STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 07/11/2019

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted 7/8/19 through 7/11/19. The facility was found in compliance with the requirement CFR 488.73, Emergency Preparedness. Event ID V37O11.	E 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		8/7/19

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

Electronically Signed | 07/31/2019

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interviews the facility failed to (1) maintain walls in residents rooms to prevent areas of exposed plaster for 1 of 16 rooms (room 100), (2) repair/replace residents doors that were chipped and splintered for 2 of 16 rooms (room 304 and 306), (3) repair/replace border wall paper that was coming loose from the wall for 1 of 16 rooms (room 304), (4) maintain clean heat/air vent wall units that had dust and food particles for 4 of 16 rooms (rooms 302, 304, 313 and 315), (5) repair/replace lighting in residents bathrooms where the lighting was dim for 2 of 16 rooms (rooms 302 and 306), (6) maintain residents windows where there were cobwebs and bugs for 2 of 16 rooms (rooms 313 and 315). Findings included: 1a Room 100 was observed on 7-8-19 at 3:20pm and was noted to have peeling paint. Another observation of room 100 occurred on 7-11-19 at 1:22pm. The resident in the room stated, "the bathroom wall is a mess." The wall in the bathroom was noted to have chips and scrapes in the paint exposing the plaster	F 584	F 584 Root Cause: The housekeeping department failed to clean and remove cob webs from the resident window sills and dirt from the AC units. Maintenance failed to repair chipped paint, splintered doors and wall paper border repair. Immediate Action: Work began correcting concerns including repairs to damaged sheet rock in Room 100 bathroom on 7-19-19 repairs to chipped or splintered doors for rooms 304 and 306 and Wall paper border repair for room 304 on 7-15-19. Lighting was addressed for rooms 302 and 306 bathrooms on 7-15-19. Tops of AC units were cleaned for rooms 302,304,313 and 315 completed on 7-15-19. Window sills and screens for rooms 313 and 315 were cleaned removing cob webs and bugs on	

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F 584	Continued From page 2 underneath. The Maintenance manager was interviewed on 7-11-19 at 1:22pm. The manager stated he was unaware of the issue but would have it fixed. He also stated maintenance completed "room rounds" twice a year but in between the rounds the staff could report any areas to maintenance by using the maintenance log book that was located at each nursing station. The manager stated the log books were checked several times a day. 2a Room 304 was observed on 7-8-19 at 2:16pm. The resident's door was noted to be chipped. Room 304 was observed again on 7-11-19 at 1:25pm with the maintenance manager and the housekeeping manager. The resident's door was noted to be chipped with pieces of wood missing from the bottom of the door. 2b Room 306 was observed on 7-8-19 at 1:59pm and was noted the door was splintered and wood was missing from the bottom of the door. Another observation of room 306 occurred on 7-11-19 at 1:27pm. The bottom of the resident's door was noted to be splintered with pieces of missing wood. The Maintenance manager was interviewed on 7-11-19 at 1:27pm. The manager stated "these doors take a beating" but that he would have the issue corrected using wood filler and stain. 3a Room 304 was observed on 7-8-19 at 2:16pm. The border wallpaper was noted to be peeling off.	F 584	7-15-19. Identification of others affected: The Plant Manager has completed rounds through the facility to identify any areas of concern related to the findings regarding this deficiency. Rooms have been evaluated for any drywall repairs needed, room doors have been inspected and repairs made to correct chipped or splintered areas of damage, Rooms have been inspected to identify needs for repair or replacement of wall paper border and AC unit covers have been inspected and cleaned as needed. An inspection of light fixtures was done to identify burned out bulbs or any improper working fixtures. All exterior windows have been inspected and cleaned to remove bugs and cobwebs between windows and screens. All inspections were completed on 7/30/19 and results reported to the Administrator. A schedule has been created reflecting 100% coverage of the patient rooms and care areas representing completion of work by 8/7/2019 for all areas of concern identified through this concern to include hall drywall/border repairs, chipped Door repairs, AC unit covers cleaned /adjusted for fit, light bulb replacement/repairs and bug/ cob webs to be removed from windows and screens. Systemic changes: A base line room inspection of all resident	

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F 584	Continued From page 3 Room 304 was observed again on 7-11-19 at 1:25pm with the maintenance manager and the housekeeping manager. The border wallpaper in the resident's room was noted to be peeling away from the wall. The Maintenance manager was interviewed on 7-11-19 at 1:27pm. The manager stated he was unaware of the issue but would have it corrected. 4a Room 302 was observed on 7-8-19 at 2:14pm. The heat/air wall unit was noted to have dust in the vent. Room 302 was observed again on 7-11-19 at 1:30pm with the maintenance manager and housekeeping manager. The heating /air wall unit was noted to have dust in the vents. 4b Room 304 was observed on 7-8-19 at 2:16pm. The resident's heat/air vent was noted to be dirty. Room 304 was observed again on 7-11-19 at 1:25pm with the maintenance manager and the housekeeping manager. The heat/air wall unit was noted to have dust and food particles in the vent. 4c Room 313 was observed on 7-8-19 at 1:42pm and was noted to have dust and debris in the heat/air wall unit vents. Room 313 was observed again on 7-11-19 at 1:32pm. The heat/air wall unit was noted to have dust and debris in the vents. 4d Room 315 was observed on 7-8-19 at 1:17pm. The heat/air wall unit was noted to have dust and debris in the vents	F 584	rooms was completed on 7/30/19 by the Maintenance Director. 100 % of all resident rooms will be inspected monthly for three months to evaluate any recurrence of concerns identified. The monthly room inspections will include inspecting for; dry wall damage, chipped doors, wall paper border concerns, properly cleaned and fitting AC unit covers, Proper and functioning lighting and windows and screen to remain clean and free of bugs and cobwebs. The Ambassadors (staff member assigned to monitor certain for the above and any other concerns resident/families may have) will make room rounds no less than once a week and document on the Ambassador Room Round Sheet any repairs needed and a maintenance request will be completed. Education was provided to the Maintenance Director and maintenance staff as well as the Housekeeping and Laundry supervisor and staff on 7/31/19 addressing the plan of correction for this alleged deficiency and the expectations for correcting and reporting any concerns identified to help assure compliance is maintained by Administrator. This information will also be added to the orientation process for the housekeeping/maintenance staff. Monitoring: The Administrator will round weekly for four weeks then monthly for three months	

