STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SPRUC	218 LAUREL CREEK COURT SPRUCE PINE, NC 28777

(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 1. CFR 483.25 at tag F689 at a scope and severity of Immediate Jeopardy. Immediate Jeopardy began on 08/13/17 when Resident #35 left the facility unknown by staff and was located across the street in the parking lot of tennis courts after his wanderguard bracelet did not sound to alert staff of his exit. Immediate Jeopardy was removed on 02/23/18 when the facility implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) for continued monitoring. An extended survey was conducted in conjunction with the recertification and complaint survey from 02/19/18 through 02/23/18.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		3/30/18

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

Electronically Signed | 03/16/2018

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F 561	Continued From page 1 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews and staff interview, the facility failed to provide resident food preferences for 2 of 2 sampled residents (Residents #8 and #67) . The findings included: 1. Resident #8 was most recently admitted to the facility on 04/18/15. His Minimum Data Set, an annual dated 11/16/17, coded him with intact cognition and being able to feed himself independently. On 02/20/18 at 5:43 PM, Resident #8 was observed to have eaten his meal except for a serving of carrots left on his plate. He stated at this time he did not like carrots. Review of his printed tray card revealed carrots were listed as a dislike. On 02/21/18 at 5:39 PM, Resident #8 was observed eating his meal. At this time he had received the vegetable medley which was	F 561	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law." Tag F561: 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 2/22/18, the food service director validated that resident #8 received food he disliked, and on 2/23/18 resident #67 foods she disliked as a result of food service employee oversight that occurred on tray line. The food service director validated both resident dislikes.	

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F 561	Continued From page 2 observed to include multiple carrot slices. Interview with the Dietary Manager on 02/22/18 at 8:23 AM revealed that he interviewed residents to determine their dislikes and also updated the dislikes through staff reports. The dislikes were then placed on the tray card for the staff who plate the food to refer to during service. He further stated that the dietary staff failed to catch Resident #8's dislike of carrots and served them to him mistakenly. 2. Resident #67 was admitted to the facility on 04/24/17. The most recent quarterly Minimum Data Set coded her as having intact cognition and able to feed herself. On 02/20/18 at 5:27 PM, Resident #67 stated her food preferences were not honored. Resident #67's printed tray card indicated no cake and no gravy. At this time, she was observed with a meal tray which included beef stroganoff in bowls with gravy and a piece of white cake. She then showed the surveyor her hand written request for this meal that also was on the meal tray which clearly indicated she wanted stroganoff with no gravy and no cake. On 02/22/18 at 8:23 AM the Dietary Manager stated he interviewed residents to determine their dislikes and also updated the dislikes through staff reports. The dislikes were then placed on the tray card for the staff who plate the food to refer to during service. Upon further interview on 02/22/18 at 8:35 AM, the Dietary Manager stated that Resident #67 sends the kitchen her personal choices for each meal and those requests were followed. He stated that if she had written that she did not want gravy or cake, the dietary staff	F 561	2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) The food dislikes of resident #8 and #67 were reviewed and revised for accuracy by the Food Service Director on 2/23/18. b.) On 2/22/18 working cook and dietary aides were re-educated by Food Service Director on tray line accuracy. All Food Service Employees will be re-educated on or before 3/21/18 by Food Service Director. 3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance: a.) The Food Service Director or Food Service Cook will audit a minimum of 12 trays daily, Monday through Friday, for 3 weeks, weekly for 3 weeks and then monthly for 2 months to ensure compliance is achieved and maintained. The Administrator will review the results of the random audits and those findings will be reported at the monthly QA/PI meeting monthly for 2 months, then quarterly x 2 until substantial compliance has been achieved. 4.) The title of the person responsible for implementing the acceptable plan of correction:	

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F 561	Continued From page 3 should not have included those items on her tray.	F 561	a.) The Food Service Director will be responsible for the implementation of the acceptable plan of correction 5.) Date when corrective action will be completed: 3/30/18	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		3/30/18

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F 584	Continued From page 4 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and sanitary environment in 2 of 4 halls (Rooms 201, 203, 205, 207, and 407) by keeping personal care equipment labeled and stored properly, maintaining mold free shower stalls in the 200 hall shower room and keeping wood doors (Rooms 205, 207, and 212) free of splintered edges. The findings included: 1. The shower room off 200 hall was observed with 4 shower stalls with black, easily removed mold in the corners in the grout lines on 02/19/18 at 11:12 AM. The moldy build up remained in place in the shower stalls when observed on 02/23/18 at 1:45 PM. Interview with the housekeeper responsible for this room stated on 02/23/18 at 1:49 PM that she normally sprayed disinfectant in the shower stalls and did not use any cleaners. On 02/23/18 at 1:50 PM the district housekeeping manager stated she was covering for the	F 584	Tag F584: 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) The shower room off of the200 hall was observed with 4 shower stalls with black, easily removed mold in the corners in the grout lines due to housekeeping staff not cleaning shower rooms appropriately. Shower room was scrubbed by housekeeping on 3/13/18. All Shower rooms were deep cleaned by Maintenance and House Keeping on 3/16/18. The facility failed to label and properly store 100% of all resident personal care belongings as a result of staff oversight. Unlabeled items were discarded and replace with new, labeled items by the Director of Nursing on 2/23/18. The inside of the bathroom doors shared by rooms 205 and 207 and the inside of	

