STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS NURSING CENTER	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

(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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		9/25/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/24/2018

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F 578	Continued From page 1 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure advance directive information matched in 2 places (electronic record and paper chart) for 1 of 1 residents reviewed for advance directives (Resident #66). The findings included: Resident #66 was admitted to the facility on 6/18/18 and had a diagnosis of hip fracture, coronary artery disease, hypertension and diabetes mellitus. Review of the clinical record on 8/27/18 revealed a gold colored form on the paper chart that contained a stop sign and noted the resident was a DNR (Do Not Resuscitate). The form contained the signature of a physician and was dated 6/18/18. Review of the physician ' s orders and face sheet on the electronic chart revealed the resident was a FULL CODE and resuscitation attempts were to be started if the resident ' s heart stopped beating or if the resident stopped breathing. On 8/29/18 at 10:49 AM an interview was conducted with Nurse #1 who stated she would first look at the electronic chart to find the code status of a resident. The Nurse stated the information was also on the paper chart. The Nurse was observed to review the paper chart and stated when the resident was in the hospital, she was a DNR and when admitted to the facility the family changed their mind and wanted the resident to be a full code and the DNR sheet	F 578	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F578 Request/Refuse/Discontinue Treatment; Form Advanced Directives Clinical record review on 8/27/18 revealed a gold colored form on the paper chart (Resident#66) that noted that the resident was a DNR (Do Not Resuscitate). The physician signed the gold form on 6/18/18. The resident□s electronic chart revealed that the resident had a signed physician order for a Full Code and resuscitation attempts were to be started if the resident□s heart stopped beating or if the resident stopped breathing. The process that lead to the alleged deficiency and the plan for correction: Daily after stand-up, all admissions and readmissions are reviewed paper chart versus electronic record to validate orders and review for accuracy. Members participating in the review are the DON, MDS nurse and Unit Manager. Resident #66 was reviewed post her admission	

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F 578	Continued From page 2 should not have been on the paper chart. The Administrator joined the interview and stated the gold DNR form came with the resident from the hospital. The Administrator further stated the nurses go directly to the electronic chart and not to the paper chart if they need to know the code status of a resident. The Administrator further stated they have a backup system if the computers were down and could very quickly print a resident ' s Medication Administration Record that contained the resident ' s code status. On 8/29/18 at 11:25 AM an interview was conducted with Nurse #2 who stated she was a nurse from an agency. The Nurse stated if she needed to know a resident ' s code status she would look at the paper chart first and then look at the electronic record. On 8/30/18 at 2:03 PM an interview was conducted with the Director of Nursing (DON). The DON stated when the resident was admitted from the hospital the gold DNR form should have been clarified and was not.	F 578	date in June. Family signed consent for her to be a full code, an order was obtained from the physician to reflect resident/family wishes, however the golden rod from transfer to the facility from the hospital was overlooked. On 8/27/18 the Social Worker and DON verified the code status with the resident/responsible party and clarified the code order with the physician. The electronic record and paper chart were audited to ensure that they matched the current code status order. The MDS nurse verified that the residents care plan reflected the ordered code status. The Golden Rod was removed from the chart. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 9/ 7/18 the Director of Nurses, Social Worker and Health Information Manager completed an audit of all current residents. The audit checked to identify that each resident had a current code status in place and that the current code status was verified as matching in the electronic record and in the paper chart. This was completed by auditing all current resident paper and electronic charts. Once the code status desire was assessed, the chart was further audited to ensure that the correct paper work and orders were present. If the resident or responsible party requested a DNR order, the chart was audited to ensure that there was not any conflicting full code paper work on the chart, the presence of MD order, as well as the Golden Rod form. If the resident or responsible party	

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F 578	Continued From page 3	F 578	requested to be a full code, the chart was audited to ensure there was not any conflicting DNR paperwork. In addition to this, a report was printed from PCC of DNR and Full Code orders to compare to the chart audit. If any discrepancies were identified they were immediately corrected. Any code status that was conflicted, was immediately corrected. The MD was called immediately if an updated order was required. Care Plans were audited as well by the MDS Coordinator to assure accuracy of the care plan with the ordered code status. On 9/17 /18 the Director of Nurses and Nurse Consultant began education of all FT, PT, PRN and Agency Nurses, the Social Worker, Health Information Manager and Administrator on: " Code Status Orders and process for implementation policy. " How to verify code status prior to initiating CPR. " When a code status might change. " Admission/readmissions and the code status process. Any nurse not completing the education by 9/25/18 will not be scheduled to work until the education has been completed. This training has been incorporated into the new hire orientation process for all licensed nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses, Social Worker or Health Information Manager will monitor	

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F 578	Continued From page 4	F 578	resident code status process , order accuracy and supporting documentation by reviewing 3 new or readmitted residents weekly x 2 weeks then monthly x 3 months and 4 long term residents weekly x 2 and monthly x 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Administrator 9/25/18	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		9/25/18

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(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