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F 584	Continued From page 4 Another observation of room 315 occurred on 7-11-19 at 1:34pm and the heat/air wall unit was noted to have dust and debris in the vents. During an interview with the maintenance manager and the housekeeping manager on 7-11-19 at 1:34pm, the housekeeping manager stated, housekeeping works with maintenance to keep the vents clean and the maintenance manager stated he would work with housekeeping to correct the issue. 5a Room 302 was observed on 7-8-19 at 2:14pm. The resident's bathroom was noted to have dim lighting. Room 302 was observed again on 7-11-19 at 1:30pm with the maintenance manager and housekeeping manager where the bathroom was noted to have dim lighting. 5b Room 306 was observed on 7-8-19 at 1:59pm and was noted to have dim lighting in the resident's bathroom. Another observation of room 306 occurred on 7-11-19 at 1:27pm. The bathroom was noted to have dim lighting. The Maintenance manager was interviewed on 7-11-19 at 1:27pm. The maintenance manager stated there were bulbs burned out in the ceiling lighting fixture. The maintenance manager stated he was not made aware of the issue but would have it corrected. 6a Room 313 was observed on 7-8-19 at 1:42pm and was noted to have cobwebs in the window.	F 584	with the Maintenance Director and Director of Housekeeping and Laundry Services and review rooms in the facility. These rounds will include the inspection of dry wall damage, chipped doors, wall paper border concerns, properly cleaned and fitting AC unit covers, Proper and functioning lighting and windows and screen to remain clean and free of bugs and cobwebs. The Regional Director of Operations will participate in the monthly rounds for three months. Findings from these rounds will be kept in a binder in the Administrators office. Findings will be reported to the QAPI Committee monthly for recommendations or modifications by the Maintenance Director for three months. If any negative findings are identified the Administrator will advise the Regional Vice President of Operations of additional plans to correct problems and will report findings to the QA committee for further recommendations or modifications. REPONSIBLE PARTY: Effective 8/7/19 the Administrator and Maintenance Director will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 584	Continued From page 5 Room 313 was observed again on 7-11-19 at 1:32pm. The residents window was noted to have cobwebs present. 6b Room 315 was observed on 7-8-19 at 1:17pm. The residents window was noted to have cobwebs and bugs attached to the cobwebs. Another observation of room 315 occurred on 7-11-19 at 1:34pm and was noted to have cobwebs and bugs attached to the cobwebs in the window. During an interview with the maintenance manager and the housekeeping manager on 7-11-19 at 1:34pm, the housekeeping manager stated, housekeeping works with maintenance to keep the windows clean and free of cobwebs. The maintenance manager stated he would work with housekeeping to correct the issue. The Director of Nursing (DON) was interviewed on 7-11-19 at 1:40pm. The DON stated she expected staff to report/record maintenance issues in the log book and the issues to be resolved as they occur.	F 584		
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 staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of	F 641	F 641	8/7/19

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F 641	Continued From page 6 behaviors and active diagnoses for 1 of 5 residents reviewed for unnecessary medications. (Resident #116). The findings included: 1.Resident #116 was admitted to the facility on 6/7/19 with cumulative diagnoses that included dementia without behavioral disturbances. Review of the June 2019 physician orders included: Quetiapine 25 milligrams (mg) at night. Quetiapine is in a class of medications called atypical antipsychotics. Sertraline 200 mg daily. Sertraline is an antidepressant drug. Record review of the Quarterly Minimum Data Set (MDS) dated 6/24/19 revealed under the Section for mood and behavior 0 (zero) was coded. Under Section for active diagnoses, depression was not checked. Review of the Medication Administration Record (MAR) for June 18, 2019 through June 24, 2019 revealed Resident #116 was administered Quetiapine 25 mg at hs and Sertraline 200 mg daily Resident #116 experienced behaviors (such as crying, use of profanity) during this look back period. Review of the behavior log sheet revealed Resident #116 experienced the same behaviors. Interview on 7/10/19 at 3:25 PM with the MDS coordinator and corporate representative was held. The MDS coordinator indicated that she	F 641	Root Cause: The MDS nurse failed to review the Behavior Log Sheet when completing the MDS Assessment for resident #116 Immediate Action: The MDS (Minimum Data Set) Assessment for #116 was reviewed and corrected on 7/10/19 by the corporate MDS Nurse Consultant to ensure the section for mood and behavior and for active diagnoses was accurate in correlation to the behaviors and conditions noted for this resident. Identification of others affected: The Corporate MDS Nurse consultant audited 100% of current residents to ensure the sections for mood and behavior and for active diagnosis was accurate for all current residents completed on 7/12/19. The were no other issues identified in the audit. Systemic changes: Education of Accuracy of the Assessments Section E (Mood and Behaviors) and Section I (active Diagnosis) and reviewing the Behavior Logs was provided to the MDS Nurses by the Corporate MDS Nurse Consultant on 7/11/19.	

