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	345555	A. BUILDING _____ B. WING _____	C 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted 9/9/19 through 9/12/19. The facility was found in compliance with the requirement CFR 488.73, Emergency Preparedness. Event ID # W84111.	E 000		
F 000	INITIAL COMMENTS A recertifucation and complaint survey was conducted from 9/9/19 through 9/12/19. 1 of the 2 complaint allegations were substantiated resulting in a deficiency.	F 000		
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 to reflect the restorative nursing services provided for 2 of 3 sampled residents reviewed for range of motion (Resident #39 and Resident #44) and failed to reflect the discharged resident going to an assisted living facility (Resident #94). The findings included: 1) Resident #39 was admitted to the facility on 1/29/19 from a hospital. Her cumulative diagnoses included dementia, generalized muscle weakness, and a history of cellulitis (a bacterial skin infection) of her right lower limb.	F 641	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 641] Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 09/12/2019 the MDS Nurse corrected	10/10/19

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

Electronically Signed | 10/04/2019

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F 641	Continued From page 1 A review of the resident ' s record entitled, "Restorative Care" from July 2019 was conducted. Directions for completion of the form were as follows: "Use one page for each program. Document the restorative program, describe the specific problem, document the goal in measurable and quantifiable terms, and document the interventions. Record restorative minutes of service using the grid. Enter initials and signatures. Complete a weekly evaluation by documenting the resident ' s response and progress towards goals on the back. The progress notes may be written by the Restorative Aide and cosigned by the Licensed Nurse or they can be written by the Licensed Nurse." Upon review, the record indicated Resident #39 began receiving services from the restorative nursing program on 7/12/19. She received at least 15 minutes of restorative nursing services on each of the following dates during the remainder of July: 7/14/19, 7/15/19, 7/16/19, 7/18/19, 7/21/19, 7/22/19, 7/23/19, 7/24/19, 7/26/19, 7/29/19, 7/30/19, and 7/31/19. Further review of Resident #39 ' s Restorative Care records from July 2019 included the following, in part: --Program: Bed mobility or sitting balance -Problem: Patient is at risk for decreased bed mobility and/or sitting balance if she does not perform these tasks regularly. -Goal: Patient to complete rolling side to side in bed 3 times with 5 repetitions and supine times one at stand by assist. Or, patient to complete sitting in unreclined geri-chair forward reaching with one upper extremity 5 times 10 repetitions each. -Interventions: Work with patient on rolling side to side in bed and supine with sit; or, if patient in	F 641	Resident #39□s MDS assessment so that it reflected involvement in the proper restorative program. The information was then submitted to CMS by the MDS Nurse. On 10/03/2019 the MDS Nurse corrected Resident #44□s MDS assessment so that it reflected involvement in the proper facility restorative program. The information was then submitted to CMS by the MDS Nurse. On 09/11/2019 the MDS nurse corrected Resident #94□s MDS assessment so that it reflected the correct discharge location. The information was then submitted to CMS by the MDS Nurse. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 09/12/2019 the DON□s designee began auditing 10% of MDS submitted last quarter (July, August, September 2019) MDS assessment to ensure proper coding for restorative program and accurate discharge locations, if errors were found they were corrected and resubmitted by the MDS nurse. Audits will be completed by October 10, 2019. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 641	Continued From page 2 unreclined geri-chair complete forward reaching with upper extremities. -Weekly Progress Notes were written by the Restorative Aide on 7/14/19, 7/21/19, and 7/28/19. -A Monthly Review/Nursing Evaluation was signed by the Restorative Nurse and dated 8/1/19. The review indicated the resident ' s plan of care was appropriate; no changes to the Restorative Program were recommended. --Program: Range of Motion (ROM) -Problem: Patient is at risk for decreased ROM and strength if she is not exercised regularly. -Goal: Patient will complete seated in the geri-chair or supine in bed active/active assist ROM all planes for bilateral lower extremities with 2 sets of 10 repetitions each. Active ROM means the performance of an exercise to move a joint without any assistance or effort of another person to the muscles surrounding the joint. Active assisted ROM means the use of the muscles surrounding the joint to perform the exercise but requires some help from the therapist or equipment. -Interventions: Patient will complete bilateral lower extremity active/active assist ROM exercise all planes 2 times 10 repetitions. -Weekly Progress Notes dated 7/14/19, 7/21/19, and 7/28/19 were written by Restorative Aide #2. A Monthly Review/Nursing Evaluation was signed by the Restorative Nurse and dated 8/1/19. The review indicated the resident ' s plan of care was appropriate; no changes to the Restorative Program were recommended. A review of Resident #39 ' s Restorative Care records from August 2019 was also completed. These records indicated the resident continued to receive services from the restorative nursing	F 641	Random audits of MDS documents by DON/designee will be performed weekly for 4 weeks, then bi-weekly x 2 months and monthly x 6 months to ensure coding is consistent with Residents actual condition and treatment. Upon discovery of errors, frequency of audits will be increased until we have two consecutive audits with no error. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction. On 09/12/2019 the MDS nurse noted to have made the errors received in-service education regarding accurately completing the MDS and avoiding errors. It was discovered the MDS errors were made due to human error. The MDS nurse that made these errors has been an MDS nurse for several years and has not had this happen prior. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 23, 2019, and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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F 641	Continued From page 3	F 641		

