STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345462	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 1/06/18-1/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID QJEF11	E 000		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident, family and staff interviews, the facility failed to provide 5 of 5 residents or their representative with quarterly statements of their personal trust fund account managed by the facility (Residents #18, #24, #41, #61, and #75). Findings included: 1a. Resident #18 was admitted to the facility on 10/01/18 with multiple diagnoses that included anxiety and altered mental status. A review of the admission Minimum Data Set (MDS) dated	F 568	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the	2/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2019

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F 568	Continued From page 1 10/20/18 coded Resident #18 with intact cognition. During an interview on 01/07/19 at 11:27 AM Resident #18 confirmed she had a personal trust fund account that was managed by the facility. She reported she had not received any statement from the facility letting her know how much she had in her account. During an interview on 01/09/19 at 4:45 PM Resident #18's family member confirmed they had not received any statements from the facility for Resident #18's personal trust fund account. b. Resident #24 was admitted to the facility on 02/02/18 with multiple diagnoses that included dementia without behavioral disturbance. A review of the quarterly Minimum Data Set (MDS) dated 10/10/18 coded Resident #24 with severe cognitive impairment. During an interview on 01/10/19 at 6:20 PM, Resident #24's Responsible Party (RP) confirmed Resident #24 had a personal trust fund account that was managed by the facility. The RP reported they had not received any statements from the facility letting them know how much Resident #24 had in her account. c. Resident #41 was admitted to the facility on 08/09/17 with multiple diagnoses that included Alzheimer's disease. A review of the annual Minimum Data Set (MDS) dated 10/17/18 coded Resident #41 with severe cognitive impairment.	F 568	quality of care and services to our residents. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Residents #18, #41, #24, #61 and #75 were issued a copy of their quarterly resident trust statement on 1/11/19. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "All other residents with accounts managed by the facility were mailed a resident trust statement on 1/11/19. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "Financial Counselor was educated on procedure by Administrator of distributing quarterly trust statements on a quarterly basis. Education was done on 1/11/19. "Facility identified quarterly dates in January, March, June and September to issue resident trust statements to residents and/or Responsible Party. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for	

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F 568	Continued From page 2 During an interview on 01/08/19 at 6:15 PM, Resident #41's Responsible Party (RP) confirmed Resident #41 had a personal trust fund account that was managed by the facility. The RP stated they had not received any statements from the facility letting them know how much Resident #41 had in his account. d. Resident #61 was admitted to the facility on 08/01/18 with multiple diagnoses that included dementia. A review of the quarterly Minimum Data Set (MDS) dated 11/10/18 coded Resident #61 with moderate impairment in cognition. Resident #61 no longer resided at the facility and was unable to be interviewed. An interview with Resident #61's Responsible Party (RP) confirmed Resident #61 had a personal trust fund account that was managed by the facility. The RP stated they had not received a quarterly statement from the facility letting them know how much Resident #61 had in her account. e. Resident #75 was admitted to the facility on 12/12/17 with multiple diagnoses that included heart failure, chronic pain and depression. A review of the annual Minimum Data Set (MDS) dated 11/12/18 coded Resident #75 with intact cognition. During an interview on 01/06/19 Resident #75 confirmed she had a personal trust fund account that was managed by the facility. Resident #75 reported she had not received any statement	F 568	monitoring to assure continued compliance. "The Administrator will verify that the quarterly trust statements have been mailed by the Financial Counselor using the quarterly calendar that was created. "Financial Counselor will report in QAPI monthly x 3 quarters or until substantial compliance is achieved. Date of Compliance: February 8, 2019	

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F 568	Continued From page 3 from the facility letting her know how much she had in her account. During an interview on 01/11/19 at 3:05 PM the Business Office Manager (BOM) reported she could access each resident's account who had a personal trust fund managed by the facility and print a statement for the resident or their Responsible Party (RP) when requested. She explained residents personal trust fund statements used to be mailed to the resident or RP by the corporate office but was informed the corporate office would no longer mail the statements when the facility switched accounting systems last year. The BOM confirmed quarterly statements were not mailed to the RP or provided to the resident unless specifically requested. During an interview on 01/11/19 at 3:24 PM the Administrator stated it was his expectation that each resident who had a personal trust fund account receive a quarterly statement as required.	F 568		
F 571 SS=D	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and	F 571		2/8/19

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F 571	Continued From page 4	F 571		

services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)
(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:
(A) Nursing services as required at §483.35.
(B) Food and Nutrition services as required at §483.60.
(C) An activities program as required at §483.24(c).
(D) Room/bed maintenance services.
(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.
(F) Medically-related social services as required at §483.40(d).
(G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.
(ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through

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F 571	Continued From page 5	F 571		

(L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:
(A) Telephone, including a cellular phone.
(B) Television/radio, personal computer or other electronic device for personal use.
(C) Personal comfort items, including smoking materials, notions and novelties, and confections.
(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.
(E) Personal clothing.
(F) Personal reading matter.
(F) Gifts purchased on behalf of a resident.
(H) Flowers and plants.
(I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c).
(J) Non-covered special care services such as privately hired nurses or aides.
(K) Private room, except when therapeutically required (for example, isolation for infection control).
(L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.
(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per

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F 571	Continued From page 6 §483.60. (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population. (iii) Requests for items and services. (A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident. (B) The facility must not require a resident to request any item or service as a condition of admission or continued stay. (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on review of the Statement of Account for Resident #41 and interviews with 1) staff, 2) family 3) the caseworker at the Department of Social Services and the corporate Regional Financial Manager, the facility failed to apply the patient monthly liability assessed by the North Carolina Division of Medical Assistance for one month for 1 of 3 sampled residents with itemized billing statements reviewed. (Resident #41) The findings included: Resident #41 was admitted to the facility 08/9/17. The quarterly Minimum Data Set assessment dated 11/30/18 assessed Resident #41 with severe cognitive impairment. A family member was listed as the Responsible Party of Resident #41.	F 571	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Resident #41 had the erroneous charges removed from the bill and the account was reconciled. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "The Financial Counselor (FC) will audit all current Medicaid residents to ensure patient monthly liability is booked correctly and to ensure no private charges are inaccurate.	

