled herself in her wheelchair to the activity room door which was across from the central supply storage area that was unlocked.

An interview on 06/29/2017 at 3:445 PM with the DON and Administrator revealed the central supply storage room door was unlocked. The DON stated that when the central supply person is working she did leave the room to make deliveries to the units. She stated the only reason people come in the storage room was to use the copier and that is why it is left open. The DON and Administrator both agreed that they have cognitively impaired residents who go up and down the main hallways in front of the door to this room. The Administrator stated his expectation was that the facility follows their policies and procedures for medication storage and items that were potentially harmful to the residents were secured at all times.

2. Resident #49 ' s was admitted 12/16/11 with a diagnosis of Alzheimer ' s disease. The quarterly MDS dated 05/08/2017 assessed the resident as severely cognitively impaired and being rarely understood. It documented the resident used a

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wheelchair.

An observation on 06/28/2017 at 10:00 AM revealed the central supply medication storage room on the main hallway was unlocked and Resident #38 (nonverbal) was seated in front of the unlocked door. This resident was observed self-propelling down the hallway attempting to open the bathroom and activity room doors which were in close proximity to the central supply room door where medications, sharps and treatment items were stored.

An observation of the central supply storage room on 06/28/2017 at 11:15 AM stock medications including bottles of Aspirin 81 milligrams (mg), Ibuprofen 200mg tablets, Aspirin 325mg, eye drops artificial tears, bottles of Milk of Magnesia 16oz. bottles, Melatonin, Prevacid, Tussin DM 12oz bottles, guaifenesin expectorant 400mg tablets, Senna Lax tablets, and Mira lax were stored in this room and the door was unlocked. There were sharp items insulin syringes, needles and scissors in this room. There were treatment items including bottles of povidone iodine solution.

An interview on 06/28/2017 at 11:51 AM with Nurse #2 the central supply medications storage area for stock medications is left unlocked so staff had access to the supplies.

An interview on 06/28/2017 at 12:15 PM with Nurse # 3 stated central supply stocked the medication rooms on the floor but if there was something they needed and it was not in the medication room, they would get it from the central supply room. The central supply room door was not kept locked.

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F 323	Continued From page 5 An observation on 06/28/2017 at 3:30 PM Resident #49, a confused resident was in a wheelchair in front of the central supply room door. The resident was attempting to self-propel down the hallway. Resident #49 asked "Where do I go?" The central supply storage room door was unlocked. An observation on 06/28/2017 at 4:59 PM the central supply/stock medication room with the Director of Nursing (DON) revealed the door to the room was unlocked and no staff were in the room. An interview on 06/28/2017 at 6:23 PM with the DON revealed the central supply /stock medication storage room on the main hallway was unlocked during the day. It was locked at night by the receptionist when she left at 6 PM. She stated the receptionist must have left the central supply room door unlocked since they were still all there. She stated the door was left open until 6:00 PM so the department heads could have access to the printer that is in the room. An interview on 06/29/2017 at 10:53 AM the receptionist stated the central supply staff person left at 4:30 PM each day and left the central supply room door unlocked. She would make sure at 6:00 PM before she left the door was locked to the central supply room. She stated the central supply person left the door open so staff could have access to the printer. An observation on 06/29/2017 at 12:00 PM revealed the central supply room with medications, sharps and treatment supplies was	F 323		

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F 323	Continued From page 6 unlocked. An interview on 06/29/2017 at 3:445 PM with the DON and Administrator revealed the central supply storage room door was unlocked. The DON stated that when the central supply person is working she did leave the room to make deliveries to the units. She stated the only reason people come in the storage room was to use the copier and that is why it is left open. The DON and Administrator both agreed that they have cognitively impaired residents who go up and down the main hallways in front of the door to this room. The Administrator stated his expectation was that the facility follows their policies and procedures for medication storage and items that were potentially harmful to the residents were secured at all times.	F 323		

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F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		7/21/17

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Electronically Signed		07/18/2017

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to respond to a reported grievance for 1 of 5 sampled residents reviewed for grievances (Resident #169). The findings included: Resident #169 was admitted to the facility 03/19/17 with diagnoses which included dementia with Lewy body with behavioral disturbance and anxiety. Resident #169 discharged home with family on 05/04/17. Review of the medical record of Resident #169 noted an initial care plan meeting dated 03/28/17 which indicated the Discharge Planner/Social Worker, Unit Manager and two family members were present. Discharge Planner/Social Worker documentation of the 03/28/17 meeting in the medical record of Resident #169 noted, Family had a concern with shower schedule. Resident was last given a shower on 03/26/17. Family was given apology and unit manager is in the process of implementing training and clarification of the importance of adhering to shower schedule. There was also a concern about dietary and a remark made by someone bringing the carts on the hall. A service concern was completed and will be completed by dietary manager.	F 166	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How the corrective action will be accomplished for the resident(s) affected During care plan meeting on 3/28/17, the family of Resident #166 expressed concerns with showers. Resident #166 also had a concern with a remark made by a dietary employee that delivered the carts to each hall. Resident #166 no longer resides at the facility. Concern resolution form was not completed for the shower or dietary concerns due to lack of education with new unit manager on the grievance process. Unit manager is no longer an employee of the facility.	

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F 166	Continued From page 3 The facility service concern policy included the following procedures: -Most often questions and concerns are best handled on the unit by the Charge Nurse and/or Unit Manager. These individuals will assist in responding to any immediate clinical concerns. -The facilities discharge planning department will also assist the patients and/or families with concerns and or questions and if deemed appropriate will consult with other departmental directors for concerns related to their support services. -The administrator, as well as any department head manager, will assist the patient and/or family with issues of concern brought to them for resolution. -Concerns, complaints and grievances related to any of said designated staff are to be filed on the In-House Service Concern Report, and all standards of reporting procedures followed. Review of the facility Monthly Service Concern Summary for March 2017 and April 2017 did not include a service concern for Resident #169. On 06/29/17 at 3:00 PM the Discharge Planner/Social Worker verified he wrote the note in the medical record of Resident #169 on 03/28/17. The Discharge Planner/Social Worker stated he did not remember the specifics related to the family report of a concern with what was overheard from a member of dietary staff. The Discharge Planner/Social Worker stated a service concern would have been filled out related to the issue and thought the unit manager might have handled the concerns. The Discharge Planner/Social Worker indicated the dietary concern would have been reported to the dietary	F 166	How corrective action will be accomplished for those residents with potential to be affected by the same practices During Jump-start meetings, which occur within 24hrs after admission, discharge planner will review care plan, address preferences, and review facility scheduled shower days. The facility schedule is according to the room placement of resident. Individual shower preference will be honored if facility shower schedule does not meet the resident needs. Any ongoing concerns will be addressed by completing daily rounds of the facility. Measure to be put in place or systemic changes made to ensure practice will not re-occur Department heads will be educated on procedures for filling out service concern forms by the discharge planner. The service concern form contains a white and yellow copy. Department heads will receive yellow copy from discharge planner during morning meeting. If there are multiple departments addressed in grievance, the department heads will collaborate to produce a resolution within 48hrs. The yellow copy will be given back to discharge planner and attached to white copy. The administrator will follow-up on grievance to ensure departments are adhering to resolution in writing to the resident and/or family within 48hrs. This process will stay in place indefinitely as part of the corporate policy guidelines. The discharge planner will give all new employees information on the grievance process during new hire	