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including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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F 623	Continued From page 7 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the family member in writing when 4 of 4 sampled residents (Residents # 69, 17, 85, and 64) were discharged to the hospital. The findings included: 1. Resident # 69 was admitted to the facility on 4/11/18 with diagnoses of chronic lymphocytic leukemia, moderate protein-calorie malnutrition, vascular dementia, malignant neoplasm of large intestine. A review of Resident # 69 ' s quarterly Minimum Data Set (MDS) dated 8/9/18 identified her as having severely impaired cognition. A review of Resident # 69 ' s medical record revealed she was sent to the hospital on 8/2/18 for evaluation due to abdominal girth, persistent abdominal pain. She returned to the facility on 8/3/18. No written notice of transfer was documented to have been provided to the resident or her responsible party (RP). During an interview on 8/29/18 at 9:37 AM the Administrator stated when residents were sent out to the hospital, staff call the Medical Director to get an order and call to notify the responsible party (RP) that they were being sent out to the hospital and why. The administrator stated that they do not send a letter to the RP, they call the RP and document the call in the medical record.	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F623 □ Notice Requirements before Transfer/Discharge The processes that lead to the alleged deficiency cited and the plan of correcting the specific deficiency: Based on record review and staff interviews, the facility failed to notify the family member in writing when 4 of 4 sampled residents (#69, #17, #85 and #64) were discharged to the hospital. " Review of Resident #69□s medical record revealed she was sent to the hospital on 8/2/18 for evaluation due to abdominal girth and persistent abdominal pain. She returned to the facility on 8/3/18. No written notice of transfer was documented to have been provided to the resident or their responsible party. During an interview with the Administrator	

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F 623	Continued From page 8 She revealed staff send the bed hold policy with the resident ' s hospital packet and the Ombudsman was notified of any resident transferred to the hospital. 2. Resident # 17 was admitted to the facility on 8/17/16 with diagnoses of Alzheimer ' s, syncope and collapse, transient ischemic attack (TIA) and anxiety. A review of Resident # 17 ' s quarterly Minimum Data Set (MDS) dated 4/20/18 identified her as alert and oriented. A review of Resident # 17 ' s medical record revealed she was sent to the hospital on 5/24/18 for evaluation after a fall. She readmitted to the facility on 5/25/18. No written notice of transfer was documented to have been provided to the resident or her responsible party (RP). During an interview on 8/29/18 at 9:37 AM the Administrator stated when residents were sent out to the hospital, staff call the Medical Director to get an order and called to notify the responsible party (RP) that they were being sent out to the hospital and why. The administrator stated that they do not send a letter to the RP, they call the RP and document the call in the medical record. She revealed staff send the bed hold policy with the resident ' s hospital packet and the Ombudsman was notified of any resident transferred to the hospital. 3. Resident # 85 was admitted to the facility on 10/6/16. Her diagnoses included: Alzheimer's dementia, epilepsy, and hypertension. Review of a nurse's note dated 4/21/18 revealed Resident #85 was sent to the hospital after a fall.	F 623	on 8/29, it was revealed a letter was not sent to the RP, the RP was called and the call was documented in the medical record. The bed hold policy is sent by staff with the resident□s hospital packet and the Ombudsman was notified of resident□s transfer to the hospital. " Review of Resident #17□s medical record revealed she was sent to the hospital on 5/24/18 for evaluation after a fall. She readmitted to the facility 5/25/18 without written notice of transfer provided to the responsible party or the resident. During an interview with the Administrator 8/29@ 9:37am, it was revealed a letter was not sent to the RP, the RP was called and the call was documented in the medical record. The bed hold policy is sent by staff with the resident□s hospital packet and the Ombudsman was notified of resident□s transfer to the hospital. " Review of Resident #85□s medical record revealed she was sent to the hospital after a fall. Further review revealed no written notice of transfer was provided to the resident□s representative for the resident□s transfer to the hospital on 4/21/18. An interview with the Social Worker on 8/30/18 @ 10:34am revealed she did not send a notice to the resident□s representative after the transfer to the hospital. The Social Worker stated she was unaware the notice was required. She reported she sends a report to the ombudsman on at least a monthly basis of the facility□s discharges and transfers. In an interview conducted with the Administrator on 8/30/18 @ 1:55 pm, the	

