STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - SHELBY	**1101 NORTH MORGAN STREET SHELBY, NC 28150**

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		11/18/18

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

Electronically Signed | 11/18/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on guardian interview, staff interview and record review, the failed to notify the responsible party when Resident #10 was placed in isolation for an infection. This affected 1 of 1 residents sampled for contact precautions. The findings included: Resident #10 was originally admitted to the facility on 01/26/18 and most recently on 08/06/18. Her diagnoses included encephalopathy, hypothermia not associated with environmental temperature, Parkinson's Disease, and acute respiratory failure. The admission Minimum Data Set dated 08/13/18 coded Resident #10 with severely impaired cognition, being nonambulatory, being frequently incontinent of bowel and bladder and requiring extensive assistance with most activities of daily living skills. Review of the medical record revealed Resident #10 's laboratory results dated 10/11/18 revealed Resident #10 was diagnosed with a urinary tract infection requiring an antibiotic. She was placed on contact precautions from 10/11/18 through	F 580	F 580 There was no adverse effect to the resident with regard to the guardian not being notified of the resident placed on contact precautions. The guardian was informed by RN Supervisor on 10/17/18 at 4 p.m. of contact precautions. Resident with potential: The Regional nurse reviewed the policy for Isolation-Initiating Transmission-Based Precautions on 11/9/18. All residents identified as having been placed on contact isolation within the past 30 days was reviewed to ensure that proper notification was given to resident□s representative as applicable. This was completed by the Staff Development Coordinator on 11/8/18. All residents had appropriate documentation of notification of resident representative.	

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F 580	Continued From page 2 10/19/18. This laboratory result was signed as reporting the results to the physician by Nurse #5. There was no indication in the nursing notes or on the lab result of any notification to the guardian of the infection or the initiation of contact isolation . Interview with Nurse #5 on 10/23/18 at 5:17 PM revealed the nurse who took the order or the infection control nurse was responsible for initiating contact isolation precautions and informing the responsible party. Nurse #5 stated she could not recall the details of Resident #10's isolation. An interview with Nurse #6, the infection control nurse, occurred on 10/24/18 at 12:23 AM. She stated she determined if a resident needed isolation based on a guide she used. She stated the nurse was responsible for informing the responsible party. Interview with the Director of Nursing (DON) on 10/24/18 at 1:01 PM revealed the guardian was to be called for all changes in conditions for Resident #10 including when she was placed on contact precautions. Interview with the guardian via phone on 10/24/18 at 1:11 PM, revealed that the facility had not called her when Resident #10 was placed on isolation. She stated she was informed by a family member who was questioning why family needed to put on gowns and gloves when they visited Resident #10. A follow up interview with Nurse #5 on 10/24/18 at 3:07 PM revealed she and the DON worked on the isolation precautions for Resident #10	F 580	Regional Nurse Consultant reviewed the policy, Isolation-Initiating Transmission Based Precautions on 11/1/18. This policy includes but is not limited to promptly notifying the resident, his or her attending physician, and resident□s representative of contact/isolation precautions. No changes were made to the current policy. One on one in service was completed with both nurses- #5 and DON regarding guardian/resident representative notification on resident being placed isolation precautions. This in-service was given by the Regional Nurse and Administrator on 11/1/18. All licensed nurses will be educated on the policy Isolation -Initiating Transmission Based Precautions. This education will be completed by Staff Development Coordinator, DON or Regional Nurse Consultant by November 18, 2018. Licensed nurses on LOA, vacation and prn will be in serviced on the policy Isolation-Initiating Transmission Based Precautions prior to returning to an assignment. Monitoring Performance: 1. An audit tool was developed to ensure that residents/ representative have been notified of contact/isolation precautions. The audit tool will list any resident placed on isolation precautions and will identify if proper notification has been satisfied. 2. DON/SDC/designee will audit 100% of all residents placed on contact/isolation	

