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	345311	A. BUILDING _____ B. WING _____	C 05/03/2018

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ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

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E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have comprehensive emergency preparedness (EP) plan. The EP manual failed to include community based risk assessment, facility risk assessment and associated strategies, the emergency plans and procedures did not include missing resident in their EP program. The EP plan failed to identify its resident population. The EP manual did not include policy and procedures for sheltered residents and staff who remained in the facility,	E 001	This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to the validity of the alleged deficient practice. E001 Based on record reviews and staff interviews the facility failed to have	5/31/18

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

Electronically Signed | 05/23/2018

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E 001	Continued From page 1 policy and procedures to track residents and staff who were moved to other facilities and policy and procedure for staff, residents and others who remained in the facility during an emergency. Manual did not include policy and procedures to preserve resident information and protect resident confidentiality, secure and maintain availability of resident ' s medical records. The EP communication plan failed to include contact information of staff, resident ' s physician and other facilities and contact information of the State Licensing and Certification Agency. EP Communication plan failed to include procedure of sharing information and medical documentation of its resident with other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency. The EP communication plan failed to establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives. The EP communication plan failed to provide the training dates done before November 2017. Findings including: a.Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure that indicated how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations in an emergency situation.	E 001	comprehensive emergency preparedness (EP) plan. The EP manual failed to include community based risk assessments, facility risk assessments, and associated strategies, the emergency plans and procedures did not include missing resident in their EP program. The EP plan failed to identify its resident population. The EP manual did not include policy and procedures for sheltered residents and staff who remained in the facility, policy and procedures to track residents and staff who were moved to other facilities and policy procedure for staff, and resident and others who remained in the facility for an emergency.The Manual did not include policy and procedures to preserve resident information and protect resident confidentiality, secure and maintain the availability of resident medical records. The EP communication plan failed to include contact information of staff, resident physician, and other facilities and contact information of the State Licensing and Certification Agency. EP communication plan failed to include procedures of sharing information and medical documentation of its resident with other healthcare providers and facilities that would be providing continuity of care and method of sharing information regarding the facility needs and its ability to provide assistance for its occupancy to authority having jurisdiction during an emergency. The EP communication plan failed to establish a procedure of sharing information and providing documents from its emergency plan to its residents, family	

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E 001	Continued From page 2 b. Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure as to how the facility would communicate and share information of its occupancy/ residents needs and facilities ability to provide assistance to authority having jurisdiction during an emergency situation. c. Review of the Communication Plan in the EP manual provided by the facility revealed no documentation as to how the facility ' s emergency plan would be shared with its residents, family members and/ or resident representatives. d. Review of the EP manual provided by the facility revealed the facility did not establish a criteria for its residents or staff who will be sheltered in the facility in case of emergency. The facility did not include a procedure for sheltering staff, residents and others who remained in the facility in an event when evacuation could not be executed. e. Review of the EP manual provided by the facility revealed lack of policies and procedures on how residents confidentiality would be maintained, how resident ' s medical information would be protected and how residents medical records will be available for continuity of care when residents were evacuated or transferred to other facilities during an emergency. f. Review of the EP manual provided by the facility revealed the communication plan did not include names and contact information of all staff working in the facility, name and contact information of residents ' physicians and names	E 001	members or resident representatives. The EP communication plan failed to provide the training dates done before November 2017. As of 05/31/18 the EP policy and procedures has been updated to show that the facility will share information with other facility through a contractual agreement that will maintain confidentiality to the professional standards and practices to uphold the continuity of care for the Residents in the happenings of a disaster or emergency should occur. As of 05/31/2018 the EP policy and procedures has been updated to show that the facility has a contractual agreement with surrounding facilities to take in, admit and assist through the sharing of information of its occupancy/residents needs with surrounding facilities; this same plan will ensure that residents and family members receive information surrounding the facilities emergency plan in the admission packet, and have sheltering guidelines for residents, family member, and staff who must remain in the facility in an event that evacuation could not be executed. The facilities EP was updated to include all resident physicians, staff working in the facility, names and contact numbers, and contact information of other facilities including but not limited to surrounding facilities that would be offering assistance in case of an emergency or disaster. This update includes information of the North	