program throughout the month. At least 15 minutes of services were documented as provided on 8/1/19 (the last day of the 7-day look back period for the most recent Minimum Data Set or MDS assessment).

The resident ' s most recent Minimum Data Set (MDS) assessment was a Significant Change MDS dated 8/1/19. The MDS revealed Resident #39 had intact cognitive skills for daily decision making. She required supervision for eating, extensive assistance from staff for bed mobility, locomotion on the unit, and dressing. The resident was totally dependent on staff for transfers, toileting, and personal hygiene. Section O of the MDS assessment did not indicate the resident had been involved in the facility ' s restorative nursing program within the 7-day look back period.

A review of Resident #39 ' s comprehensive care plan included a Problem/Need related to her increased risk of a decrease in range of motion (Problem onset: 8/9/19).

An interview was conducted on 9/11/19 at 2:35 PM with Restorative Aide (RA) #1, RA #2, and the facility ' s Restorative Nurse. During the interview, RA #2 reported Resident #39 received services from the restorative nursing program and was typically part of her assignment. She stated restorative nursing services were routinely offered 6 days a week for this resident and generally included 2 sets of 10 exercises for her upper and lower extremities either while lying in bed or sitting in a chair.

An interview was conducted on 9/11/19 at 3:57 PM with MDS Nurse #2 (who was also the

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Restorative Nurse). During the interview, the nurse was asked to review Section O of Resident #39 ' s MDS dated 8/1/19. When asked if the MDS was coded correctly to reflect the Restorative Nursing services provided for this resident, the nurse stated it was not.

An interview was conducted on 9/12/19 at 8:59 AM with the facility ' s MDS Coordinator. During the interview, the MDS Coordinator reported Section O of Resident #39 ' s MDS was found to be inaccurate. She reported it was modified in accordance with the guidelines.

An interview was conducted on 9/12/19 at 11:22 AM with the facility ' s Director of Nursing (DON). During the interview, the concerns identified with coding of the restorative nursing program on the MDS assessments were discussed. When asked, the DON stated her expectation was for the MDS to be accurate.

2) Resident #44 was admitted to the facility on 11/24/17 with reentry on 8/23/17 from a hospital. His cumulative diagnoses included a history of an intracranial hemorrhage and a persistent vegetative state.

A review of Resident #44 ' s Restorative Referral dated 7/6/18 was conducted. The resident was referred to the restorative nursing program for Range of Motion (ROM). The restorative category and services were noted to include: 1) active assist ROM (AAROM) right upper extremity, AAROM right lower extremity, and AAROM bilateral lower extremities. Active assisted ROM refers to the use of the muscles surrounding the joint to perform the exercise but requires some help from the therapist or

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F 641	Continued From page 5	F 641		

equipment; and, 2) passive ROM (PROM) left upper extremity and PROM right lower extremity. Passive ROM refers to the movement of a joint through the range of motion with no effort from the patient.