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F 641	Continued From page 7 reviewed the progress notes and the MAR to determine whether the resident had experienced behaviors and was not aware of the behavior log sheet. Interview on 07/11/19 at 12:41PM with the Administrator and the Corporate Representative was held. The Administrator indicated the facility identified 2 (two)MDS coordinators were needed in the facility and 1 (one) MDS had been recently hired so that the MDS assessments could be accurate. The Administrator indicated the MDS assessment should be accurate.	F 641	Monitoring: The Corporate MDS Nurse Consultant will audit 10 completed MDS assessments weekly for four weeks then a sample of 10 or more MDS assessments will be monitored monthly for three months to ensure the coding of MDS Sections is coded correctly. These audits will be kept in a binder in the Executive Directors office. Findings will be reported monthly for four months by the MDS Nurse to the QAPI Committee for recommendations or modifications to the audit process to ensure compliance is achieved. REPONSIBLE PARTY: Effective 8/7/19 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
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 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	F 690		8/7/19

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F 690	Continued From page 8 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 record review, observations and staff interviews the facility failed to keep a urinary catheter bag from touching or dragging on the floor to reduce the risk of infection or injury for 1 of 3 residents (Resident # 18) reviewed for indwelling urinary catheters. Findings included: Resident #18 was initially admitted to the facility on 9-2-15 and then readmitted on 3-4-19 with multiple diagnosis that included urinary retention.	F 690	F 690 Root Cause: The nursing staff failed to properly secure the Foley bag in such a way that the tubing was of the floor. Immediate Action: The catheter bag for Resident # 18 was	

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F 690	Continued From page 9 The quarterly Minimum Data Set (MDS) dated 4-11-19 coded Resident #18 as moderately cognitively impaired and needed extensive assistance with one person for toileting. Resident #18 was also coded for an indwelling urinary catheter. Resident #18's care plan dated 4-18-19 revealed a goal that she would have no signs and symptoms of a recurrent infection related to her indwelling urinary catheter. The interventions for that goal included; to position the urinary drainage bag below the level of the bladder and keep tubing from being kinked. During an initial observation of Resident #18 on 7-8-19 at 1:45pm, the resident's catheter bag was noted to be laying on the floor while the resident was sitting in her recliner. On 7-9-19 at 9:45am Resident #18's catheter bag was noted to be laying on the floor while the resident was sitting in her recliner. Another observation was made on 7-9-19 at 2:40pm of Resident #18. During the observation, it was noted that her catheter bag was laying on the floor while the resident was sitting in her recliner. An interview with nursing assistant (NA) #1 occurred on 7-9-19 at 2:45pm. NA #1 stated the catheter bag was to be off the floor and should be hung under the wheelchair. She also stated if the resident was in a regular chair, then the resident should have a leg bag attached to the catheter so there would not be a catheter bag laying on the floor.	F 690	placed inside a the pocket of the recliner by the floor nurse. Staff responsible for this resident's care were notified of this process. Identification of others: All residents with indwelling catheters were evaluated by 7/22/19 for appropriate placement of catheter bags by Director of Nursing. No other residents were found to be affected by the deficient concern. Systemic Changes: Foley observation monitoring will be reviewed in the daily clinical meeting by the Director of Nursing, Assistant Director of Nursing or Unit Manager to ensure and document that all catheters are being covered by a privacy bag and secured so the tubing in not on the floor. The weekend Supervisor will also add this observation monitoring to their weekend rounding sheet. The observation monitoring audit of Foley bags will be completed by the Director of Nurses, Assistant Director of Nurses or Unit Managers daily Monday through Friday and by the weekend Supervisor. In-service education presented by the Director and Assistant Director of Nursing was completed on 7/26/19 for nursing staff over the proper securement of Foley Bags. This education will be added to the orientation program for all new hires to ensure secure placement of indwelling	

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F 690	Continued From page 10 NA #2 was observed and interviewed on 7-9-19 at 2:50pm. NA #2 was observed emptying Resident #18's catheter bag and then hanging it on the pocket of the resident's recliner still allowing the catheter bag to touch the floor. The NA stated, "the catheter bag is not supposed to touch the floor, but I don't know where else to put it". She also denied reporting the issue of the catheter touching the floor. During an interview with Nurse #1 on 7-9-19 at 3:20pm, the nurse stated Resident #18's catheter bag was hung from the pocket of the resident's recliner but that it still touches the floor "so it should go in the pocket of the resident's recliner, so it is off the floor". The nurse denied discussing the issue with the nursing assistants or reporting the problem to the Director of Nursing. The Director of Nursing (DON) was interviewed on 7-9-19 at 4:10pm. The DON stated she had expected a resident's catheter bag be kept off the floor. She also stated she had talked with NA #2 and Nurse #1 on 7-9-19 to place Resident #18's catheter bag inside the pocket of her recliner when the resident was out of bed.	F 690	urinary catheters into privacy bags. Monitoring: The Director of Nursing, Assistant Director of Nursing / Unit Manager will audit daily Monday through Friday for four weeks then three times a week for four weeks then weekly for four weeks to ensure all catchers are placed in privacy bags and tubing off of the floor at all times. The weekend Supervisor will audit Saturday and Sunday for eight weeks and document on the weekend rounding sheet. Findings will be reported monthly for three months to the QAPI committee by the Director of Nursing for recommendations or modification until a pattern of compliance is achieved. If any negative findings are identified the Corporate Nursing Consultant will coordinate with the Director of Nurses to implement further corrective measures. REPONSIBLE PARTY Effective 8/7/19 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
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	F 695		8/7/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 11 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 observation, record review and staff interview the facility failed to provide the correct liters of oxygen as ordered by the physician for 1 of 3 residents (Resident #31) reviewed for oxygen therapy. Findings included: Resident #31 was initially admitted to the facility on 1-23-18 and readmitted on 3-28-19 with multiple diagnosis that included chronic obstructive pulmonary disease. A review of the physician orders dated 3-28-19 revealed Resident #31's oxygen was to be set at 2 liters per minute by nasal canula. The 14-day Minimum Data Set (MDS) dated 4-14-19 revealed Resident #31 was moderately cognitively impaired and was coded for oxygen use. Resident #31's care plan dated 7-8-19 revealed a goal that the resident will exhibit signs of adequate air exchange, clear lung sounds and no shortness of breath. The interventions for that goal included; monitor for signs and symptoms of respiratory distress, check oxygen saturation levels as ordered and oxygen as ordered. During the initial interview with Resident #31 on	F 695	F 695 Immediate Action: The Director of Nursing validated the O2 order for resident #2 to ensure the concentrator was set correctly at 2.0 liters Staff responsible for this resident's care were notified of this process. Identification of others: The nurse for resident #2 incorrectly set the o2 at 3 liters which was outside the Physicians orders therefore the Director of Nursing / Unit Managers audited residents with orders for oxygen for appropriate setting of O2 liters by 7/22 per Physicians orders. No other residents were found to be affected by the deficient concern. Systemic Changes: An audit of O2 concentrator settings is being completed by the Director of Nursing, Assistant Director of Nursing or Administrative nurses daily for four weeks then three times per week for a month. By 7/26/19 in-service education was	