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F 623	Continued From page 9 A review of the medical record revealed no written notice of transfer was provided to the resident representative for the resident's transfers to the hospital on 4/21/18. An interview was conducted with the Social Worker on 8/30/18 at 10:34 AM. She stated she did not send a notice to the resident representative after the transfer to the hospital. The social worker stated that she was unaware the notice was required. She reported that she sends a report to the ombudsman on at least a monthly basis of the facility's discharges and transfers. An interview was conducted with the Administrator on 8/30/18 at 1:55 PM. The Administrator indicated that the resident representative was notified via phone the day of the hospital transfer, but no written notice was given to the resident representative for the hospital transfer on 4/21/18. She indicated that it was the social worker's responsibility and it was not done. 4. Resident #64 was admitted to the facility on 8/18/16 and had a diagnosis of dementia with behavioral disturbance, epilepsy and intellectual disabilities. A Significant Change Minimum Data Set (MDS) Assessment dated 7/12/18 revealed the resident had moderate cognitive impairment. Review of the clinical record revealed the resident was discharged to the hospital on 8/9/18 after several episodes of vomiting. On 8/30/18 at 2:32 PM an interview was conducted with the facility ' s social worker. The Social Worker stated she did a discharge report	F 623	Administrator indicated that the resident representative was notified via phone the day of the hospital transfer, but no written notice was provided to the resident or their responsible party for the hospital transfer on 4/21/18. She indicated this was the Social Worker□s responsibility and it was not done. " Review of Resident # 64□s clinical record revealed the resident was discharged to the hospital 8/9/18 after several episodes of vomiting. On 8/30/18 @2:32pm during an interview with the social worker, the sw stated she did a discharge report that she sent to the corporate office on a weekly basis and sent a list to the Ombudsman twice a month, but she did not know she was supposed to send a letter to the responsible party regarding the reason for transfer/discharge. On 8/30/18 @ 2:11pm, during an interview with the Administrator, the Administrator stated when the new regulations came out, she told the facility□s social worker, a letter needed to be sent to the resident□s responsible part when a resident was discharged or transferred to the hospital. The administrator stated she social worker had faithfully been sending their corporate office information on residents that were discharged on a weekly basis via email, but had not been sending a letter to the RP On 9/21/18 the Social Worker sent the written notice of transfer to the responsible parties of the resident□s listed above utilizing the Nursing Home	

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F 623	Continued From page 10 that she sent to the corporate office on a weekly basis and sent a list to the ombudsman twice a month but did not know she was supposed to send a letter to the responsible party regarding the reason for the transfer/discharge. On 8/30/18 at 2:11 PM, the Administrator stated in an interview when the new regulations came out she told the facility ' s social worker that she needed to send out letters to a resident ' s responsible party (RP) when a resident was discharged or transferred to the hospital. The Administrator stated the social worker had faithfully been sending their corporate office information on residents that were discharged on a weekly basis via e-mail but had not been sending a letter to the RP.	F 623	Transfer and Discharge Notice Form. This form incorporates information required in 483.15 (c)(3)(4)(5)(6)(8). A copy of the form sent to the family will also be sent to the Ombudsman on a Monthly basis for their records. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 9/21/18 the Administrator, Social Worker and Health Information Manager completed an audit of all residents discharged from 8/30/18 to present. The audit checked to identify that each resident discharged had a notice of discharge sent, and this notification and contents of the notification were documented. Upon the discharge of each Resident, the HIM Audits the resident□s medical record in the following manner. " The day of discharge, Social Services provides the HIM with the Consent of ROI form and the Nursing Home Transfer and Discharge Notice. The HIM will send copies of the information out to listed agencies at the bottom of the form, recording the date the information was sent. This was completed by auditing all current resident paper and electronic charts. If any deficiencies were identified they were immediately corrected. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:	

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F 623	Continued From page 11	F 623	The Social Worker or Health Information Manager will monitor the Nursing Home Transfer and Discharge Notice 3 discharged residents weekly x 2 weeks then monthly x 3. Reports will be presented to the weekly QA committee by the HIM to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Administrator 9/25/18	
F 641 SS=E	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 reviews and staff interviews, the facility failed to accurately code Section I of the Minimum Data Set (MDS) for 4 of 5 sampled residents reviewed for diagnoses for antipsychotic medication (Resident #11, Resident #19, Resident #22 and Resident #5). The facility also failed to code Section P of the MDS under	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has	9/25/18

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F 641	Continued From page 12 alarms for 1 of 1 sampled residents reviewed for a wanderguard device. (Resident #85). The findings included: 1. Resident #11 was originally admitted to the facility on 8/11/16 with diagnoses including Unspecified Dementia with Behavioral Disturbance, Unspecified Intellectual Disabilites, Anxiety Disorder Unspecified and Major Depressive Disorder Single Episode Unspecified. According to the most recent Quarterly Minimum Data Set (MDS) dated 5/24/18 Resident #11 required extensive to total assistance in most areas of activities of daily living. Review of Section I of the MDS dated 8/24/18 revealed Resident #11 was coded for Non-Alzheimer's Disease and Depression, however she was not coded for psychotic disorder. Review of Resident #11's doctors orders for August revealed the resident received Risperidone 0.25 mgs. for dementia with aggression. The start date for the antipsychotic medication was 8/10/18. During an interview on 8/30/18 at 10:10 AM, the MDS Coordinator revealed Resident #11 had been on antipsychotic medication for many years. She acknowledged that Resident #11 was not coded on Section I of the MDS for psychotic disorder. She said, "I missed it and I don't know why I missed it." She stated she was the only one back then trying to get everything done. During an interview on 8/30/18, at 4:00 PM, the Administrator revealed her expectation was to accurately code the MDS.	F 641	taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 641 The processes that lead to the alleged deficiency cited and the plan of correcting the specific deficiency: The process identified that lead to this area of concern is that the MDS nurse failed to include the appropriate psychiatric diagnoses for above residents in Section I of the above-mentioned MDS assessments. The facility process is that the MDS nurse thoroughly review resident□s medical record in order to include all diagnoses assigned by the MD on the MDS assessment. It was also identified that the MDS nurse failed to accurately assess and code residents who have wander guard alarms in Section P of the MDS. The facility process is that prior to coding Section P, the MDS nurse must assess the resident for use of any devices, including any alarms. " Resident #11: The specific deficiency was corrected on 8/30/18 by modifying the MDS with an ARD of 5/24/18 and adding the diagnosis of Psychotic Disorder to Section I. This was completed by the	