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F 584	Continued From page 5 housekeeping supervisor who was on vacation. She stated she was not sure what type of cleaners the facility used but knew the showers should be sprayed after each shower with disinfectant. She stated the mold should not be present in the shower stalls. Upon further interview on 02/23/18 at 2:08 PM, the last time the shower room was deep cleaned was 01/31/18. 2. Wood bathroom doors were observed in resident rooms with splintered jagged edges as follows: a. The inside of the bathroom doors shared by Rooms 205 and 207 had chipped jagged splintered edges. This was observed on 02/20/18 at 9:21 AM; on 02/20/18 at 3:43 AM; on 02/21/18 at 9:04 AM; on 02/22/18 at 8:13 AM; on 02/23/18 at 9:52 AM and on 02/23/18 at 2:26 AM. b. The inside of the bathroom door of Room 212 was chipped and splintered on 02/20/18 at 3:47 PM and on 02/23/18 at 2:26 PM. Interview with the Maintenance Manager on 02/23/18 at 2:26 PM revealed he ordered 4 new doors at a time to sand, refinish and replace as needed for chipped splintered edges. He further stated he has been purchasing plastic corner guards to help protect the edges from splintering. He fixed the doors as they were reported to need care or that he observed himself in need of repair. 3. Resident personal care equipment was not labeled or stored to protect against contamination as follows on the 200 hall:	F 584	the bathroom door of room 212 was chipped and splintered as a result from wear and tear from resident equipment such as wheel chair, lifts, etc. scrubbing edges when entering or exiting doorway. Facility Maintenance will replace the bathroom doors shared by rooms 205 and 207 and the inside of the bathroom doors by 3-23-18. 2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) On or before 3-23-18 Director of Nursing or Nurse Manager will conduct audit to validate that all resident personal belongings are properly labeled with the resident□s name and properly stored, place signage in supply storage area reminding staff to label supplies prior to delivering to residents rooms. Supplies provided upon admission to resident(s) will be labeled prior to being delivered to resident□s room. On 3/16/18 facility shower rooms were deep cleaned by the Maintenance and Housekeeping staff to ensure removal of any mold build up. On 3/13/18 the Facility Administrator Conducted a 100% audit of all facility doors to identify any chipped, jagged, or splintered edges. Maintenance Director will repair or replace doors identified to have chipped, jagged, or splintered edges	

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F 584	Continued From page 6 a. The bathroom shared between Rooms 201 and 203 had solid deodorant which was unlabeled on the shelf above the sink. This was observed on 02/19/18 at 9:31 AM; on 02/20/18 at 3:41 PM; on 02/22/18 at 4:09 PM; on 02/23/18 at 9:45 AM and on 02/23/18 at 2:22 PM. b. The bathroom shared by Rooms 205 and 207 had an unlabeled toothbrush and an unlabeled hair brush with hair on the shelf in the bathroom. This was observed on 02/20/18 at 9:21 AM; on 02/20/18 at 3:43 AM; on 02/21/18 at 9:04 AM; on 02/22/18 at 8:13 AM; on 02/23/18 at 9:52 AM and on 02/23/18 at 2:26 AM. Interview with Nurse Aide #4 on 02/23/18 at 2:17 PM revealed that personal care equipment should in bags in resident drawers. Interview with the Director of Nursing on 02/23/18 at 2:22 PM revealed that all personal care equipment should be labeled and stored in a plastic container. 2. An observation on 2/20/18 at 2:30 pm of the shared bathroom for room 407 revealed 1 unlabeled hairbrush, 1 opened but unlabeled package of personal care wipes, 1 opened but unlabeled container of shaving cream, 1 opened but unlabeled bottle of shampoo, 1 opened but	F 584	no later than 3/23/18. b.) All staff will be re-educated on labeling and storing resident□s personal items prior to delivering to resident on or before 3/21/18 by Administrator, Director of Nursing, and/or Nurse Manager. Administrator will re-educate the Maintenance staff on the importance of identifying and repairing/replacing doors with chipped, jagged edges on or before 3-21-18. The Housekeeping Supervisor will re-educate all housekeeping employees of the procedures and importance of the procedures for cleaning the shower rooms per cleaning schedules in order to prevent moldy build up on or before 3-21-18. Housekeeping Supervisor will be responsible to ensure the proper cleaning of shower rooms is performed as scheduled to prevent moldy build up. 3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance: a). The Director of Nursing, Nurse Manager, or Ambassador will document random audits for labeling and storage of resident□s personal belongings by checking 5 random rooms 1x per week x 6 weeks, then 3x per month x 4 months to ensure compliance is achieved and maintained. The DON will review results	

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F 584	Continued From page 7 unlabeled tube of zinc cream, and 1 opened but unlabeled tube of skin protectant cream on the shelf above the sink. An observation on 2/21/18 at 3:45 pm of the shared bathroom for room 407 revealed 1 unlabeled hairbrush, 1 unlabeled package of personal care wipes, 1 opened but unlabeled bottle of shampoo, 1 opened but unlabeled container of shaving cream, 1 opened but unlabeled tube of zinc cream, and 1 opened but unlabeled tube of skin protectant cream on the shelf above the sink. An observation on 2/22/18 at 4:00 pm of the shared bathroom for room 407 revealed 1 unlabeled hair brush, 1 opened but unlabeled container of shaving cream, 1 opened but unlabeled package of personal care wipes, 1 opened but unlabeled bottle of shampoo, 1 opened but unlabeled tube of zinc cream, and 1 opened but unlabeled tube of skin protectant cream on the shelf above the sink. An observation on 2/23/18 at 8:50 am of the shared bathroom of room 407 revealed 1 unlabeled hair brush, 1 opened but unlabeled container of shaving cream, 1 opened but unlabeled bottle of shampoo, 1 opened but unlabeled tube of zinc cream, and 1 opened but unlabeled tube of skin protectant cream on the shelf above the sink. During an interview and tour on 2/23/18 at 3:50 pm the Director of Nursing (DON) acknowledged that personal care items in the shared bathroom of room 407 were not labeled with the residents' names. The DON revealed that it was her expectation that all personal care items in a	F 584	of the random audits and those findings will be reported at the monthly QAPI meeting monthly X 2 months then quarterly X 2 until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. The Housekeeping Supervisor, Maintenance Director, or Administrator will audit each shower room daily, Monday through Friday, for 3 weeks, weekly for 3 weeks and then monthly for 2 months to ensure compliance is achieved and maintained. The Administrator will review the results of the random audits and those findings will be reported at the monthly QA/PI meeting monthly for 2 months, then quarterly for 2months until substantial compliance has been achieved. The Maintenance Director, Maintenance Helper, or Administrator will monitor 15 random doors daily, Monday through Friday, for 3 weeks, weekly for 3 weeks and then monthly for 2 months to ensure compliance is achieved and maintained. The Administrator will review the results of the random audits and those findings will be reported at the monthly QA/PI meeting monthly for 2 months, then quarterly for 2months until substantial compliance has been achieved. 4.) The title of the person responsible for	

