STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345298	A. BUILDING _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF PENDER	311 S CAMPBELL STREET BURGAW, NC 28425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted on 08/21/17 through 08/25/17. Immediate Jeopardy was identified at: CFR 483.25 at tag F323 at a scope and severity of J. CFR 483.75 at tag F490 at a scope and severity of J. The tag F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/10/16 and it is ongoing. An extended survey was conducted. No deficiencies were cited as a result of complaint investigation on 08/25/17. Event B7IT11. 9/1/17 After review of the F 323 credible allegation and discussion with CMS, F 490 is removed from the 2567. BW	F 000		
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	F 166		9/18/17

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

Electronically Signed | 09/08/2017

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F 166	Continued From page 1	F 166		

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 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

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F 166	Continued From page 2 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 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 observation, staff and resident interviews, and record review the facility failed to	F 166	The Laurels of Pender wishes to have this submitted plan of correction stand as	

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F 166	Continued From page 3 provide a written grievance decision regarding a resident's complaint about the use of a wander guard for 1 of 1 residents reviewed for wander guard use (Resident #110). Findings included: Review of a Power of Attorney form dated 5/6/16 revealed Resident #110 had a family member appointed to be his Power of Attorney. Resident #110 was admitted to the facility on 6/15/16. His active diagnoses included anxiety disorder, hypertension, cerebrovascular disease, alcohol dependence with alcohol induced persisting dementia, and cerebral infarction. Review of Resident #110's quarterly Minimum Data Set assessment dated 11/30/16 revealed the resident was assessed as cognitively intact. Resident #110 was also assessed to exhibit no behaviors of wandering. Review of Resident #110's quarterly Minimum Data Set assessment dated 3/1/17 revealed the resident was assessed as cognitively intact. Resident #110 was also assessed to exhibit no behaviors of wandering. Review of Resident #110's most recent Minimum Data Set assessment dated 5/31/17, coded as an annual assessment, revealed the resident was assessed as cognitively intact. Resident #110 was also assessed to exhibit no behaviors of wandering. Review of Resident #110's risk for elopement assessment signed 6/1/17 revealed he was assessed as no risk for elopement.	F 166	written allegation of compliance. Our date of alleged compliance is September 18, 2017. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F166 □ 1. Resident #110 was given opportunity to file a facility grievance form and received a written grievance decision regarding his complaint. Grievance was processed and resolved. 2. Current residents have the potential to be affected. Current residents or responsible party will be given a copy of the grievance policy. New residents/responsible party will receive a copy of the grievance policy during the admission process. 3. The staff development coordinator will in-service all staff by 9/14/17 on the grievance policy to include the right to receive a written response of the grievance decision. 4. The Social Worker or designee will conduct 5 resident interviews weekly X 4 weeks and then be an agenda item on the resident counsel monthly X 2 months to ensure that residents are aware of their	

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F 166	Continued From page 4 Review of Resident #110's behavior monitoring sheet for 7/25/17 through 8/23/17 revealed the resident had not exhibited any behaviors including wandering. Review of the facility's Grievance Log from September 2016 to August 2017 revealed there were no recorded grievances for Resident #110. During observation on 8/22/17 at 9:00 AM Resident #110 was observed to have a wander guard on his right ankle. During an interview on 8/22/17 at 9:01 AM Resident #110 stated when he first entered the facility he had no real short term memory because of a stroke and tried to leave because he did not understand how much help he needed. He further stated that was over a year ago and he had not attempted to leave since. He stated a wander guard was put on his ankle but he was alert and oriented now and understood why he needed the help. He further stated he had told the facility he was not going to leave the facility and would like to have the wander guard off. Resident #110 stated he asked to have the wander guard taken off months ago and was told to speak with the Director of Nursing and file a complaint with her. He stated the Director of Nursing simply told him no she could not take it off and did not give him a reason. He further stated that he understood why his family member was his legal guardian. Resident #110 further stated that he wanted his family member to continue being his legal guardian and did not want that changed. During an interview on 8/23/17 8:14 AM Nurse	F 166	right to file grievance and to receive a written grievance decision. Any variance will be corrected at the time of finding. Results of auditing will be forwarded to quality assurance committee for compliance tracking and trending. Quality Assurance Committee will review for 3 months or until resolved. 5. Date of Compliance: 9/18/17	

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Aide #5 stated that Resident #110 had requested to have his wander guard removed and she had told the resident to talk to his nurse.

During an interview on 8/23/17 8:22 AM Nurse #5 stated he had behaviors in his past but she had not had any concerns with his behaviors lately. She further stated when he first came to the facility in June he went out with his sister and got a beer and went behind the store to drink and the police had to bring him back. A wander guard was put in place after this and he did pull it off a few times. She stated they had to watch his wander guard to make sure to put a new wander guard on but that he had not tried to get out when the wander guard was off. She further stated he asked about getting his wander guard off every day and she had told the resident it is not up to her and directed him to the Director of Nursing.

During an interview on 8/23/2017 at 8:42 AM the Director of Nursing stated they placed a wander guard on Resident #110 in June of 2016 after he left his Power of Attorney during an outing. The Director of Nursing stated that Resident #110 often asked to have his wander guard removed but the facility systematically evaluated residents with wander guards yearly. She further stated she did not evaluate wander guards based on request. The Director of Nursing stated that she did not have an answer for why she did not include him in an evaluation earlier when he requested to have the wander guard removed or when he was assessed as no risk for elopement in May 2017. She stated the facility did not see his verbal complaint as a grievance and she did not do an investigation of his concern.