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F 166	Continued From page 4 manager to address and then the administrator would have reviewed the completed concern. The Discharge Planner/Social Worker explained when a completed service concern was given to him it was then recorded on the Monthly Service Concern Summary. The Discharge Planner/Social Worker stated he couldn't explain what happened to the dietary concern from the 03/28/17 meeting and thought the service concern might not have been returned to him which was why it was not logged in the Monthly Service Concern Summary. On 06/29/17 at 3:54 PM the Unit Manager stated she had just started working at the facility at the time of the 03/28/17 meeting with the family of Resident #169. The Unit Manager recalled the meeting and the concern the family had related to provision of showers for Resident #169. The Unit Manager stated she recalled informing the family she would take care of the shower concern and, after the meeting, she made sure Resident #169 received a shower and then addressed the concern with nursing assistants. The Unit Manager stated nursing assistants had reported to her that Resident #169 would often refuse showers and she asked the nursing assistants to report any refusals to herself or the charge nurse so they could speak to Resident #169. The Unit Manager stated she could not remember what the specific concern was related to dietary but thought it was something the family overheard being said by a dietary aide. The Unit Manager stated at the time of the meeting on 03/28/17 she was not aware of the service concern form and would not have known to complete the form. In a follow-up interview on 06/29/17 at 4:15 PM the Discharge Planner/Social Worker stated he	F 166	orientation. How facility will monitor corrective action(s) to ensure deficient practice will not reoccur Customer service concerns will be reviewed in weekly risk meeting x 4 weeks, monthly x 2 months and the in the quarterly QA meeting x 2 to ensure proper completion and resolution. Facility Administrator will be responsible for implementing the plan of correction for F166.	

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could not find the service concern related to Resident #169 and could not explain what happened. The Discharge Planner/Social Worker stated there was not tracking of service concerns to ensure they were addressed; only logging of concerns once the service concern form was returned to him by the appropriate department manager or the administrator.

On 06/29/17 at 4:35 PM the Director of Nursing stated she was aware the Unit Manager had handled the concern related to showers with Resident #169. The Director of Nursing stated she was not aware of the issue with the dietary employee as reported in the 03/28/17 care plan meeting.

On 06/29/17 at 6:45 PM the corporate Nurse and Director of Nursing stated any staff member could fill out a service concern. The corporate Nurse stated the concern would be given to the appropriate department head for a response and then to the administrator for review and response to the person filing the concern.

On 06/29/17 at 6:50 PM the Administrator stated he did not recall a service concern related to a dietary employee from 03/28/17. The Administrator stated all service concerns were routed to him and he would have been aware of it had a service concern form been completed. The Administrator stated the current Dietary Manager had recently started in the position and would not be able to recall if a service concern had been received from the 03/28/17 meeting with the family of Resident #169. The Administrator reported he could not explain what happened but expected service concerns to be completed when there were expressed concerns from a family.

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F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to maintain a properly functioning toilet in 1 of 8 bathrooms on the 200 hall (bathroom for rooms 209-211). The facility failed to have 1 of 6 bathroom sinks in good repair on the 100 hall (bathroom for rooms 102-104). Findings included: 1. An observation on 06/26/2017 at 3:50 PM revealed the toilet in the shared bathroom for rooms 209-211 was not flushing and refilling correctly. The top of the toilet tank did not fit correctly. An observation on 06/27/2017 at 4:52 PM revealed the toilet in the shared bathroom for rooms 209-211 was not flushing and refilling correctly. The top of the toilet tank did not fit the tank. An interview on 06/27/2017 at 5:15 PM with the Maintenance Director revealed staff submitted work orders and also verbally told him about maintenance issues. He stated he did rounds and if he could fix something on the spot he did so. An interview on 06/28/2017 3:25 PM with Nurse Aide (NA) #1 revealed the toilet not flushing correctly and the top of the toilet tank not fitting correctly had been this way awhile. She stated	F 253	How corrective action will be accomplished for each resident found to have been affected by the deficient practice. On 6/26/17, the facility maintenance director was verbally notified of an improperly functioning toilet for shared room 209/211 and bathroom sink for shared rooms 102/104. It was noted that the work orders for the toilet and sink were not properly submitted to the maintenance director via electronic work orders. Upon inspection, it was noted that the toilet tank fill valve inside the tank was broken and the tank lid did not fit properly. There was buildup around the bottom of the sink. The toilet was replaced on 6/29/17. The sink was immediately cleaned with a pumie bar and sanitized, removing all buildup. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. A Center inspection of all toilets and bathroom sinks was performed on 07/17/17 to observe for any defects that needed to be fixed. Any toilet or sink requiring maintenance was completed at the time of the inspection. Maintenance director initiated facility in-services on 7/18/17 detailing how to properly submit an electronic work order for any maintenance repair. As of	7/21/17

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F 253	Continued From page 7 she had reported it to the nurse and the maintenance staff were made aware of these issues. She stated the resident in room 211 used the bathroom regularly with assistance from staff. An interview on 06/27/2017 4:33 PM with Nurse #7 revealed that depending on the problem he either called the emergency number for maintenance or put in a work order. He stated the resident in room 211 was assisted by staff to be toileted in the bathroom. He wasn't sure if the toilet not operating correctly and the toilet tank top not fitting the tank had been report to maintenance, but he thought it had been reported. Review of the maintenance log for June 2017 revealed there was no work order for the toilet in the bathroom for rooms 209-211. An interview on 06/29/2017 at 9:40 AM with the Director of Nursing (DON) and the Administrator revealed the toilet in the shared bathroom for rooms 209-211 was filled with stool and tissues and the top on the toilet tank did not fit. The DON confirmed that any of the ways including verbally telling maintenance, filling out a form for maintenance on the computer, filling out a paper request, and for nurse aides, reporting the maintenance problem to the nurse were all ways of communicating the need for maintenance work to the maintenance. The Administrator stated he expected that all maintenance issues were reported and maintenance would address the issues in a timely manner. He stated he expected all requests to be logged in the maintenance log. 2. An observation on 06/26/2017 at 10:40 AM revealed the hand sink in the bathroom for rooms	F 253	7/18/17, the maintenance director will no longer accept a verbal request for repairs. Measures to be put in place or systemic changes made to ensure practice will not re-occur. Administrator, or designee, will perform audits to make sure all toilets and sinks are properly functioning to ensure resident safety/preventative maintenance. The maintenance director will print work orders weekly and complete needed repairs. This will be noted on an audit tool. Audits will be completed weekly x4, then every 2 weeks x4 for a total of 3 months. Education to be completed by 7/21/17. Anyone not in-serviced will be in-serviced before returning to work. All new employees will be shown and given an instruction sheet with screen shots on how to enter work orders. How facility will monitor corrective action(s) to ensure deficient practice will no re-occur. The building engines work orders for toilet and sink repairs will be reviewed and reported in the quarterly QA meeting by Administrator quarterly X2 for continued compliance and revisions to the plan if needed. Facility Administrator will be responsible for implementing the plan of correction for F253.	