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F 571	Continued From page 7 On 01/08/19 at 6:15 PM the family of Resident #41 reported there had been ongoing issues with the monthly bill received from the facility for Resident #41. The family stated Resident #41 began receiving Medicaid funds 01/01/18 after Resident #41's personal funds were spent down consistent with guidance from the Department of Social Services caseworker. The family member stated they met with the caseworker at the Department of Social Services on multiple occasions in 2018 and the caseworker reviewed his case and reported he should not owe anything to the facility. The family stated he spoke to the facility Business Office Manager and called the corporate office multiple times and was assured he shouldn't worry about the bills and that they would take care of it. The family member provided recent billing statements (from December 2018) which showed an outstanding balance. On 01/11/19 the North Carolina Division of Medical Assistance eligibility letter for Resident #41 was reviewed and showed the patient monthly liability for the month of January 2018 was $0. However, review of the Statement of Account (provided by the facility on 01/11/19) for Resident #41 noted a private room and board charge of $8459 charged for the month of January 2018 which led to the outstanding balance. On 01/09/19 at 11:00 AM the caseworker (assigned to Resident #41) at the Department of Social Services was interviewed and reported she had met with the family member of Resident #41 on multiple occasions. The caseworker stated the family of Resident #41 asked her to review concerns with bills he had received since	F 571	"The FC will cross reference these to a current census showing insurance status of each resident. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "The FC was educated by the Administrator on 2/5/19 related to updating "The FC was also educated by Administrator to ensure monthly liability and Medicaid status is correct to process billing accurately. "An audit tool was developed to assess whether patient monthly liabilities have been applied correctly and reflect accurately in the billing system. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "A monthly audit will be conducted by the Financial Counselor to assess whether the patient monthly liabilities are applied correctly. "The Financial Counselor will bring audit tool to QAPI monthly x 6 months or until substantial compliance is achieved. Date of Compliance: February 8, 2019	

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F 571	Continued From page 8 Resident #41 became eligible for Medicaid coverage 01/01/18. The caseworker stated prior to 01/01/18 she guided the family to spend down personal funds for Resident #41 and confirmed Medicaid coverage began 01/01/18 with a patient monthly liability of $0 for January 2018. The caseworker stated she reviewed statements provided to her from the family of Resident #41 and questioned charges on the billing statements. The caseworker stated she called the corporate office multiple times to review the billing statements that had been sent to the family of Resident #41 and was assured the concerns would be addressed. The caseworker stated she had not met with the family of Resident #41 recently and assumed the concern had been resolved. On 01/11/19 at 5:45 PM the Business Office Manager stated she could not explain the Statement of Account for Resident #41 in relation to a private room and board charge assessed for the month of January 2018 when a $0 patient monthly liability had been issued by the North Carolina Division of Medical Assistance. On 01/11/19 at 6:10 PM the Administrator stated he could not explain the Statement of Account for Resident #41 in relation to a private room and board charge assessed for the month of January 2018 when a $0 patient monthly liability had been issued by the North Carolina Division of Medical Assistance. At the time of the interview the Administrator called the corporate Regional Financial Manager and she could not explain the private room charge for Resident #41 which was assessed January 2018.	F 571		
F 623	Notice Requirements Before Transfer/Discharge	F 623		2/8/19

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F 623 SS=B	Continued From page 9 CFR(s): 483.15(c)(3)-(6)(8)	F 623		

§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.
(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,

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F 623	Continued From page 10	F 623		

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, 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.

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F 623	Continued From page 11 §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 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, Regional Ombudsman and staff interviews, the facility failed to notify the Regional Ombudsman of residents' discharges and/or transfers for 1 of 3 residents reviewed for hospitalization and discharge (Resident #50). Findings included: Resident #50 was admitted to the facility on 08/10/18 with multiple diagnoses that included displaced bimalleolar (ankle) fracture of right lower leg and depression. Review of the admission Minimum Data Set (MDS) dated 08/17/18 coded Resident #50 with intact cognition. Review of Resident #50's medical record	F 623	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "On 1/6/19 a summary of discharges from the month of December 2018 were sent to the Ombudsman via fax. "On 1/31/19 a summary of discharges from the month of January 2019 were sent to the Ombudsman via fax How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "An audit tool was developed to track discharges from the facility to ensure the Ombudsman is notified monthly as	

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F 623	Continued From page 12 revealed she returned to the community and discharged from the facility on 11/08/18. There was no evidence the Regional Ombudsman (RO) was notified in writing of the date and reason for Resident #50's discharge. Review of the discharge summary notices, provided by the facility for the period February 2018 through December 2018, revealed no evidence the discharge summary notices were submitted monthly to the Regional Ombudsman (RO). During an interview on 01/07/19 at 2:30 PM, the RO stated she received a notice of residents who discharged or transferred from the facility during the month of December 2018 via fax on 01/06/19. The RO added it was the first discharge summary notice she received from the facility for the year 2018. During interviews on 01/09/19 at 3:18 PM and 01/11/19 at 9:26 AM, the Administrator confirmed discharge summary notices were not submitted to the RO for the months of February 2018 through November 2018. He explained he thought the discharge summary notices were only required to be submitted to the RO when it was facility-initiated discharge. The Administrator stated going forward it would be the responsibility of the Nurse Navigator to submit the discharge summary notices monthly to the RO as required.	F 623	required. This tool tracks all discharges from facility. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "The Nurse Navigator was educated by the Administrator on the process of notifying the Ombudsman of all discharges monthly. Education occurred on 1/11/19. "The audit will be brought to morning clinical meeting (Monday □ Friday) and updated with all discharges from the prior day. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "The Administrator will confirm that the audit is correctly being used by the Nurse Navigator by checking it weekly x 4 weeks, then monthly x 3 months. The audit tool will be cross referenced to the discharge list from LTC to ensure all discharges have been accounted for. "Results from the audits will be brought to QAPI monthly x 3 months or until substantial compliance is achieved. Date of Compliance: February 8, 2019	