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F 584	Continued From page 8 shared bathroom be labeled and placed in a bag so the items can be identified to prevent residents from using items that did not belong to them.	F 584	implementing the acceptable plan of correction: a.) The Administrator will be responsible to oversee the implementation of the acceptable plan of correction. 5.) Date when corrective action will be completed: 3-30-18	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately complete the Minimum Data Sets (MDSs) for 2 of 26 sampled residents whose MDSs were reviewed. This involved Resident #35 in the areas of cognition and participation in the assessment and Resident #63 in the area of bathing. The findings included: 1. Resident #35 was admitted to the facility on 08/08/16 with diagnoses including cerebral infarction, unspecified dementia with behavioral disturbance, unspecified psychosis, cognitive communication deficit and anxiety. The annual MDS dated 08/09/17 coded Section B with Resident #35 having clear speech, understands and understood. When staff completed Section C on cognitive patterns, Resident #35 was coded as rarely or never understood so the Brief Interview for Mental	F 641	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law." F641 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 02/22/18, the Director of Nursing (DON) validated that the modification of resident #63 MDS with ARD 1/3/18 was completed to correct coding of bathing in section G, was made, and reflected accurate coding and was submitted to CMS. On 03/14/18, the DON validated	3/30/18

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F 641	Continued From page 9 Status (BIMS) was not marked as attempted by staff and staff proceeded to complete the staff assessment of this area. Under the section of preferences, section F, the resident answered the questions. In addition, section Q regarding participation in assessment was noted that he did not participate in the assessment. The quarterly MDS dated 09/24/17 and the quarterly MDS dated 12/19/17 both coded section B as Resident #35 having clear speech, understands and understood. Both MDSs also coded section C regarding cognitive patterns as not assessing the BIMS due to him rarely or never being understood. On 02/23/18 at 10:44 AM, an interview was conducted with the MDS Coordinator #1 and the Social Worker (SW). The SW stated that when she completed section C during each of the 3 previous assessments, Resident #35 did not respond to her question and he would just walk away. Because of this response, the SW marked the rarely understood/understands and proceeded to complete the staff assessment for cognition. The SW and the MDS Coordinator #1 stated they did not understand that three questions had to be asked before marking the response as "99" and then proceeding to the staff interview. In addition, both stated they thought the participation in the assessment had to do with the discharge planning of the resident not if he participated in any part of the MDS assessment. 2. Resident #63 was admitted to the facility on 5/10/13 with diagnoses that included hemiplegia (paralysis on one side of the body), vitamin D	F 641	the modification of resident #35 MDS□s with ARD□s 8/9/17, 9/24/17 and 12/19/17 was completed to correct coding of the BIMS in section C, was made, reflected accurate coding and was submitted to CMS. b.)The facility failed to accurately code bathing and BIMS score on (5) completed MDS assessments. 2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) The MDS□s for Resident #35 and #63 have been modified to reflect accurate coding of each section. b.) An audit of all current residents having an MDS completed in the last 14 days will be completed to verify accurate coding of the BIMS score in Section C and accurate coding of Bathing in Section G of the MDS. The audit will be completed by RCMD (Resident Care Management Director). Corrections will be made as identified per the RAI manual guidelines. The audit will be completed by 3/16/18. c.) On 02/26/18, the MDS Coordinator and the Director of Social Services were in-serviced by the Resident Care Management Director (RCMD) on the accurate coding of sections C and G on the MDS assessment per the RAI manual. 3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited	

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F 641	Continued From page 10 deficiency, gastro-esophageal reflux disease (GERD), and obstructive sleep apnea. A quarterly Minimum Data Set (MDS) dated 1/3/18 revealed that Resident #63 required extensive assistance for bed mobility, transfers, dressing, and personal hygiene. The MDS also stated that bathing did not occur by Resident #63 or with staff assistance during the look back period. A review of Resident #63's Treatment Administration Record (TAR) for December 2017 revealed that the resident did receive her shower during the look back period. An interview on 2/22/18 at 10:15 am with the MDS Coordinator revealed that Resident #63 did get a shower during the look back period and it was not coded correctly on the MDS. The MDS Coordinator stated he would complete a correction to the MDS. An interview on 2/23/18 at 10:45 am with the Director of Nursing (DON) revealed that it was her expectation that the MDS be coded accurately and that since it was not that a correction be completed. An interview on 2/23/18 at 3:00 pm with the Administrator revealed that it was her expectation that the MDS be coded accurately and that since it was not that a correction be completed.	F 641	remains corrected and/or in compliance with the regulatory compliance: a). The RCMD or MDS Coordinator will document random MDS audits for coding accuracy of the BIMS score in Section C and bathing in Section G of 3 completed MDS□s per week x 6 weeks, then 3 residents per month x 4 months to ensure compliance is achieved and maintained. b.) The DON will review results of the random audits and those findings will be reported at the monthly QA/PI meeting monthly X 2 months then quarterly X 2 until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Care Management or designee to maintain continued compliance. 4.) The title of the person responsible for implementing the acceptable plan of correction; The DON will be responsible for the implementation of the acceptable plan of correction. 5.) Dates when corrective action will be completed: 6/30/18	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		3/30/18