During an interview on 8/24/17 at 8:33 AM

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F 166	Continued From page 6 Resident #110's Power of Attorney stated she agreed Resident #110 had the right to be informed why the wander guard was still in place and if there was an in depth assessment, she would be perfectly fine with the facility revisiting the use of his wander guard. She further stated she had not been notified of any reevaluation of his wander guard placement since June of 2016.	F 166		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to promote a resident's dignity by allowing the resident, who was totally dependent on staff for feeding assistance, to eat a pureed meal with her fingers for 1 of 1 residents observed (Resident #18). Findings Included: Resident #18 was admitted to the facility on 03/15/17 with diagnoses which included protein-calorie malnutrition, dysphagia, weakness, lack of coordination, blindness, diabetes mellitus stage 2 and end stage renal disease with dependence on renal dialysis. A review of Resident #18's significant change Minimum Data Set (MDS), dated 03/22/17, indicated resident #18 was moderately cognitively	F 241	F241 □ Dignity 1. Resident #18 was given a shower and linens were changed. Her care plan was reviewed and determined to be appropriate for assistance level (dependent) and care card was updated to reflect this level of assistance. There was no negative outcome to this resident. 2. Residents who are dependent with eating were determined to be at risk. These residents were reviewed and care cards were updated to match appropriate level of assistance for eating. 3. The Staff Development Coordinator or designee will in-service Licensed nursing and certified nursing staff by 9/14/17 on not setting tray in front of residents who are dependent upon staff for eating until assistance can be provided and providing	9/18/17

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F 241	Continued From page 7 impaired. A review of Resident #18's MDS, dated 07/18/17 revealed Resident #18 required total dependence on staff for eating. The MDS indicated resident had impairment on both side of her upper and lower extremities. A review of Resident #18's Care Plan, last updated 05/17/17, revealed Resident #18 required staff to feed her for all meals. During an observation of Resident #18 on 08/21/17 at 6:15 p.m., Resident #18 was observed to be lying in her bed with the head of the bed elevated at a 45 degree angle and she was leaning to her right. Resident's divided plate containing pureed food items had been placed on her over-bed table which was positioned across the bed. Resident #18 was observed using the fingers of her left hand to scoop and drag the food off of the plate, across a portion of the over-bed table and into her mouth. Resident #18 was observed to have pureed food on her right cheek, right neck and chest area, and on her blouse. During an interview with Nursing Assistant (NA) #1 on 08/24/17 at 4:05 p.m., NA #1 stated she had been assigned to care for Resident #18 on 08/21/17 for the 3:00 p.m. to 11:00 p.m. shift. NA #1 stated she had brought Resident #18's supper tray in to her, set it up and gave her a spoon so she could feed herself. NA #1 stated Resident #18 was an independent diner sometimes and a dependent diner sometimes. When asked for clarification, NA #1 stated on the days Resident #18 went to dialysis, she is too tired to feed herself and on those days she fed her. NA #1	F 241	a dignified meal service. New nursing employees will be trained during orientation on this process. 4. The DON or designee will audit 10 residents who need to be fed per week X 4 weeks; Then 10 residents who need to be fed X 2 months to ensure that appropriate assistance level is provided during meals. Any variance will be corrected at the time of finding. Results of auditing will be forwarded to quality assurance committee for compliance tracking and trending. Quality Assurance Committee will review for 3months or until resolved. 5. Date of compliance: 9/18/17	

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F 241	Continued From page 8	F 241		

stated on days the resident did not go to dialysis, she could feed herself. When asked if she was aware Resident #18 had used her fingers to feed herself on 08/21/17, NA #1 stated Resident #18 did that often even though she provided a spoon for her to use. When asked if she had noticed the pureed food on Resident #18's body and clothes, NA #1 stated she had noticed it and stated by the time she had returned to the room, Resident #18 had pulled her plate into the bed with her and she had to give the resident a shower and changed her bed linens. When asked how she would know how a resident had been assessed for feeding assistance, she stated there was a care card inside the closet door.

During an observation of the Nursing Care Card, dated 05/17/17 located inside Resident #18's closet on 08/24/17 at 4:10 p.m., NA #1 pointed to the part of the card which indicated Resident #18's eating skills. The letter "E" was circled. When asked what "E" stood for, NA #1 was unable to provide an answer. Nurse #1 entered the room to offer assistance and informed NA #1 the meaning of "E" was extensive. NA #1 stated she had not known the resident needed extensive assistance with meals.

During an interview with the Director of Nursing (DON) on 08/25/17 at 1:35 p.m., the DON stated it was her expectation the nursing staff treat the residents with dignity and respect by providing the appropriate feeding assistance.

During an interview with the Administrator on 08/25/17 at 1:20 p.m., the Administrator stated it was his expectation the staff treat residents with dignity and respect.