Further review of Resident #44 ' s records revealed a Rehabilitation Screen dated 2/5/19 was completed. The resident was noted to be functioning at baseline. The resident ' s most recent Rehabilitation Screen was completed by a Registered Occupational Therapist (OTR) and dated 7/18/19. The screen ' s observations/concerns noted the patient was currently dependent on staff for assistance with all of his Activities of Daily Living (ADLs) and was functioning at baseline.

A review of the resident ' s record entitled, "Restorative Care" from July 2019 was conducted. Directions for completion of the form were as follows: "Use one page for each program. Document the restorative program, describe the specific problem, document the goal in measurable and quantifiable terms, and document the interventions. Record restorative minutes of service using the grid. Enter initials and signatures. Complete a weekly evaluation by documenting the resident ' s response and progress towards goals on the back. The progress notes may be written by the Restorative Aide and cosigned by the Licensed Nurse or they can be written by the Licensed Nurse." Upon review, the records indicated Resident #44 received at least 15 minutes of restorative nursing services on each day during the month of July, with the exception of the following dates: 7/5/19, 7/6/19, 7/7/19, 7/11/19, 7/13/19, 7/14/19, 7/19/19, and 7/25/19.

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Further review of Resident #44 ' s Restorative Care records from July 2019 included the following, in part:
--Program: AAROM
-Problem: Patient is at risk for decline in strength and contracture development.
-Goal: Patient will tolerate 10 repetitions of active assist right should flexion (the bending of a limb or joint)/extension (a straightening movement that increases the angle between body parts), elbow flexion/extension, wrist finger flexion/extension.
-Interventions: Right upper extremity 10 repetitions in all available planes. Right knee extension and hip flexion times 10 repetitions; PROM left upper extremity and hip flexion/abduction (the movement of a limb or other part away from the midline of the body)/adduction (the movement of a limb or other part toward the midline of the body) times 10 repetitions each.
-Weekly Progress Notes dated 7/7/19, 7/14/19, 7/21/19, and 7/28/19 were written by Restorative Aide #2. The progress note dated 7/7/19 read, "Resident participated 4 days of his restorative exercise 10 reps (repetitions) on PROM B (bilateral) LE (lower extremity) and UE (upper extremity) in all planes to prevent contractures."
The progress note dated 7/14/19 read: "Resident participated 4 days of his restorative program in PROM B (bilateral) LE and UE 10 reps in all planes to prevent contractures."
The progress note dated 7/21/19 read: "Resident participated 6 days of his restorative program in B (bilateral) UE and LE. PROM 10 reps in all planes to prevent contractures."
The progress note dated 7/28/19 read: "Resident participated 6 days of his restorative exercise in his PROM 10 reps in all planes to prevent

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F 641	Continued From page 7	F 641		

contractures."
-A Monthly Review/Nursing Evaluation was signed by the Restorative Nurse and dated 8/1/19. The review indicated the resident ' s plan of care was appropriate; no changes to the Restorative Program were recommended.

The resident ' s most recent Minimum Data Set (MDS) assessment was an annual MDS dated 7/26/19. The MDS revealed Resident #44 had severely impaired cognitive skills for daily decision making. He was totally dependent on staff for all of his Activities of Daily Living (ADLs). Section O of the MDS assessment reported the following restorative nursing program was performed for at least 15 minutes a day in the last 7 calendar days: active ROM on 6 out of the last 7 days.

A review of Resident #44 ' s comprehensive care plan included the following area of focus, in part:
--8/9/19 Restorative: ROM; the resident was at risk for a decline in strength and contracture development. (Problem onset: 8/9/19).

An interview was conducted on 9/11/19 at 2:35 PM with Restorative Aide (RA) #1, RA #2, and the facility ' s Restorative Nurse. During the interview, RA #2 reported Resident #44 was typically part of her assignment. She stated restorative nursing services were routinely offered 6 days a week for this resident. Upon further inquiry, the facility ' s Restorative Nurse reported the resident received PROM for all joints in his upper and lower extremities.

An interview was conducted on 9/11/19 at 3:36 PM with MDS Nurse #2 (who also served as the Restorative Nurse). During the interview, the

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nurse was asked to review Section O of Resident #44 ' s MDS dated 7/26/19. During the interview, MDS Nurse #2 was asked if the MDS was coded correctly to reflect the Restorative Nursing services provided for this resident. Upon review of the MDS and based on the restorative program information, she reported the MDS should have been coded to indicate the resident received PROM (not AROM).