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F 658	Continued From page 11 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to stay in the presence of 1 of 1 resident observed with medications at beside without staff present. This affected Resident #78 who did not have any physician orders or assessment to self medicate. The findings included: Resident #78 was admitted to the facility on 10/25/16. His most recent Minimum Data Set, a quarterly dated 02/12/18, coded him with intact cognition, having no behaviors and under Hospice care. Review of the medical record revealed no assessment for self administration of medications. On 02/23/18 at 9:47 AM, the surveyor knocked on Resident #78's closed door. He was observed in bed. On his overbed table was a plastic medicine cup which contained 11 pills. He began to take them during this observation. Upon leaving the room, the nurse (#4) was observed at her medication cart down the hall. An interview was conducted with Nurse #3 on 02/23/18 at 10:15 AM. She stated that she left the pills in Resident #78's room when she was called to assist another resident down the hall. She told the resident she would be right back. Nurse #3 further stated she should not have left the pills in	F 658	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law." Tag F658 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) Resident #78□s nurse exited resident□s room prior to resident ingesting medications due to another staff member calling the nurse to another resident room for help. The Director of Nursing Validated that resident #78 received all scheduled medications on 2/23/18. 2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) On 2/23/18 the Director of Nursing (DON) validated that resident #78 received all scheduled medications for 2/23/18. On 2/23/18 Director of Nursing completed re-education with resident #78□s nurse on resident observation	

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F 658	Continued From page 12 Resident #78's room and she returned to check on him. She stated the medications left were all his morning medications. Nurse #3 stated she did not normally leave his medications for him to take independently. Review of the Medication Administration Record revealed Resident #78's morning medications provided 02/23/18 included: *Aspirin 81 milligrams (mg); *Cyanocobalamin 500 micrograms (mcg): *Furosemide 20mg; *Methadone HCl 10 mg 4 tablets; *Omeprazole Capsule delayed release 20 mg; *Paxil 10 mg; *Paxil 40 mg; *Ativan 0. 5mg: *FerrouSul tablet 325mg; *Pregabalin capsule 75 mg; *Oxycodone HCl 20 mg Interview with the Director of Nursing on 02/23/18 at 11:55 AM revealed the nurse should never leave medications at bedside and Nurse #3 should have taken the medications with her when she left the room.	F 658	during medication pass. b.) On or before 3/21/18 Licensed Professional Staff will be re-educated on Medication Administration in the Nursing Facility with emphasis on resident observation during medication pass. 3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance: a). The DON or Nurse Manager will document random Med Pass audits to ensure no medications were left at bedside of 3 random residents per week x 6 weeks, then 3 residents per month x 4 months to ensure compliance is achieved and maintained. b.) The DON will review results of the random audits and those findings will be reported at the monthly QA/PI meeting monthly X 2 months then quarterly X 2 until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. 4.) The title of the person responsible for implementing the acceptable plan of correction: a.) The DON will be responsible for the implementation of the acceptable plan of correction. 5.) Date when corrective action will be completed: 3/30/18	

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F 689	Continued From page 13	F 689		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to prevent 1 of 2 cognitively impaired residents from exiting the facility (Resident #35) by not ensuring a wanderguard bracelet (a device that would trigger an alarm when a resident gets in the proximity of the exit door) was in working order. In addition, the facility failed to supervise a resident (Resident #151) to prevent her from putting a rubber exercise band in her mouth for 1 of 2 sampled residents reviewed for accidents. Immediate Jeopardy began on 08/13/17 when Resident #35 left the facility unsupervised by staff and was located across the street in the parking lot of tennis courts after his wanderguard bracelet did not sound to alert staff of his exit. Resident #35 sustained no injuries. Immediate Jeopardy was removed on 02/23/18 when the facility implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) for continued monitoring. Example #2 (Resident #151) was cited at a scope and severity of a D	F 689	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law." Tag F689 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) The facility failed to prevent resident #35 from exiting the facility by not ensuring a Wanderguard bracelet was in working order. Resident was discharged from the facility on 3/9/18. The facility and staff leadership have no knowledge of any other residents having unsupervised exits from the facility.	3/30/18

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F 689	Continued From page 14 where a plan of correction is required. The findings included: 1. Resident #35 was admitted to the facility on 08/08/16 with diagnoses including cerebral infarction, unspecified dementia with behavioral disturbance, unspecified psychosis, cognitive communication deficit and anxiety. A care plan was established 11/19/16 which addressed Resident #35 being at risk for elopement related to adjustment in the nursing facility, having impaired safety awareness, and wandering aimlessly. Interventions included: *check function of wanderguard daily on night shift; *check placement of wanderguard every shift; and *observed for fatigue and weight loss. Nursing notes dated 05/30/17 at 2:12 PM revealed Resident #35 was very agitated and pacing the halls. Resident was wanting to leave and has neared the doors. The wanderguard bracelet was in place and has alarmed at the exits. Resident #35 began seeing the psychiatrist on 06/02/17 due to disorganized, confused thinking. Nursing notes dated 06/30/17 at 1:32 PM revealed Resident #35 was wandering the halls asking to get out of "here." He was reoriented 4 times before being medicated with as needed Haldol (an antipsychotic medication) at 9:00 AM. Per the psychiatric progress note dated 07/28/17, staff reported Resident #35 had been wandering	F 689	The facility failed to supervise resident #151, and prevent a potential accident by keeping her from obtaining an orange theraband that she was observed to be chewing on. Facility suspects that theraband was provided to resident #151 by another resident residing in the facility. On 2/21/18 the Rehab Program Manager validated removal of the orange theraband from resident #151□s room. 2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) Assistant Director of Nursing, (ADON), immediately completed a head to toe assessment of Resident #35 with no injuries noted. Assistant Director of Nursing removed Wanderguard bracelet and replaced it with a new Wanderguard bracelet which was verified to be functioning properly. Increased supervision was initiated for Resident #35 to include every 15 minute checks to monitor location. These checks were completed by the Nursing Assistants and documented for 24 hours following the incident. Additionally, facility initiated medication changes, labs, and increased observations and redirection of resident as needed by facility staff and IDT team. ADON conducted a complete head count of all residents in facility and determined all residents were accounted for. Resident #35□s care plan was reviewed and updated by the ADON on 8/13/17. An updated Elopement Assessment was completed for Resident #35 on 8-14-17 by	