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F 636	Continued From page 13	F 636		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 636		2/8/19

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F 636	Continued From page 14 assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory timeframe for 2 of 2 residents selected to be reviewed for Resident Assessments (Residents #5 and #6). Findings included: 1. Resident #5 was admitted to the facility on 07/23/10. A review of the Minimum Data Set (MDS) assessments for Resident #5 revealed the last MDS completed was an annual assessment	F 636	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Resident #5□s comprehensive Assessment with an ARD date of 11/23/18 was completed and transmitted on 1/3/19. "Resident # 6□s comprehensive Assessment with an ARD date of 11/30/18 was completed and transmitted on 1/8/19. How will you identify other residents having the potential to be affected by the same deficient practice and what	

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F 636	Continued From page 15 with an ARD (Assessment Reference Date - the last day of the MDS look-back period) of 11/23/18. An interview and electronic medical record review was conducted with the MDS Coordinator on 01/11/19 at 11:30 AM. The MDS Coordinator confirmed Resident #5's annual MDS assessment with an ARD date of 11/23/18 was not completed until 01/03/19 and explained she got behind on completing MDS assessments after the second MDS Coordinator quit last year. She added the assessment for Resident #5 should have been completed 14 days after the ARD date of 11/23/18. The MDS Coordinator acknowledged the annual MDS assessment for Resident #5 was not completed within the regulatory timeframe. An interview was conducted with the Director of Nursing (DON) on 01/11/19 at 3:05 PM. The DON stated it was her expectation that MDS assessments were completed accurately and within the required timeframe. 2. Resident #6 was admitted to the facility on 05/11/16. A review of the Minimum Data Set (MDS) assessments for Resident #6 revealed the last MDS completed was an annual assessment with an ARD (Assessment Reference Date - the last day of the MDS look-back period) of 11/30/18. An interview and electronic medical record review was conducted with the MDS Coordinator on	F 636	corrective action will be taken? "Clinical Reimbursement Consultant (CRC) met with the Case Mix Director and reviewed the Assessment summary report on 2/4/19. "Any outstanding assessments were scheduled for completion by 2/8/19. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "An additional CMD was hired on 12/16/2018. "Education with Interdisciplinary team members (CMDs, Social Services, Activities, Dietary Manager, Wound nurse) was completed by CRC on 2/4/19 related to the particular area these members are responsible for and the time limit they have to complete their section. "An audit tool was created to monitor most recent completion of comprehensive assessment for each resident currently in the facility. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "The audits of comprehensive assessment audit tool will be reviewed weekly x 4 weeks and then monthly x 3 months by the Administrator.	

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F 636	Continued From page 16 01/11/19 at 11:30 AM. The MDS Coordinator confirmed Resident #6's annual MDS assessment with an ARD date of 11/30/18 was not completed until 01/08/19 and explained she got behind on completing MDS assessments after the second MDS Coordinator quit last year. She added the assessment for Resident #6 should have been completed 14 days after the ARD date of 11/30/18. The MDS Coordinator acknowledged the annual MDS assessment for Resident #6 was not completed within the regulatory timeframe. An interview was conducted with the Director of Nursing (DON) on 01/11/19 at 3:05 PM. The DON stated it was her expectation that MDS assessments were completed accurately and within the required timeframe.	F 636	"Results of these audits will be taken to QAPI by the CMD and reviewed x 3 months or until substantial compliance is achieved. Date of Compliance: February 8, 2019	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the regulatory timeframe for 2 of 2 residents selected to be reviewed for Resident Assessments (Residents #5 and #6). Findings included:	F 638	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Resident # 5□s Quarterly MDS Assessment with an ARD of 8/26/18 was completed and transmitted on 10/01/2018 "Resident # 6□s Quarterly MDS	2/8/19

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F 638	Continued From page 17 1. Resident #5 was admitted to the facility on 07/23/10. A review of the Minimum Data Set (MDS) assessments for Resident #5 revealed the most recent quarterly MDS completed had an ARD (Assessment Reference Date - the last day of the MDS look-back period) of 08/26/18. An interview and electronic medical record review was conducted with the MDS Coordinator on 01/11/19 at 11:30 AM. The MDS Coordinator confirmed Resident #5's quarterly MDS with an ARD date of 08/26/18 was not completed until 10/01/18 and explained she got behind on completing MDS assessments after the second MDS Coordinator quit last year. She added the quarterly assessment for Resident #5 should have been completed 14 days after the ARD date of 08/26/18. The MDS Coordinator acknowledged the quarterly MDS assessment for Resident #5 was not completed within the regulatory timeframe. An interview was conducted with the Director of Nursing (DON) on 01/11/19 at 3:05 PM. The DON stated it was her expectation that MDS assessments were completed accurately and within the required timeframe. 2. Resident #6 was admitted to the facility on 05/11/16. A review of the Minimum Data Set (MDS) assessments for Resident #6 revealed the most recent quarterly MDS completed had an ARD (Assessment Reference Date - the last day of the MDS look-back period) of 09/04/18.	F 638	Assessment with an ARD of 9/4/18 was completed and transmitted on 10/04/2018. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "Clinical Reimbursement Consultant (CRC) met with the Case Mix Director and reviewed the Assessment summary report on 2/4/19. "Any outstanding assessments were scheduled for completion by 2/8/19. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "An additional CMD was hired on 12/18/2018. "Education with Interdisciplinary team members (CMDs, Social Services, Activities, Dietary Manager, Wound nurse) was completed by CRC on 2/4/19 related to the particular area these members are responsible for and the time limit they have to complete their section. "An audit tool was created to monitor most recent completion of Quarterly assessment for each resident currently in the facility. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued	