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F 282	Continued From page 9	F 282		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide care in accordance with the plan of care for 1 of 1 resident observed (Resident #128) who required total dependence on staff to be fed. Findings Included: Resident #18 was admitted to the facility on 03/15/17 with diagnoses which included protein-calorie malnutrition, dysphagia, weakness, lack of coordination, blindness, diabetes mellitus type 2 and end stage renal disease with dependence on renal dialysis. A review of Resident #18's significant change Minimum Data Set (MDS), dated 03/22/17, indicated Resident #18 was moderately cognitively impaired. A review of Resident #18's MDS, dated 07/18/17, revealed Resident #18 required total dependence on staff for eating. The MDS indicated resident had impairment on both side of her upper and lower extremities.	F 282	F282 □ Care plan 1. Residents #18□s care plan was reviewed and determined to be appropriate for assistance level (dependent) and care card was updated to reflect this level of assistance. There was no negative outcome to this resident. 2. Residents who are dependent with eating were determined to be at risk. These residents were reviewed and care cards were updated to match appropriate level of assistance for eating. 3. The Staff Development Coordinator or designee will in-service Licensed and certified staff by 9/14/17 on providing assistance with meals in accordance with care plan/care card. New nursing employees will be trained during orientation on this process. 4. The DON or designee will audit 10 residents who need to be fed per week X 4 weeks; Then 10 residents who need to be fed X 2 months to ensure that appropriate assistance level is provided during meals. Any variance will be corrected at the time of finding. Results	9/18/17

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F 282	Continued From page 10 A review of Resident #18's Care Plan, last updated 05/17/17, revealed Resident #18 required staff to feed her for all meals. During an observation of Resident #18 on 08/21/17 at 6:15 p.m., Resident #18 was observed to be lying in her bed with the head of the bed elevated at a 45 degree angle and she was leaning to her right. Resident's divided plate containing pureed food items had been placed on her over-bed table which was positioned across the bed. Resident #18 was observed using the fingers of her left hand to scoop and drag the food off of the plate, across a portion of the over-bed table and into her mouth. Resident #18 was observed to have pureed food on her right cheek, right neck and chest area, and on her blouse. During an interview with Nursing Assistant (NA) #1 on 08/24/17 at 4:05 p.m., NA #1 stated she had been assigned to care for Resident #18 on 08/21/17 for the 3:00 p.m. to 11:00 p.m. shift. NA #1 stated she had brought Resident #18's supper tray in to her, set it up and gave her a spoon so she could feed herself. NA #1 stated Resident #18 was an independent diner sometimes and a dependent diner sometimes. When asked for clarification, NA #1 stated on the days Resident #18 went to dialysis, she was too tired to feed herself and on those days she would feed her. NA #1 stated on days the resident did not go to dialysis, she fed herself. When asked if she was aware Resident #18 had used her fingers to feed herself on 08/21/17, NA #1 stated Resident #18 does that often even though she will provide a spoon for her to use. When asked if she had noticed the pureed food on Resident #18's body and clothes, NA #1 stated she had noticed it and	F 282	of auditing will be forwarded to quality assurance committee for compliance tracking and trending. Quality Assurance Committee will review for 3 months or until resolved. 5. Date of Compliance: 9/18/17	

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F 282	Continued From page 11 stated by the time she had returned to the room, Resident #18 had pulled her plate into the bed with her and she had to give the resident a shower and change her bed linens. When asked how she would know how a resident had been assessed for feeding assistance, she stated there was a care card inside the closet door. During an observation of the Nursing Care Card, dated 05/17/17, inside Resident #18's closet on 08/24/17 at 4:10 p.m., NA #1 pointed to the part of the card which indicated Resident #18's eating skills. The letter "E" was circled. When asked what "E" stood for, NA #1 was unable to provide an answer. Nurse #1 entered the room to offer assistance and informed NA #1 the meaning of "E" was extensive. NA #1 stated she had not known the resident needed extensive assistance with meals. During an interview with the Director of Nursing (DON) on 08/25/17 at 8:05 a.m., the DON stated it was her expectation nursing staff follow the residents' Care Plans and feed them accordingly. During an interview with the Administrator on 08/25/17 at 1:20 p.m., the Administrator stated it was his expectation residents be fed according to their plan of care.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		9/18/17

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(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 312	Continued From page 12 Based on observation, staff interview, and record review the facility failed to provide nail care for 1 of 4 residents reviewed for Activities of Daily Living care (Resident #66) and failed to provide feeding assistance to 1 of 4 residents reviewed for Activities of Daily Living care (Resident #18). Findings included: 1) Review of Resident #66's most recent Minimum Data Set assessment dated 7/20/17 revealed he was assessed as severely cognitively impaired and totally dependent on staff for personal hygiene care. He was also assessed as not rejecting care. Review of Resident #66's care plan last updated 7/22/17 revealed he was care planned to be dependent upon staff for all Activities of Daily Living related to worsening dementia with severe cognitive and communication impairment. The goal was for Resident #66 to be kept clean, dry, comfortable, and appropriately dressed and groomed daily with staff assistance. During observation on 8/22/17 at 9:10 AM Resident #66 was observed to have long fingernails. During observation on 8/23/17 at 2:35 PM Resident #66 was observed to still have long fingernails. During an interview on 8/23/17 at 3:18 PM Nurse Aide #6 stated that residents who are totally dependent on staff for personal hygiene are supposed to have their fingernails clipped every other day. She stated that any diabetic residents have to have the podiatrist clip their toenails but	F 312	F312 □ ADLS 1. Resident #66□s nails were cleaned and trimmed as needed. Resident #18 was given a shower and linens were changed. There was no negative outcome to this resident. 2. All residents are at risk for need of nail care. All residents will be checked for needed nail care and provided assistance as needed. Residents who are dependent with eating were determined to be at risk. These residents were reviewed and care cards were updated to match appropriate level of assistance for eating. 3. The Staff Development Coordinator or designee will in-service Licensed and certified staff by 9/14/17 on providing assistance with meals in accordance with care plan/care card and provision of nail care. New nursing employees will be trained during orientation on this process. 4. The DON or designee will audit 10 residents per week X 4 weeks; Then 10 residents monthly X 2 months that are dependent for eating and nail care to ensure that residents receive the appropriate assistance level for meals and nail care. Any variance will be corrected at the time of finding. Results of auditing will be forwarded to quality assurance committee for compliance tracking and trending. Quality Assurance Committee will review for 3 months or until resolved. 5. Date of compliance: 9/18/17	

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	345298	A. BUILDING _____ B. WING _____	C 08/25/2017

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the Nurse Aides clip their fingernails. She stated that she had performed nail care on Resident #66 but that she could not remember the last time and that she would look into it.