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E 001	Continued From page 3 and contact information of other facilities including but not limited to its sister facilities that would be providing services and care to the residents during an emergency. g. Review of the EP manual provided by the facility revealed the communication plan did not include contact information of the North Carolina Nursing Home Licensure and Certification Agency and contact information of Long Term Care Ombudsman. h. Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure that indicated how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations in an emergency situation. i.Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure as to how the facility would communicate and share information of its occupancy/ residents needs and facilities ability to provide assistance to authority having jurisdiction or " the Incident Command Center" during an emergency situation. j. Review of the Communication Plan in the EP manual provided by the facility revealed no documentation as to how the facility ' s emergency plan would be shared with its residents, family members and/ or resident representatives. k. Review of the Communication Plan and the EP manual provided by the facility revealed there was no documentation of the dates when the	E 001	Carolina Nursing home Licensure and Certification Agency and contact information of Long Term Care Ombudsman; and to include information of residents needs to ensure that the Command Center established by the facility can provide the appropriate assistance in the event of an emergency or disaster.	

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E 001	Continued From page 4	E 001		

emergency drills, comprehensive or table discussion were completed.

During an interview on 5/3/18 at 2:10 PM, the Administrator indicated that he had joined the facility a few weeks ago. He further stated the facility Maintenance Director was more aware of the EP plan as he was involved in the process had had all the documentation. The Administrator and consultant revealed the facility Maintenance Director and the previous administrator were responsible for the emergency preparedness. The Administrator indicated he was unsure why the EP manual was not completed.

During an interview on 5/3/18 at 2:10 PM, the Maintenance Director, revealed the fire, tornado and elopement drills were completed on 3/28/18. The Maintenance Director was unable to provide training dates of when the comprehensive or table discussion for the emergency plan was completed. Maintenance Director was unsure how the tracking of residents and staff would be conducted during an emergency situation. Maintenance Director indicated that he had no access to resident ' s electronic records and it was the management decision on how these documents would be handled. Maintenance Director indicated that the names and contact information of facility staff were easily assessable from facility Human Resource personnel. Maintenance Director indicated that he was unaware that all contact information needed to be included. He further stated that he had no assess to the facility electronic medical records and it was the facility Administration who needed to decide as to how it would be included in the communication plan. Maintenance Director indicated that he had no documentation or

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E 001	Continued From page 5 information that he could share with residents, family members or resident representatives related to emergency preparedness.	E 001		
F 565 SS=C	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the	F 565		5/31/18

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F 565	Continued From page 6 families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to resolve grievances that were reported in the resident council meetings for 5 of 5 consecutive months. Findings included: An observation of a Resident Council Meeting was conducted on 5/02/18 at 10:00 AM that revealed an issue with the resolution of grievances. The residents in the meeting reported not all grievances were acted on promptly by the facility and there were no explanations given as to the reason some grievances were not resolved. The residents in the meeting explained that during each meeting only concerns with resolution from the prior month were discussed by the Activities Director (AD). The residents also indicated the AD did not give them the resolution to concerns not resolved from previous meeting. The Resident Council president reported the AD documented their issues/ concerns, and discussed the ongoing concerns during each meeting. Several of the members indicated the AD explained during the meetings that the issues were passed along to the appropriate staff to ensure resolution of the issues. Resident Council Meeting minutes from November 2017 to April 2018 were reviewed. Review of the Resident Council minutes dated November 7th, 2017 indicated the concerns	F 565	This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to the validity of the alleged deficient practice. F565: Based on record review and staff and resident interviews, the facility failed to resolve grievances that were reported in the resident council meetings for 5 of 5 consecutive months. All managers were in-serviced as to the importance and the necessity of the grievance process and their role in the grievance process. Through this process staff were in-serviced on what to report to our grievance officer or Administrator, that all concerns should be followed through and reported in a timely manner. Staff were in-serviced as to when to report events and how to forward concerns to the grievance officer, and where grievance officer and grievance forms are located. The Social Worker, and Activities Director were in-serviced as to the importance of resident council grievances, and how such grievances should be treated no differently. Grievance Counselor will report in the standup meeting daily and report of any	