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F 580	Continued From page 3 together. She stated she did not call the guardian about Resident #10 being placed on isolation precautions. A follow up interview with the DON on 10/24/18 at 3:09 PM revealed that Nurse #5 took the order for isolation precautions and she would have been responsible for contacting the guardian. The DON stated she did not call the guardian about the contact isolation for Resident #10. The Administrator stated during interview on 10/24/18 at 4:47 PM that she expected the guardian to be notified when Resident #10 was placed on contact precautions.	F 580	precautions for notification of resident/representative. 3. Audits will be completed weekly x 4 weeks, Bi-weekly x 2 months, then monthly x 3 months. 4. Ongoing audits will be determined based on prior 5 months of auditing. QAPI: The results of the audits will be reviewed at QAPI meetings for 5 months.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, family interviews, staff interviews and record reviews, the facility failed to maintain the physician ordered rate of oxygen for 1 of 2 residents reviewed for respiratory care. Resident #26. The findings included: Resident #26 was admitted to the facility on	F 695	F 695 There was no adverse effects to resident #26 with regard to observation of Oxygen gauge settings at 2 LPM and 4.5 LPM. Nurse # 4 adjusted oxygen setting for resident #26 to 3 LPM on 10/22/18 at 12:52 p.m.	11/18/18

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F 695	Continued From page 4 06/30/17. Her diagnoses included Alzheimer's Disease, metabolic encephalopathy and chronic obstructive pulmonary disease. Review of the computerized October 2018 physician orders revealed Resident #26 was to be on 3 liters per minute (lpm) of oxygen in order to keep her oxygen saturation levels greater than 90 percent. This was originally ordered on 03/07/18. On 10/22/18 at 12:52 PM, Resident #26 was coming back from the dining room in her wheelchair. The portable oxygen tank located on the back of her wheelchair and in use was observed as set at 2 liters per minute. Nurse #4 stated at this time the oxygen was to be set at 3 lpm and proceeded to change the gauge from 2 lpm to 3 lpm. On 10/23/18 at 1:51 PM, Resident #26 was observed in her room receiving oxygen via an oxygen concentrator at 4.5 lpm. On 10/23/18 at 2:26 PM, Nurse Aides #1 and #2 assisted her to the bathroom. At the time of the transfer, staff turned off the concentrator. On 10/23/18 at 4:30 PM, Resident #26 was observed in her room in her wheelchair receiving oxygen from an oxygen concentrator which was observed set at 4.5 lpm. Her responsible family member was also in the room and stated it was to be set at 3 lpm and proceeded to adjust the oxygen rate to 3 lpm. An interview with Nurse Aide (NA) #1 who cared for Resident #26 on 10/23/18 was conducted on 10/24/18 at 12:14 PM. She stated she was not sure how the setting was changed to 4.5 lpm as	F 695	On 10/23/18 at 4:30 p.m. oxygen setting adjusted to 3 LPM. Residents with potential: 100 % of residents on oxygen were audited for the correct gauge setting based on physician orders by Regional Nurse on 11/1/18. No residents were found to have any discrepanies based on physician orders and gauge setting. The licensed nurses will be in serviced/re-educated from the facility policy titled Oxygen Administration. Licensed nurses in service/re-educated included: Follow physician orders pertaining to oxygen administration at number of liters per minute. Follow physician order for how oxygen will be administered, and when providing care for all residents on oxygen, nurses to check oxygen setting on medication passes as per physician order. This in service will be given by Regional Nurse, DON, and Staff Development Coordinator. Completion date: 11/18/18. Nurses not available (LOA, vacation and prn) will be in serviced upon return to an assignment. Monitoring Performance: 1. Audit tool was developed to monitor for accuracy of oxygen administration. The audit includes: Does resident have an MD order for oxygen, does care plan include the use of oxygen, and does the	