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F 253	Continued From page 8 102 -104 had rust, corrosion at the drain area and large dark brown stain in the sink bowl. An interview on 06/28/2017 at 12:45 PM with the Maintenance Director in the bathroom between rooms 102-104 revealed he was not aware of the large dark brown stain in the sink or the rust around the drain. An interview on 06/28/2017 at 3:35 PM with Nurse Aide (NA) #3 revealed that she was aware of the large dark brown stain and rust around the drain on the bathroom sink in the bathroom for rooms 102-104. She state she thought someone else had reported it to maintenance. She stated she reported things like that to the nurse. An interview on 06/28/2017 with Nurse #8 for the 100 halls revealed they place a maintenance work order for repairs. She stated the NA would tell the nurse but also could go into the computer and complete the maintenance request. The nurses did the same thing and completed the work order. They also could tell the maintenance staff verbally about the problem. She stated she was not aware of the problem of the large stained in the sink bowl and the rusty sink in the bathroom for rooms 102-104. Review of the maintenance log for June 2017 revealed there was no work order for the bathroom sink stain and rusty drain for rooms 102-104. An interview on 06/29/2017 at 9:40 AM with the Director of Nursing (DON) and the Administrator revealed that they were not aware of the large brown stain and rusty drain in the bathroom sink in the bathroom for rooms 102-104. The DON	F 253		

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F 253	Continued From page 9 stated that any of the ways including verbally telling maintenance, filling out a form for maintenance on the computer, filling out a paper request, and for nurse aides, reporting the maintenance problem to the nurse were all ways of communicating the need for maintenance work to the maintenance. The Administrator stated he expected that all maintenance issues were reported and maintenance would address the issues in a timely manner. He stated he expected all requests to be logged in the maintenance log.	F 253		
F 318 SS=E	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and medical record review, the facility failed to evaluate and treat a right hand contracture, decreased ambulation and decreased range of motion in bilateral arms to maintain/improve range of motion for 1 of 3 sampled residents reviewed for range of motion (Resident #15). Resident #15 was admitted to the facility on	F 318	How the corrective action will be accomplished for the resident(s) affected: Resident #15 was initially screened by physical therapy on 10/24/16 and again on 12/19/16 for decreased range of motion and/or to prevent further decline in range of motion with recommendations of a therapy evaluation after the physician gave a steroid injection. The therapy department was notified by the physician	7/21/17

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F 318	Continued From page 10 10/6/15 for rehabilitation with physician orders for physical/occupational therapy evaluation and treatment. Diagnoses on admission included in part, hand contracture, rheumatoid arthritis, chronic gout, and cerebral infarction. An annual Minimum Data Set (MDS) assessment dated 10/07/16 assessed Resident #15 with the ability to be understood/understand, intact cognition, requiring extensive staff assistance of 1 person for bed mobility, two or more staff persons for transfers, total staff assistance with dressing, toileting, hygiene, and bathing, set-up assistance with eating, unsteady moving from seated to standing position and surface to surface transfers, and functional limitations in range of motion (ROM) with impaired bilateral upper extremities (BUE). A quarterly MDS dated 6/01/17 assessed Resident #15 with the ability to be understood/understand, intact cognition, requiring extensive staff assistance of 1 person for bed mobility, dressing, toileting, and hygiene, two or more staff persons for transfers, supervision and set up help with eating, total staff assistance with bathing, unsteady moving from seated to standing position and surface to surface transfers, and functional limitations in ROM with impaired BUE. Resident #15's care plan, reviewed June 2017, revealed a plan for rheumatoid arthritis and right hand contracture management. The goal was to maintain an acceptable level of comfort without a decline in mobility or an increase in contracture formation/changes. The care plan interventions	F 318	on 6/29/17 that the resident was at risk for complications of the side effects of the steroid injections due to her medical history. The physician also noted that the steroid injection would be a contraindication and decided not to administer the injection. A physical therapy evaluation was then completed on 6/30/17 with a projected plan of care of four weeks. As of today, the patient continues to receive skilled therapy services. How corrective action will be accomplished for those residents with the potential to be affected by the same practice: On 7/13/17, Therapy manager and Occupational Therapist completed clinical rounds of all long term care residents within the facility to establish a baseline and identify residents with decreased range of motion/contractures. A list was generated with patients identified for range of motion and needs are currently being addressed. Those residents were listed on the audit tool. Measure to be put in place or systemic changes made to ensure practice will not re-occur: All charge nurses and nurse administration will be educated by the Staff Development Coordinator (SDC) or designee to alert therapy if any resident has a contracture or any new therapy screen/orders. SDC will also educate the Medical Director on how to notify the therapists if a resident is not a candidate for any course of treatment recommended by therapy due to underlying medical concerns. The residents identified by nursing as needing a therapy screen for	

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F 318	Continued From page 11 included to monitor/document/report to the physician complications related to joint pain, decreased mobility/self-care ability with exercise and weight bearing and to use a mechanical lift for transfers. Medical record review revealed a "Nursing & Rehabilitation Long Term Care Clinical Round Action Item" dated 10/24/16 which recorded that Resident #15 would receive a physical therapy (PT) evaluation for ambulation after the physician gave a steroid injection. Review of a Rehabilitation Services Screen, dated 12/19/16 recorded a PT recommendation for Resident #15 to receive steroid injections by the physician prior to a PT evaluation. Review of physician's orders for Resident #15 revealed the following: - 12/22/16, Apply Ethyl Chloride Aerosol (anesthesia) to injection site topically one time only for joint injection for 1 day, include Lidocaine (pain medication) 1% vial and Methylprednisone (steroid) 80 milligrams 1 dose - 12/14/16 Methylprednisone & Anesth (anesthesia) Kit 40 mg/ml (milliliter) A physician's progress note dated 1/16/17 indicated the reason for the visit was to follow up on chronic medical conditions and to continue the current pain regimen (Tylenol Extra Strength 1 gram every 8 hours) for management of osteoarthritic related pain. Resident #15 was observed in her room on 06/27/17 at 11:46 AM applying lotion to her face using her left hand. Her right hand was observed in her lap with all 5 fingers in a contracted position	F 318	contractures/a decline in range of motion will be placed on an audit tool x 12 weeks to ensure that the appropriate recommendations have been implemented and completed accurately and timely. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Therapy manager initiated an audit tool on 7/18/17 to ensure that therapy screens are being reported by nursing on an ongoing basis. Any new long term care screens will be brought to the weekly risk meeting initially for 4 weeks and monthly for an additional 2 months. To ensure a continuum of care, it will also be added to the quarterly QA minutes for the next 3 months to ensure compliance. Facility Administrator will be responsible for implementing the plan of correction for F318.	