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F 638	Continued From page 18 An interview and electronic medical record review was conducted with the MDS Coordinator on 01/11/19 at 11:30 AM. The MDS Coordinator confirmed Resident #6's quarterly MDS with an ARD date of 09/04/18 was not completed until 10/04/18 and explained she got behind on completing MDS assessments after the second MDS Coordinator quit last year. She added the quarterly assessment for Resident #6 should have been completed 14 days after the ARD date of 09/04/18. The MDS Coordinator acknowledged the quarterly MDS assessment for Resident #6 was not completed within the regulatory timeframe. An interview was conducted with the Director of Nursing (DON) on 01/11/19 at 3:05 PM. The DON stated it was her expectation that MDS assessments were completed accurately and within the required timeframe.	F 638	compliance. "The audits of quarterly assessment audit tool will be reviewed weekly x 4 weeks and then monthly x 3 months by the Administrator. "Results of these audits will be taken to QAPI by the CMD and reviewed x 3 months or until substantial compliance is achieved. Date of Compliance: February 8, 2019	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess 1 of 5 sampled residents reviewed for unnecessary medication utilizing the Minimum Data Set (MDS) to reflect antipsychotic medication received (Resident #49). Findings included:	F 641	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "A modification was completed for resident #49 related to use of	2/8/19

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F 641	Continued From page 19 Resident #49 was admitted to the facility on 11/12/18 with diagnoses which included dementia and depression. Monthly physician orders from 11/12/18 to 12/12/18 and signed by the nurse practitioner indicated Resident #49 had an order for Seroquel (antipsychotic medication) 25 milligrams (mg) 0.5 mg tablet by mouth every bedtime. A review of the medication administration record (MAR) from 11/12/18 to 11/30/19 indicated Resident #49 received Seroquel 25 mg 0.5 mg tablet by mouth at bedtime per documentation on the MAR during the 7 day look back period from 11/13/18 to 11/19/18. A review of the nurse practitioner's progress note dated 11/13/18 indicated Resident #49's medication list was reviewed and he was on Seroquel 12.5 mg by mouth nightly. A review of the admission Minimum Data Set (MDS) assessment dated 11/19/18 indicated Resident #49 had not been coded under Section N Medications (N0410 Medications Received) as receiving antipsychotic medication for 7 days during the look back period from 11/13/18 to 11/19/18. On 01/10/19 at 4:34 PM an interview was conducted with the MDS Coordinator who stated she was responsible for coding Section N Medications (N0410 Medications Received) and missed coding that Resident #49 received Seroquel 25 mg 0.5mg tablet every bedtime during the look back period from 11/13/18 to 11/19/18. The MDS Coordinator stated she would	F 641	antipsychotic medication. The modification was accepted by the QIES on 1/11/2019. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "Resident orders were audited by PruittHealth Pharmacy consultant on 1/29/19 and a list of residents with current antipsychotic medications was compiled. "Using the pharmacist□s report all residents with current orders for antipsychotic medications had section N0410A of their latest MDS assessment audited for coding accuracy related to antipsychotic medication usage during the look back period. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "CMDs were assigned a continuing education course related to section N on the MDS by the Regional Clinical Competency Coordinator. " CMD coordinator will create a master list of all residents currently prescribed antipsychotic medications. "The master list will be updated Monday through Friday during morning clinical meetings. How will the corrective action be	

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F 641	Continued From page 20 need to submit a modification to Resident #49's admission MDS Assessment dated 11/19/18 to indicate Resident #49 received Seroquel times 7 days during the look back period. On 01/10/19 at 4:54 PM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that the admission MDS assessment dated 11/19/18 would have been accurately coded to reflect Resident #49 received antipsychotic medication Seroquel during the look back period from 11/13/19 to 11/19/18. The DON stated it was her expectation that a modification to the admission MDS assessment dated 11/19/18 would be submitted to indicate Resident #49 received Seroquel times 7 days during the look back period from 11/13/18 to 11/19/18. On 01/10/19 at 5:07 PM an interview was conducted with the Administrator who stated his expectation was that the admission MDS assessment dated 11/19/18 would have been accurately coded to reflect Resident #49 received antipsychotic medication during the look back period from 11/13/18 to 11/19/18. The administrator stated his expectation was that the MDS Coordinator would submit a modification to the admission MDS assessment dated 11/19/18 to accurately reflect Resident #49 received antipsychotic medication during the look back period from 11/13/18 to 11/19/18.	F 641	monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "These audits will be completed daily x 1 week, then twice weekly x 1 week, then weekly x 2 weeks and then monthly x 3 months. The Case Mix Director will be responsible for conducting these audits. "Results of all audits will be brought by the Case Mix Director to QAPI monthly x 3 months or until substantial compliance is achieved Date of Compliance: February 8, 2019	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		2/8/19

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F 690	Continued From page 21 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure 2 of 4 residents with indwelling urinary catheters had physician orders to address care and services for the indwelling catheters. (Residents #24 and #61)	F 690	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Resident #24 had indwelling urinary	