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F 695	Continued From page 5 she was aware it needed to be at 3 lpm. Interview with Nurse #4 on 10/24/18 at 1:42 PM revealed she checked the oxygen rate frequently and all nurse aides know the oxygen setting should be at 3 lpm. She stated the concentrator gauge could have been bumped while staff are moving Resident #26 around in the room or that it was somehow was changed when non-nursing staff assisted her with the portable oxygen unit. NA #3 stated during interview on 10/24/18 at 4:11 PM that she was aware the oxygen rate for Resident #26 was 3 lpm. She "guessed" that the concentrator may have gotten bumped while staff were providing care to the resident. The Administrator stated during interview on 10/24/18 at 4:47 PM that she expected the oxygen to be administered as ordered by the physician.	F 695	oxygen setting match MD order for liters per minute. DON/designee will audit 100 % of all residents on oxygen weekly x 4, then every 2 weeks x 4, then monthly x 3 months. 2. Ongoing audits will be determined by the prior 5 months of audit results. QAPI: The results of the audits will be reviewed at QAPI meetings monthly x 5 months.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and review of manufacturer's recommendations for medication administration, the facility failed to have a medication error rate less than 5% as evidenced by 3 medication errors out of 25 opportunities, resulting in a medication error rate of 12% for 3 of 8 residents (Resident	F 759	F759 There was no adverse effects to the residents with regard to the medication incidents for residents # 80, # 19, and # 238.	11/22/18

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F 759	Continued From page 6 #80, Resident #19, and Resident #238) observed during medication pass. The findings included: 1. On 10/24/18 at 9:50 AM, Nurse #1 was observed as she prepared and administered medications to Resident #80. The administered medications included two tablets of a single-ingredient medication containing 8.6 milligrams (mg) sennosides (a bowel stimulant medication). The medication was obtained from a stock bottle stored on the medication cart. A review of Resident #80's Physician Order Report included a current medication order for a combination medication containing 8.6 mg sennosides and 50 mg docusate (a stool softener) to be given to the resident as two tablets by mouth twice daily. An interview was conducted on 10/24/18 at 11:20 AM with Nurse #1. During the interview, the labeling of the stock bottle containing the medication administered to Resident #80 was reviewed with the nurse. At that time, Nurse #1 confirmed the medication administered to Resident #80 only contained 8.6 mg sennosides; it was not a combination medication which contained both 8.6 mg sennosides and 50 mg of docusate. Upon review of the Resident #80's Medication Administration Record (MAR), Nurse #1 reported the resident's orders indicated he should have received two tablets of a combination medication which contained both 8.6 mg sennosides and 50 mg of docusate. The nurse confirmed the wrong stock medication (which contained only 8.6 mg sennosides per tablet) was given during the medication pass	F 759	Resident with Potential: All licensed nurses have been re-educated/in serviced regarding Medication Administration Compliance. This in service was given by the Regional Nurse, DON and SDC initiated on 11/1/18. Completion date : 11/22/18. The Attending Physician was notified of medication incidents for residents #80, #19, and #238 on 11/15/18. Medication OTC bottle of 8.6 mg. of sennosides (a bowel stimulant) was removed from medication cart on October 25, 2018. Measure and changes to practice: 1. Regional Nurse reviewed Medication Administration on 11/1/18, no changes were necessary to the policy. 2. An medication administration audit was initiated with licensed nurses on 11/1/18, this included, but not limited to the six rights of medication administration and included medication administered as ordered, all meds given in appropriate time frame, medication expiration dated were checked, parameters are noted as required, controlled drugs are signed for all required documents. 3. Licensed nurses on LOA, vacation and prn will be in serviced prior to taking an assignment. 4. Pharmacy will conduct an in service on medication administration on 11/20/18.	