During an interview on 8/23/17 at 3:23 PM the Director of Nursing stated that either the treatment nurse or other staff will clip the fingernails of residents including diabetic residents. She stated it was her expectation that dependent residents have their nails trimmed regularly and that staff would do this as needed. The Director of Nursing observed Resident #66 ' s fingernails during the interview and stated that Resident #66 did have long fingernails and that she would have a nurse clip them immediately.

2. Resident #18 was admitted to the facility on 03/15/17 with diagnoses which included protein-calorie malnutrition, dysphagia, weakness, lack of coordination, blindness, diabetes mellitus type 2 and end stage renal disease with dependence on renal dialysis.

A review of Resident #18's significant change Minimum Data Set (MDS), dated 03/22/17, indicated Resident #18 was moderately cognitively impaired.

A review of Resident #18's MDS, dated 07/18/17, revealed Resident #18 required total dependence on staff for eating.
The MDS indicated resident had impairment on both side of her upper and lower extremities.

A review of Resident #18's Care Plan, last updated 05/17/17, revealed Resident #18 required staff to feed her for all meals.

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During an observation of Resident #18 on 08/21/17 at 6:15 p.m., Resident #18 was observed to be lying in her bed with the head of the bed elevated at a 45 degree angle and she was leaning to her right. Resident's divided plate containing pureed food items had been placed on her over-bed table which was positioned across the bed. Resident #18 was observed using the fingers of her left hand to scoop and drag the food off of the plate, across a portion of the over-bed table and into her mouth. Resident #18 was observed to have pureed food on her right cheek, right neck and chest area, and on her blouse.

During an interview with Nursing Assistant (NA) #1 on 08/24/17 at 4:05 p.m., NA #1 stated she had been assigned to care for Resident #18 on 08/21/17 for the 3:00 p.m. to 11:00 p.m. shift. NA #1 stated she had brought Resident #18's supper tray in to her, set it up and gave her a spoon so she could feed herself. NA #1 stated Resident #18 was an independent diner sometimes and a dependent diner sometimes. When asked for clarification, NA #1 stated on the days Resident #18 went to dialysis, she was too tired to feed herself and on those days she would feed her. NA #1 stated on days the resident did not go to dialysis, she fed herself. When asked if she was aware Resident #18 had used her fingers to feed herself on 08/21/17, NA #1 stated Resident #18 does that often even though she will provide a spoon for her to use. When asked if she had noticed the pureed food on Resident #18's body and clothes, NA #1 stated she had noticed it and stated by the time she had returned to the room, Resident #18 had pulled her plate into the bed with her and she had to give the

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F 312	Continued From page 15 resident a shower and change her bed linens. When asked how she would know how a resident had been assessed for feeding assistance, she stated there was a care card inside the closet door. During an observation of the Nursing Care Card, dated 05/17/17, inside Resident #18's closet on 08/24/17 at 4:10 p.m., NA #1 pointed to the part of the card which indicated Resident #18's eating skills. The letter "E" was circled. When asked what "E" stood for, NA #1 was unable to provide an answer. Nurse #1 entered the room to offer assistance and informed NA #1 the meaning of "E" was extensive. NA #1 stated she had not known the resident needed extensive assistance with meals. During an interview with the Director of Nursing (DON) on 08/25/17 at 8:05 a.m., the DON stated it was her expectation nursing staff provide feeding assistance to meet the resident's Activities of Daily Living (ADLs) needs. During an interview with the Administrator on 08/25/17 at 1:20 p.m., the Administrator stated it was his expectation staff meet the residents' ADL needs for meal assistance.	F 312		
F 323 SS=J	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	F 323		9/18/17

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F 323	Continued From page 16 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 observation, record review and staff interviews, the facility failed to prevent 1 of 1 cognitively impaired residents with wandering and exit-seeking behaviors (Resident #128) from exiting the facility on 3 separate occasions. Immediate jeopardy began on 10/10/16 when Resident #128 exited the facility unattended by facility staff and was observed standing in the grass between a ditch and a road in front of the facility. Immediate jeopardy is present and ongoing. Findings Included: Resident #128 was originally admitted to the facility on 05/31/16 with diagnoses which included muscle weakness, difficulty walking, history of falling, paranoid personality disorder, unspecified	F 323	F323 □ Accidents Resident #128 admitted to facility on 10/6/16 with diagnosis of Alzheimer dementia with behavioral disturbance, paranoid personality disorder, adjustment disorder with anxiety, other cerebral infarction and cognitive communication deficit. Elopement risk observation was completed 10/6/16 at a score of 15. The RN nurse assessor indicated that resident is not at risk for elopement as resident has made no attempt to exit the facility, and has not demonstrated any exit seeking behavior On 10/10/2016 resident #128 was observed walking on grassy strip on paved road next to facility. Facility	