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F 690	Continued From page 22 The findings included: 1. Resident #24 was readmitted to the facility 11/26/18 after hospitalization for surgical repair of a fracture. Prior to hospitalization, Resident #24 did not have an indwelling catheter but returned to the facility with the indwelling urinary catheter in place. Re-admission physician orders were reviewed and did not address the indwelling Foley catheter. Subsequent physician orders (up through 01/08/19) were reviewed and the only order about the Foley catheter was dated 11/30/18 which read, Leave Foley catheter out overnight. If resident has not voided by morning reinsert Foley catheter. Review of the Treatment Administration Records noted nothing regarding the indwelling Foley catheter or catheter care for Resident #24. Review of the December 2018 and January 2019 Medication Administration Records for Resident #24 noted a handwritten entry for catheter care every shift. Review of nurses notes in the medical record of Resident #24 noted on 11/30/18 at approximately 6:00 PM Resident #24 pulled out her Foley catheter. The nurse indicated in the progress note that the on call practitioner was notified with orders to leave the Foley catheter out overnight and replace in the morning if the resident did not void. On 12/01/18 at 4:30 AM Nurse #1 wrote a progress note which indicated she inserted a #16 Foley catheter in Resident #24 because Resident #24 had not voided since 11/30/18 at 6:00 PM. On 01/09/19 at 2:00 PM Nurse #2 (the nurse that typically worked on the unit Resident #24 resided)	F 690	catheter removed after orders were received from the physician to do so. "Resident #61 no longer resides in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "A body audit was completed on all current residents in the facility on 2/4/19 to ensure that any residents with indwelling urinary catheters were accounted for. "All residents noted to have an indwelling urinary catheter were cross-referenced to their current MAR to ensure that orders for care and services of the indwelling urinary catheter were present. "Any newly admitted resident will be visually assessed by the admitting nurse to ensure that if a resident is admitted to the facility with an indwelling urinary catheter that the orders are transcribed onto the POF and MAR to address care and services. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "All nurses were educated on 1/10/19 by the Director of Health Services, on the expectation of Foley care, orders including size and care q shift, catheter care, and diagnosis related to indwelling urinary catheters. "Nurse education sign in sheet for Indwelling urinary catheter education was	

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F 690	Continued From page 23 stated the nurse that admitted a resident would be initially responsible for addressing admission orders for catheter care. Nurse #2 explained Resident #24 returned to the facility on 11/26/18 and was initially readmitted to another unit of the facility (where she didn't work). Nurse #2 noted any orders for catheter care were addressed on the individual resident's Medication Administration Record (MAR) and showed where catheter care every shift had been handwritten on the January 2019 MAR for Resident #24. On 01/09/19 at 4:00 PM the Director of Nursing (DON) stated she expected orders to be obtained for residents with an indwelling Foley catheter. The DON stated orders would include shift care, if the catheter needed to be flushed, replacement timing and the size for replacement. The DON explained there was not a policy to address catheter care but she expected all nurses would know orders should be in place to address treatment and services of a urinary catheter. On 01/09/19 at 5:52 PM Nurse #3 confirmed she wrote admission orders and the initial admission note for Resident #24 when Resident #24 was readmitted to the facility on 11/26/18. Nurse #3 stated she was not sure if she completed the entire admission process for Resident #24 but indicated orders should address Foley catheter care if a catheter was present on admission. Nurse #3 indicated it must have been an oversight that orders had not been written about catheter care for Resident #24 when readmitted on 11/26/18. On 01/10/19 at 4:30 PM the physician of Resident #24 stated he expected orders for residents admitted with a Foley catheter and noted the	F 690	cross referenced to current employee list to ensure all nurses had received the education. "An audit tool was created to track all residents with indwelling urinary catheters to include having orders present for care and services of said catheter. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "All new admissions will be discussed in morning clinical meeting (Monday- Friday) and any resident admitted to the facility with an indwelling urinary catheter will be added to the audit tool. "Twenty- four hour chart check will be done on any new admission with an indwelling urinary catheter to ensure orders are accurate and transcribed correctly. This will be a new permanent process. "All audit tools will be completed and reviewed for accuracy weekly x 4 weeks and then monthly x 3 months by the Director of Health Services. "Results of all audits will be brought to QAPI x 3 months or until substantial compliance is achieved. Date of Compliance: February 8, 2019	

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F 690	Continued From page 24	F 690		

orders would include catheter care, changing the catheter and the size of the catheter to use. The physician stated if discharge orders (from the receiving facility) did not address a Foley catheter he relied on the admission nurse to alert him of the need for orders.

On 01/11/19 at 4:25 AM Nurse #1 stated she recalled putting the catheter in Resident #24 on 12/1/18. Nurse #1 stated because there were not specific orders for the size catheter to use she and another nurse decided to use a #16 because it was a standard size catheter.

2. Resident #61 was admitted to the facility on 08/01/18 with multiple diagnoses that included peripheral vascular disease (narrowing of the arteries resulting in reduced blood flow), diabetes and dementia.

Review of Resident #61's medical record revealed an admission nurse note dated 08/01/18 that read in part, "Foley catheter in place." Review of the admission orders for Resident #61 revealed no order related to an indwelling catheter or catheter care.

A review of the admission Minimum Data Set (MDS) dated 08/13/18 indicated Resident #61 had moderate impairment in cognition and displayed no rejection of care. Further review of the MDS revealed she had an indwelling catheter.

Review of Resident #61's physician order summaries for the months of August 2018, September 2018 and October of 2018 revealed no order addressing the indwelling catheter or

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F 690	Continued From page 25	F 690		

catheter care. Review of the November 2018 physician order summary revealed an order that read, "Foley catheter #18 french (size of the catheter) with 10 cubic centimeter (cc) bulb (size of the balloon that holds the fluid). Change catheter monthly on the 22nd and as needed." Further review revealed a handwritten order that read, "catheter care every shift."