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F 759	Continued From page 7 observation. An interview was conducted on 10/24/18 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, concerns identified during the medication pass observations were discussed. Upon inquiry, the DON indicated she would expect the medication ordered to be the same as the medication given during med pass administration. 2. On 10/23/18 at 5:00 PM, Nurse #2 was observed as she prepared and administered medications to Resident #19. The medications pulled for administration included 110 microgram (mcg) per activation Flovent HFA inhaler (an inhaled steroid medication used for the management of asthma or chronic obstructive pulmonary disease). Resident #19 was observed as he took the Flovent HFA inhaler and used it while in the presence of the nurse. The nurse did not prompt the resident to rinse and spit out water after he used the inhaler; the resident did not rinse and spit after the inhaler was used. Immediately after using the inhaler, Resident #19 was observed taking his pills and then drinking water provided by Nurse #2. An interview was conducted on 10/23/18 at 5:12 PM with Nurse #2. During the interview, the nurse was asked if Resident #19 should have been encouraged to rinse and spit out water after use of the Flovent inhaler (prior to taking the pills and drinking the water provided). The nurse reported the resident was very particular about how he took his medications and she was not sure whether or not he would accept this direction.	F 759	Monitoring Performance: 1. An audit tool was developed i.e. Medication Administration Observation. 2. Medication Administration Observation included the 6 rights of medication administration. 3. Once all nurses have been in serviced on medication administration, a random sample of 10% of nurses will be audited weekly by the DON/designee. 4. On going audits will be based on prior 8 weeks of audits. Audits will be conducted by the DON/designee. QAPI: The results of the audits will be reviewed at QAPI meetings for 3 months.	

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F 759	Continued From page 8	F 759		

A review of Resident #19's Physician Order Report included a current medication order for 110 mcg per activation Flovent HFA to be given as two puffs inhaled twice daily. The physician's order included instructions to "rinse and spit after use."

A review of the manufacturer's information for Flovent HFA included the following instructions: "After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis (a yeast infection)."

A follow-up interview was conducted on 10/23/18 at 5:30 PM with Nurse #2. During the interview, the physician's orders for administration of the Flovent HFA were discussed and it was noted the directions included instructions for the resident to rinse and spit out water after using the inhaler. The nurse stated she would try to encourage Resident #19 to rinse his mouth out with water after using the Flovent HFA inhaler. Nurse #2 acknowledged she did not encourage the resident to rinse and spit after use of the inhaler during the medication pass observation.

An interview was conducted on 10/24/18 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, concerns identified during the medication pass observations were discussed. Upon inquiry, the DON stated she would expect a nurse to at least offer water for the resident to rinse and spit out after a steroid inhaler has been used.

3. On 10/24/18 at 10:05 AM, Nurse #1 was observed as she pulled a Symbicort HFA aerosol inhaler (containing 80 microgram or mcg

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F 759	Continued From page 9 budesonide and 4.5 mcg formoterol per actuation) from the medication cart for administration to Resident #238. Symbicort is an inhaled steroid medication used for the management of asthma or chronic obstructive pulmonary disease. Resident #238 was observed as she took the inhaler and self-administered the medication while in the presence of Nurse #1. The nurse did not offer the resident any water to rinse her mouth out after using the inhaler. A review of Resident #238's Physician Order Report dated 10/24/18 included a current medication order for 80 mcg/4.5 mcg Symbicort HFA aerosol inhaler to be administered as two inhalations every 12 hours as needed. A review of the manufacturer's information for Symbicort HFA included the following instructions: "After inhalation, the patient should rinse the mouth with water without swallowing." An interview was conducted on 10/24/18 at 11:25 AM with Nurse #1. Upon inquiry, the nurse acknowledged she did not give or offer Resident #238 any water to rinse her mouth our after using the Symbicort inhaler. An interview was conducted on 10/24/18 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, concerns identified during the medication pass observations were discussed. Upon inquiry, the DON stated she would expect a nurse to at least offer water for the resident to rinse and spit out after a steroid inhaler has been used.	F 759		
F 761	Label/Store Drugs and Biologicals	F 761		11/18/18

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F 761 SS=D	Continued From page 10 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and manufacturers recommendations, the facility: 1) Failed to label an insulin pen stored on 1 of 3 medication carts observed (the C/D Diabetes Cart) with the minimum required information, including the name of the resident for whom it was prescribed,; and, 2) Failed to discard expired medications stored in 1 of 1 medication room (Cherry Circle/Dewberry Drive Medication Room) and in 2 of 3 medication carts observed	F 761	F 761 There were no adverse effects the residents with regard to Labeling of Drugs and biologicals used in the facility. 100 % audit completed on all medication carts, diabetic carts, medication room and medication room refrigerator for expired medication and proper labeling completed on 10/26/18.	