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and no splinting device in place. Resident #15 complained of intermittent pain to her right hand that was managed with pain medication and stated that she had not yet received physical therapy for her right hand contracture, but that she would like to. She denied pain to her right hand at the time of the observation.

Resident #15 was observed on 06/28/17 at 1:10 PM feeding herself lunch with her left hand. Her right hand was observed in her lap, all fingers contracted and without a splinting device in place. She denied pain to her right hand at the time of the observation.

An interview occurred on 06/29/17 at 10:23 AM with the rehab manager who stated that on 10/24/16, during clinical rounds, Resident #15 was assessed with a decline in ambulation and expressed to the rehab manager and to PT#1 that she was having pain in the left knee due to osteoarthritis. Resident #15 requested rehab services for ambulation, but expressed a desire for a steroid injection to her left knee for pain management before rehab services were initiated. The rehab manager stated that she shared this with the Resident's physician in December 2016 and due to the Resident's receipt of steroid injections in the past, PT #1 recommended this course of treatment and the physician expressed agreement. The rehab manager stated the plan was to have the physician provide the steroid injections and then have Resident #15 evaluated/treated for therapy after her left knee pain was managed. The rehab manager further stated she was not aware of the right hand contracture and there was no plan discussed regarding contracture management for the right hand. The rehab manager stated that a

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physician's order was received in December 2016 for the steroid injection. She further stated that sometime in January 2017, the rehab manager spoke to the physician because the steroid injection had not been administered and he expressed that he would complete the injection. The rehab manager stated that the PT evaluation had not yet been completed because the rehab department was awaiting the physician's administration of the steroid injection and expected him to follow up with her department if anything changed.

Resident #15 was observed in her room on 06/29/17 at 11:04 AM with the rehab manager and PT #1. Resident #15 complained of pain to her left knee with movement and stated "I would like to have any therapy I can get so I can get out of here." When asked to move the fingers to her right hand, Resident #15 expressed "I can only open my fingers this far, my fingers were like this before I came, but I can't raise my arms, I can only lift my arms up so far." The PT #1 stated that she was waiting for the physician to administer the steroids to the Resident's left knee because she did not feel Resident #15 would benefit from PT treatment without the steroid injections. The PT #1 stated she was not aware of the right hand contracture, or limited ROM in her arms/shoulders, this was not noted during the clinical rounds in October 2016 and there was not a current plan in place for contracture management.

An interview occurred on 6/29/2017 at 11:11 AM with nurse #8. Nurse #8 stated she was the routine nurse for Resident #15 since January 2017 and was aware of the right hand contracture since January 2017. Nurse #8 stated Resident

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#15 expressed relief with her routine pain management, but that the nurse was not aware if Resident #15 received any rehab/contracture management services.

An interview with nurse aide (NA) #4 occurred on 6/29/17 at 11:18 AM and revealed she worked routinely with Resident #15 since February 2016. NA #4 expressed that Resident #15 required a mechanical lift with transfers, could not bear weight and her right hand contracture was present in February 2016.

An interview occurred on 6/29/17 at 11:28 AM with Nurse #4 (unit manager). Nurse #4 stated she started at the facility in March 2017 and noted Resident #15 had limited ROM in her bilateral arms and difficulty gripping things with her right hand due to a right hand contracture. Nurse #4 stated that she had not reported this because she thought this was the baseline for Resident #15 and did not know that the rehab department was not already aware.

A telephone interview occurred on 6/29/17 at 1:30 PM with the physician. During the interview, the physician stated he was made aware sometime in December 2016, by the rehab department, of Resident #15's request for a steroid injection to manage pain to her left knee prior to receipt of PT services. He stated that he wrote an order for the injection, but when he assessed Resident #15 in January 2017, he determined that she was at increased risk for complications of the side effects of steroid injections due to her medical history. The physician stated he determined receipt of the steroid injection would be a contraindication and decided not to administer the injection to Resident #15. He stated that he

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F 318	Continued From page 15 expressed this change to the rehab department. The physician further stated that he expected the rehab department to follow up with him if there was a question/concern regarding administration of a steroid injection. A follow up interview occurred on 6/29/17 at 2:00 PM with the rehab manager and the director of nursing (DON). The rehab manager and DON stated they were unaware that the physician no longer intended to administer the steroid injection for Resident #15, but that the rehab department would make attempts with alternative methods to manage the left knee pain for Resident #15 after evaluation of therapy services regarding a decrease in ambulation. The DON and rehab manager stated they expected nursing staff to make them aware of any changes in a resident that would require an evaluation for rehab services and that the right hand contracture and decreased ROM in the bilateral arms for Resident #15 should have been evaluated for therapy services.	F 318		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		7/21/17

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F 323	Continued From page 16 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to lock all medications, and biologicals, including treatment items. The facility had residents with severe cognitive impairment who had access to these items. (Residents #38, #49). Findings included: 1. Resident #38 was admitted 08/07/2009 with a diagnosis of dementia. The quarterly Minimum Data Set (MDS) dated 06/01/2017 assessed the resident as severely cognitively impaired. It documented the resident used a wheelchair with limited assistance. An observation on 06/28/2017 at 10:00 AM revealed the central supply medication storage room on the main hallway was unlocked and Resident #38 (nonverbal) was seated in front of the unlocked door. This resident was observed self-propelling down the hallway attempting to open the bathroom and activity room doors which were in close proximity to the central supply room door where medications, sharps and treatment	F 323	How the corrective action will be accomplished for the resident(s) affected □ On 6/26/17, it was noted that the facility failed to lock the central supply medication storage room. On 6/29/17 the maintenance director removed the key lock and replaced it with a keypad entry lock to ensure that the door will remain locked at all times. How corrective action will be accomplished for those residents with the potential to be affected by the same practice □ New keypad door lock was installed on central supply room door on 6/29/17. No residents were affected by deficient practice. Measure to be put in place or systemic changes made to ensure practice will not re-occur □ A keypad lock was placed on the door on 6/29/2017, the door is currently locked and residents do not have access to the supplies. A keypad lock will	

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F 323	Continued From page 17 items were stored. An observation of the central supply storage room on 06/28/2017 at 11:15 AM stock medications including bottles of Aspirin 81 milligrams (mg), Ibuprofen 200mg tablets, Aspirin 325mg, eye drops artificial tears, bottles of Milk of Magnesia 16oz. bottles, Melatonin, Prevacid, Tussin DM 12oz bottles, guaifenesin expectorant 400mg tablets, Senna Lax tablets, and Mira lax were stored in this room and the door was unlocked. There were sharp items insulin syringes, needles and scissors in this room. There were treatment items including bottles of povidone iodine solution. An interview on 06/28/2017 at 11:51 AM with Nurse #2 the central supply medications storage area for stock medications was left unlocked so staff had access to the supplies. An interview on 06/28/2017 at 12:15 PM with Nurse # 3 stated central supply stocked the medication rooms on the floor but if there was something they needed and it was not in the medication room, they would get it from the central supply room. The central supply room door was not kept locked. An observation on 06/28/2017 at 3:30 PM revealed Resident #38 a confused resident in a wheelchair was in front of the central supply room door. The resident was attempting to self-propel down the hallway. The central supply medication storage room door was unlocked. An observation on 06/28/2017 at 4:59 PM the central supply/stock medication room with the Director of Nursing (DON) revealed the door to	F 323	remain on the door at all times. Staff will be educated on making sure that the door remains closed and locked at all times. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur Maintenance Director will check the function of the door weekly x4 weeks. To ensure continuum of care, it will also be reviewed at the quarterly QA meeting for the next 3 months to ensure compliance. Maintenance Director will implement changes for F323.	