Review of Resident #61's Medication Administration Records (MAR) for the months of August 2018 and September 2018 revealed no order that addressed catheter care. Review of the October 2018 and November 2018 MAR revealed handwritten entries for catheter care every shift.

A review of a wound observation and assessment form for Resident #61 revealed an entry dated 11/15/18 that read in part, "removed foley catheter on 11/13/18."

During an interview on 01/09/19 at 4:00 PM the Director of Nursing (DON) stated she expected orders to be obtained for residents with an indwelling foley catheter. The DON stated orders would include shift care, if the catheter needed to be flushed, replacement timing and the size for replacement. The DON explained there was not a policy to address catheter care but she expected all nurses would know orders should be in place to address treatment and services for a urinary catheter.

During an interview on 01/10/19 at 2:20 PM

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Nurse #7 (the nurse that typically worked on the unit Resident #61 resided) confirmed Resident #61 was admitted with an indwelling catheter. Nurse #7 reviewed Resident #61's medical record and showed where catheter care had been handwritten on the October and November MAR. Nurse #7 added he wrote an order to remove the indwelling catheter on 11/13/18. Nurse #7 was unable to explain why there was no order addressing catheter care on the August or September MAR. Nurse #7 stated although there was no order catheter care was provided each shift.

During an interview on 01/10/19 at 4:30 PM the Medical Director (MD) stated he expected orders to be obtained for residents admitted with an indwelling catheter and relied on the admitting nurse to alert him of the need for orders. The MD added the orders would include catheter care, changing the catheter and the size of the catheter to use.

During an interview on 01/10/19 at 5:00 PM Nurse #8 confirmed he worked on 08/01/18 and completed the admission paperwork for Resident #61. Nurse #8 stated Resident #61 had an indwelling catheter upon admission and he must have overlooked writing the order for catheter care.

During a follow-up interview on 01/10/19 the DON stated she would expect for the admitting nurse to write the order for catheter care and clarify the order with the Nurse Practitioner and/or MD.

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F 761	Continued From page 27	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff, Nurse Practitioner and Pharmacist interviews the facility failed to store insulin in the refrigerator until opened and dispose/discard expired medications in 2 of 6 medication carts (200 hall and 500 hall medication carts). (Residents #38, #59, #342) Findings included:	F 761	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Resident # 38 had their Levimir flex pen that was identified as unrefrigerated discarded immediately by the nurse on duty.A new levimir flex pen was obtained	2/8/19

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F 761	Continued From page 28 1. Resident #38 was admitted to the facility on 07/26/18 with diagnoses including diabetes mellitus (DM). A physician's order dated 07/26/18 indicated that Resident #38 was to receive Levemir (insulin) at bedtime related to DM. On 01/07/19 at 2:45 PM an unopened and undated Levemir Flexpen for Resident #38 was found in the 500 hall medication cart. The pharmacy sticker stated the pen was to be kept refrigerated until opened. On 01/07/19 at 2:45 PM an interview was conducted with Nurse #4. She stated the Levemir Flexpen should have been kept refrigerated until opened. She did not know why the unopened, undated, and unrefrigerated Flexpen was in the medication cart. Nurse #4 stated the medication cart was checked weekly every Wednesday on night shift for undated medications. On 01/07/19 at 3:15 PM an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was there would be no expired medications on the medication carts and refrigerated medications would be refrigerated per the pharmacy recommendations. She further stated a week prior to this survey she had initiated a new process where the medication carts were to be checked for expired medications by the night nurse every Wednesday night. This expired medications checklist was reviewed during the interview with the DON and she could not explain why the checklist had not been completed.	F 761	from the pharmacy. " Resident # 59 identified as having an expired levemir flex pen was discarded by the nurse on duty. A new levemir flex pen was obtained from the facilty e-kit. The Levemir flex pen found on the 500 hall medication cart that was unopened, unlabeled, and undated was discarded by the nurse on duty. "The expired medications were immediately discarded from the medication cart by the nurse on duty. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "All six medication carts were audited by the Pharmacy consultant on 1/29/19 and no further expired or improperly stored medications were found at that time. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "The Director of Health services educated nursing staff on procedures for insulin storage, removing expired medications from the medication cart and storage in original containers. Any nurse on FMLA, PTO or PRN partner will be educated by the DHS prior to working their next shift.	

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F 761	Continued From page 29 On 01/08/19 at 4:00 PM an interview was conducted with the Family Nurse Practitioner (FNP) and she stated her expectation for insulin was that it would be refrigerated until use. The FNP stated she did not feel there were any likely adverse effects for a resident receiving unrefrigerated insulin. On 01/09/19 at 10:58 AM an interview was conducted with the Pharmacist. He indicated Levemir should be refrigerated until opened and once it was opened it was good out of the refrigerator for 6 weeks. 2. Resident #59 was admitted to the facility on 05/12/17 with diagnoses including diabetes mellitus (DM). A physician's order dated 05/12/17 indicated that Resident #59 was to receive Levemir (insulin) daily related to DM. On 01/07/19 at 2:45 PM an expired Levemir Flexpen for Resident #59 was found in the 500 hall medication cart. There was a white sticker located on the opened Levemir Flexpen which indicated it expired on 12/31/18. On 01/07/19 at 2:45 PM an interview was conducted with Nurse #4. She stated the expired Levemir Flexpen should have been discarded. She stated nurses were instructed to check the expiration date of the medication before administration. She did not know why the expired Flexpen was in the medication cart. Nurse #4 confirmed she had administered the expired Levemir Flexpen to Resident #59 that morning. She stated she had not checked the date on the Levemir before administering it that morning.	F 761	"An audit tool was created for the third shift nurse to monitor each medication cart on Wednesday of each week. This process will be a permanent process change. " Policy and Procedure for labeling and storage of drugs in the med carts will be added to new partner orientation and responsibilities of each nurse will be reviewed during orientation. This orientation will be provided by the Clinical Competency Nurse or the Director of Nursing. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "The DHS will monitor two carts per week x 2 weeks for unopened and unrefrigerated insulin pens and expired medications, then one cart per week x 2 weeks, then monthly x 3 months or until substantial compliance is achieved. "All results of audits will be brought to QAPI x 3 months or until substantial compliance is achieved. Date of Compliance: February 8, 2019	

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On 01/07/19 at 3:15 PM an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was there would be no expired medications on the medication carts. She further stated a week prior to this survey, she had initiated a new process where the medication carts were to be checked for expired medications by the night nurse every Wednesday night. This expired medications checklist was reviewed during the interview with the DON and she could not explain why the checklist had not been completed. The DON stated it was her expectation that the nurses would check the expiration of medications before administering them to the resident.