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F 695	Continued From page 12 7-8-19 at 3:30pm, the resident was noted to be receiving oxygen from an oxygen concentrator and wearing a nasal canula. The resident's oxygen setting was noted to be at 2.5 liters per minute. The resident stated she was unaware of how much oxygen she was to receive. Resident #31 was interviewed on 7-10-19 at 4:45pm. The resident stated she had just returned from dialysis and she was tired. Resident #31 was noted to be receiving oxygen from an oxygen concentrator and wearing a nasal canula. The oxygen was noted to be set at 2.5 liters per minute. An observation of Resident #31's oxygen occurred on 7-11-19 at 8:45am. Resident #31 was noted to be receiving oxygen from an oxygen concentrator and wearing a nasal canula. The oxygen level was noted to be set at 2.5 liters per minute. During an interview with Nurse #2 on 7-11-19 at 8:55am, The nurse observed Resident #31 receiving oxygen from an oxygen concentrator and wearing a nasal canula. She stated the oxygen setting was set at 2.5 liters per minute. The nurse stated the oxygen level should be set at 2.0 liters per minute per the physician orders. Nurse #2 stated she did not know how the setting was at 2.5 liters and that the nurse was the only one who could set a resident's oxygen level. She also stated the resident could not have changed it herself The Director of Nursing (DON) was interviewed on 7-11-19 at 1:40pm. The DON stated the resident could not have changed the oxygen settings on her own and that she expected staff to	F 695	completed by the Director of Nursing and Assistant Director of Nursing for nursing staff over the following oxygen setting per Physician Orders. This education will be added to the orientation program for all new nursing staff hires over the following Oxygen setting per Physician Orders. Monitoring: The Director of Nursing, Assistant Director of Nursing and or Unit Manager will audit daily for four weeks then three times per week for four weeks the weekly for four weeks to ensure all residents receiving oxygen are receiving per MD order. Findings will be reported monthly for four months to the QAPI committee by the Director of Nursing for recommendations or modification until a pattern of compliance is achieved. If any negative findings are identified the Corporate Nursing Consultant will coordinate with the Director of Nurses to implement further corrective measures. Nursing management will continue to audit weekly as needed until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 8/7/19 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 695	Continued From page 13 follow physicians orders and check residents oxygen settings each shift.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to date medications when opened in 2 of 3 medication carts and medication room. (100 Unit and 200 Unit) The facility failed to store ophthalmic medication vial as specified by the manufacturer in 1 of 3	F 761	F 761 Root Cause: The facility failed to date open	8/7/19

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F 761	Continued From page 14 medication carts (300 Unit medication cart). The findings included: 1a) Accompanied by Nurse #10, an observation was made on 7/11/19 at 10:10 AM of the 100 Unit medication cart and medication cabinet. The observation of the medication cabinet revealed 3 opened 250 count of Vitamin E 400 that was not dated. In the 100 Unit med cart there was an open bottle of Vitamin B-12 that was not dated. Interview on 7/11/19 during the observations with the Medication Technician #2 (Med Tech) revealed all medications should be dated when opened. 1b) Accompanied by Nurse #11, an observation was made on 7/11/19 at 10:35 AM of the 200 Unit medication room. The observation revealed a bottle of Gabapentin oral solution stored in the refrigerator opened and undated. Two (2) of the Unit 200 medication carts were observed and the following were noted: Cart 1: 2 bottles of Pradaxa 75 milligrams bottle seal was broken, opened and undated. Stock bottles of Milk of Magnesium and Lactulose were opened and undated. Dorzolamide 2% ophthalmic vial was opened and undated. Cart2: 1 bottle of clear Laxative 8.3% was opened and undated. Interview on 7/11/19 at 10:47 AM with Nurse #11 stated medications once opened should be dated by either a nurse or Med Tech.	F 761	medications and to store ophthalmic vials properly per manufactures recommendations. Immediate Action: The Director of Nursing removed the undated Vitamin E 400 and Vitamin B-12 from the 100-unit med cart med cabinet on 7-11-19. The bottle of Gabapentin oral solution was removed from the 200-unit med room refrigerator on 7-11-19 . The Pradaxa 75 mg bottle, undated bottles of Milk of Magnesium, bottle of Lactulose and the Dorzolamide 2% ophthalmic vial located on unit 200 cart 1 were removed on 7-11-19. A bottle of clear laxative 8.3% was removed from 200-unit cart 2 on 7-11-19. On unit 3 medication cart the Prednisolone acetate ophthalmic drops were removed on 7-11-19. Proper storage containment for these drops was obtained for each med cart 7-11-19. All medications that were undated or improperly stored were discarded and re-ordered by DON on 7-11-19. Identification of others: As of 7/17/19 medications carts have been audited by Director of Nursing, Asst. Director of Nurses and Unit Managers to ensure no improperly stored, undated open medications or vitamins are present. Any expired, improperly stored or undated items identified were removed and re-ordered. These audits are maintained	