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F 689	Continued From page 15	F 689		

the halls, wondering what he was supposed to do and where he was supposed to go, and questioning if he was (his name). At this time Haldol was changed from an as needed basis to a routine basis.

The physician's progress note dated 08/02/17 at 1:15 PM noted that staff reported the resident with increased confusion, getting anxious and starts to look for a way to leave. At this time the antipsychotic medication Seroquel 25 milligrams (MG) at bedtime was initiated.

The annual Minimum Data Set (MDS) dated 08/09/17 coded him with long and short term memory impairments, severely impaired decision making skills, having continuous inattention and disorganized thinking, having no wandering behaviors, and requiring limited assistance with activities of daily living skills.

Nursing notes dated 08/11/17 at 9:06 AM revealed Resident #35 had become increasingly confused in the past month. The recent medication changes have not been effective. The resident had been redirected 12 times this morning.

The psychiatric progress notes revealed Resident #35 was seen on 08/11/17 due to staff reports of the resident having increased confusion, becoming anxious and started to look for a way to leave the facility. A change in medication was initiated at this time. which included discontinuing Seroquel and starting the antipsychotic medication Risperdal 0.25 mg twice a day.

Review of the Treatment Administration Records revealed that Resident #35's wanderguard

the MDS Coordinator. On 8/14/17 Administrator, DON, and Maintenance Director referred to manufacture user instruction but was unable to determine why device stop working prematurely.

On 2/21/18 the Rehab Program Manager validated removal of the orange theraband from resident #151□s room. On 2/22/18 therabands were removed from the rooms of the other two residents who had a home exercise program. The Rehab Program Manager conducted a 100% audit of all resident rooms for therabands on 2/22/18.On 2/26/18 □ 2/28/18 all staff were educated regarding resident #151□s tendency to place non-food items in her mouth by Director of Nursing or Nurse Manager.

b.) From 8/14/17, to 8/23/17 the Director of Nursing and ADON re-educated All Facility Staff by reviewing the facilities policy and procedures with emphasis on increased observation and redirection for resident #35 and any resident on the need for increased need for observation and redirection as needed for resident #35 or other resident identified at risk, change of door codes, to educate visitor when informing them of door code including to keep door code discrete, do not allow others to exit with you, and to refer others to facility staff for assistance with exit. On 8/14/17 the Maintenance Director changed the code for all doors.

All staff will be re- educated regarding

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F 689	Continued From page 16 bracelet had been checked as functioning during the night shift of 08/12/17. Nursing notes dated 08/13/17 at 7:30 PM revealed that at 3:00 PM, a visitor came to nurse aide (NA) #1 and told her a resident was out of the building walking towards the tennis courts across the road. NA #1 immediately left the facility to get the resident. When she reached him he had crossed the road and was in the parking lot of the tennis courts. The visitor who saw the resident stated he exited through the main entrance. The alarm did not sound and after testing the resident's wanderguard, it was found not to be working. A new wanderguard was placed on the resident, tested and found to be working. A head to toe assessment was completed and no injury was noted. Resident #35 was placed on every 15 minute checks. The physician was called and medication changes were made. Also a urinalysis was obtained and taken to the lab. Observations on 02/21/18 at 2:30 PM revealed the tennis courts were across a two lane street in front of the facility's parking lot. The two lane road's signage stated the speed limit was 20 miles an hour. The road passed the facility and ended directly into a community park with a swimming pool, picnic areas and a ball park. The facility sat at the crest of the hill. The tennis courts were not visible from the front door of the facility. Per the weather history, the high temperature for 08/13/17 was 84 degrees Fahrenheit with a mean temperature of 74 degrees Fahrenheit. The mileage from the front entrance to the tennis courts was 0.1 miles. The wandergard system was observed to be in working order.	F 689	reporting any resident who is placing any non food items in their mouth to the Director of Nursing, Assistant Director of Nursing, and, or Unit Coordinator on or before 3/21/18 by Administrator, Director of Nursing, or nurse manager. 3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance: a). Resident Wanderguards will continue to be checked for placement each shift and daily for function by the Resident Care Specialist and documented on the treatment record by their nurse. Results will be reviewed and discussed in the facilities QAPI Process. The Director of Nursing or Nurse Manager will check 5 random residents per week x 6 weeks, then 3 residents per month x 4 months to ensure compliance is achieved and maintained. b.) The DON will review results of the random audits and those findings will be reported at the monthly QA/PI meeting monthly X 2 months then quarterly X 2 until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. 4.) The title of the person responsible for implementing the acceptable plan of correction:	