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F 761	Continued From page 11 (Medication Cart A and the C/D Diabetes Cart). The findings included: 1. Accompanied by Med Aide #1, an observation was conducted of the C/D Diabetes Cart on 10/23/18 at 2:30 PM. The observation revealed an opened Novolog insulin pen was stored on the cart. The insulin pen did not include the minimum identifying information required, including the name of the specific resident for whom it was prescribed or the date it had been opened (or put on the med cart). Upon inquiry, Med Aide #1 confirmed there was no identifying information on the Novolog insulin pen. An interview was conducted on 10/24/18 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, the DON stated she would expect every insulin pen to be labeled with a resident's name and date. 2. Accompanied by Med Aide #1, an observation was conducted of the C/D Diabetes Cart on 10/23/18 at 2:30 PM. The observation revealed an opened Novolog insulin pen dispensed by pharmacy on 9/12/18 for Resident #19 was stored on the cart. The insulin pen was not dated as to when it had been opened (or put on the med cart). Upon inquiry, Med Aide #1 confirmed the Novolog insulin pen was not dated as to when it had been opened or put on the med cart. A review of the manufacturer's storage information for Novolog insulin pens instructed that insulin pens may be stored at room temperature for 28 days. The manufacturer also stipulated that once punctured (in use), the insulin pen should be used within 28 days.	F 761	On C/D Diabetic Cart Novolog insulin pen that was observed without the name of whom it was prescribed was removed from cart and discarded on 10/23/18. On C/D Diabetic Cart the Novolog insulin pen that was observed with dispensed by pharmacy on 9/12/18 , without opened date was removed from cart and discarded on 10/23/18. Resident #60- an opened bottle of calcitonin nasal spray dated 6/25/18 was removed from the medication room refrigerator and discarded on 10/23/18. Resident #246- Magic Mouthwash observed with expiration date of 9/18/18 was removed from medication room refrigerator and discarded on 10/23/18. Resident # 60 -on Medication Cart A an opened bottle of calcitonin nasal spray was labeled as open date of 9/5/18. Medication was removed from medication cart and discarded on 10/23/18. Resident with potential: All nurses re-educated/in serviced regarding compliance with medication storage/disposal and included procedure for dating medication when opened, this was completed by Regional Nurse, DON, and SDC nurse. Licensed nurses on LOA, vacation, and PRN will be in serviced on return to an assignment. Completion date	

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F 761	Continued From page 12 An interview was conducted on 10/24/18 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, the DON reported if an insulin pen was not specifically dated as to when it had been opened or put on the med cart, the nursing staff used the pharmacy's dispensed date to determine the shortened expiration date of the pen. The DON stated she would expect a Novolog insulin pen placed on the medication cart to be used or discarded within 28 days. 3. Accompanied by Nurse #3, an observation was conducted on 10/23/18 at 1:55 PM of the Cherry Circle/Dewberry Drive Medication Room. An opened bottle of calcitonin nasal spray (a medication frequently used to treat osteoporosis) was stored in the refrigerator. The calcitonin nasal spray was dispensed by the pharmacy for Resident #60 and was labeled as having been opened on 6/25/18. A review of the manufacturer's storage information for calcitonin nasal spray indicated unopened bottles may be stored under refrigeration until the manufacturer ' s expiration date. After opening, the medication may be stored at room temperature; it may be stored for up to 35 days. An interview was conducted on 10/23/18 at 2:12 PM with Nurse #3. During the interview, the nurse questioned why an opened bottle of calcitonin was stored in the refrigerator and indicated this normally would have been stored on the med cart once opened. She reported she would let the facility's Director of Nursing (DON) know about the concern related to the medication's shortened expiration date.	F 761	11/18/18. Measure and changes to practice: The facility policy - Medication storage/disposal was reviewed by the Regional Nurse on 11/1/18. All nurses were/will be re-educated regarding the need for compliance with policy and procedure for storage of medication and policy and procedure for dating medication when opened. In service/re-education included but not limited to; How to dispose of expired meds, policy for dating medication when opened. Remove expired medication from medication carts, diabetic carts and medication room and medication room refrigerator. Completion date: 11/18/18. In -services were conducted by Regional Nurse, DON, and SDC nurse. Monitoring Performance: 1. An audit tool was implemented titled," Medication Storage Audit Tool".This medication administration audit tool includes, but not limited to : Are OTC medications within the expiration date, Insulin/Insulin pens are within the expiration date, liquid medication are within the expiration date, blister packed meds are within the expiration date, are all other medications within the expiration dates? 2. Audits for all licensed nurses for compliance of Medication storage was/will be completed by 11/18/18.	