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F 641	Continued From page 13 2. Resident #19 was originally admitted to the facility on 2/23/18, with diagnoses including Unspecified Dementia without Behavioral Disturbance and Major Depressive Disorder. According to the most recent Minimum Data Set (MDS) dated 6/2/18, Resident #19 required extensive assistance in most areas of activities of daily living. Review of Section I of the MDS dated 6/2/18 revealed Resident #19 was coded for Non-Alzheimer's Disease and Depression, however the resident was not coded for psychotic disorder. Review of Resident #19's doctors orders for August revealed he received Seroquel 25 mgs. for hallucination. The start date for the antipsychotic medication was 5/3/18. Review of Resident #19's Care Plan dated 5/31/18, revealed the resident was care planned for antidepressant medication and anti-psychotic medication. During an interview on 8/30/18 at 10:00 AM, the MDS Coordinator revealed Resident #19 was admitted from another state and she had to see what mental health said about him. She acknowledged that Resident #11 was not coded on Section I of the MDS for psychotic disorder. She said, "I missed it and I don't know why I missed it." She stated she was the only one back then trying to get everything done. During an interview on 8/30/18, at 4:00 PM, the Administrator revealed her expectation was to accurately code the MDS. 3. Resident #22 was originally admitted to the facility on 8/11/16, with diagnoses including	F 641	MDS Nurse. Corrected MDS was re-submitted to State Database in Batch #290 and accepted on 8/31/18. " Resident #19: The specific deficiency was corrected on 8/30/18 by modifying the MDS with an ARD of 6/2/18 and adding the diagnosis of Hallucination Disorder to Section I. This was completed by the MDS Nurse. Corrected MDS was re-submitted to State Database in Batch #290 and accepted on 8/31/18. " Resident #22: The specific deficiency was corrected on 8/30/18 by modifying the MDS with an ARD of 6/4/18 and adding the diagnosis of Psychotic Disorder to Section I. This was completed by the MDS Nurse. Corrected MDS was re-submitted to State Database in Batch #290 and accepted on 8/31/18. " Resident #5 (a): The specific deficiency was corrected on 8/30/18 by modifying the MDS with an ARD of 5/14/18 and adding the diagnosis of Psychotic Disorder to Section I. This was completed by the MDS Nurse. Corrected MDS was re-submitted to State Database in Batch #291 and accepted on 9/4/18. " Resident #5 (b): The specific deficiency was corrected on 8/30/18 by modifying the MDS with an ARD of 8/14/18 and adding the diagnosis of Psychotic Disorder to Section I. This was completed by the MDS Nurse. Corrected MDS was re-submitted to State Database in Batch #290 and accepted on 8/31/18.	

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F 641	Continued From page 14 Dementia without Behavioral Disturbance and Major Depressive Disorder. According to the most recent Quarterly Minimum Data Set (MDS) dated 6/4/18, Resident #22 required extensive assistance in most areas of activities of daily living. Review of Section I of the MDS dated 6/4/18 revealed Resident #22 was coded for Non-Alzheimer's Disease and Depression, however the resident was not coded for psychotic disorder. Review of Resident #22's doctors orders for August revealed the resident received Seroquel 25 mgs. for Dementia with Psychosis. The start date for the antipsychotic medication was 4/12/18. Review of Resident #22's Care Plan dated 8/17/18, revealed the resident was care planned for risk of side effects from antipsychotic medication and the risk of side effects from anti-depressant medication. During an interview 8/30/18 at 9:56 AM, the MDS Coordinator acknowledged that Resident #22 was not coded on Section I of the MDS for psychotic disorder. She said, "I missed that." She stated she was the only one back then trying to get everything done. During an interview on 8/30/18, at 4:00 PM, the Administrator revealed her expectation was to accurately code the MDS. 4a. Resident #5 was admitted to the facility on 8/11/16 and had a diagnosis of schizophrenia and psychosis. The Care Area Assessment dated 2/23/18 for	F 641	" Resident #85: The specific deficiency was corrected on 8/30/18 by modifying the MDS with an ARD of 11/11/17 and coding question P0200(e) as Used Daily. This was completed by the MDS Nurse. Corrected MDS was re-submitted to State Database in Batch #291 and accepted on 9/4/18. Procedure for implementing the acceptable plan of correction for specific deficiency The MDS Consultant provided education to the MDS Nurse and Director of Nursing on 9/21/18. Information Provided on Education included: (See Attached Education Packet) " Explanation of the intent of Sections I and P0200 on the MDS. Items in Section I are intended to code diseases that have a direct relationship to the resident□s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident□s current health status. Anytime a resident is receiving an Antipsychotic medication, he/she must have an acceptable diagnoses for use on record from the MD. This diagnoses must be reflected on the MDS assessment.	