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F 565	Continued From page 7 related to nursing were sent to Assistant Director of Nursing (ADON). No further details regarding the concerns were documented in the minutes. Review of the Resident Council minutes dated December 7th, 2017 revealed nursing a concern form the previous meeting had not been addressed. Minutes also indicated new concerns voiced during the meeting related to nursing were sent to Director of Nursing (DON). No further details regarding the concerns were documented in the minutes. Review of the Resident Council minutes dated January 2, 2018 indicated the residents reported the concerns from the previous month's meeting related to nursing were not addressed. The minutes reported the new concerns related to nursing were sent to ADON. No further details regarding the concerns forwarded to ADON were documented. Review of the Resident Council minutes dated February 6, 2018 indicated old and new nursing concerns were sent to ADON. No further details related to nursing issues were documented in the minutes. Review of the Resident Council minutes dated March 5, 2018 indicated nursing concerns were sent to ADON. No further details related to nursing issues were documented in the minutes. During an interview on 5/1/18 at 9:30 AM, Administrator indicated, he was new to the facility and the previous administrator could not locate the facility grievance folder. He stated he was unsure how the previous administrator kept track of any grievance and what the resolutions were.	F 565	new or outstanding grievances that remain incomplete. The grievance officer will manage this process, and follow up with families and residents within 48 hours. The Activities Director will report the following day all grievances that arise from the resident council meetings. These will be passed along to the grievance officer who will then record and investigate. Any grievances that arise in the resident council meeting will be followed up in the next resident council meeting to ensure compliance and resolve. The Administrator will review the grievance log for accurate completion, twice per month for two months, and once a month thereafter. This information will be presented at our quarterly QAPI meeting for quality assurance by our Grievance Officer.	

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He further stated a plan of correction for grievance process was started on 3/24/18 when the grievance folder was not locatable.

Review of the Plan of correction for the grievance process dated 3/24/18 revealed the Administrator and Social Worker (SW) would respond to grievances in a timely manner and follow up residents and family members. The plan of correction also indicated that SW would maintain a grievance log.

Review of the Grievance log for April 2018 revealed no grievances entered related to resident council nursing concerns.

Review of the individual grievance forms for April 2018 revealed conclusion of the grievance was incomplete and residents were not provided with a written grievance summary.

During an interview on 5/1/18 at 4:30 PM, AD indicated the concerns from the Resident council meeting were forwarded to the specific department and nursing concerns were forwarded to the Administrator and DON. AD further stated, she provided to the resident council a general resolution in the next meeting. She indicated she was unsure if all the concerns were handled, how the previous administrator recorded and documented the concerns and their resolutions. She stated, she assumed the previous administrator and DON had resolved the issue. AD indicated the resident council minutes did not contain the details related to nursing concern, just a generalized statement that the council had concerns related to the nursing. She further indicated the concerns were recorded on a separate sheet and forwarded to the DON or

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F 565	Continued From page 9 Administrator. She stated she did not keep a copy of the concerns, unaware some of the concerns were not resolved and she assumed the administrator was handling their concerns. During an interview on 5/2/18 at 11:00 AM, the SW indicated she would record the resident's concerns on a concern form and forwarded it to the administrator or department heads based on the concern. She acknowledge she had not kept any log prior to the new Administrator. She stated she was unsure how the follow up or documentation was done by the previous administrator or other departments. During an interview on 05/03/18 a 06:50 PM, the Administrator acknowledged that he was unable to locate the grievance logs or any resolutions to any grievances from the previous administration. He stated it was his expectation the residents, family members and resident council members were able to file grievance without any issue or fear. The Administrator stated the expectation was all grievances would be investigated when reported and the actions of the investigations be documented and reported to ensure resolution. He stated it was his expectation that appropriate follow up was completed and log maintained appropriately. He also indicated a system would be implemented to address resident council concerns on a monthly bases and follow-up would be done with the resident council members.	F 565		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585		5/31/18