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the room was unlocked and no staff were in the room.

An interview on 06/28/2017 at 6:23 PM with the DON revealed the central supply /stock medication storage room on the main hallway was unlocked during the day. It was locked at night by the receptionist when she left at 6 PM. She stated the receptionist must have left the central supply room door unlocked since they were still all there. She stated the door was left open until 6:00 PM so the department heads could have access to the printer that is in the room.

An interview on 06/29/2017 at 10:53 AM the receptionist stated the central supply staff person left at 4:30 PM each day and left the central supply room door unlocked. She would make sure at 6:00 PM before she left the door was locked to the central supply room. She stated the central supply person left the door open so staff could have access to the printer.

An observation on 06/29/2017 at 11:24 AM Resident #38 was self-propelling herself in her wheelchair and opened the door and let herself into the activity room across from the central supply room. She needed to be redirected by staff.

An observation on 06/29/2017 at 12:00 PM revealed the central supply room with medications, sharps and treatment supplies was unlocked.

An observation on 06/29/2017 at 1:11 PM revealed Resident #38 again opened the door and rolled herself in her wheelchair to the activity

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room door which was across from the central supply storage area that was unlocked.

An interview on 06/29/2017 at 3:445 PM with the DON and Administrator revealed the central supply storage room door was unlocked. The DON stated that when the central supply person is working she did leave the room to make deliveries to the units. She stated the only reason people come in the storage room was to use the copier and that is why it is left open. The DON and Administrator both agreed that they have cognitively impaired residents who go up and down the main hallways in front of the door to this room. The Administrator stated his expectation was that the facility follows their policies and procedures for medication storage and items that were potentially harmful to the residents were secured at all times.

2. Resident #49 ' s was admitted 12/16/11 with a diagnosis of Alzheimer ' s disease. The quarterly MDS dated 05/08/2017 assessed the resident as severely cognitively impaired and being rarely understood. It documented the resident used a wheelchair.

An observation on 06/28/2017 at 10:00 AM revealed the central supply medication storage room on the main hallway was unlocked and Resident #38 (nonverbal) was seated in front of the unlocked door. This resident was observed self-propelling down the hallway attempting to open the bathroom and activity room doors which were in close proximity to the central supply room door where medications, sharps and treatment items were stored.

An observation of the central supply storage room

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on 06/28/2017 at 11:15 AM stock medications including bottles of Aspirin 81 milligrams (mg), Ibuprofen 200mg tablets, Aspirin 325mg, eye drops artificial tears, bottles of Milk of Magnesia 16oz. bottles, Melatonin, Prevacid, Tussin DM 12oz bottles, guaifenesin expectorant 400mg tablets, Senna Lax tablets, and Mira lax were stored in this room and the door was unlocked. There were sharp items insulin syringes, needles and scissors in this room. There were treatment items including bottles of povidone iodine solution.

An interview on 06/28/2017 at 11:51 AM with Nurse #2 the central supply medications storage area for stock medications is left unlocked so staff had access to the supplies.

An interview on 06/28/2017 at 12:15 PM with Nurse # 3 stated central supply stocked the medication rooms on the floor but if there was something they needed and it was not in the medication room, they would get it from the central supply room. The central supply room door was not kept locked.

An observation on 06/28/2017 at 3:30 PM Resident #49, a confused resident was in a wheelchair in front of the central supply room door. The resident was attempting to self-propel down the hallway. Resident #49 asked "Where do I go?" The central supply storage room door was unlocked.

An observation on 06/28/2017 at 4:59 PM the central supply/stock medication room with the Director of Nursing (DON) revealed the door to the room was unlocked and no staff were in the room.

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An interview on 06/28/2017 at 6:23 PM with the DON revealed the central supply /stock medication storage room on the main hallway was unlocked during the day. It was locked at night by the receptionist when she left at 6 PM. She stated the receptionist must have left the central supply room door unlocked since they were still all there. She stated the door was left open until 6:00 PM so the department heads could have access to the printer that is in the room.

An interview on 06/29/2017 at 10:53 AM the receptionist stated the central supply staff person left at 4:30 PM each day and left the central supply room door unlocked. She would make sure at 6:00 PM before she left the door was locked to the central supply room. She stated the central supply person left the door open so staff could have access to the printer.

An observation on 06/29/2017 at 12:00 PM revealed the central supply room with medications, sharps and treatment supplies was unlocked.

An interview on 06/29/2017 at 3:445 PM with the DON and Administrator revealed the central supply storage room door was unlocked. The DON stated that when the central supply person is working she did leave the room to make deliveries to the units. She stated the only reason people come in the storage room was to use the copier and that is why it is left open. The DON and Administrator both agreed that they have cognitively impaired residents who go up and down the main hallways in front of the door to this room. The Administrator stated his expectation

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F 323	Continued From page 22 was that the facility follows their policies and procedures for medication storage and items that were potentially harmful to the residents were secured at all times.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review, the facility failed to provide Resident #75 with a frozen nutritional supplement, with all meals, as ordered by the physician, due to a history of weight loss for 1 of 4 sampled residents reviewed for nutritional support. The findings included: Resident #75 was admitted to the facility on	F 325	How the corrective action will be accomplished for the resident(s) affected □ Resident #75 was brought the correct nutritional supplement at time this was identified by the surveyor. Mealtracker profile was reviewed by the Corporate Dietitian and updated to reflect supplements given at meal time per orders (changed to TID versus BID). How corrective action will be accomplished for those residents with the	7/21/17