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F 761	Continued From page 13 An interview was conducted on 10/24/18 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, the DON reported Resident #60 was no longer residing at the facility. She stated her expectation would have been for the medication to be removed and destroyed, or returned to the pharmacy. 4. Accompanied by Nurse #3, an observation was conducted on 10/23/18 at 1:55 PM of the Cherry Circle/Dewberry Drive Medication Room. A medication bottle containing approximately 180 milliliters (ml) Magic Mouthwash (a solution used to treat mouth sores) dispensed for Resident #246 on 9/6/18 was stored in the refrigerator. A pharmacy auxiliary sticker placed on the bottle indicated the medication expired on 9/18/18. Nurse #3 confirmed the medication was expired and was observed as she removed the bottle of Magic Mouthwash from the medication room. An interview was conducted on 10/24/18 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, the DON reported Resident #246 was no longer residing at the facility. She stated her expectation would have been for the medication to be removed and destroyed, or returned to the pharmacy. 5. Accompanied by Nurse #4, an observation was conducted on 10/23/18 at 2:23 PM of Medication Cart A. An opened bottle of calcitonin nasal spray (a medication frequently used to treat osteoporosis) dispensed for Resident #60 and labeled as having been opened on 9/5/18 was observed to be stored on the med cart. Nurse #4 acknowledged the medication was expired. The nurse was observed as she disposed of the	F 761	3. Medication carts, diabetic carts and medication room refrigerator will be audited by nurses assigned to carts and audited by DON weekly x 4 weeks, then monthly x 2, then random audits. 4. An audit tool was implemented titled" Medication Storage Audit Tool". This tool includes, but not limited to Medication Labeling. Insulin pens will arrive from pharmacy with label identifying, resident name, date sent from pharmacy, and name of medication. DON/designee will audit all insulin pens weekly x 4, then bi-weekly x 2, then monthly x 3 to ensure proper labeling of insulin pens. 5. Ongoing audits will be determined based on prior 3 months audits. QAPI: The results of audits will be reviewed at QAPI meetings x 3 months.	

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F 761	Continued From page 14 medication. A review of the manufacturer's storage information for calcitonin nasal spray indicated unopened bottles may be stored under refrigeration. After opening, the medication may be stored at room temperature; it may be stored for up to 35 days. An interview was conducted on 10/24/18 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, the DON reported Resident #60 was no longer residing at the facility. She stated her expectation would have been for the medication to be removed and destroyed, or returned to the pharmacy.	F 761		
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.	F 812		11/18/18

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F 812	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date, label and /or wrap food securely in the freezer and keep the ice scoop and scoop container free of debris. This occurred in one of one walk in freezer and one of one ice machine located in the kitchen. The findings included: 1. On initial tour of the kitchen beginning on 10/22/18 at 10:04 AM the following was observed: a. The walk in freezer had a bag of french fries which was opened to air with two dates 10/19 and 10/25. b. There was a bag of what appeared to be frozen chicken without a label for identification or date. The Dietary Manager stated at the time of this observation that all food should be labeled and dated and secured closed and not open to air. She further stated the chicken was used Saturday and the date was on the discarded box. 2. On initial tour of the kitchen beginning on 10/22/18 at 10:04 AM the ice machine was observed. Outside the ice machine was an ice scoop holder which had an ice scoop inside. Inside the scoop holder was a piece of white debris and the bottom had standing water with some black small spots in the water. The cook stated at this time that she though the staff cleaned the ice scoop once a week. Review of the cleaning schedule for the previous week of 10/15/18 through 10/21/18 revealed the ice scoop	F 812	F812 ¿ Corrective action taken: ¿ All food items identified as improperly stored were immediately discarded. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. ¿ The Dining Services Manager completed staff education on proper food storage in accordance with HCSG procedure on 10/22/18. All dietary employees on duty that day were in-serviced. All remaining staff received education prior to their next scheduled shift. ¿ The food service worker will properly wrap, date, label each food item handled prior, or after, completion of the meal in accordance with food code/HCSG procedure. Any improperly stored item identified will be corrected/discarded in accordance with procedure. ¿ Measures/Systemic Changes put in place to assure the deficient practice does not occur: ¿ The cook is responsible for the daily completion of the Cooler/Freezer/Dry Storage Labeling Log. The cook will review storage of items in the freezer, cooler, and dry storage room to ensure	