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F 761	Continued From page 15 Interview on 7/11/19 at 11:20 AM with Med Tech #3 stated medication once opened must be labeled with a date. 2) A review of the manufacturer ' s storage instructions indicated bottles (vials) should be stored in an upright position Accompanied by Nurse #12 an observation was made on 7/11/19 at 11 AM of Unit 3 medication cart revealed a vial of Prednisolone acetate ophthalmic drops was stored laying in the med cart not in an upright position. Interview on 7/11/19 at 11am with Nurse #14 stated she was aware Prednisolone vial should be stored upright and stated the facility used a divided crate to position the eye vial in an upright position. Interview on 7/11/19 at 11:30 AM with the Director of Nurses (DON) stated when medications are opened the person who opens the medication should date. The DON also indicated Nurse Managers should monitor the medication rooms and carts. Interview on 7/11/19 at 12:43 PM with the Administrator and Corporate was held. The Administrator stated he expected the proper storage of medications.	F 761	in a binder in the ED office. Systemic Changes: A weekly audit will be completed by the administrative nurses three times per week for four weeks then weekly for four weeks then monthly for two months to monitor for any other unlabeled open medications, expired or improperly stored medications or feeding products to ensure compliance. The initial Audit will be completed by 8/2/19. The facilities consultant Pharmacist will also conduct monthly audits of no less than one medication room and three medication carts to ensure all open meds are dated and that ophthalmic vials are stored correctly. This will be an ongoing. The pharmacist will report the finding to the Director of Nursing monthly when her/his audit is complete. Licensed nursing staff were in-serviced by 7/17/19 on ensuring Medications are properly stored, opened medications are dated and expired medications are not present on med carts and medication rooms. This in-service will be added to the nursing orientation. Monitoring: A weekly audit will be completed by the administrative nurses three times per week for four weeks then weekly for four weeks then monthly for two months to monitor for any other unlabeled open	

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F 761	Continued From page 16	F 761	medications, expired or improperly stored medications or feeding products to ensure compliance. Audits will occur on alternating shifts to ensure all medications are properly stored, opened medications are clearly labeled with the resident name and date opened and expired medications are not present on med carts. The facilities Consultant Pharmacist will also conduct monthly audits of no less than one medication room and three medication carts to ensure all open meds are dated and that ophthalmic vials are stored correctly. The pharmacist will report the finding to the Director of Nursing monthly when her/his audit is complete. The findings will be reported monthly for four months to the QAPI committee for recommendations or modification until a pattern of compliance is achieved by the Director of Nursing. If any negative findings are identified the Corporate Nursing Consultant will coordinate with the Director of Nurses to implement further corrective measures. Nursing management will continue to audit weekly as needed until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 8/7/19 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 803	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		8/7/19

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F 803 SS=E	Continued From page 17 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of the planned menu and staff interview the facility failed to serve the menu as planned for 16 of 16 residents that received a low fat/low cholesterol diet. Findings included: A review of the breakfast menu dated 7-10-19 revealed the residents with a diet of low fat/low	F 803	F 803 Root Cause: Dietary staff failed to follow the posted therapeutic diet menu plan. Immediate Action:	

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F 803	Continued From page 18 cholesterol were to receive ¼ cup egg substitute, 1 slice of toast, oatmeal, orange juice and skim milk. An observation of the breakfast tray line on 7-10-19 from 7:05am to 8:40am revealed the steam table had regular scrambled eggs, fried eggs and boiled eggs. Cook #1 was noted to remove a basket of fried tator tots from the frying oil and place them on the tray line. It was also noted when a low fat/ low cholesterol diet was called out, the back up cook placed a ¼ cup of regular eggs, 2 pieces of toast and a handful of tator tots on the plate which was then placed on the residents' trays and then placed on the cart for delivery. The dietary manager was interviewed on 7-10-19 at 7:30am. The dietary manager stated the tator tots were for the low fat/ low cholesterol diet residents and that dietary did not use egg substitutes because "we use liquid eggs which is like the egg substitute." During an interview with Cook #1 on 7-10-19 at 1:10pm, the cook stated she fixed regular eggs, toast and oatmeal for the low fat/ low cholesterol diet residents. She also stated the low fat/ low cholesterol residents should not have received the tator tots. The dietary manager and back up cook were interviewed on 7-10-19 at 1:20pm. The back up cook stated she had fed the tator tots to the low fat/ low cholesterol residents and the dietary manager stated, "because they need it." The dietary manager also stated the liquid eggs were appropriate for the low fat/ low cholesterol residents and after reviewing the liquid egg carton	F 803	On 7/24/19 the Dietary Manager educated the dietary staff on following menus as approved by the Registered Dietician. Identification of others affected: All residents have the potential to be affected by this practice therefore the dietary manger and cooks with be educated the Reregistered Dietician by 8/2/2019 on what foods are acceptable for each diet type the facility uses to ensure those foods are available so the menu plan can be followed for each resident. Systemic changes: On 7/24/19 the Dietary Manager educated the dietary staff on following menus as approved by the Registered Dietician. This education will be added to the orientation program for all new dietary staff hires. The Dietary Manager is doing daily monitoring five days a week documented on a Meal Monitoring Checklist. The Registered Dietician will conduct a weekly meal observation to ensure the meal plan is being followed. In the event the menu must be changed a list of Substitutions will be clearly identified by the Dietary Manager and approved by the Registered Dietician. Monitoring:	