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F 323	Continued From page 17 dementia with behavioral disturbance. The resident had an admission Minimum Data Set (MDS) on 6/12/16. A review of Resident #128's Care Plan, last updated on 07/27/16, indicated Resident #128 was a wanderer and an elopement risk related to his aimless wandering, impaired safety awareness and history of attempts to leave the facility unattended. The Care Plan indicated the facility was to identify his pattern of wandering by questioning if the wandering is purposeful, aimless or escapist. The Care Plan included an intervention of monitoring Resident #128's location every 15 minutes to ensure his whereabouts and to document his wandering behavior and attempted diversional interventions in the behavior log. The Care Plan indicated Resident #128 had a Wander Guard bracelet applied to his left wrist. (A Wander Guard is a device worn by a resident that signals an exit door to lock when approached by the resident wearing it or sounds an alarm if a resident wearing one exits the door). The resident was discharged from the facility to home on 8/8/16. The resident was admitted to the facility on 10/6/16. The resident was assessed as a new resident on this admission. A review of Resident #128's admission Minimum Data Set (MDS) dated 10/13/16 revealed Resident #128 was severely cognitively impaired with behaviors that included inattention, disorganized thinking, and wandering. The MDS indicated Resident #128's wandering placed him at significant risk of getting into a potentially dangerous place. The MDS indicated Resident #128 needed limited assistance with walking in his room and in the corridor and his balance	F 323	employee assisted resident to get in personal vehicle then resident escorted back into building by AMH LPN. At that point resident was pleasant and cooperative. Unable to determine reason to leave because resident did not respond to questions. Based on staff interviews there is no indication of exit route or obvious reason for resident leaving the facility. Resident #128 was reassessed and noted as an elopement risk 10/10/16 after leaving facility. The alarm bracelet was applied per staff interviews on 10/10/16. MD order received 10/12/16 Nurse Practitioner discontinued resident #2346 Seroquel at 12:50pm on 10/26/16 after determining resident□s behavior was stable. Nurse Practitioner made a medication change on 11/1/16 5:25P.M. related to resident□s unsuccessful attempt to leave the facility. 11/2/16 resident was not able to be found for dinner. At 5:30pm DON initiated a head count. Resident discovered not to be in the facility. Search was initiated. Police and EMS notified. Resident was located in wooded area one block behind the facility. Staff and EMS assisted resident out of woods. Resident ambulated with assistance while talking non-stop about his adventure stating he wasn□t doing that again. When resident #128 was asked why he exited the building he responded I looked outside and did not	

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during transitions and walking was not steady and only able to stabilize with staff assistance. The MDS indicated Resident #128 used a cane as a mobility device and had a fall in the last month prior to admission.

A review of Resident #128's Care Area Assessment (CAA), dated 10/13/16, indicated Resident #128 had cognitive loss and dementia and was easily distracted. The CAA indicated Resident #128 had behavioral symptoms which included daily wandering, resistance to care, pacing and physically abusive at times. The CAA indicated Resident #128 was an immediate threat to himself and an immediate intervention was required.

On 08/24/17 at 9:14 a.m., the Director of Nursing (DON) was asked to provide a copy of the behavior log mentioned in Resident #128's Care Plan. The DON stated there was no log because they do not do that type of log at this facility.

A review of the Daily Skilled Nursing Notes indicated Resident #128 exhibited wandering behaviors on October 7, 10, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 29, 30 of 2016.

Record review indicated Resident #128 exited the facility unattended by staff on 10/10/16, 11/02/16 and 11/06/16.

A review of an Incident Report of the elopement written by Nurse #3 on 10/12/16 indicated Resident #128 was found ambulating in the street on 10/10/16 at 4:15 p.m. The report included a witness statement by Nurse #2 which stated, "I was driving down road in front of VOC (The Village of Campbell which was the previous name see anyone with guns so I ran. Resident #2346 is a 28-year veteran who thought he was at war. Resident sent to emergency room by EMS for evaluation. Administrator at 6:15PM on 11/2/16 checked all doors not equipped with wander guard system to ensure function of main alarm system. The Administrator and Maintenance director determined the dining room door did not latch properly, therefore not allowing the main alarm system to sound. Maintenance Director repaired closure on dining room door which allowed door to latch. After repairs all doors latched properly.

On 11/2/16 at 6:45pm, Director of Nursing in-serviced all licensed staff on checking doors that are not equipped with Wander Guard system to ensure doors are closed and latched to ensure proper function of main alarm system. Any licensed staff not in-serviced on 11/2/16 were educated prior to next scheduled shift by Director of Nursing or designee.

Plan of Correction enacted by Administrator. All staff educated on 11-2-16 and prior to next scheduled work day on ensuring doors closed and latched for proper functioning of alarm system. 11/2/16 at 8:25 PM resident returned to facility with soft tissue swelling of ankle and placed on 1:1 supervision.