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F 641	Continued From page 15 Psychotropic Drug Use noted the resident received antipsychotic medication for a diagnosis of schizophrenia and psychotic disorder. A Psychiatric evaluation note dated 4/4/17 noted the resident had a diagnosis of schizophrenia spectrum disorder A Psychiatric evaluation note dated 6/8/18, 7/10/18 and 7/27/18 revealed a diagnosis of psychosis. A Quarterly Minimum Data Set (MDS) Assessment dated 5/14/18 under Section N revealed the resident received antipsychotic medications for 7 days during the 7 day assessment period and during the assessment period received an antipsychotic on a routine basis only. The MDS did not list a diagnosis of schizophrenia or psychosis under Section I of the assessment. On 8/30/18 at 9:56 AM an interview was conducted with the MDS Nurse who stated when coding the MDS Assessment she reviewed the mental health evaluations for diagnoses. The MDS Nurse could not explain why the diagnoses were not coded on the MDS. An interview was conducted with the Administrator and the Director of Nursing on 8/30/18 at 2:09 PM. The Administrator stated they had not had an MDS Coordinator since May 2018 and the MDS Nurse had to do the entire facility and the error was probably an oversight. 4b. Resident #5 was admitted to the facility on 8/11/16 and had a diagnosis of schizophrenia and psychosis.	F 641	The intent of Section P0200 is to identify residents who have any type of alarm in use. An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident□s clothing, motion sensors, door alarms, or elopement/wandering devices. " Education for MDS nurse also included steps for accurately assessing and coding Sections I and P0200. This information has been integrated into the standard orientation training for MDS Nurses. Monitoring procedure to ensure the plan of correction is effective and specific deficiency remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will perform Quality Assurance Audits by using the tool entitled Accurate Coding of Psychiatric Diagnoses in Section I Audit Tool. This audit will be completed weekly for 4 weeks and then monthly for 2 months. This quality assurance audit will start on 9/21/18. In addition, the Director of Nursing or designee will also perform Quality Assurance Audits by using the tool entitled Accurate Coding of Alarms in Section P Audit Tool. The Administrator will monitor completion of these Quality Assurance audits to ensure regulatory	

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F 641	Continued From page 16 The Care Area Assessment dated 2/23/18 for Psychotropic Drug Use noted the resident received antipsychotic medication for a diagnosis of schizophrenia and psychotic disorder. A Psychiatric evaluation note dated 4/4/17 noted the resident had a diagnosis of schizophrenia spectrum disorder A Psychiatric evaluation note dated 6/8/18, 7/10/18 and 7/27/18 revealed a diagnosis of psychosis. A Quarterly Minimum Data Set (MDS) Assessment dated 8/14/18 revealed the resident received an antipsychotic medication for 7 days of the 7 day assessment period and received on a routine basis only. The MDS did not list schizophrenia or psychosis as a diagnosis under Section I of the assessment. On 8/30/18 at 9:56 AM an interview was conducted with the MDS Nurse who stated when coding the MDS Assessment she reviewed the mental health evaluations for diagnoses. The MDS Nurse could not explain why the diagnoses were not coded on the MDS. An interview was conducted with the Administrator and the Director of Nursing on 8/30/18 at 2:09 PM. The Administrator stated they had not had an MDS Coordinator since May 2018 and the MDS Nurse had to do the entire facility and the error was probably an oversight. 5. Resident # 85 was admitted to the facility on 10/6/16. Her diagnoses included Alzheimer's dementia, epilepsy, and hypertension.	F 641	compliance. Any negative findings will immediately be addressed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Activity Director, Admissions Coordinator and the Dietary Manager. Title of person responsible for implementing the acceptable plan of correction The Administrator is responsible for implementation and completion of the acceptable plan of correction. Compliance Date 9/25/18	

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F 641	Continued From page 17	F 641		

Review of a MDS assessment dated 11/11/17, coded as an annual assessment, specified no wander alarms were use during the look back period.

Review of the November 2017 TAR revealed the battery on the wander alarm was checked nightly.

Review of Resident #85's most recent MDS (Minimum Data set) assessment dated 8/14/18, coded as a quarterly assessment, specified no wander alarms were used during the look back period.

Review of a physician's order, dated 4/21/17 ordered the use of a wander alarm.

Review of care plan dated 8/8/18 indicated a wander alarm was used daily.

Review of the August 2018 Treatment Administration Record (TAR) revealed the battery on the wander alarm was checked nightly. During an observation on 8/27/18 at 12:14 PM Resident # 85 was observed ambulating on various halls of the facility. A wander alarm was present on her right wrist.

During an interview with the MDS Coordinator on 8/30/18 at 9:57 AM, she stated the November MDS assessment was completed by someone who no longer is employed at the facility. She indicated she made an error on the August 2018 MDS which was an oversight. The MDS Coordinator stated she would correct both assessments immediately.