An interview was conducted on 9/12/19 at 8:59 AM with the facility ' s MDS Coordinator. During the interview, questions regarding the type of services received from the restorative nursing program and coding of the MDS assessment were discussed. Accompanied by the MDS Coordinator, an interview was conducted on 9/12/19 at 9:10 AM with the OTR identified as having completed the last evaluation of Resident #44 on 7/18/19. During the interview, Resident #44 ' s Restorative Referral and Rehab Screenings were reviewed. The OTR reported the AAROM (active assisted ROM) on the initial restorative care plan was no longer appropriate. She stated the resident was only able to receive PROM services at this point in time.

An interview was conducted on 9/12/19 at 11:22 AM with the facility ' s Director of Nursing (DON). During the interview, the concerns identified with the coding of restorative nursing program services on the MDS assessments were discussed. When asked, the DON stated her expectation was for the MDS to be accurate.

3. Resident #94 was admitted to the facility on 6/15/2019 with diagnoses of chronic diastolic heart failure and muscle weakness.

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F 641	Continued From page 9 Review of a Minimum Date Set (MDS) dated 7/19/2019 revealed in Section A that Resident #94 was discharged to acute hospital. Record Review on 9/11/ 2019 at 3pm revealed that Resident #94 was discharged to an Assisted Living Facility (ALF) on 7/19/2019. An interview was conducted with the MDS coordinator on 9/11/2019 at 8:30am. She reported the MDS nurses were responsible for coding all MDS assessments accurately. She reported the MDS for Resident #94 should have reflected the residents discharge to an ALF. During an interview with the Administrator on 9/12/2019 at 2:30 pm revealed it was her expectation that MDS's were completed without error.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to completely transcribe a physician ordered medication (Prednisone 5 milligrams) for 1 of 6 residents (Resident #1) whose medications were reviewed. Findings included:	F 658	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and	10/10/19