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F 325	Continued From page 23 4/30/12. Diagnoses included Alzheimer's disease and mild protein calorie malnutrition. Medical record review revealed Resident #75's physician ordered a regular diet to include a frozen nutritional supplement for all meals on 03/20/15, due to a history of weight loss. A dietary progress note dated 12/23/16, recorded that Resident #75 continued to tolerate a regular diet, ate on average 51 - 100% of her meals, ate meals in her room with staff set up assistance and received a nutritional supplement for all meals for nutritional support. Review of a quarterly Minimum Data Set assessment dated 6/08/17 revealed Resident #75 was assessed with severely impaired cognition, unclear speech, rarely understood/understands, and required staff supervision and the physical assistance of 1 staff person with meals. Resident #75's care plan, reviewed June 2017, identified the Resident was at risk for weight fluctuations related to a diagnoses of Alzheimer's disease and a history of varying food intake. The goal was to avoid significant weight changes with interventions that included to provide the diet as ordered. Review of Resident #75's weight history from December 2016 to June 2017 revealed the following weight fluctuations: ·December 2016, 101 pounds (#) ·January 2017, 103# ·February 2017, 102# ·March 2017, 104# ·April 2017, 104# ·May 2017, 106#	F 325	potential to be affected by the same practice □ A review of Mealtracker profiles for all patients receiving supplements was completed 7/18/17 by Corporate Dietician to ensure supplements are correctly indicated on all menu tickets as ordered. Measure to be put in place or systemic changes made to ensure practice will not re-occur □ The Corporate Dietitian in-serviced on-shift dietary staff on 6/28/17 at time of incident. All remaining dietary staff were in-serviced by the Corporate Dietitian on 7/18/17 regarding importance of reading menu tickets and providing food/supplement items indicated on meal trays to ensure resident preferences and nutritional needs are met. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur □ The Corporate Dietitian will complete a nutritional supplement audit once per week x 4 weeks, then once monthly x 2 months, and report results to the Administrator. To ensure acceptable performance is maintained, a nutritional supplement audit will be conducted by the Dining Services Manager on a quarterly basis and reviewed at the quarterly QA meeting x 4 and revisions as needed. Corporate Dietician will be responsible for implementing plan of correction for F325.	

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F 325	Continued From page 24 ·June 2017, 105# Resident #75 was observed eating lunch in her room on 6/26/17 at 1:09 PM and on 6/28/17 at 1:17 PM. The lunch meal tray card for each meal recorded that Resident #75 should receive a frozen supplement. Resident #75 did not receive a frozen nutritional supplement at either meal observed. An interview with the consultant dietitian occurred on 6/28/17 at 1:25 PM. The consultant dietitian stated that he expected dietary staff to check the meal tray card to make sure all items were provided on the resident's tray. He further stated that he expected nursing staff to inform dietary staff if a resident was missing a food item. The consultant dietitian observed the lunch meal tray for Resident #75 during the interview and confirmed that Resident #75 did not receive a frozen nutritional supplement, but that she should receive it with all meals. The director of nursing (DON) was interviewed on 6/28/17 at 7:32 PM and stated that she expected residents to receive the foods as recorded on the meal tray card. The DON further stated that if a food item was not provided by the dietary department, she expected the nursing staff to follow up and obtain the food item that was missed. An interview occurred on 6/29/17 at 11:18 AM with Nurse Aide (NA) #4. NA #4 stated that the meal tray card was used to identify the correct resident, correct room and the right kind of food the resident should receive. NA #4 stated that if a food item was missing, she was trained to go the dietary department to get what the resident	F 325		

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F 325	Continued From page 25 needed. An interview with the certified dietary manager (CDM) occurred on 6/29/17 at 6:11 PM. During the interview, the CDM provided a copy of the meal tray cards for all meals for Resident #75. Review of the meal tray cards for all meals revealed a frozen nutritional supplement was not recorded on the breakfast tray card, but was recorded on the meal tray cards for the lunch/dinner meals. The CDM stated the meal tray card was used by the dietary staff to identify what food items to provide to a resident. The CDM stated she was not aware that Resident #75 should receive a frozen nutritional supplement for all meals, including breakfast, but that she would add that to the breakfast meal tray card. The CDM stated that Resident #75 had a history of weight loss and the frozen nutritional supplement should have been provided with all meals, as ordered by the physician.	F 325		
F 371 SS=E	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	F 371		7/21/17

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F 371	Continued From page 26 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 observations, staff interviews and manufacturer recommendations, the facility failed to provide hot water 100 - 108 degrees Fahrenheit for hand washing, store fresh produce (onions) at 45 - 50 degrees Fahrenheit, according to manufacturer recommendations, monitor cold/dry storage units for expired foods (onions, cottage cheese, chicken salad), store foods in cold/dry storage with a date of storage and in sealed containers for 2 of 2 kitchen observations. Findings included: 1. An observation on 06/25/17 at 2:58 PM revealed the hot water at the cook's hand sink was cool to touch, not hot. The certified dietary manager (CDM) was observed on 06/25/17 from 3:00 PM - 3:05 PM monitoring the temperature of the hot water with a digital thermometer at the cook's hand sink and obtained a temperature of 83 - 87.4 degrees Fahrenheit (F). The CDM stated the hot water was not hot enough and should be at least 115 - 116 degrees F. The CDM stated she was not aware of a concern related to the hot water in the kitchen. Dietary staff #1 (DS #1) was observed on	F 371	How the corrective action will be accomplished for the resident(s) affected On 6/28/17 expired food items were identified (chicken salad and cottage cheese) and discarded immediately. Corporate Dietician and Dietary Manager checked all food storage areas for expired items and reviewed sanitation expectation Dining Services Manager. Corporate Dietitian notified Maintenance Director regarding the improper water temperatures at cook hand sink at time of incident and maintenance check was completed on 6/28/17 and water flow was corrected to obtain proper water temperature on 6/28/17. How corrective action will be accomplished for those residents with the potential to be affected by the same practice Dietary department meeting was held on 7/18/17 to reiterate job expectations per position and daily job responsibilities. Corporate Dietitian and Dining Services Manager in-serviced all dining services staff on labeling and dating, food storage guidelines, and position responsibilities to ensure all staff	

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F 371	Continued From page 27 06/25/17 at 3:07 PM to wash hands at the same sink and reported that the water was "a little warm, but not hot." DS #1 donned gloves and proceeded to prep food for the dinner meal. DS #2 was interviewed on 06/25/17 at 3:10 PM and stated that when she washed her hands that morning the water was hot, but when she washed her hands at the cook's hand sink a few moments ago, the water was not hot at all, but warm. DS #2 stated after she washed her hands, she put on gloves and started prepping for the dinner meal. DS #2 stated that she noticed over the last few days that when she used the water at the 3 compartment sink, it seemed to reduce the temperature of the water available at other sinks. DS #2 stated "I don't know why that is, but the water is not hot at other sinks, if I have the hot water turned on at the 3 compartment sink." DS #2 stated she had not yet reported this concern. On 06/25/17 at 4:55 PM the housekeeping/maintenance director was interviewed and stated that he rounded daily and checked the water temperature at all the sinks in the dietary department. He stated that he last checked the water temperatures in the kitchen on Friday, 6/23/17 and all sinks had water temperatures above 116 degrees F. The housekeeping/maintenance director stated he was not aware of a concern related to the hot water in the kitchen. 2. Observations on 06/25/17 from 3:17 - 3:18 PM of the walk-in freezer and dry storage room revealed the following concerns with food storage: Freezer:	F 371	is routinely monitoring food storage areas for expired items. Maintenance Director completed temperature checks of all hand sinks in the kitchen on 6/28/17 to ensure temperatures of other food service hand sinks were at proper range. Measure to be put in place or systemic changes made to ensure practice will not re-occur All new dietary staff hired will be given education on food storage guidelines, information on labeling and dating food, and position responsibilities to ensure food storage is monitored for proper storage, disposal of expired food items, and proper hand sink water temperature. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur An audit of all storage areas (refrigerators, freezer, and dry storage) will be completed by the Dining Services Manager once a week for 4 weeks, once monthly x 2 months, then quarterly for 9 months to ensure sanitation expectations are met and results reported to the Administrator. The Maintenance Director will complete daily water temperature checks of all hand sinks in the kitchen to ensure water temps between 100-108¿F maintained. To ensure acceptable performance is maintained, an audit of food service hand sink water temperatures will be conducted by the Dining Services Manager on a quarterly basis and reviewed at the quarterly QA meeting x 4 and revisions as needed. Corporate Dietician will be responsible for implementing plan of correction for F371.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