An interview was conducted with the Director of Nursing on 8/30/18 at 1:44 PM, who stated it was

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F 641	Continued From page 18 her expectation that MDS assessments are completed accurately. She indicated the wander alarm should have been coded on Resident #85's MDS assessment. During an interview with the Administrator on 8/30/18 at 1:56 PM, who stated it is her expectation that MDS assessments are completed accurately.	F 641		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		9/25/18

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F 758	Continued From page 19 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to conduct an AIMS (Abnormal Involuntary Movements) test for 1 of 5 residents reviewed for antipsychotic medications (Resident #5). The findings included: Resident #5 was admitted to the facility on 8/11/16 and had a diagnosis of schizophrenia spectrum disorder and psychotic disorder. The Care Area Assessment (CAA) dated 2/23/18 for Psychotropic Drug Use noted the resident received antipsychotic medication for a diagnosis of schizophrenia and psychotic disorder and was at risk for side effects.	F 758	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F758 Free from Unnecessary Psychotropic Meds/PRN Use An AIMS (Abnormal Involuntary Movement Scale) had not been completed since 1/11/18 for Resident #5,	

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F 758	Continued From page 20 The resident ' s current physician ' s orders included an order dated 7/10/18 for Seroquel (antipsychotic medication) 25 milligrams (mg) daily for mood/behaviors. There was also a physician ' s order dated 7/10/18 for Seroquel 125mg every day at bedtime. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 8/14/18 noted the resident had moderate cognitive impairment and received an antipsychotic medication for 7 days of the 7 day assessment period and received on a routine basis. The resident ' s Care Plan updated 8/14/18 noted the resident received antipsychotic medication related to dementia with behaviors with a risk for adverse side effects. The interventions included the following: Consulting pharmacist to review medications for possible changes or reductions. AIMS every 6 months. Review of the clinical record revealed an AIMS assessment was done on 1/11/18 and no AIMS assessments were found on the clinical record after that date. A pharmacist ' s note revealed the resident ' s medications were reviewed between 8/14/18 and 8/17/18 by the consulting pharmacist who wrote a recommendation to please make sure AIMS assessment had been completed every 6 months since patient was on Seroquel. The Director of Nursing (DON) stated in an interview on 8/29/18 at 11:53 AM they did not have an AIMS assessment on the resident since 1/18/18 and an AIMS assessment was done	F 758	who was receiving Seroquel for a diagnosis of Schizophrenia Spectrum Disorder and Psychotic Disorder. The process that lead to the alleged deficiency and the plan to correct the specified deficiency: The RN Unit Manager was responsible for the tracking and completion of the AIMS. The RN Unit Manager position became open the first full week in August 2018. The tracking of the AIMS was not completed, resulting in resident #5 not having a completed AIMS since January 2018. On 8/29/18, the MDS nurse completed an AIMS (Abnormal Involuntary Movement Scale) on Resident #5. No signs of abnormal involuntary movements were found. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 8/29/18, Resident #5 was assessed by the MDS nurse, for the presence of any abnormal involuntary movements utilizing the Abnormal Involuntary Movement Scale (AIMS). No signs of abnormal involuntary movements were found. On 9/20/18 the Director of Nurses, Support Nurse and staff nurses assessed all residents receiving psychotropic medications for the presence of an AIMS (Abnormal Involuntary Movement Scale) that has been completed within the last 6 months. Zero residents receiving a psychotropic medication were identified without a current AIMS in place. Corrective Action: On 9/17/18 the Director of Nurses and	

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F 758	Continued From page 21 today. Review of the AIMS assessment dated 8/29/18 at 10:09 AM revealed the resident had no signs of abnormal involuntary movements. The Administrator stated in an interview on 8/30/18 at 2:09 PM they had not had a MDS Coordinator since May 2018 so the current MDS Nurse had to do the entire facility and it was probably an oversight.	F 758	Nurse Consultant began educating all FT, PT, PRN and Agency Nurses on: requirements for completing the AIMS (Abnormal Involuntary Movement Scale) for residents receiving psychotropic medications. Education will be completed by 9/25/18 for all FT, PT, PRN and Agency Nurses. Any nurse not completing the education by 9/25/18 will not be scheduled to work until the education has been completed. This training has been incorporated into the new hire orientation process for all licensed nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses/Support Nurse will monitor that an AIMS (Abnormal Involuntary Movement Scale) is being completed every 6 months for residents receiving psychotropic medications. A list of residents receiving psychotropic medications was printed by the DON and reviewed for presence of AIMS assessment. To ensure AIMS are completed as indicated, four residents receiving a psychotropic medication will be reviewed weekly x 2 weeks and monthly x 3 months by the DON or their designee. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 22	F 758	Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing 09/25/18	
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	F 761		9/25/18