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F 812	Continued From page 16 and scoop holder was not on a cleaning schedule. Interview with the Administrator on 10/24/18 at 4:47 PM revealed she expected foods to be securely wrapped, labeled and dated in the freezer and the ice scoop and holder to be on a cleaning schedule to maintain cleanliness.	F 812	that these items are properly stored, label, and dated. This log will be initialed daily by the cook after completion of the meal service to verify that all items are stored in accordance with procedure. Any improperly stored item will be corrected/discarded in accordance with procedure. ¿ Date back in compliance: November 18, 2018 ¿ Monitoring Performance: ¿ The Dining Services manager will review the Cooler/Freezer/Dry Storage Labeling Log 3 times per week for 3 months to ensure that the cook has completed the checklist for the meals on the day prior. Any incomplete documentation and/or identification of a food item without proper storage/label by the Dining Services Manager during her routine kitchen monitoring will be addressed with the responsible staff member(s) and further education/disciplinary action will occur. In addition, the Dining Services Manager will personally check all coolers/freezer/dry storage for dating, labeling, and storage, each day she is scheduled in the facility to work, and will document on the monitoring tool that this has been completed. This will be audited for 3 months. ¿ The District Manager will review audit tool during routine facility visits monthly for 3 months and further advise the Dining Services Manager/Food Service staff accordingly	

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F 812	Continued From page 17	F 812	¿ QAPI ¿ The results of the audits will be reviewed at monthly QAPI meetings for 3 months. After that time the team will determine need for further continuation/adjustment in audit tool and/or education needed to ensure ongoing compliance. F812 ¿ Corrective action taken: ¿ The ice scoop and container was cleaned and replaced immediately upon discovery of debris present. All remaining ice scoops/containers in the facility were also checked and found to be clean and free of debris. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. ¿ The Dining Services Manager completed staff education on procedure for daily cleaning of ice scoop and container. This in-service occurred on 10/24/18 with all employees on duty at that time. All remaining staff received education prior to their next scheduled shift.	

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F 812	Continued From page 18	F 812	¿ Measures/Systemic Changes put in place to assure the deficient practice does not reoccur: ¿ The dietary aid responsible for delivery of the HS snacks to the units will clean, and replace the ice scoop and container prior to closing the kitchen in the evening. That employee will initial the Ice Scoop and Ice Bucket Cleaning Log daily. ¿ Date back in compliance: November 18, 2018 ¿ Monitoring Performance: ¿ The Dining Services manager will review the Ice Scoop and Ice Bucket Cleaning Log 3 times per week for 3 months to ensure that the diet aide has completed the checklist for the day prior. Any incomplete documentation and/or identification of improperly cleaned ice scoop or container by the Dining Services Manager, during her routine kitchen monitoring, will be addressed with the responsible staff member and further education/disciplinary action will occur. In addition, the Dining Services Manager will personally check the ice scoop/container, each day she is scheduled in the facility to work, and will document on the monitoring tool that this has been completed. This will be audited for 3 months. ¿ The District Manager will review audit tool during routine facility visits monthly for 3 months and advise the Dining Services Manager/Food Service staff accordingly.	

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F 812	Continued From page 19	F 812	¿ QAPI: ¿ The results of the audits will be reviewed at monthly QAPI meetings for 3 months. After that time the team will determine need for further continuation/adjustment in audit tool and/or education needed to ensure ongoing compliance.	