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F 658	Continued From page 10 The hospital discharge summary dated 8/29/19 read, in part, "Continue these medications which have changed-Prednisone 10mg (milligrams)-take 3 tablets (30mg total) by mouth once daily for 2 days, then 2 tabs (tablets) (20mg) daily for 3 days, then 1 (10mg) daily for 3 days, then back to 5mg dose." Resident #1 was admitted to the facility on 8/29/19. Review of a 5 day MDS (Minimum Data Set-a tool used for resident assessment) dated 9/5/19 revealed Resident #1 was cognitively intact and had adequate vision, hearing and clear speech. Limited assistance was required for all Activities of Daily Living and active diagnoses included, but were not limited to arthritis, bronchiectasis, and rheumatoid arthritis. Review of the physician orders dated 8/29/19 read, in part, "Prednisone 10mg-3 tabs po (by mouth) daily x (times) 2 days; Prednisone 10mg tabs-2 tabs (20mg) po daily x 3 days; Prednisone 10mg tabs-1 tab po daily x 3 days; Prednisone 5mg tab-1 tab po daily." Review of the MAR dated 8/29/19 through 8/31/19 read, in part, "Prednisone 10mg-3 tabs po (by mouth) daily x (times) 2 days; Prednisone 10mg tabs-2 tabs (20mg) po daily x 3 days; Prednisone 10mg tabs-1 tab po daily x 3 days; Prednisone 5mg tab-1 tab po daily." Review of the Medication Administration Record (MAR) dated 9/1/19 through 9/30/19 revealed Prednisone 10mg tabs-2 tabs (20mg) was received 9/1/19, 9/2/19, and 9/3/19. Prednisone 10mg tabs-1 tab (10mg) was received 9/4/19, 9/5/19, and 9/6/19. No other doses of Prednisone were received between 9/7/19 and 9/12/19. The	F 658	federal law. [F 658] Services Provided Meet Professional Standards Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 9/11/2019 Resident #1 was discharged from the facility and did not return. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 9/11/2019, the DON's designee began auditing all Resident charts to ensure no other prednisone tapering was missed. Any discrepancies found will be corrected immediately and proper communication will take place. The audit will be completed by 10/10/2019. All Nurses will be educated by DON/designee as to proper procedure and implementation of review and verification of Medication Administration Records. The in-service will be completed by 10/10/2019. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 658	Continued From page 11 MAR was not set up for Prednisone 5mg tab-1 tab po daily. A review of hospital records dated 9/11/19 revealed Resident #1 was brought to the Emergency Department on 9/11/19 for a reported 2 day history of shortness of breath with a non-productive cough and increased generalized weakness. The hospital record revealed a physician note dated 9/11/19 which read, in part, "Patient's chronic Prednisone was NOT continued at SNF (Skilled Nursing Facility). Resume usual dose of 5mg (milligrams). Resident #1 was not in the facility at the time of the investigation, however, an interview was conducted with a family member (FM) on 9/12/10 at 12:00PM. She stated the chronic dose of Prednisone was not included on the MAR submitted by the facility to the hospital at the time of transfer on 9/11/19. An interview was conducted with Nurse #3 on 9/12/19 at 12:25PM. She stated, "We follow the hospital discharge summary orders until we hear otherwise from our facility doctor. MAR entries are checked twice at the end of the month by two different staff members for accuracy, but I didn't verify (Resident #1's) chart." On 9/12/19 at 12:45PM an interview was attempted with Nurse #4 who was the second verification nurse for Resident #1's September medications. A voicemail was left, but no call was returned. An interview was conducted with the Director of Nursing on 9/12/19 at 12:55PM. She stated, "The discharge summary is faxed to our pharmacy.	F 658	Random audits of Medication Administration Records will be performed by DON/designee weekly x 4 weeks, then bi-weekly x 2, and monthly x 1 to ensure policy and procedures are followed relating to verification of Medication Administration Records and ensuring accurate transcription has occurred. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 23, 2019 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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F 658	Continued From page 12 We verify the medications with the physician and them then we fill out a physician order sheet. The MAR, physician order sheet and discharge summary are all faxed to our pharmacy. At the end of the month each nurse is assigned specific charts to review. They check the medication record on hand against the orders on the chart for accuracy. The medications are checked by 2 nurses for accuracy. My expectation is for them to be transcribed correctly and checked for accuracy. We are a really busy facility because we have such a high patient turnover ratio, but that's no excuse. The medications should be accurate. I don't know why the missed 5mg Prednisone wasn't picked up on the MAR by (Nurse #4)."	F 658		
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	F 761		10/10/19

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F 761	Continued From page 13 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to discard expired medications on 1 of 4 medication carts observed (PP Hall Med Cart 1); and failed to store medications as indicated by the manufacturer on 2 of 4 medication carts observed (TG Hall Med Cart 1 and TG Hall Med Cart 2). The findings included: 1-a) In the presence of Nurse #1, an observation was conducted of the PP Hall Med Cart 1 on 9/10/19 at 12:00 PM. The observation revealed an opened vial of Lantus insulin dispensed by the pharmacy on 8/6/19 and labeled for use by Resident #91 was stored on the medication cart. The insulin vial was dated as having been opened on 8/6/19; no shortened expiration date was written on the vial. At the time of the observation, Nurse #1 reported the opened vial of insulin was expired and needed to be discarded. The shortened expiration date for the opened vial of insulin was calculated to be 9/3/19. Nurse #1 stated the insulin vial should have been discarded 28 days after opening. A review of the manufacturer ' s storage instructions indicated once opened (in use), vials of Lantus insulin should be used within 28 days.	F 761	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 761] Label/Store Drugs and Biologicals Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 9/10/2019 the cited deficiency regarding resident #91 and #70 was corrected immediately by having Nurse #1 discard insulin and ordered new insulin vial on 9/10/2019. On 9/10/2019 the cited deficiency regarding residents # 39 and #25 was corrected immediately by having Nurse #3 removing and discarding eye drops and ordered new eye drops. On 09/11/2019 dividers were ordered, these dividers were installed on 09/15/2019 and will ensure eye drops	