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F 803	Continued From page 19 which revealed the liquid eggs contained 57% cholesterol, the dietary manager stated, "well this is what we always use." The Director of Nursing (DON was interviewed on 7-11-19 at 1:40pm. The DON stated she expected residents to be provided food that had been ordered per their diet and/or restrictions.	F 803	The Dietary Manager will monitor tray service for alternating meals on the line five days each week for four weeks and then three days a week for four weeks then weekly for four weeks. The Registered Dietician will be responsible to audit kitchen compliance with this Plan of Correction bi-monthly for 3 months. Findings will be reported monthly for 3 months to the QAPI committee by the dietary manager for recommendations or modification until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 8/7/19 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, test tray, record review, resident interview and staff interview the facility failed to provide food that was palatable for 1 of 2	F 804	F 804	8/7/19

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F 804	Continued From page 20 meal observations. Findings included: Resident #5 was admitted to the facility on 3-28-18 with multiple diagnosis that included diabetes and acute kidney failure. The yearly Minimum Data Set (MDS) dated 4-4-19 revealed Resident #5 was mildly cognitively impaired. Resident #5 was interviewed on 7-8-19 at 12:25pm. The resident stated the breakfast meal was "usually" cold and "sometimes the sausage is not cooked all the way". An observation of the breakfast meal on 7-10-19 at 7:20am was conducted related to a complaint (Resident #5) regarding food palatability. Cook #1 took the temperatures, using a calibrated thermometer, of the food on the steam tables. The temperatures were: oatmeal 197 degrees F, grits 184 degrees F, eggs 212 degrees F, bacon 154 degrees F, sausage 151 degrees F, mechanical meat 179 degrees F, puree meat 152 degrees F, puree eggs 165 degrees F, a second container of eggs 151 degrees F, fried eggs 163 degrees F, hash browns 145 degrees F. A regular diet test tray was prepared and served with 35 resident trays for hall 300. The trays were delivered to hall 300 at approximately 8:40am and the last tray was served on hall 300 at approximately 8:55am. The Dietary Manager used the same calibrated thermometer and the temperatures of the food on the test tray were: eggs 114 degrees F, oatmeal 142 degrees F, sausage 105 degrees F and hash browns 105	F 804	Immediate Action: The facility was notified of the test tray concern after the meal. No immediate action could be taken for this specific observation. The root cause was identified by a review of the temperatures by the administrator of the food leaving the kitchen it was determined that the temperatures met the state requirements however could have been hotter to allow for tray distribution time on hall prior to the residents receiving them. Identification of others: All residents have a potential to be affected by this practice. An interview of five alert and/ oriented residents on the five different halls by the facility Activity Director and Social Workers on 8/5/2019 confirmed that other residents do have concerns with the food being cold at times. Systemic Changes: On 7/24/19 the dietary manager in-serviced dietary staff on proper meal temperatures for tray distribution. The Director of Nursing also inserviced the nursing staff on meal service times and passing trays as soon as they delivered to the hall on 7-22-19. The dietary department will announce meal delivery to alert floor staff. This education will be added to the orientation program for all	

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F 804	Continued From page 21 degrees F. The eggs were noted to taste rubbery and cold, the oatmeal was warm to taste, the sausage was noted to have a good flavor but was cold and the hash browns tasted crunchy and cold. The Dietary Manager stated she expected the food to be warm when it was served to the residents. Resident #5 was interviewed on 7-10-19 at 9:15am. Resident #5 stated her breakfast was cold but was noted to have eaten everything on her plate. The resident stated, "if I didn't eat it I would be starving by lunch time." During an interview with the Director of Nursing (DON) on 7-11-19 at 1:40pm, the DON stated she expected the food to be at the correct temperature and served to the residents warm.	F 804	new dietary staff. The Director of Nursing, Assistant Director of Nursing or Unit Managers will in-service staff on the process of timely tray distribution in order to adequately support the ability for resident to receive warm and palatable food. Monitoring: The Dietary Manager will monitor the meal service distribution process five days per week for four weeks then three times a week for four weeks then weekly for four weeks to ensure meals leave the kitchen on time at the proper temps. Test trays will be used in the monitoring process and results will be documented on the Resident Tray Assessment monitoring tool. The Dietary Manager will observe the tray distribution on the hall and work in coordination with the Director of Nursing, Assistant Director of Nursing or Unit Managers to ensure trays are past efficiently and that food is served to residents warm and palatable. The Dietary Manager will then continue audits at least 3 days a week for four additional weeks. The Registered Dietician will be responsible to audit kitchen compliance with this Plan of Correction at least monthly for 3 months. Findings will be reported monthly for 3 months to the QAPI committee by the dietary manager for recommendations or modification until a pattern of compliance is achieved. REPONSIBLE PARTY: Effective 8/7/19	

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F 804	Continued From page 22	F 804	the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to allow dishware to air dry before being stacked and placed on the tray line for use, ensure dishware was clean prior to being placed on the tray line for use, maintain and clean plate warmer lids and the facility failed to remove dented cans from the can rack. This was evident in 2 of 2 kitchen observations.	F 812	F 812 Root Cause: The dietary manager failed to properly train new kitchen staff on ensuring the dishes were able to air dry before use and	8/7/19

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F 812	Continued From page 23 Findings included: The initial tour of the kitchen area on 7-8-19 at 10:25am with the dietary manager revealed the following: 1.12 plate lids, 12 plastic trays and 7 plates were stacked wet and placed on the tray line ready for use. 2. 12 plastic trays and 3 dishes were noted to be on the tray line with yellow, white and brown substances as well as empty sugar packets and white paper on them. 3. 3 plate warmer lids were noted to have been placed on top of clean plates in the plate warmer with a dried yellow substance and a brown substance on them. 4. The dry storage area had a large rack of canned goods that were ready to be used and was noted to have 1- 6 pound can of green beans and 2 - 50-ounce cans of tomato soup that were dented. The dietary manager was interviewed on 7-8-19 at 10:40am. The manager stated they had a new dietary aide that was in training and "probably" did not know items needed to be dry before they were stacked. She also stated the lids for the plate warmer became dirty during breakfast and had not been cleaned yet. The dietary manager stated dented cans were to be placed on the shelf, so they could be returned and did not know why the soup and green bean cans were not removed from the rack.	F 812	checking the dishes after being run through the dishwasher to ensure dishes were free of food and paper particles. The dietary manager failed to ensure that all dented cans were set aside form the cans that to be used. Immediate Action: Wet or dirty small wares were removed, washed and allowed to properly dry and then were stored in clean condition on 7-8-19. The dented cans in the kitchen identified were also removed and disposed of. Identification of others: All residents have a potential to be affected by this practice. Cans in the kitchen and dry storage were inspected to ensure no other concerns of dented cans were present. All dishes and small ware are being washed dried and stored property. Systemic Changes: On 7/24/19 the Dietary manager educated the dietary staff over the proper washing and storage of small wares to ensure they are stored dry and in a clean sanitary condition. Staff were also educated on identifying and removing any damaged cans or food containers. Education included proper procedures for safe	