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	345240	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 761	Continued From page 23 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to store refrigerated medications per manufacturer ' s specifications for 2 of 2 medication refrigerators and failed to discard expired insulins on a medication cart for 1 of 3 medication carts observed. The findings included: The facility ' s undated policy for medication storage revealed medications that required refrigeration or temperatures between 36-46 degrees Fahrenheit (F) were kept in a refrigerator with a thermometer to allow temperature monitoring. 1. On 8/30/18 at 11:42 AM the refrigerator used to store medications for residents on the 100, 200 and 400 Halls was observed with Nurse #3. The refrigerator temperature was 32 degrees F and confirmed by Nurse #3. There was one multi-dose vial of Tubersol (skin test for tuberculosis) and 2 vials of PPD stored in the refrigerator. The information printed on the box of all three vials read: "Store at 35-46 degrees Fahrenheit." Also stored in the refrigerator were multiple containers of Trulicity. Trulicity is a medication given by injection for the treatment of diabetes. On the outside of the box of Trulicity read: "Store at 36-46 degrees F." The refrigerator contained multiple unopened Novolog and Lantus Flexpens. The manufacturer's package insert noted the insulin flexpens were to be stored at 36-46 degrees F prior to opening. During the observation of the refrigerator, Nurse	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F761 Label/Store Drugs and Biologics The facility failed to store refrigerated medications per manufacturer□s specifications for 2 of 2 medication refrigerators and failed to discard expired insulin on a medication cart for 1 of 3 medications observed. The process that lead to the alleged deficiency and plan of correcting the specific deficiency: Facility process is for third shift to check all medication carts for expired medications and all medication refrigerators to ensure maintenance of appropriate temperatures between 36 and 46 degrees Fahrenheit. Charge nurses should also check to make certain medications administered are within date. Facility failed to identify one insulin pen was out of date. Facility failed to notify maintenance of temperatures out of range. On 8/30/18 the Director of Nurses removed the identified expired insulin	

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F 761	Continued From page 24 #3 provided a refrigerator temperature log that read: "Notify maintenance of any Refrigerator reading less than 41 degrees Fahrenheit. This log did not include the month and Nurse #3 stated this was the only refrigerator temperature log she could find in the medication room where the medication refrigerator was located and the night shift was responsible for checking the refrigerator temperatures. The temperature for the refrigerator was documented as follows: Second day of the month 34 degrees F. The 3rd, 4th, 6th and 7th the temperature was documented as 32 degrees F. The 11th and 12th the temperature was documented as 34 degrees F. The 16th, 20th, 24th, 25th and the 27th was documented as 34 degrees F. On 8/30/18 at 1:37 PM the Maintenance Director stated in an interview the staff filled out a maintenance request if the medication refrigerator temperature needed to be adjusted. The Maintenance Director further stated he had not received any recent requests to adjust the temperature of the medication refrigerator. On 8/30/18 at 1:56 PM an interview was conducted with the Director of Nursing (DON). The DON stated the refrigerator temperature should be between 36 and 46 degrees Fahrenheit and the staff should notify maintenance if the temperature was not within this range. 2. On 8/30/18 at 1:21 PM the medication refrigerator used to store medications for residents on the 600 Hall was observed with Nurse #4. The refrigerator temperature was 34 degrees Fahrenheit (F). A sign posted on the front of the refrigerator door read: "Must be between 36-46 per regulation." Stored in the	F 761	from the medication cart. The insulin was replaced with new insulin and dated to reflect the manufacturer□s specification to discard 28 days after opening. On 8/30/18 the Maintenance Director checked all medication refrigerators to assure that the temperatures range in each refrigerator was between 36-46 degrees Fahrenheit. Results: Zero Corrective Action if needed: Not Applicable The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 8/30/18 the Director of Nurses and staff nurses checked all medication carts and refrigerators to verify that no expired medications were present and that all insulin was dated when opened and labeled to discard 28 days after opening the insulin. Results: Zero Corrective Actions: If needed: Not Applicable On 8/31/18, the Director of Nurses verified that all mediation refrigerators had refrigerator log sheets in place for the upcoming month of September. The Director of Nurses verified that the log reflected that the temperature range in each refrigerator is to be maintained between 36-46 degrees Fahrenheit, the Maintenance Director is to be notified if a refrigerator□s temperature is found to be outside of the 36-46 degree Fahrenheit range and the refrigerator temperature is to be verified daily by a staff nurse. On 9/3/18, the Director of Nurses began education of all FT, PT, PRN and Agency	