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F 689	Continued From page 17 A phone interview with NA #1 on 02/20/18 at 4:46 PM revealed she was working on a different hall and a visitor informed her that a resident was outside. Resident #35 was found almost at the tennis courts and was wearing nonskid socks and no shoes. She could not recall what he was wearing that day. NA #1 stated it was damp outside and he was a little difficult to get him back in the building and other staff came to help. NA #1 was unable to recall the other staff who assisted her. She further stated she had little contact with Resident #35 as she worked every other weekend on a different hall. A written statement by Nurse #1 dated 08/13/17 revealed she had seen and heard Resident #35 multiple times at the nurses station from around 2:00 PM until 2:55 PM to 3:00 PM. He was stating he was lost. A phone interview with Nurse #1 on 02/21/18 at 3:20 PM revealed she was employed by an agency and had just come for her shift. She recalled Resident #35 was at the nursing station, asking general questions and then the next thing she knew he was found outside. A phone interview was conducted on 02/21/18 at 9:53 AM with NA #2 who worked the night shift on 08/12/17 into 08/13/17. She stated the wanderguards were checked nightly by nurse aides using the list of residents with wanderguard bracelets and a device with which to check them. She recalled no problems with Resident #35's wanderguard that night or ever. A phone interview was conducted on 02/21/18 at 8:32 AM with NA #3 who was working on	F 689	a.) The DON will be responsible for the implementation of the acceptable plan of correction. 5.) Date when corrective action will be completed: 3/30/18	

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08/13/17 on the 2:30 PM to 10:30 PM shift on Resident #35's hall. NA #3 stated he recalled Resident #35 wandering the halls per usual. NA #3 did not recall the resident talking about leaving that day but the resident sometimes talked about leaving as he was very confused. NA #3 could not recall any other details about the incident other than he tried to keep him close to him the remainder of his shift.

Interview with the Director of Nursing (DON) on 02/21/18 at 9:13 AM revealed she was the assistant DON at the time when Resident #35 left the facility. The DON stated she was working the floor at the time of the incident. She verified that Resident #35 was wearing the wanderguard bracelet but that when tested upon reentry into the facility, she found it did not work and it was replaced. She could not locate the visitor who found him (for either identification or additional information) but assumed a visitor let him out because even if the wanderguard quit working, he needed a numeric code to exit the front door, which she believed he was incapable of knowing or remembering. The DON further stated the wanderguard that was on Resident #35's wrist had been checked the previous night which found it functional and the wanderguard was not yet expired per expiration date.

Review of the maintenance logs revealed that the Maintenance Director checked the function of the wanderguards at each door daily which was noted as working properly.

The Administrator was informed of immediate jeopardy on 02/28/18 at 2:30 PM. The Administrator provided the following Credible Allegation:

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Facility's Corrective Action Plan:
1. Resident #35 was assessed as being at risk for elopement and a Wanderguard was initiated upon admission on 08/08/16. On 8/13/17, at approximately 3:00 pm, a visitor reported to NA#1 that Resident #35 was observed in the facility parking lot. Resident #35 was assisted back into the facility by the NA#1. Resident's Wanderguard bracelet was determined to be defective upon re-entry to facility as it did not trigger alarm and was not expired per manufacturer expiration date. Resident's Wanderguard was documented to have been in place every shift and the prior shift and was documented that functioning was verified on the previous night shift.

2. Assistant Director of Nursing, (ADON), immediately completed a head to toe assessment of Resident #35 with no injuries noted. Assistant Director of Nursing removed Wanderguard bracelet and replaced it with a new Wanderguard bracelet which was verified to be functioning properly. Increased supervision was initiated for Resident #35 to include every 15 minute checks to monitor location. These checks were completed by the Nursing Assistants and documented for 24 hours following the incident. Additionally, facility initiated medication changes, labs, and increased observations and redirection of resident as needed by facility staff and Interdisciplinary Team (IDT). ADON conducted a complete head count of all residents in facility and determined all residents were accounted for. Resident #35's care plan was reviewed and updated by the ADON on 8/13/17. An updated Elopement Assessment was completed for Resident #35 on 8/14/17 by the MDS

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Coordinator. On 8/14/17 Administrator, DON, and Maintenance Director referred to manufacture user instruction but was unable to determine why device stop working prematurely.

3. ADON notified Resident #35's Responsible Party and Physician regarding Resident #35 exiting the facility, resident's physical assessment following the event, and the plan for increased monitoring on 8/13/17 which included every 15 minute checks and increased observations by staff and IDT with redirection as needed. New Physician's orders were received for medication and a urinalysis with culture and sensitivity (UA&CS). An Investigation was completed by ADON on 8/13/17 which included an incident report. Based on the results of the ADON's investigation on 8/13/17, it was determined that Resident #35's Wanderguard bracelet malfunctioned and likely resulted in resident exiting the facility via the front door when a visitor exited the facility. Additional signage warning visitors to not allow anyone to leave the facility as they enter or exit facility was typed and added to facility entrance/exit doors.

On 8/13/17 Incident and Accident reports for the last 90 days were reviewed by the ADON with the Administrator via phone and it was determined that there were no other unsupervised exits reported for Resident #35. There were no other unsupervised exits reported for other residents assessed at risk for elopement during the last 90 days. To the knowledge of Facility Staff and Leadership, Resident #35 has had no other instances of exiting the facility without supervision. To the knowledge of staff and leadership no other residents have exited the facility without supervision since 8/13/17.