On 01/08/19 at 4:00 PM an interview was conducted with the Family Nurse Practitioner (FNP) and she stated her expectation for insulin was that it would be discarded when expired. The FNP stated she did not feel there were any likely adverse effects for a resident receiving expired insulin.

On 01/09/19 at 10:58 AM an interview was conducted with the Pharmacist. He indicated Levemir should be discarded 6 weeks after it is opened. He further stated it was unlikely there were any side effects or decreased efficacy of the medication. If there was any decreased efficacy, the capillary blood glucose (CBGs) results would be increased.

A record review of CBGs dated 1/1/19 through 1/7/19 Resident #59 did not reveal any abnormal readings.

3. On 01/07/19 at 2:45 PM an unopened,

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unlabeled, and undated Levemir (insulin) Flexpen was found in the 500 hall medication cart. The pharmacy sticker stated the pen was to be kept refrigerated until opened.

On 01/07/19 at 3:15 PM an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was there would be no unlabeled or undated medications on the medications carts and refrigerated medications would be refrigerated per the pharmacy recommendations. She further stated a week prior to this survey, she had initiated a new process where the medication carts were to be checked for expired medications by the night nurse every Wednesday night. This expired medications checklist was reviewed during the interview with the DON and she could not explain why the checklist had not been completed. The DON stated it was her expectation all medications would be labeled with a resident's name. She further stated she did not know why there was an unlabeled Flexpen in the medication cart drawer.

On 01/08/19 at 4:00 PM an interview was conducted with the Family Nurse Practitioner (FNP) and she stated her expectation for insulin was that it would be refrigerated until use.

On 01/09/19 at 10:58 AM an interview was conducted with the Pharmacist. He indicated Levemir should be refrigerated until opened and once it was opened it was good out of the refrigerator for 6 weeks. He further stated it was unlikely there were any side effects or decreased efficacy of the medications.

4. Resident #342 was admitted to the facility on 01/05/19 with diagnoses including Parkinson's

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disease.

A physician's order dated 01/05/19 indicated that Resident #342 was to receive Rytary 61.25 mg (milligrams)/245 mg 2 capsules daily at 3:30 AM related to Parkinson's disease.

On 01/07/19 at 11:20 AM an expired bottle of Rytary for Resident #342 was found in the 200 hall medication cart. The expiration date printed on the opened bottle of Rytary indicated it expired on 04/18.

On 01/07/19 at 11:20 AM an interview was conducted with Nurse #5. She agreed the bottle of Rytary was expired and should have been discarded. She stated nurses were instructed to check the expiration date of the medication before administration. She stated the family provided the bottle of medication to the facility since Resident #342 was admitted on the weekend and Rytary was a specialized medication. Nurse #5 further stated the family indicated they were using the bottle for transportation and she did not know the correct expiration date of the medication in the bottle.

On 01/07/19 at 3:15 PM an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was there would be no expired medications on the medication carts. She further revealed she was unaware the family had provided the medication to be given to Resident #342 or that the correct expiration date of the medication was uncertain. She further stated a week prior to this survey, she had initiated a new process where the medication carts were to be checked for expired medications by the night nurse every Wednesday night. This

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F 761	Continued From page 33 expired medications checklist was reviewed during the interview with the DON and she could not explain why the checklist had not been completed. On 01/08/19 at 4:00 PM an interview was conducted with the Family Nurse Practitioner (FNP). Her expectation for expired medications was they would be disposed of after the expiration date and that residents would not receive expired medications. She further stated she did not feel there were any likely adverse effects for a resident receiving the potentially expired Rytary. On 01/08/19 at 9:37 PM an interview was conducted with Nurse #6. She stated she had given Resident #342 his Rytary from the bottle provided by the family on 01/07/19 at 3:30 AM. She further stated she had not looked at the expiration date on the bottle before administering the medication. On 01/09/19 at 10:58 AM an interview was conducted with the Pharmacist. He indicated it is was unlikely there were any side effects or decreased efficacy of the expired Rytary.	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	F 812		2/8/19

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F 812	Continued From page 34 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 clean the ice scoop holder, failed to correctly indicate expiration date of milkshakes and failed to sanitize hands between handling soiled and clean dishware. The findings included: During the initial tour of the facility kitchen on 01/06/19 from 2:20 PM-2:35 PM observations were made of the kitchen with the following concerns identified: a. Two dietary aides were observed operating the dish machine. One dietary aide was taking trays out of the returned lunch food cart, discarding trash and placing dishware on the soiled side of the dish machine. The second dietary aide was observed placing soiled dishware on the racks and into the dish machine and then pulling racks out of the clean area of the dish machine and placing dishes in storage. Between handling dirty and clean dishware the second dietary aide was observed to submerge both hands in a bucket of clear liquid. The aide was asked about the liquid and stated it contained sanitizing solution and reported when she saw me come into the kitchen	F 812	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "All current Residents that recieve mikshakes on their trays has the potential to be affected by this deficient practice.The correct date was applied to the milkshake that was deemed incorrect on 1/6/19. "All current Residents have the potential to be affected by this deficient practice. The Ice scoop holder was immediately cleaned and disinfected on 1/6/19. "All current residents that recieved items on facility dishware from the kitchen have the potential to be affected by this deficient practice. Dietary Staff educated on how to wash their hands appropriately between clean and dirty dishware by the Dietary Manager on 1/11/19.The two trays identified and food processor were run through the dish machine to ensure	