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F 812	Continued From page 24 A follow up visit to the kitchen occurred on 7-10-19 at 7:15am and revealed the following with the dietary manager present: 1.7 divided plates and 12 plate covers were stacked wet on the tray line ready for use. 2. 4 dirty plates were in the plate warmer on the tray line ready for use. 3. 3 plate warmer lids were noted on top of the clean plates in the plate warmer with yellow and brown substances on them. The dietary manager was interviewed on 7-10-19 at 7:17am. The manager stated she had in-serviced all the dietary staff yesterday (7-9-19) about "making sure items were dry before stacking them." She also stated she was unaware there were dirty plates in the plate warmer or that the plate warmer lids had not been cleaned. During an interview with the Director of Nursing (DON) on 7-11-19 at 1:40pm, the DON stated she expected dietary staff to make sure the dishes and equipment in the kitchen were clean and dry prior to serving food.	F 812	storage of food items in storage areas. This education will be added to the orientation program for all new dietary staff. The Maintenance Director and the Dietary Manager will ensure rack space to ensure the staff have the needed space to air dry dishes by 8/2/2019. Monitoring: The Dietary Manager will audit to ensure that all dished and silverware are cleaned and have been air dried using the Kitchen Sanitation Audit tool five times per week for four weeks then three time a week for four weeks then weekly for four weeks. The Dietary Manager will use the same monitor tool to ensure that staff has separated the dented cans from the cans to be used five times per week for four weeks then three times a week for four weeks then weekly for four weeks. The Registered Dietician will also complete a sanitation round to ensure the kitchen for compliance with this Plan of Correction at least bi-monthly for 3 months. Findings will be reported monthly for 3 months to the QAPI committee by the dietary manager for recommendations or modification until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 8/7/19 the Administrator and Dietary Manager will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial	

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F 812	Continued From page 25	F 812	compliance.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility ' s Quality Assessment and Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification and complaint survey of 6/15/18. This was for 3 recited deficiencies in the area of accuracy of assessments (F-641), label and store drugs and biologicals (F-761) and food procurement and storage (F-812). These deficiencies were re-cited during the annual recertification and complaint survey of 7/11/19. The continued failure of the facility during 2 federal surveys of record showed a pattern of the facility ' s inability to sustain and effective QAPI program. Findings included: This tag is cross referred to: 1. F-641 Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of	F 867	F867 Root Causes: The MDS nurse failed to review the Behavior Log Sheet when completing the MDS Assessment for resident #116 The facility failed to date open medications and to store ophthalmic vials properly per manufactures recommendations The dietary manager failed to properly train new kitchen staff on ensuring the dishes were able to air dry before use and checking the dishes after being run through the dishwasher to ensure dishes were free of food and paper particles. The dietary manager failed to ensure that all dented cans were set aside form the cans that to be used. Immediate Actions:	8/7/19

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F 867	Continued From page 26 behaviors and active diagnoses for 1 of 5 residents reviewed for unnecessary medications (Resident #116). During the recertification and complaint survey of 6/15/18 the facility was cited for failure to accurately code the MDS assessment for 1 of 2 residents reviewed for behaviors (Resident #120), 1 of 7 residents reviewed for unnecessary medications (Resident #117) and 1 of 5 residents reviewed for pain management (Resident #105). 2. F-761 Based on observations, record review and staff interviews, the facility failed to date medications when opened in 2 of 3 medication carts and medication room. (100 Unit and 200 Unit) The facility failed to store ophthalmic medication vial as specified by the manufacturer in 1 of 3 medication carts (300 Unit medication cart). During the recertification and complaint survey of 6/15/18 the facility was cited for failure to store medications at the refrigeration temperature specified by the manufacturer in 1 of 2 medication rooms (100/200 hall med room) and failed to label an insulin pen stored on 1 of 3 medication carts (200 hall med cart) with the name of the specific resident for whom it was prescribed and the date it was opened. 3. F-812 Based on observations and staff interviews the facility failed to allow dishware to air dry before being stacked and placed on the tray line for use, ensure dishware was clean prior to being placed on the tray line for use, maintain and clean plate warmer lids and the facility failed to remove dented cans from the can rack. This was evident	F 867	The MDS (Minimum Data Set) Assessment for #116 was reviewed and corrected on 7/10/19 by the corporate MDS Nurse Consultant to ensure the section for mood and behavior and for active diagnoses was accurate in correlation to the behaviors and conditions noted for this resident The Director of Nursing removed the undated Vitamin E 400 and Vitamin B-12 from the 100-unit med cart med cabinet on 7-11-19. The bottle of Gabapentin oral solution was removed from the 200-unit med room refrigerator on 7-11-19 . The Pradaxa 75 mg bottle, undated bottles of Milk of Magnesium, bottle of Lactulose and the Dorzolamide 2% ophthalmic vial located on unit 200 cart 1 were removed on 7-11-19. A bottle of clear laxative 8.3% was removed from 200-unit cart 2 on 7-11-19. On unit 3 medication cart the Prednisolone acetate ophthalmic drops were removed on 7-11-19. Proper storage containment for these drops was obtained for each med cart 7-11-19. All medications that were undated or improperly stored were discarded and re-ordered by DON on 7-11-19. Wet or dirty small wares were removed, washed and allowed to properly dry and then were stored in clean condition on 7-8-19. The dented cans in the kitchen identified were also removed and disposed of. Identification of others:	