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F 689	Continued From page 21 The Maintenance Director completed a review of the Wanderguard System including validation of proper functioning of Door key pads and Wanderguard keypads/alarms for all facility doors on 8/13/17. There was no repair needed or required to the door key pads or Wanderguard System. The code for the entrance/exit doors were changed on 8/13/17 requiring a visitor(s) to need the new code and allowing facility to provide verbal education prior to visitor(s)being able to exit facility. Additional signage was placed on each exit door on 8/13/17 a STOP sign was placed on 8/14/17 by Maintenance Director to provide increased visual reminders to not assist other in exiting the facility. The Maintenance Director changed all door codes 8/14/17. Visitors only have code to exit doors. All Visitors on all shifts were verbally educated by facility employees including Receptionist, IDT team members, Managers, and other facility staff members when visitor(s) exited building for the first time after exit door codes were changed as well as educated to keep the code discrete, to not allow others to exit the facility when entering/exiting the facility, and refer others to see staff for assistance with exiting the facility. New Family members are provided the code and provided education to keep the code discrete, not allow others to exit the facility with them when exiting the facility, and refer others to see facility staff for assistance with exiting the facility upon admission or their initial visit to the facility. Verbal education from facility staff members, the signage, and stop signs all serve as forms of education as well as continuous reminders to keep the code discrete, to not allow others to exit the facility when entering/exiting the	F 689		

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facility, and refer others to see staff for assistance with exiting the facility to not assist others to exit the facility. The Maintenance Director, Maintenance Assistant, or Restorative Aides have continued to monitor the doors to ensure the door locking system and keypad and Wanderguard System and key pad are functioning properly since 08/13/17 without any problems identified. Results were reviewed and discussed in the facilities QA Process.

The ADON completed an audit of all current residents with Wanderguards and validated placement and function of each device on 8/13/17. Wanderguard will continue to be checked for placement each shift and daily for function by the CNAs and document on the treatment record by their nurse. Since 8/13/17, the Aides have continued to validate the placement each shift and function of Resident #35's Wanderguard daily without any problems identified.

Director of nursing or designee monitor treatment record to ensure check for placement and function are completed. On 8/14/17, the MDS Coordinators and Unit Manager conducted an audit of all current residents at risk for elopement to include a review of current Elopement Assessments for accuracy.

Elopement care plans were reviewed by IDT team and validated on 8/14/17 by the MDS coordinators. The facility and staff leadership have no knowledge of any other residents having supervised exits from the facility.

The Admissions Director will continue to review future referrals for potential admissions with

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identified exit seeking behaviors with the Director of Nursing and/or Administrator prior to offering placement to ensure proper placement. The Director of Nursing and Assistant Director of Nursing will continue to review new admissions and readmission daily during the Clinical Morning Meeting to validate accurate elopement assessments and care plans as required.

The Director of Nursing and Nurse Managers will review current residents assessed at risk for elopement monthly to validate accurate assessments and care plans.

4. Although facility policy was followed, on 8/13/17 ADON initiated re-education of elopement policy and procedures. From 8/14/17, to 8/23/17 the Director of Nursing and ADON re-educated All Facility Staff by reviewing the facility's policy and procedures with emphasis on increased observation and redirection for Resident #35 and any resident on the need for increased need for observation and redirection as needed for Resident #35 or other resident identified at risk, change of door codes, to educate visitor when informing them of door code including to keep door code discrete, do not allow other to exit with you, and to refer others to facility staff for assistance with exit.

On 8/14/17 the Maintenance Director changed the code for all doors Wanderguard System and conducted an impromptu elopement drill with staff on duty at that time on 8/17/17. Resident elopement will continue to be reported immediately to the Facility's Administrator or Director of Nursing and an Incident and Accident report will be completed.

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F 689	Continued From page 24 No staff shall work after 8/23/17 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 8/23/17. The facility Administrator is responsible for implementing the acceptable plan of correction. Immediate Jeopardy was removed on 02/23/18 at 5:54 PM when interviews with direct and supervisory staff confirmed they had been inserviced on the policy and procedures for elopement. This was also confirmed with record review. Family interviews confirmed they had been educated on not letting unknown persons leave the facility with them. Observations revealed that all residents with wanderguards were in working order. Record reviews revealed all wanderguards were checked for function every night and for placement every shift. Record reviews revealed that the alarmed doors were checked for function daily and the code changed. Observations revealed new larger signage were in place on the exit doors. The facility remains out of compliance at a lower scope and severity.	F 689		

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2. Resident #151 was admitted to the facility 2/8/18 with diagnoses that included muscle weakness, constipation, and Alzheimer's Disease.

The admission Minimum Data Set (MDS) dated 2/15/18 revealed Resident #151 was severely impaired for cognition and required extensive assistance for bed mobility, transfers, dressing, and personal hygiene.

The admission Care Area Assessment (CAA) dated 2/15/18 for activities revealed Resident #151 had dementia that affected her cognitive ability and the facility was to provide 1 to 1 activities such as sensory therapy, conversation, and fidget items to stimulate cognitive abilities.

The initial care plan dated 2/8/18 for activities stated that Resident #151 needed 1:1 bedside/in-room visits and that she should be engaged in simple, structured activities such as folding wash cloths and offering other fidget items of interest.

Observation of Resident #151 on 2/21/18 at 8:40 am revealed resident sitting in a wheelchair alone in her room biting on an orange rubber exercise band.

An interview on 2/21/18 at 8:43 am with the nurse aide (NA) caring for Resident #151 revealed the resident had the rubber exercise band to occupy her hands. The NA stated she wasn't sure how Resident #151 got the rubber exercise band.

An interview on 2/21/18 at 10:55 am with the speech therapist (ST) working with Resident #151

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revealed that the resident was sensory seeking and was known to chew on items such as blankets, clothing protectors, and stuffed animals. The ST also stated that Resident #151 should be supervised when using a rubber exercise band due to the risk of being a choking hazard. The ST further stated she did not use rubber exercise bands with the resident.