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F 761	Continued From page 25 refrigerator was a box with multiple doses of Perforomist. Perforomist is a solution that is put in a nebulizer and inhaled by the resident and used to treat Chronic Obstructive Pulmonary Disease (COPD). The manufacturer ' s package insert noted the medication was to be stored at 36-46 degrees Fahrenheit prior to dispensing to the resident. Also stored in the refrigerator was one vial of unopened Novolog Insulin, 4 unopened Novolog Insulin Flexpens, and 1 unopened Levemir Flexpen. The manufacturer ' s package inserts provided instructions to store all unopened insulin at 36-46 degrees Fahrenheit. During the observation of the medication refrigerator, Nurse #4 provided a refrigerator temperature log for August 2018 that listed the following temperatures: August 6,7, and 8, 32 degrees F. August 9, 30 degrees F. August 13, 32 degrees F. August 18 and 19, 34 degrees F. August 20, 22, 23 and 29, 32 degrees F. August 24, 22 degrees F, August 25, 28 degrees F, August 26, 26 degrees F and August 28, 30 degrees F. On 8/30/18 at 1:37 PM an interview was conducted with the Maintenance Director who stated the staff would fill out a request if the medication refrigerator temperature needed to be adjusted. The Maintenance Director stated he had not received any recent requests to check the temperature of the medication refrigerator. On 8/30/18 at 1:56 PM an interview was conducted with the Director of Nursing (DON). The DON stated the refrigerator temperature should be between 36 and 46 degrees Fahrenheit and the staff should notify maintenance if the temperature was not in this range.	F 761	Nurses, Medication Aides and the Maintenance Director. The following education was provided: following manufacturer specifications for insulin expiration dates, verification that expired medications are promptly removed from the medication cart or refrigerator, verifying that medication refrigerator temperatures are verified daily and maintained within the required temperature range and to notify the Maintenance Director if temperatures are not maintained in the required range. Any nurse, medication aid or the Maintenance Director who do not complete the education by 9/25/18 will not be scheduled to work until the education has been completed. This training has been incorporated into the new hire orientation process for all licensed nurses and nursing assistants. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses/Support Nurse will monitor the removal of expired medications and insulin from medication carts and medication refrigerators, that refrigerator temperatures are being completed, documented on the appropriate log and if refrigerator temperatures are not maintained within the required temperature range, that the Maintenance Director has been notified for correction x 2 weeks and monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of	

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F 761	Continued From page 26 3. On 8/30/18 at 1:05 PM the medication cart used to store medications for residents on the 200 Hall was observed with Nurse #3. Found on the medication cart was the following: one Novolog Insulin Flexpen dated as opened on 7/24/18. Written on the flexpen beside the space for the date was as follows: Expires in 28 days. The manufacturer ' s package insert for Novolog Flexpen revealed once open the medication should be discarded after 28 days. Nurse #3 stated the medication had expired and should have been removed from the medication cart. One vial of Lantus Insulin dated as opened on 7/30/18. Written on the vial beside the space for the date read: "Expires in 28 days." The Manufacturer ' s package insert noted once opened, Lantus Insulin must be discarded after 28 days. The Nurse stated the medication had expired and should have been removed from the medication cart. One vial of Lantus Insulin dated as opened 7/27/18. Written on the vial beside the space for the date read: "Expires in 28 days." The Manufacturer ' s package insert noted once opened, Lantus Insulin must be discarded after 28 days. The Nurse stated the medication had expired and should have been removed from the medication cart. Nurse #3 stated it was the responsibility of the nurse on every shift to ensure there were no expired medications on the medication cart. The Nurse confirmed that the resident ' s whose names were on the above insulins remained in the facility and continued to receive the insulin. An interview was conducted with the Director of Nursing (DON) on 8/30/18 at 1:56 PM. The DON stated the insulin on the medication carts should be removed from the cart when out of date.	F 761	Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Administrator 09/25/18	

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent the harboring of pests by failing to clean the convection oven. The findings included: During the initial tour of the kitchen on 8/27/18 at 9:47 AM the convections oven was observed. The top convection oven had black dried food particles 1/8 inch deep observed on the bottom shelf of the oven. A second observation of the convection oven on 8/30/18 at 10:48 AM revealed black dried food	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 □ Food Procurement, Store/Prepare/Serve The process that led to deficiency cited	9/25/18

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F 812	Continued From page 28 particles 1/8 inch deep observed on the bottom shelf of the oven. In an interview with the Dietary Manger on 8/30/18 at 10:50 AM she stated that staff scraped out the convection oven every other day. She stated the convection oven was old and hard to keep clean. During an interview on 8/30/18 at 11:12 AM the Administrator stated if the convection oven was dirty, she expected staff to clean the oven.	F 812	and the plan for correcting the specific deficiency. The convection oven is 36 years old and original to the facility. Though the oven is on a daily cleaning schedule, the particles on the bottom shelf are scraped down during the cleaning process but the buildup is difficult/impossible to remove. Due to the age and condition of the convection oven, the facility has ordered a replacement. The procedure for implementing the acceptable plan of correction. Dietary Cleaning schedule includes deep cleaning of the Convection Oven Monday, Thursday and Saturday, as well as being cleaned daily as needed. Quotes for replacing the existing Convection Ovens were obtained 9/4/18. The equipment has been ordered with an expected delivery date of 10/5/18. The Convection Oven was delivered on 10/1/18 and is in the process of being installed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Dietary Services or designee will monitor scheduled cleaning of the convection oven per cleaning schedule using Dietary QA audit. This will be done 5 days per week, including	

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F 812	Continued From page 29	F 812	weekend days, for two months and then weekly for one additional month. Reports will be presented to the weekly Quality Assurance meeting by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Committee. The weekly Quality Assurance Meeting is attended by The Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Director of Food & Nutrition. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction. Completion date: 9/25/18	