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grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(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.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of

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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 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

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F 585	Continued From page 12 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 record review, resident and staff interview the facility failed to provide a written grievance summary for 4 of 4 residents (Resident #23, Resident # 26, Resident #40, and Resident # 49). Findings included: During an interview on 5/1/18 at 9:30 AM, Administrator indicated, he was new to the facility and the previous administrator could not locate the facility grievance folder. He stated he was unsure how the previous administrator kept track of any grievance and what the resolutions were. He further stated a plan of correction for grievance process was started on 3/24/18 when the grievance folder was not locatable. Review of the Plan of correction for the grievance process dated 3/24/18 revealed the Administrator and Social Worker (SW) would respond to grievances in a timely manner and follow up with residents and family members. The plan of correction also indicated that SW would maintain a grievance log.	F 585	This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to the validity of the alleged deficient practice. F585: Based on record review and staff and resident interviews, the facility failed to provide a written grievance summary for 4 of 4 residents (Resident #23, Resident #26, Resident #40 and Resident #49). As of 05/31/2018 Resident #23, #40, #26, and #49 and/or the Representative all received closure and written follow-ups to their grievances. Resident #23 received a written response on 05/25/18 and the items that were part of the grievances were replaced. Resident #40 received a written response on 05/25/18 and closure to the grievances, the CNA that was accused was suspended pending investigation and was terminated as a	

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	345311	A. BUILDING _____ B. WING _____	C 05/03/2018

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F 585	Continued From page 13 Review of the facility complaints/ Grievances policy and procedure revised 02/23/17 revealed the department heads have up to 48 hours to investigate the issues/complaint, make written report on the form and return the grievance form to the Administrator. Policy also indicate the administrator has no later than next business day to evaluate the formulated plan after receiving it from department heads. Policy also states once the plan of correction was decided the grievance officer would render a written decision to the resident/family member which includes a summary of the statement, steps taken in investigation, a summary of the pertinent findings or conclusion, corrective action taken by the facility and date the written decision was issues by the end of next business day, Review of the individual grievance forms for April 2018 revealed conclusion of the grievances were incomplete and residents were not provided with a written grievance summary. 1. Review of the Minimum Data Set (MDS) dated 2/28/18 revealed Resident # 23 was admitted to the facility on 4/1/14 with diagnoses of chronic obstructive pulmonary disease (COPD), Irritable bowel syndrome and Morbid Obesity. Resident # 23 was cognitively intact, and needed limited to extensive assistance for all activities of daily living (ADLs). Review of the grievance form dated 4/25/18 revealed Resident # 23's socks were missing. Conclusion of the grievance was incomplete and did not indicated the resident was provided with a written grievance summary.	F 585	result of our findings. Resident #26 received a written response 05/25/18 and the items that were missing were replaced. Resident #49 received a written response 05/25/18 and her missing items were replaced as well. The grievance officer will manage the Grievance process, and follow up with families and residents within 48 hours via written response. A copy of the written response will be stapled and kept with the grievance form for record keeping. All staff members were in-serviced as to the importance and the necessity of the grievance process and their role in the grievance process. Through this process staff were in-serviced on what to report to our grievance officer or Administrator, that all concerns should be followed through and reported in a timely manner. Staff were in-serviced as to when to report events and how to forward concerns to the grievance officer, and where grievance officer and grievance forms are located. The Administrator will review the grievance log for accurate completion, twice per month for two months, and once a month thereafter. This information will be presented at our quarterly QAPI meeting for quality assurance by our Grievance Officer.	