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F 867	Continued From page 27 in 2 of 2 kitchen observations. During the recertification and complaint survey of 6/15/18 the facility was cited for failure to discard expired food and beverages stored in 1 of 1 kitchen reach-in refrigerators and in the kitchen ' s dry storage room. An interview on 7/11/19 at 2:43 pm with the Administrator revealed the facilities quality assurance team consisted of himself, the Director of Nursing, Medical Director, Pharmacy Consultant and other department heads. He stated they try and meet monthly but do meet quarterly at a minimum. He stated they utilized a schedule of data that was evaluated and if concerns were identified they developed a QA plan. He added the team also worked on enhancement goals. The Administrator stated it was his expectation the QA system translated into the outcomes that were required for compliance. He added the facility had added an additional unit manager, staff development coordinator, an additional MDS nurse and increased wages for nursing assistants to help meet desired outcomes.	F 867	The Corporate MDS Nurse consultant audited 100% of current residents to ensure the sections for mood and behavior and for active diagnosis was accurate for all current residents completed on 7/12/19. The were no other issues identified in the audit. As of 7/17/19 medications carts have been audited by Director of Nursing, Asst. Director of Nurses and Unit Managers to ensure no improperly stored, undated open medications or vitamins are present. Any expired, improperly stored or undated items identified were removed and re-ordered. All residents have a potential to be affected by this practice. Cans in the kitchen and dry storage were inspected to ensure no other concerns of dented cans were present. All dishes and small ware are being washed dried and stored property. Systematic Changes: Education of Accuracy of the Assessments Section E (Mood and Behaviors) and Section I (active Diagnosis) and reviewing the Behavior Logs was provided to the MDS Nurses by the Corporate MDS Nurse Consultant on 7/11/19. A weekly audit will be completed by the administrative nurses three times per week for four weeks then weekly for four weeks then monthly for two months to monitor for any other unlabeled open	

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F 867	Continued From page 28	F 867	medications, expired or improperly stored medications or feeding products to ensure compliance. The initial Audit will be completed by 8/2/19. Licensed nursing staff were in-serviced by 7/17/19 on ensuring Medications are properly stored, opened medications are dated and expired medications are not present on med carts and medication rooms. On 7/24/19 the Dietary manager educated the dietary staff over the proper washing and storage of small wares to ensure they are stored dry and in a clean sanitary condition. Staff were also educated on identifying and removing any damaged cans or food containers. Education included proper procedures for safe storage of food items in storage areas. This education will be added to the orientation program for all new dietary staff. The Maintenance Director and the Dietary Manager will ensure rack space to ensure the staff have the needed space to air dry dishes by 8/2/2019. The facility will institute the following measures to ensure that alleged deficient practice will not recur; The facility will diligently follow the policies and procedures of the quality assurance process to prevent a deficiency from recurring. On 8/2/18, the Clinical Regional Consultant will conduct in-service training with the Administrator and Director of Nursing regarding the QAPI process. The	

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F 867	Continued From page 29	F 867	education will include how to identify quality deficiencies. Monitoring: The Corporate MDS Nurse Consultant will audit 10 completed MDS assessments weekly for four weeks then a sample of 10 or more MDS assessments will be monitored monthly for three months to ensure the coding of MDS Sections is coded correctly. These audits will be kept in a binder in the Executive Directors office. Findings will be reported monthly for four months by the MDS Nurse to the QAPI Committee for recommendations or modifications to the audit process to ensure compliance is achieved. A weekly audit will be completed by the administrative nurses three times per week for four weeks then weekly for four weeks then monthly for two months to monitor for any other unlabeled open medications, expired or improperly stored medications or feeding products to ensure compliance. Audits will occur on alternating shifts to ensure all medications are properly stored, opened medications are clearly labeled with the resident name and date opened and expired medications are not present on med carts. The facilities consultant Pharmacist will also conduct monthly audits of no less than one medication room and three medication carts to ensure all open meds are dated and that ophthalmic vials are stored correctly. The pharmacist will	

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F 867	Continued From page 30	F 867	report the finding to the Director of Nursing monthly when her/his audit is complete. The findings will be reported monthly for four months to the QAPI committee for recommendations or modification until a pattern of compliance is achieved by the Director of Nursing. If any negative findings are identified the Corporate Nursing Consultant will coordinate with the Director of Nurses to implement further corrective measures. Nursing management will continue to audit weekly as needed until a pattern of compliance is achieved. The Dietary Manager will audit to ensure that all dished and silverware are cleaned and have been air dried using the Kitchen Sanitation Audit tool five times per week for four weeks then three time a week for four weeks then weekly for four weeks. The Dietary Manager will use the same monitor tool to ensure that staff has separated the dented cans from the cans to be used five times per week for four weeks then three times a week for four weeks then weekly for four weeks. The Registered Dietician will also complete a sanitation round to ensure the kitchen for compliance with this Plan of Correction at least bi-monthly for 3 months. Findings will be reported monthly for 3 months to the QAPI committee by the dietary manager for recommendations or modification until a pattern of compliance is achieved. Results of the monitoring process mentioned above will be reported to the	

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F 867	Continued From page 31	F 867	facility Quality Assurance, Performance Improvement committee by the Dietary Manager, Director of Nursing, Assistant Director of Nursing and/or Unit manager monthly x 4 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the committee deems appropriate. REPONSIBLE PARTY: Effective 8/7/19 the Administrator will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	