(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 371	Continued From page 28 - A 30 pound (#) box of frozen green beans was stored in a plastic bag which was stored open to air; there was no date of storage - A plastic bag of approximately 2# frozen pepperoni slices was observed with a large hole in the bag which left the pepperoni open to air; there was no date of storage Dry storage: - An opened 5# bag of cocoa was stored with the top of the bag rolled down loosely, the bag was not sealed and there was no date of opening - Two graham cracker crusts were wrapped in plastic wrap with no date of storage - A 25# box of raw onions was stored and observed with black hair like growth on the onions; the box included manufacturer stamped recommendations which read "Store 45 - 50 degrees Fahrenheit." On 06/25/17 at 5:01 PM the housekeeping/maintenance director was observed to use a laser thermometer to obtain an ambient temperature of the onions stored in dry storage. The temperature was 72.5 - 73.5 degrees F. On 06/26/17 at 12:40 PM the CDM stated that she expected all foods to be stored with a date of storage, if opened, stored in sealed containers and that all staff were responsible for monitoring storage units for expired items. The CDM also stated that it was the facility ' s typical practice to store onions in the dry storage room and confirmed that the black hair-like growth on the onions appeared to be mold growth. The CDM stated that she had not noticed the manufacturer recommendations stamped on the box of onions which read to store at 45-50 degrees F.	F 371		

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F 371	Continued From page 29	F 371		

3. During the initial tour of the facility kitchen on 6/25/17 at 3:30 PM, two unopened five pound containers of small curd low fat cottage cheese with a manufacturer stamped use by date of 05/21/17 were observed in the reach in refrigerator. In addition, there were also two, unopened five pound containers of small curd low fat cottage cheese with a manufacturer stamped use by date of 06/25/17 in this same refrigerator. The four containers of cottage cheese were stored on shelving, ready for use.

In a follow-up review of the facility kitchen on 06/28/17 at 10:10 AM these four containers of cottage cheese remained on shelving in the reach in refrigerator, ready for use. In addition, an open five pound container of chicken salad supreme with a manufacturer stamped use by date of 06/27/17 was stored on shelving, ready for use, in the same reach in refrigerator. Handwritten on the container of chicken salad supreme was "6/22."

The facility consultant dietitian was present at the time of the observation on 06/28/17 and stated it was the responsibility of all staff to daily discard outdated items from refrigerated storage, including the reach in refrigerator. The consultant dietitian stated staff write the date when a product is open and use the opened item within 7 days. The consultant dietitian stated the manufacturer stamped use by date would supercede any date written on a product by dietary staff and agreed the four unopened containers of cottage cheese

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F 371	Continued From page 30 and container of chicken salad supreme should have been discarded. The consultant dietitian could not explain why the five containers of expired food had not been removed by dietary staff prior to 06/28/17.	F 371		
F 431 SS=E	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	F 431		7/21/17

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F 431	Continued From page 31 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 observations, staff interviews and record review the facility failed to remove from use expired medications from 2 of 5 medications carts and 1 of 2 medication storage rooms. The facility failed to lock 1of 1 central supply medication storage rooms. Findings included: On 06/26/2017 at 10:49 AM revealed the 200 front hall medication cart had a vancomycin 50milligram (mg) bottle of medication on the cart. The pharmacy label instructions were to refrigerate the medication. Also, a bottle of lansoprazole suspension was observed on the cart. The pharmacy label indicated the medication expired 06/21/2017.	F 431	How corrective action will be accomplished for each resident found to have been affected by the deficient practice On 6/26/17, the facility failed to remove 2 expired medications from the medication carts and 1 expired medication from the storage room. Upon identification, nurse #1 immediately removed the expired medications from the 200 hall medication cart during findings. Nurse #1 was then educated on proper storage and labeling of medications. Director of Nursing (DON) removed expired Zosyn from medication storage room on 6/28/17. On 7/20/17, all full and part time nurses were in-serviced on the correct way to check medication	

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F 431	Continued From page 32 An interview on 06/26/2017 at 10:49 AM an observation with Nurse #1 revealed the vancomycin was for a resident for resident who had been discharged. She stated the label did indicate it was to have been refrigerated. She stated she did not know why it was on the cart. She stated she had given the expired lansoprazole that morning. She thought the date on the label was the date the medication had been opened, not that it had expired. An observation on 06/28/2017 at 10:00 AM revealed the central supply medication storage room on the main hallway was unlocked and Resident #38 (nonverbal) was seated in front of the unlocked door. This resident was observed self-propelling down the hallway attempting to open the bathroom and activity room doors which were in close proximity to the central supply room door with medications in it. An observation on 06/28/2017 at 11:15 AM revealed the central supply storage room on the main hallway contained stock medications including bottles of Aspirin 81mg, Ibuprofen 200mg tablets, Aspirin 325mg, eye drops artificial tears, bottles of Milk of Magnesia 16oz. bottles, Melatonin, Prevacid, Tussin DM 12oz bottles, guaifenesin expectorant 400mg tablets, Senna Lax tablets, and Mira lax were stored in this room and the door was unlocked. An interview on 06/28/2017 at 11:51 AM with Nurse #2 revealed the central supply medications storage area for stock medications was normally left unlocked. She could get medications she needed if they were not on her cart or in the other medication storage room from this room during	F 431	carts/medication rooms for expired medication, proper labeling of medications, and the removal of any medications for discharged residents. On 6/26/17, it was also noted that the facility failed to lock the central supply medication storage room. On 6/29/17 the maintenance director removed the key lock and replaced it with a keypad entry lock to ensure that the door with remain locked at all times. Staff in-services outlining that the central supply door must be locked at all times, nor can it be left open for any reason. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ An initial audit and in-service of medication carts and medication rooms were completed on 7/17/17 in the facility with no other issue noted on medication storage, labeling and expired medication. All nurses were in-serviced on the proper labeling and storage of medication to include checking each medication bottle/push pack daily for expiration date prior to administering the medication to the resident. Measures to be put in place or systemic changes made to ensure practice will not re-occur -All nurses will be educated to check expiration dates on all meds and removal of expired medications. All nurses will be educated/in-serviced on the protocol for medication storage and labeling. DON and/or designee will	