11/6/16 Resident #128 was 1-1 with Certified Nursing Assistant. He was observed to be sleeping on sofa in hallway. Certified Nursing Assistant left

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F 323	Continued From page 19 of this facility) and resident was walking across the street from driveway on 100 Hall of VOC. I stopped and assisted resident into vehicle and brought him back to the parking lot of VOC and assisted resident inside facility. Resident was pleasant and talkative. No harm or injury noted." The incident report indicated an Elopement Assessment was performed and a Wander Guard was placed on the resident's left wrist. The incident report indicated the root cause of the incident to be a history of dementia and recent hospitalization for delirium. The incident report was signed by the Director of Nursing (DON) on 10/13/16 indicating she was aware of the elopement. During an interview with Nurse #2 on 08/24/17 at 12:04 p.m., Nurse #2 stated on 10/10/16 she was driving in to work and noticed Resident #128 standing in the grass between the ditch and the road near the facility sign. Nurse #2 stated she did not think he had jumped the ditch but rather walked out of the parking and the down to an area between the road and ditch near the facility sign. Nurse #2 stated the only way she could maneuver the resident was to get him in her car as if they were going somewhere. Nurse #2 stated she pulled into the parking lot near the 400 Hall and Nurse #3 assisted her in getting the resident back in the facility. Nurse #2 stated she and Nurse #3 walked with the resident to his assigned nurse, Nurse #4. Nurse #2 stated under normal situations, the resident's elopement would have been discussed the following morning at their stand-up meeting. Nurse #2 stated the facility was in a bit of chaos following the aftermath of Hurricane Matthew therefore the resident's elopement of 10/10/16 did not get discussed until 10/12/16.	F 323	resident for bathroom adjacent to hallway. A second nursing assistant observed resident walking down hallway and notified the nurse. Second nursing assistant and nurse followed resident on to side porch. The alarm sounded and nurse assisted #2346 back into the building. A total of 87 staff members were educated on 1-1 supervision policy by DON and ADON on 11/6/16 and 11/7/16 #128 discharged on 11/17/16 to a locked unit. The guardian was in agreement. The need for improved safety systems at the facility were identified prior to 2/1/17 New Door Guardian by Secure Care system ordered on 1/30/17. This system locks the doors when a resident approaches with an alarm bracelet and inhibits an unplanned exit. In addition, new system installed includes coded locked exit doors. Facility reviewed compliance with all new policies including resident safety as part of monthly QA on 2/7/17. New policies and procedures were adopted by the QA Committee. General orientation was conducted for current employees from 3/1/17 to 3/9/17. This orientation included review of residents rights, abuse and facility disaster plan. The Missing Person Policy and Procedure is a component of the disaster plan. New Door Guardian by Secure Care	

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F 323	Continued From page 20 A Risk of Elopement Review form, completed on Resident #128 on 10/12/16 by Nurse #3, indicated Resident #128 was cognitively impaired with poor decision making skills, had a pertinent diagnosis of dementia and had a history of leaving the facility without informing staff. The assessment indicated Resident #128 was at risk for elopement as evidenced by having left the facility without informing staff on 10/10/16 and a Wander Guard bracelet was placed on his left wrist with staff to check the placement of the bracelet every four hours with daily signal checks to be placed in the log. During an interview with the DON on 08/24/17 at 12:02 p.m., the DON stated she did not recall being made aware of Resident #128's 10/10/16 elopement because she was out of the state. During an interview with the former Administrator on 08/25/17 at 9:28 a.m., the former Administrator stated she did not complete an investigation of the 10/10/16 elopement or put a Plan of Correction (POC) in place. The former Administrator stated a Wander Guard had been placed on the resident and she had hoped it would prevent future elopements. When asked how the resident exited the building, she stated he just walked out. During an interview with Nurse #2 on 08/25/17 at 10:30 a.m., Nurse #2 stated she thought Resident #128 exited the facility on 10/10/16 through the 100 Hall front door because he resided on that hall. An observation of the distance from the 100 Hall front door to the point where the resident was	F 323	system installed 3/9/17. Pathway Technologies is a service company responsible for maintenance of Door Guardian Secure Care system to ensure the integrity of the security system effective 3/9/17. Front entrance door designated to be only door to use by visitor 16 out of 16 residents with Physician orders for alarm bracelets were visually verified for placement by Assistant Director of Nursing and function by Treatment nurse on 8/24/17. Each resident with an alarm bracelet has placement verified each shift and function daily by licensed nursing staff. Re-Assessments of all residents for elopement risk were completed by Director of Nursing, Assisted Director of Nursing Staff Development Coordinator and Unit Managers to determine the need for alarm bracelet for exit seeking behavior on 8/24/17. Appropriate care plans are in place. The wander guard system and all alarmed doors were re-checked on 8/24/17 for proper function by Maintenance Department/Designee. As part of preventative maintenance, a daily check of all alarmed doors was implemented with installation of new system in March of 2017. Administrative Nurses have audited all residents with Physicians orders for	