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F 761	Continued From page 14 A review of Resident #91's physician orders revealed the resident had a current order for Lantus insulin (initiated on 8/6/19). An interview was conducted on 9/12/19 at 11:15 AM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported nursing staff was expected to date insulin when it was opened and to store insulin appropriately. She acknowledged both Lantus and Humalog insulins had shortened expiration dates once opened and needed to be discarded 28 days after opening. An interview was conducted on 9/12/19 at 1:25 PM with the facility ' s consultant pharmacist. During the interview, the medication storage concerns identified from observations were discussed. When asked, the pharmacist reported she would expect insulins to be dated with a shortened expiration date. She also stated Lantus and Humalog insulin would need to be discarded when expired (28 days after opening). 1-b) In the presence of Nurse #1, an observation was conducted of the PP Hall Med Cart 1 on 9/10/19 at 12:00 PM. The observation revealed an opened vial of Humalog insulin dispensed by the pharmacy on 8/2/19 and labeled for use by Resident #79 was stored on the medication cart. The insulin vial was dated as having been opened on 8/4/19 with a shortened expiration date of 9/2/19 written on the vial. At the time of the observation, Nurse #1 reported the opened vial of insulin was expired and needed to be discarded. She stated the insulin vial should have been discarded 28 days after opening. A review of the manufacturer ' s storage	F 761	could be stored upright. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 9/10/2019 the pharmacy consultant observed medication carts on Carolina Shores and confirmed all insulins were dated appropriately and no issues identified with storage of eye drops. All nurses in-serviced by the pharmacy consultant/nurse supervisor on proper storage of insulin and eye drops. In-services will be completed by 10/10/2019. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Random audits of 6 med carts for proper storage and disposal of insulin and proper storage of eye drops will be conducted by the nurse supervisors/designee for a period of weekly x 4 weeks, bi-weekly x 2 months, to ensure there is no expired medication on the cart and medication is stored properly. The DON/designee will be responsible for implementing the acceptable plan of correction. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality	

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F 761	Continued From page 15 instructions indicated opened vials of Humalog insulin should be used within 28 days. A review of the resident's physician orders revealed Resident #79 had a current order for Humalog insulin (initiated on 8/1/19). An interview was conducted on 9/12/19 at 11:15 AM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported nursing staff was expected to date insulin when it was opened and to store insulin appropriately. She acknowledged both Lantus and Humalog insulins had a shortened expiration date once opened and needed to be discarded 28 days after opening. An interview was conducted on 9/12/19 at 1:25 PM with the facility ' s consultant pharmacist. During the interview, the medication storage concerns identified from observations were discussed. When asked, the pharmacist reported she would expect insulins to be dated with a shortened expiration date. She also stated Lantus and Humalog insulin would need to be discarded when expired (28 days after opening). 2) Accompanied by Nurse #2, an observation of the TG Hall Med Cart 1 was conducted on 9/10/19 at 12:10 PM. A bottle of 0.5% Lotemax ophthalmic suspension (a steroid-containing eye drop) dispensed from the pharmacy on 6/3/19 for Resident #39 was observed to be lying down on its side in the drawer of the medication cart. The position of the eye drop container in the med cart was shown to the nurse, along with the manufacturer labeling on the bottle which indicated the medication needed to be stored in an upright position.	F 761	Assurance meeting October 23, 2019 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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F 761	Continued From page 16	F 761		

The manufacturer recommendations for storage of Lotemax ophthalmic suspension indicated the bottle of eye drops should be stored in the upright position.

A review of Resident #39's physician orders included a current order for 0.5% Lotemax ophthalmic suspension (initiated 2/11/19).

An interview was conducted on 9/12/19 at 11:15 AM with the facility ' s Director of Nursing (DON). When asked about the storage of ophthalmic suspension eye drops, the DON stated, "It should be stored in (an) upright position."

An interview was conducted on 9/12/19 at 1:25 PM with the facility ' s consultant pharmacist. During the interview, the medication storage concerns identified from observations were discussed. Upon inquiry, the pharmacist reported she would expect ophthalmic suspensions to be stored in an upright position.