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F 431	Continued From page 33 her shift. An interview on 06/28/2017 at 12:15 PM with Nurse #3 revealed night shift went through carts and removed expired medications, discontinued medications and medications of residents who had been discharged. She stated central supply staff stocked the medication rooms on the floor but if there was something they needed and it was not in the medication room, they would get it from the central supply storage room. The door to the central supply storage room was not kept locked. An observation on 06/28/2017 at 1:24 PM revealed the 200 hall medication room refrigerator had Zosyn 3.75grams (GM) expiration date 06/27/2017 and Vancomycin H 1200mg IV in Sodium Chloride 0.9% 250mg with an expiration date of 06/27/2017 labeled for Resident #180. An interview on 06/28/2017 at 1:24 PM with Nurse #4 revealed she was returning medication to the pharmacy at that time. She stated these expired medication were no longer ordered for the Resident #180. She stated the night shift usually pulls expired medications, discontinued medications and medication for residents who had been discharged. An observation on 06/28/2017 at 3:30 PM revealed Resident #38 and Resident #49, both confused residents in wheelchairs in front of the central supply room door. They were attempting to self-propel down the hallway and Resident #49 asked "Where do I go?" The central supply medication storage room door was unlocked. An observation on 06/28/2017 at 4:59 PM the	F 431	conduct an audit of 2 medication carts and both medication rooms weekly for 4 weeks; every other week for 4 weeks and monthly x 1 month. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Results of audit will be reported during weekly Risk Meeting and reported at the quarterly QA x 2 for analysis and revision if needed. Staff development Coordinator will implement changes for F431	

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central supply/stock medication room with the Director of Nursing (DON) revealed the door to the room was unlocked and no one was in the room. The DON stated the Central supply person was on emergency leave.

An interview on 06/28/2017 at 6:23 PM with the DON revealed the central supply /stock medication storage room on the main hallway was open during the day. It was locked at night by the receptionist when she leaves at 6 PM. She stated the receptionist must have left it open since they were still all there. The nurse on the 100 hallway had a key for it so there was access during the night. She stated the door was left open until 6:00 PM so the department heads could have access to the printer that is in the room.

An interview on 06/29/2017 at 10:53 AM the receptionist stated the central supply staff person left the facility at 4:30 PM. The door to central supply was left unlocked. The receptionist stated she would make sure when she left at 6:00 PM the door to central supply was locked. She stated the central supply person left the door open so staff could have access to the printer.

An observation on 06/29/2017 at 11:24 AM Resident #38 was self-propelling herself in her wheelchair and opened the door and let herself into the activity room across from the central supply room. She required redirecting by the staff.

An observation on 06/29/2017 at 12:00 PM revealed the central supply room with medications was unlocked.

An observation on 06/29/2017 at 1:11 PM

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revealed Resident #38 again rolled in her wheelchair to the activity room door and let herself into the room across from the central supply storage area.

An interview on 06/29/2017 at 1:48 PM with the Medical Director (MD) revealed there was not an issue for the resident who received a recently expired lansoprazole. He stated generally the medications were effective for a period of time after the expiration date. He stated it is best for medications to given or replaced before the expiration date. The medications should have been reordered or replaced per pharmacy and facility protocols.

During an interview on 06/29/2017 at 3:27 PM the DON stated the night shift goes through the medication carts and storage rooms for expired medications. She stated it was her expectation that all medications that were administered would be in date. Her expectation was that all expired medications, those no longer order for a resident or medications from a resident who was discharged would be removed from the medication carts or storage areas and would be returned to the pharmacy.

An interview on 06/29/2017 at 3:45 PM with the DON and Administrator revealed the central supply storage room door was unlocked. The DON stated that when the central supply person was working she did leave the room to make deliveries to the units. She stated the only reason people come in the storage room is to use the copier and that is why it is left open. The DON and Administrator both agreed that they have cognitively impaired residents who go up and down the main hallways in front of this door. The

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F 431	Continued From page 36 Administrator stated his expectation was that the facility followed their policies and procedures for medication storage and items that are potentially harmful to the residents are secured at all times.	F 431		
F 520 SS=E	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 records of such committee except in so far as	F 520		7/21/17

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F 520	Continued From page 37 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 observations, staff interviews and review of facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place on September 02, 2016. This was for one recited deficiency that was originally cited during a recertification survey conducted on August 05, 2016 and subsequently recited during the current recertification survey. The deficiency was in the area of medication storage. The continued failure of the facility during two surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F 431, Drug Records, Label/Store Biologicals: Based on observations, staff interviews and record review the facility failed to remove from use expired medications from 2 of 5 medications carts and 1 of 2 medication storage rooms. The facility failed to lock 1 of 1 central supply medication storage rooms. F 431 was originally cited during a recertification	F 520	How the corrective action will be accomplished for the resident(s) affected On 6/26/17, the facility failed to remove 2 expired medications from the medication carts and 1 expired medication from the storage room. Upon identification, nurse #1 immediately removed the expired medications from the 200 hall medication cart during findings. Nurse #1 was then educated on proper storage and labeling of medications. Director of Nursing (DON) removed expired Zosyn from medication storage room on 6/28/17. On 7/20/17, all full and part time nurses were in-serviced on the correct way to check medication carts/medication rooms for expired medication, proper labeling of medications, and the removal of any medications for discharged residents. On 6/26/17, it was also noted that the facility failed to lock the central supply medication storage room. On 6/29/17 the maintenance director removed the key lock and replaced it with a keypad entry lock to ensure that the door with remain locked at all times. Staff in-services outlining that the central supply door must be locked at all times, nor can it be left	

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F 520	Continued From page 38 survey in August 2016 for failure to label/date the canister of an open/used inhaler and recited on the current recertification survey for failure to remove expired medication and maintain the central supply room locked. During an interview on 06/29/17 at 6:10 PM with the administrator and director of nursing (DON), the interview revealed that the facility's QAA committee met at least quarterly. During the quarterly meetings, the administrator/DON stated the facility's QAA committee reviewed survey results for trends/identity problems and to develop/implement a performance plan for correction. The DON stated that the facility had a system for monitoring medication storage for expired medications, but that the monitoring was not conducted daily and said that more frequent monitoring may be needed. The DON also stated that the facility had just relocated central supply to its current location about 2 weeks prior and the facility was in the process of developing a system for keeping the door locked at all times.	F 520	open for any reason. QA members were educated on F0431. Staff Development Coordinator will ensure education/in-service are completed and will continue monitoring. DON will report audits results at quarterly QA meeting and adjust POC accordingly. How corrective action will be accomplished for those residents with the potential to be affected by the same practice: All QA members were educated on 7/20/17 on process to review all at-risk areas during weekly risk meeting and at the quarterly QA meeting by the Staff Development Coordinator (SDC). Measures to be put in place or systemic changes made to ensure practice will not re-occur: SDC or designee will attend all risk and QA meetings to ensure QA team is discussing the medication storage audits. DON will report audit results at quarterly QA meeting and adjust POC accordingly. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Meeting x 4 weeks and Quarterly Quality Assurance meeting X 4 for further resolution if needed. Facility Administrator will implement changes to F0520.	