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F 323	Continued From page 21 picked up was made on 08/25/17 at 10:30 a.m. Accompanied by Nurse #2 and using a measuring wheel provided by the therapy department, the distance the resident traveled equaled 223 feet. Wunderground.com, an affiliate of the Weather Channel, indicated the outside temperature on 10/10/16 was 68 degrees Fahrenheit with a wind speed of 15 mph. A review of a Nurse Progress Note, written on 11/02/16 at 7:00 p.m. by the DON, revealed Resident #128 had exited the facility and a search had been started. The note indicated the resident had been found in the woods approximately a block from the facility. During an interview with the former Social Worker (SW) on 08/25/17 at 8:49 a.m., the former SW stated she had become aware Resident #128 was missing from the facility after she noticed the former Staff Development Coordinator (SDC) looking for him on the 100 Hall. The former SW stated she and the former SDC went out the exit door at the end of the 100 Hall, near room 130, and began calling Resident #128's name. The former SW stated they heard Resident #128 respond and they both kept calling his name and followed his voice to get to him. The former SW stated the resident was found lying on his back in a wooded area and the nursing staff (who had already arrived) along with the help of a police officer, assisted Resident #128 to a standing position. Wunderground.com, an affiliate of the Weather Channel, indicated the outside temperature on 11/02/16 was 75 degrees Fahrenheit with a wind speed of 6 mph. Per the former SW, the resident was dressed with pants, shoes and a jacket which he wore all the time regardless of the weather. The former SW stated	F 323	wander guards for placement, function, and documentation on 8/24/17. 32 of 32 Licensed Nurses, 42 of 42 certified nursing assistant, 17 of 17 Therapy Staff, 2 of 2 Activity Staff, 1 of 1 Social Service Staff, 1 of 1 Maintenance Staff, 9 of 9 Housekeeping/ Laundry Staff, 11 of 11Dietary Staff, 10 of 10 Administrative Staff were in-serviced by the Administrator/Designee between 8/24/17 and 8/25/17 related to missing guest policy procedure and reporting. All employees will be educated before returning to work. ADON or designee is auditing Treatment Administration Records (TAR) daily for 2 weeks and twice per week for 2 weeks and weekly X 2 months for documentation of function and placement of alarm bracelets. Central Supply Clerk is auditing exit doors daily for 2 weeks and twice per week for 2 weeks and weekly X 2 months for function. Administrator is responsible to ensure that Missing person drills are conducted daily for 5 days and weekly X 4 weeks. Nursing is auditing daily Monday through Friday new admitted resident charts to determine if elopement risk assessment was completed and if interventions to prevent elopement were initiated if appropriate. Any variances will be corrected at time of findings. Results of auditing will be forwarded to quality assurance committee for compliance tracking and trending. All new employees will be trained during orientation on this policy. Quality Assurance Committee will	

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F 323	Continued From page 22 Resident #128 was taken to the hospital by Emergency Medical Services (EMS). During an interview with Nurse #5 on 08/25/17 at 9:11 a.m., Nurse #5 stated she had been in a resident's room providing care with the door closed on 11/02/16. Nurse #5 stated when she exited the resident's room, she noticed one or two police cars outside behind the facility. Nurse #5 stated she went outside and asked the police officers if everything was okay and stated they told her they had been called because of a missing resident. Nurse #5 stated she and the two police officers walked the back woods line in an attempt to find a way to where she thought she saw someone. Nurse #5 stated she found entry into the woods on the side of the parking lot and by the time she made it to Resident #128's location in the woods other facility staff were already there. Nurse #5 stated Resident #128 had vines wrapped around his feet and one of the police officers had to take out his pocket knife and cut the vines from around his feet. During an interview with the DON on 08/24/17 at 1:25 p.m., the DON stated a Nursing Assistant (NA) came to her office and told her a resident was trying to get out of the building or he may already be out. The DON stated she went to the dining room door that leads to the back of the facility and started out the door. She stated she and the former SW ran for over a "good block". The DON stated the resident was cutting across yards. When asked how she thought Resident #128 had gotten out of the locked and alarmed door, she stated she assumed Resident #128, who was a very observant man, must have known if he held the door long enough the lock would release. The DON stated the former	F 323	review for 3 months or until resolved. Date of compliance: 9/18/17	

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	345298	A. BUILDING _____ B. WING _____	C 08/25/2017

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Administrator was in her car trying to "head him off". The DON stated there was a wooded area about 1 to 1½ blocks away from the facility and stated they could hear him yelling. The DON stated once they got to the wooded area where Resident #128 was, his feet were tangled in some ground vines and he could not get free. The DON stated after the resident was assisted, he walked out of the woods and was taken by EMS to the hospital for evaluation of possible injuries. The DON stated she sent a staff member over to the hospital to remain with the resident. The DON stated when the resident returned to the facility, she placed him on 1:1 the duration of his stay at the facility. When asked, the DON stated there had been no incident report filed related the Resident #128's elopement of 11/02/16. The DON stated there was no investigation of the elopement documented. The DON stated they had placed him on 1:1 and an attempt was made to find Resident #128 placement in a locked or memory care unit at another facility.

During an interview with the former Administrator on 08/25/17 at 9:28 a.m., the former Administrator stated on 11/02/16 she had already left the facility for the day when she received a phone call from facility staff who informed her Resident #128 had exited the facility. The former Administrator stated by the time she returned to the facility, the resident had already been found. The former Administrator stated the decision was made to send Resident #128 to the hospital to get checked out as he had some scratches from being tangled in the vines. The former Administrator stated she sent a facility staff member over to the hospital to sit 1:1 with him and once Resident #128 returned to the facility later the evening of 11/02/16, he remained on a

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1:1 observation.

The former Administrator was interviewed on 08/25/17 at 9:28 a.m. She stated after Resident #128's elopement on 11/02/16, she went back into the facility and staff reported to her the door the resident exited from had not alarmed. The former Administrator stated all front and side doors at the facility had been equipped with the Wander Guard system except for the back doors. She stated the door Resident #128 exited had a button at the top of the door and once someone pressed the button, the door could be opened and it would not alarm. The former Administrator stated only staff knew about this button and the door was used for deliveries. She stated after inspecting the door, it had been determined the automatic closure had been set to have the door close slowly which did not create enough force to have the door latch properly. The former Administrator stated if the door was not latched and someone exited through it, the alarm would not sound. She stated she had the maintenance director adjust the automatic door closure which corrected the problem.

A review of an Incident Report written by Nurse #7 on 11/06/16 indicated Resident #128 had exited the facility at 5:30 p.m. The incident report indicated "resident on 1:1 observation with aide (NA #2), no falls noted, aide went to bathroom and resident went out side door, alarms went off, on 100 Hall". The incident report was signed by the DON and the former Administrator.