3) Accompanied by Nurse #3, an observation of the TG Hall Med Cart 2 was conducted on 9/10/19 at 12:13 PM. During the observation, a bottle of 0.1% fluorometholone ophthalmic suspension (a steroid-containing eye drop) was observed to be lying down on its side in a drawer of the med cart. The eye drops were dispensed from the pharmacy on 9/2/19 and labeled for Resident #25. Manufacturer labeling on the bottle of the eye drops read in part, "Store in an upright position." An interview conducted with Nurse #3 at the time of the observation confirmed the eye drops were lying down on its side in the drawer of the med cart. The nurse also confirmed the instructions on the bottle of the fluorometholone eye drops (partially covered by a

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F 761	Continued From page 17 pharmacy sticker) indicated the container needed to be stored in an upright position. A review of the manufacturer recommendations for the storage of fluorometholone ophthalmic suspension indicated the bottle of eye drops should be stored in an upright position. A review of Resident #25's physician orders included a current order for 0.1% fluorometholone ophthalmic suspension. An interview was conducted on 9/12/19 at 11:15 AM with the facility ' s Director of Nursing (DON). When asked about the storage of ophthalmic suspension eye drops, the DON stated, "It should be stored in (an) upright position." An interview was conducted on 9/12/19 at 1:25 PM with the facility ' s consultant pharmacist. During the interview, the medication storage concerns identified from observations were discussed. Upon inquiry, the pharmacist reported she would expect ophthalmic suspensions to be stored in an upright position.	F 761		
F 867 SS=D	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	F 867	This plan of correction constitutes my written allegation of compliance for the	10/10/19

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F 867	Continued From page 18 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 9/07/2018. This was for 1 recited deficiency in the area of accuracy of assessments (F-641). The deficiency was re-cited during the annual recertification and complaint survey of 9/12/2019. The continued failure of the facility during 2 federal surveys of record showed a pattern of the facility ' s inability to sustain an 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 to reflect the restorative nursing services provided for 2 of 3 sampled residents reviewed for range of motion (Resident #39 and Resident #44) and failed to reflect the discharged resident going to an assisted living facility (Resident #94). During the recertification and complaint survey of 9/20/2018 the facility was cited for failure to accurately code the MDS assessment to reflect the active diagnoses and medications received for 1 of 7 residents reviewed for unnecessary medications (Resident #18). During an interview with the Administrator on 9/12/2019 at 2:30 pm she revealed it was her expectation that MDS's would be completed withour error.	F 867	deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 867] QAPI/QAA Improvement Activities Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 9/12/2019 the MDS Nurse corrected Resident #39's MDS assessment so that it reflected involvement in the proper restorative program. The information was then submitted by the MDS Nurse to CMS. On 10/03/19 the MDS Nurse corrected Resident #44's MDS assessment so that it reflected involvement in the proper facility restorative program. The information was then submitted by MDS Nurse. On 09/11/2019 the MDS nurse corrected Resident #94's MDS assessment so that it reflected the correct discharge location. On 10/4/2019 the QAA committee was notified via email that accurate completion of MDS assessments and compliance with F641 would be re-entered into the agenda for the meeting set for October 23, 2019.	

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F 867	Continued From page 19	F 867	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 09/12/2019 the DON's designee began auditing last quarter (July, August, September 2019) MDS assessments to ensure proper coding for restorative program and accurate discharge locations, if errors were found they were corrected and MDS was resubmitted by MDS nurse. Audits will be complete by October 10, 2019. On October 23, 2019, the QAA Committee will review the September 12, 2019 F641 deficiency and plan of correction created to address the same. The QAA committee will keep this concern reference F641 on the agenda for no less than one year. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Random audits of MDS documentation by DON/designee will be performed weekly for 4 weeks, then bi-weekly x2 months and monthly x6 months to ensure coding is consistent with resident's actual condition and treatment. Upon discovery of errors, frequency of audits will be increased until we have two consecutive audits with no errors. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction.	

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F 867	Continued From page 20	F 867	On 09/12/2019 the MDS nurse noted to have made the errors received in-service education regarding accurately completing the MDS and avoiding errors. The MDS nurse that made these errors has been an MDS nurse for several years and has not had this happen prior. The QAA committee will review audits and conduct interviews with the DON/MDS nurse to ensure compliance and determine if additional audits or training are necessary. The QAA committee will review these systematic changes quarterly for no less than one year to ensure this deficient practice does not occur. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed by the QAA Committee in the next regularly scheduled Quality Assurance meeting October 23, 2019 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee but will remain for no less than one year. The QAA committee will also review the results of the random audits conducted the week of 9/23, 09/30, 10/7 and 10/14.	