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During an interview on 5/3/18 at 4:00 PM, Resident # 23 indicated that she had filed a grievance related to her missing socks on 4/25/18 and the staff had informed her that the socks would be replaced if not found. Resident # 23 further stated she had not received any resolution for her grievance or any written grievance summary.

2. Review of the Minimum Data Set (MDS) dated 3/09/18 revealed Resident # 40 was admitted to the facility on 5/15/14 with diagnoses of chronic kidney disease, hemiplegia following cerebrovascular accident, heart failure. Resident # 40 was cognitively intact, and needed limited to extensive assistance for all activities of daily living (ADLs).

Review of the grievance form dated 4/16/18 revealed Resident # 40 self-reported the grievance which stated, the resident did not like the attitude or language used by nurse aide during resident 's care. Grievance form also indicated that the action taken was staff member suspended. Conclusion of the grievance was incomplete and did not indicate the resident was provided with a written grievance summary.

During an interview on 5/3/18 at 4:10 PM, Resident # 40 indicated that she had filed a grievance as the nurse aide was too rude while assisting her with dressing. Resident # 40 stated someone had told her the nurse aide was suspended. Resident # 40 further stated she did not received any written grievance summary.

3. Review of the Minimum Data Set (MDS) dated 3/02/18 revealed Resident # 26 was admitted to

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the facility on 8/31/16 with diagnosis of congestive heart failure, diverticulosis, and muscular dystrophy. Resident # 26 was cognitively intact, and needed limited to extensive assistance for all activities of daily living (ADLs).

Review of the grievance form dated 4/25/18 revealed Resident # 26 had reported a missing gown. Grievance form also indicated that the action taken was gown replaced. Conclusion of the grievance was incomplete and did not indicate the resident was provided with a written grievance summary.

During an interview on 5/3/18 at 4:20 PM, Resident # 26 indicated that she had filed a grievance and the facility replaced her gown. Resident # 26 further stated she did not receive any written grievance summary. Resident # 26 also stated, no written grievance summary was provided to her for earlier grievances. Resident # 26 did not want to elaborate on her previous grievances.

4. Review of the Minimum Data Set (MDS) dated 3/16/18 revealed Resident # 49 was admitted to the facility on 6/23/14 with diagnosis of heart failure, COPD and Shortness of breath. Resident # 49 was cognitively intact, and needed limited to extensive assistance for all activities of daily living (ADLs).

Review of the grievance form dated 4/25/18 revealed Resident # 49 had reported a missing gown. Grievance form also indicated that the action taken was gown replaced. Conclusion of the grievance was incomplete and did not indicate the resident was provided with a written grievance summary.

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F 585	Continued From page 16 During an interview on 5/3/18 at 4:30 PM, Resident # 49 indicated that she had filed a grievance and the facility replaced her gown. Resident # 49 further stated she did not receive any written grievance summary. During an interview on 5/2/18 at 11:00 AM, the SW indicated she would record the resident's concerns on a grievance form and forwarded it to the administrator or department heads based on the concern. She acknowledge she had not kept any log prior to the new Administrator. She indicated grievances received from the residents or family member were resolved verbally and had not provided a written resolution and summary for the grievance to the residents or their family member. She stated she was unsure how the follow up or documentation was done by the previous administrator or other departments. During an interview on 05/03/18 a 06:50 PM, the Administrator acknowledged that he was unable to locate the grievance logs or any resolutions to any grievances from the previous administration. He stated it was his expectation the residents, family members and resident council members were able to file grievance without any issue or fear. The Administrator stated the expectation was all grievances would be investigated when reported and the actions of the investigations be documented and reported to ensure resolution. He stated it was his expectation that appropriate follow up was completed and log was maintained accurately.	F 585		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		5/31/18