During an interview with the DON on 08/24/17 at 1:35 p.m., the DON stated Resident #128 had been assigned NA #2 for his 1:1 observation on 11/06/16. The DON stated the resident exited the

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facility when NA #2 left Resident #128 unattended to use the bathroom. When asked how Resident #128 exited the facility, the DON stated she thought it was an instance similar to his 11/02/16 elopement when she thought Resident #128 had pushed on the door long enough for it unlock and he then exited the facility.

During an interview with NA #2 on 08/24/17 at 2:15 p.m., NA #2 stated she was assigned to work 1:1 with Resident #128 on 11/06/16. NA #2 stated Resident #128 was focused on wanting to leave and did not want to eat supper. NA #2 stated she and Resident #128 sat on a couch in an alcove near the main dining room. NA #2 stated Resident #128 began to doze on and off and stated when he fell asleep she walked across the hall to use the bathroom. NA #2 stated when she was finished and opened the door, Resident #128 was no longer sitting on the couch. NA #2 stated she immediately went into the main dining room and asked if anyone had seen Resident #128. NA #2 stated she left the dining room and walked down the service hall to the 100 Hall in search of Resident #128. NA #2 stated she noticed Nurse #8 bringing Resident #128 back into the building through an exit door to the right of the nurses' station.

During an interview with Nurse #8 on 08/24/17 at 3:02 p.m., Nurse #8 stated she could not remember an incident involving Resident #128's elopement on 11/06/16 therefore could neither confirm nor deny Resident #128's elopement.

During an interview with the former Administrator on 08/25/17 at 9:28 a.m., the former Administrator stated she had been informed Resident #128 had been observed by staff at all

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times when he exited the facility on 11/06/16. The former Administrator stated she did not consider the incident an elopement therefore she did not complete an investigation or a POC.

During an interview with NA #3 on 08/25/17 at 11:50 a.m., NA #3 stated she had been working on 2nd shift on 11/06/16. NA #3 stated she and Nurse #8 heard the alarm of the exit door by the 100 Hall nurses' station sound. NA #3 stated she and Nurse #8 investigated the alarm and saw Resident #128 standing outside under the awning. NA #3 stated Resident #128 never walked past the awning. NA #3 stated Nurse #8 went outside and assisted Resident #128 back into the building.

During an interview with the (current) Administrator on 08/25/17 at 11:44 a.m., the Administrator stated another corporation owned the facility during Resident #128's elopements. The Administrator stated it was his expectation the staff follow the current corporation's policy for the elopement of a resident and all the delineations within the policy.

An observation was made on 08/25/17 at 12:10 p.m. of the distance from the exit door near the 100 Hall nurses' station to the end of the awning of the outside. The distance equaled 15 feet. Wunderground.com, an affiliate of the Weather Channel, indicated the outside temperature on 11/06/16 was 61 degrees Fahrenheit and there was no wind. The resident was discharged to another facility on 11/17/16.

The Administrator was notified of the Immediate Jeopardy on 08/24/17 at 6:00 p.m.

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F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431		9/18/17

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F 431	Continued From page 28 (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 and staff interviews the facility failed to discard expired medications on 1 of 3 medication carts reviewed and 1 of 2 medication storage rooms reviewed (100 hall skilled medication cart, 100 hall medication storage room). Findings included: 1) During an observation on 8/24/17 at 9:46 AM, two blister packs of 120 Glycopyrrol 1 milligram tablets, which expired on 6/30/17, were in the 100 hall skilled cart stock drawer. During an interview on 8/24/17 at 9:46 AM, Nurse #9 stated the 120 Glycopyrrol 1 milligram tablets had expired on 6/30/17. She stated none of the expired medication had been used to her knowledge. She further stated no expired medications should be on the medication cart. During an interview on 8/24/17 at 10:18 AM the	F 431	F431 Drugs and Biologicals 1. Expired medications in medication cart and rooms were properly discarded. 2. All medication carts and storage rooms were determined to potentially be at risk for expired medications. 3. Staff Development Coordinator will in-service licensed nurses on properly disposing of expired medications by 9/14/17. New nursing employees will be trained during orientation on this process. 4. The Unit managers or designee will check medication carts and medication rooms 2 X week for 4 weeks and then 2 X month for 2 months for outdated medication. Any variances will be corrected at the time of finding. Results of auditing will be forwarded to quality assurance committee for compliance tracking and trending. Quality Assurance Committee will review for 3 months or until resolved.	

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F 431	Continued From page 29 Director of Nursing stated it was her expectation that medication stock be rotated, reviewed, and discarded before the expiration date. She further stated the Glycopyrrol 1 milligram tablets should not have been in the skilled medication cart on the 100 hall. 2) During an observation on 8/24/17 at 9:54 AM an opened bottle of Senna 8.6 milligram tablets with the expiration date of 3/17 was observed in the 100 hall medication room. During an interview on 8/24/17 at 9:55 AM Nurse #1 stated the bottle of Senna 8.6 milligram tablets expired on 3/17. She further stated no expired medications were supposed to be in the medication storage cabinet. Nurse #1 stated that they reviewed the medication room for out of date medications multiple times each month and they must have missed the bottle that expired in March. She stated she did not know if any doses had been given from the bottle since the expiration date. During an interview on 8/24/17 at 10:18 AM the Director of Nursing stated it was her expectation that medication stock be rotated, reviewed, and discarded before the expiration date. She further stated that the bottle of Senna 8.6 milligram tablets should not have been in the medication storage room.	F 431	5. Date of Compliance: 9/18/17	