An interview on 2/21/18 at 11:25 am with the physical therapy assistant (PTA) working with Resident #151 revealed that the resident should be supervised when using a rubber exercise band because she was known to place items in her mouth. The PTA was not sure why Resident #151 had a rubber exercise band in her room or how it got there.

An interview on 2/21/18 at 11:35 am with the physical therapist (PT) working with Resident #151 revealed that the resident was very sensory seeking and was known to chew on her clothing. The PT further stated that Resident #151 should be supervised when using a rubber exercise band. The PT was not sure why Resident #151 had a rubber exercise band in her room or how it got there.

An interview with the Director of Nursing (DON) on 2/21/18 at 4:00 pm revealed that it was her expectation that Resident #151 be supervised when using a rubber exercise band. The DON stated she didn't know why Resident #151 had a rubber exercise band in her room or how it got there.

An interview with the activities director on 2/22/18 at 2:22 pm revealed that Resident #151 was known to place items such as stuffed animals in

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F 689	Continued From page 27 her mouth and that she did not use a rubber exercise band with the resident.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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 and staff interviews the facility failed to secure and label unidentified loose pills for 1 of 5 medication carts (400 hall med cart), failed to label and/or date opened medications for 2 out of 5 medication carts (300 hall and 400 hall med carts), and failed to date a	F 761	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is	3/30/18

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F 761	Continued From page 28 refrigerated multi-dose vial that was opened and available for use in 1 of 2 medication refrigerators (the refrigerator in the main nurses' station medication storage room). The findings included: 1. An observation on 2/23/18 at 1:54 pm of the 400 hall medication cart revealed 4 unidentified loose pills in the second drawer, 3 unidentified loose pills in the third drawer, and 2 and a half tablets of unidentified loose pills in the fourth drawer. The observation further revealed a green plastic cup with a clear lid with a handwritten label of Biofreeze (a topical pain relief gel) that contained a green gel-like substance. The observation also revealed a second green plastic cup with a clear lid that had no label and also contained a green gel-like substance. Also observed was 1 opened but undated Breo inhaler (a respiratory medication), 1 opened but undated Spiriva inhaler (a respiratory medication), 1 opened but undated bottle of Nitroglycerin tablets (medication given for chest pain), 2 opened but undated boxes of Duoneb nebulizer solution (a respiratory medication), 1 opened but undated box of Ipratropium nebulizer solution (a respiratory medication), 1 opened but undated bottle of Fluticasone nose spray (a medication given for allergies), 1 opened but undated bottle of Nystatin suspension (a medication used to treat fungus), 2 opened but undated tubes of Diclofenac cream (topical pain cream), and 1 opened but undated tube of Clobetasol 0.05% cream (a topical steroid cream). During an interview with Nurse #1 on 2/23/18 at 1:54 pm, she verified the unidentified loose pills in the medication cart and stated she did not know	F 761	prepared and/or executed solely because it the required by the provisions of federal and state law." Tag F761: 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) The facility failed to properly label 100% of all drugs and biologicals with the date opened. Any item identified as not labeled or dated were discarded by the Director of Nursing on 2/23/18. 2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) On 02/23/18, the Director of Nursing (DON) validated that all open vials and ointments in the medication storage room and medication/treatment carts were properly labeled with date opened. b.) On or before 3-21-18 all licensed professional staff will be re-educated on the policy and procedure for Storage and Expiration of Medications and Biologicals with emphasis on labeling any medication or biological once package is opened by Diretor of Nursing or Assistant Director of Nursing. 3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:	

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F 761	Continued From page 29 what the medications were. Nurse #1 also stated that the 2 green cups with clear lids contained Biofreeze that was obtained from a large bottle of Biofreeze. Nurse #1 stated she did not know when either of the containers of Biofreeze was obtained from the large bottle. Nurse #1 also stated that all medications were to be dated when opened. 2. An observation on 2/23/18 at 2:23 pm of the 300 hall medication cart revealed an opened but undated bottle of Fluticasone nasal spray, 1 opened but undated Anoro inhaler (a respiratory medication), 1 opened but undated box of Duoneb nebulizer solution, 1 opened but undated bottle of Nystatin powder (a topical medication used to treat fungus), 3 opened but undated bottles of Ketoconazole 2% shampoo (a shampoo used to treat fungus), 2 opened but undated bottles of normal saline, an opened but undated tube of Venlex ointment (a topical wound treatment), and an opened but undated tube of Phytoplex ointment (a topical ointment for fungus). During an interview with Nurse #2 on 2/23/18 at 2:23 pm she stated that all medications were to be dated when opened. 3. An observation on 2/23/18 at 2:42 pm of the medication refrigerator in the main nurses' station medication storage room revealed an opened but undated multi-dose vial of Tuberculin Solution. During an interview on 2/23/18 at 2:42pm with the Director of Nursing (DON) she confirmed that the multi-dose vial of Tuberculin Solution was opened but undated and available for resident use. The DON stated that once opened and dated the	F 761	a). The Director of Nursing or Nurse Manager will document random Medication Storage audits for proper labeling of drugs/ointments 3x per week x 6 weeks, then 3x per month x 4 months to ensure compliance is achieved and maintained. b.) The DON will review results of the random audits and those findings will be reported at the monthly QA/PI meeting monthly X 2 months then quarterly X 2 until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services to maintain continued compliance. 4.) The title of the person responsible for implementing the acceptable plan of correction: a.) The DON will be responsible for the implementation of the acceptable plan of correction. 5.) Date when corrective action will be completed: 3/30/18	

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F 761	Continued From page 30 multi-dose vial of Tuberculin Solution was good for 30 days per the manufacturer's instructions, but since then was no date reflecting when the medication vial was opened that it would have to be discarded. The DON further stated that all medications were to be dated when opened, no loose pills should be present on the medication carts, and that all medications should be in their original container.	F 761		