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F 761	Continued From page 17 §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 observation and staff interviews, the facility failed to store 205 tablets and capsules in labeled packaging to identify the medication name, strength and expiration date in four of four mobile medication carts inspected. Findings included: 1. During an inspection of Hall 200 ' s medication cart 05/01/18 at 9:02 a.m., a total of 68 loose medications were found in the bottom of two drawers. The following is a summary: 32 colored	F 761	This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to the validity of the alleged deficient practice. F761: Based on observation and staff interviews, the facility failed to store 205 tablets and capsules in labeled packaging to identify	

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F 761	Continued From page 18 tablets, 14 white tablets, 7 partial tablets and 3 capsules were found in the bottom of the second drawer on the left-hand side; and 8 colored tablets and 4 white tablets were found in the bottom of the third drawer on the left-hand side. In an interview on 05/01/18 at 9:02 a.m., Nurse #2 could not identify the unpackaged medications. She acknowledged they were not labeled or stored correctly. Nurse #2 wasted the medication in the sharps container affixed to the medication cart. 2. During an inspection of Hall 500 and 600 ' s medication cart on 05/01/18 at 9:26 a.m., one loose white tablet was found in the bottom of the second drawer on the left-hand side. In an interview on 05/01/18 at 9:26 a.m., Medication Technician #1 could not identify the tablet or where it had come from. She wasted the medication during the interview. 3. During an inspection of Hall 400 ' s medication cart on 05/01/18 at 9:41 a.m., a total of 116 loose medications were found in the bottom of three drawers. The following is a summary: 1 white tablet in the top drawer on the left-hand side; 44 white tablets, 27 colored tablets, 10 partial tablets, 3 capsules and 1 gel capsule in the second drawer on the left-hand side; and 19 white tablets, 7 colored tablets, 3 partial tablets and 1 capsule in the third drawer on the left-hand side. In an interview on 05/01/18 at 9:41 a.m., Medication Technician #2 stated that if she had found the loose medications during her medication pass she would have shown them to	F 761	the medication name, strength and expiration date in four or four mobile medication carts inspected. As of 05/31/2018 any extra medications that could has caused crowding and/or unnecessary clutter of the medication carts were removed and stored safely and with best practices in the medication storage room. All loose medications that were discovered were immediately wasted. As of 05/01/2018 all Med Techs, LPN□s and RN□s that could have the potential to work the medication cart were in-serviced as to proper procedures and protocol in the storage and deliverance of medications to residents. 05/05/18 the facility purchased extra storage bins for each medication cart and all multiple cards of medication were removed from medication carts. These medications were placed in storage bins in the medication rooms to eliminate clutter and waste of said medications. These bins were securely placed and kept up to best standards and practice. All medications carts will be inspected by our RN Supervisors weekly for one month, and once monthly thereafter, and should be reviewed and reevaluated at the quarterly QAPI meetings. This information will be monitored by our RN supervisors and will be brought to our quarterly QAPI meeting by our Director of Nursing (DON). This inspection will be logged and reviewed to ensure no loose	

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F 761	Continued From page 19 the charge nurse. She wasted them in the sharps container affixed to the medication cart. 4. During an inspection of Hall 100 and 300 ' s medication cart on 05/01/18 at 9:45 a.m., a total of 20 loose medications were found in the bottom of the second drawer on the left-hand side: 10 white tablets, 7 colored tablets, and 3 capsules. In an interview on 05/01/18 at 9:45 a.m., Nurse #1 acknowledged that the medications were not labeled or stored properly. She indicated that if she had seen the tablets during her medication pass she would have wasted them on discovery. She wasted the medications during the interview. In an interview on 05/01/18 at 10:12 a.m., the Director of Nursing (DON) acknowledged that the medications discovered on inspection of the medication carts were not stored properly. She indicated that the pills may have broken free from the pharmacy blister packs when they were moved against each another in the drawer. The DON shared her expectation that medications be stored in appropriately labeled packaging.	F 761	meds, name, strength and expiration dates are all accounted for and up to date.	