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F 812	Continued From page 35 she refilled the bucket with fresh sanitizing solution. At the time of the interview the solution in the bucket was tested with two separate containers of test strips and neither of the test strips tested positive for sanitizing solution. The aide refilled the bucket with solution from the three compartment sink and, at that time, it tested positive for sanitizing solution. The aide could not explain why there was not sanitizing solution in the bucket she had been earlier using when going between dirty and clean dishware. The Food Service Director stated he expected staff to dip their hands in sanitizing solution if they were at the dish machine and going between dirty and clean dishware. The Food Service Director indicated there had been issues with the pump for the sanitizing solution and didn't know if that factored into the solution not being present in the water when initially tested. b. A clear plastic ice scoop holder was observed stored at an angle on the side of the ice machine. The scoop was stored inside the ice scoop holder and the scoop base made contact with the interior bottom of the holder. Holes were observed in the bottom of the ice scoop holder and a watery brown matter was pooled in the left hand interior portion of the holder (because it was stored at an angle.) The Food Service Director was present at the time of the observation and stated the ice scoop holder was supposed to be removed from the ice machine once a week and cleaned. The interior portion of the ice scoop holder was felt and a slimy substance was easily removed. The Food Service Director stated he could not explain what happened or why the ice scoop holder was stored in such a manner. c. Four thawed strawberry milk shakes were	F 812	proper sanitation on 1/11/19 prior to being used for any other food service or delivery. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? " Any Resident that recieves items from the kitchen has the potential to be affected by this defficient practice." "The Dietary Manager audited all milkshakes in kitchen to ensure correct dates were labeled. There were no others identified at that time to be labeled incorrectly. "The Dietary Manager ensured ice scoop holder was clean and free of debris after it had been washed on 1/6/19 "The Dietary Manager monitored appropriate handwashing techniques between clean and dirty dishware after staff was educated. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? " The procedure for using the sanitation bucket was discontinued." " The expectation is for dietary workers to wash their hands appropriately with soap and water between clean and dirty dishware."	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345462	A. BUILDING _____ B. WING _____	C 01/11/2019

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F 812	Continued From page 36 observed on shelving in the reach in refrigerator. Handwritten on the individual milk shakes was a date which the Food Service Director identified as 1/22. The manufacturer instructions stamped on each carton of milk shake indicated the product was good for 14 days after thawed. The Food Service Director stated the milk shakes should have been dated 1/20 and noted the staff member that was in charge of dating thawed milk shakes sometimes had difficulty processing numbers. 2. On 1/11/19 from 11:35 AM-11:50 AM observations were made of staff working in the kitchen. One of the staff members working in the kitchen was identified as new and in their second week of training. This staff member was observed washing two separate trays at the dish machine. The staff member was wearing disposable gloves and ran each tray through the dish machine and then retrieved each tray with the same gloved hands without washing/sanitizing hands. The Food Service Director was observed to speak privately to the staff member before a food processor was placed on a rack and run through the dish machine. After the food processor was run through the dish machine this staff member removed the disposable gloves and donned new disposable gloves. The staff member did not wash or sanitize hands in between the glove change. A bucket of clear liquid was positioned at the dish machine. The Food Service Director identified the bucket as the solution staff were expected to use between handling dirty and clean dishware. The contents of the bucket were tested and there was no sanitizing solution present as noted on the test strip. The Food Service Director stated there had been problems with the sanitizng dispenser	F 812	"A new schedule was implemented and posted for ice scoop disinfection "A new, removable ice scoop holder has been ordered so that it can be removed from the wall and run through the dishwasher daily. "Dietary workers were educated on the policy for placing correct expiration dates on milkshakes on 2/6/2019 by the Dietary Manager and/or Dietary Consultant. "Dietary workers were educated on the policy and procedure related to hand sanitation between clean and dirty dishware by the Dietary Manager and/or Dietary Consultant on 2/6/19. "An audit tool was created to monitor cleanliness of ice scoop holder. "An audit tool was created to monitor expiration dates on milkshakes. "A random audit tool was created to assess handwashing techniques of dietary workers. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "Monitoring of the ice scoop holder cleanliness will be conducted twice daily x 1 week, once daily x 2 weeks and three times per week x 1 week, then monthly x 3 months by the Dietary Manager. "Monitoring of expiration dates on milkshakes will be conducted twice daily x 1 week, once daily x 2 weeks and three times per week x 1 week, then monthly x	

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F 812	Continued From page 37 and he planned to call the company that maintained sanitizing solutions to address the concern. On 1/11/19 at 2:00 PM the Registered Dietitian (RD) that provided oversight of the kitchen stated she performed a monthly review of the kitchen. The RD stated she expected staff to ensure sanitizing solution was present in the solution used to sanitize hands between handling dirty and clean dishware when working at the dish machine. In addition, the RD stated she expected the ice scoop holder to be cleaned as scheduled and the milk shakes to be dated 14 days from the date they were thawed.	F 812	3 months by the Dietary Manager. " Audits of dietary workers will be completed by Dietary Manager related to hand sanitation between clean and dirty dishes. These audits will be done daily x 1 week, twice weekly x 1 week, weekly x 2 weeks, then monthly x 3 months. "The audit results will be brought to QAPI monthly x 3 months or until substantial compliance is achieved. Date of Compliance: February 8, 2019	