STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	C 08/29/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 8/26/19 through 8/29/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OW3T11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 8/26/19 through 8/29/19. Event ID #OW3T11. Four of the four complaint allegations were not substantitated.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		9/26/19

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

Electronically Signed | 09/16/2019

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F 623	Continued From page 1 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623		

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F 623	Continued From page 2 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to include residents discharged to the hospital on the list of discharged residents provided each month to the Ombudsman for 2 of 2 residents reviewed for hospitalization (Resident #82 and #34). The findings included:	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	

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F 623	Continued From page 3 1. Resident #82 was admitted to the facility on 9/29/17 and had a diagnosis of chronic obstructive pulmonary disease, congestive heart failure, moderate protein-calorie malnutrition, anemia and cerebrovascular accident (stroke). Review of the clinical record revealed Resident #82 was discharged to the hospital on 6/20/19. The hospital discharge summary dated 6/25/19 noted the resident was admitted for septic shock related to aspiration pneumonia. Resident #82 was re-admitted to the facility on 6/25/19. The clinical record noted the resident was also discharged to the hospital on 7/12/19. The hospital discharge summary dated 7/17/19 noted the resident was admitted from the clinic for wound care, intravenous antibiotics and a feeding tube. The resident was re-admitted to the facility on 7/17/19. On 8/28/19 at 3:45 PM an interview was conducted with the facility's social worker. The Social Worker stated she did a discharge report for resident's discharged to the community or home and would send the list to the ombudsman once a month. The Social Worker stated she did not realize the list sent to the ombudsman needed to include residents discharged to the hospital and had not been including those residents. On 8/29/19 at 10:17 PM the Director of Nursing (DON) stated in an interview she thought the residents discharged to the hospital were on the list sent to the ombudsman. The DON further stated it was her expectation the list of residents sent to the ombudsman include the residents discharged to the hospital.	F 623	plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to include residents discharged to the hospital on the list of discharged residents provided each month to the ombudsman. 1. Corrective action for resident(s) affected by the alleged deficient practice: Residents discharged to the hospital for the month of July 2019 were included on the discharge listing report and faxed to the Ombudsman by the Social Worker on 09/16/19. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 9/16/19 the list of residents discharged to the hospital was reviewed by the Administrator for the month of August 2019 to monitor that all residents who had been discharged that month, were present on the report that was faxed to the ombudsman on 09/16/2016 by the social worker. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 623	Continued From page 4 2. Resident #34 was admitted to the facility on 1/30/19 and had diagnoses of diabetes mellitus, Coronary artery disease and chronic kidney disease. A review of the clinical record revealed Resident #34 was discharged to the hospital on 5/27/19. The hospital discharge summary dated 5/30/19 noted the resident was admitted for severe anemia related to chronic disease and an infected left AKA (above knee amputation) stump s/p debridement. Resident #34 was readmitted to the facility on 5/30/19. On 8/28/19 at 3:45 PM an interview was conducted with the facility ' s social worker. The Social Worker stated she did a discharge report for resident ' s discharged to the community or home and would send the list to the ombudsman once a month. The Social Worker stated she did not realize the list sent to the ombudsman needed to include residents discharged to the hospital and had not been including those residents. On 8/29/19 at 10:17 PM the Director of Nursing (DON) stated in an interview she thought the residents discharged to the hospital were on the list sent to the ombudsman. The DON further stated it was her expectation the list of residents sent to the ombudsman include the residents discharged to the hospital.	F 623	On 8/29/19, the Administrator educated the Social Worker on the requirement to include all residents discharged to the hospital on the list of discharged residents provided to the Ombudsman monthly. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor compliance utilizing the F623 Quality Assurance Tool for compliance with inclusion of residents discharged to the hospital and faxing of the Discharged Resident Report monthly to the Ombudsman. This will be monitored monthly x 4 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 9/26/19	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals	F 645		9/26/19

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F 645	Continued From page 5	F 645		

with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the

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F 645	Continued From page 6 preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to submit information for Preadmission Screening and Resident Review (PASARR) for Level II evaluation for 1 of 1 sampled residents reviewed. (Resident #56). The findings included: Resident #56 was originally admitted to the facility on 11/1/18 with diagnoses including Schizophrenia, Major Depressive Disorder and Bipolar Disorder. According to the most recent Quarterly Minimum Data Set (MDS) dated	F 645	F645 Screening for Mental Disorder/Intellectual Disabilities Corrective actions for Resident #56 Specific deficiency for Resident #56 was corrected on 08/29/19 by requesting a new PASSAR based on a new Mental Health diagnosis . This was completed by Warren Hills Admission Coordinator. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	

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F 645	Continued From page 7 7/17/19, Resident #56 was cognitively impaired and required extensive assistance in most areas of activities of daily living. Resident #56's medical record revealed that prior to being admitted to the facility a PASARR Level I Determination had been completed on 10/31/18. Review of the Admission MDS dated 11/8/18 revealed Resident #56 was not coded for schizophrenia. Resident #56 was discharged to the hospital on 1/24/19 and was readmitted back to the facility on 2/4/19. A hospital discharge summary on 2/4/19 noted Resident #56 with a diagnosis of bipolar disorder and schizophrenia. On 2/12/19, Resident #56 was coded on the quarterly MDS with a diagnosis of schizophrenia and bipolar disorder. Review of Resident #56's medical record revealed she was seen by the psychiatrist the first time on 2/8/19 and on that date she was given a diagnosis of schizo-affective disorder. Review of Resident #56's care plan which was revised on 5/21/19 revealed the resident was resistive to care related to schizophrenia. The care plan also addressed Resident #56 displaying inappropriate behaviors such as hitting staff, yelling at staff and taking food items from another resident's room and eating them. A Psychiatric Evaluation completed on 8/21/19 revealed Resident #56 had a diagnosis of Schizo-affective Schizophrenia. During an interview on 8/29/19 at 9:17 AM, the facility Admissions Coordinator revealed there	F 645	A 100 % audit of all current residents was completed to identify all residents who either already have a diagnosis of mental illness and/or intellectual disabilities to ensure that the State Mental Health Authority had been notified via NCMUST to request a new PASRR level review upon receipt of diagnosis. The audit also identified those residents who have diagnosis of mental illness and/or intellectual disabilities AND have had a Significant Change in Condition Minimum Data Set Assessment completed during the past 6 months from 03/01/19 □ 09/01/19 to ensure that a request for new PASRR review was submitted via NCMUST at the time of the assessment. Audit results are: 15 residents were identified as having diagnosis of Serious Mental Illness and/or Intellectual Disability. 3 residents with diagnosis of mental illness and/or intellectual disability had a Significant Change MDS during past 6 months. 12 of the 15 residents were noted to have been screened and assigned a Level II PASRR number already. 12 of the 15 residents were noted to have PASRR screenings that are up to date. 3_of the 15 residents were identified as NOT having new requests for PASRR review submitted via NCMUST. This audit was completed by Stacy Ricks on 09/16/19.	

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F 645	Continued From page 8 was only one application for PASARR for Resident #56 and that was from the hospital when she was admitted to the facility on 11/1/18. She stated typically she would be informed of a significant change and would do a change of condition form within NC MUST (Medicaid Uniform Screening Tool). She said typically the MDS Nurse would let her know about a significant change during daily morning meetings. During an interview on 8/29/19 at 9:30 AM, the MDS Nurse stated the diagnosis of schizophrenia was not put into the system until 11/19/18 under medical diagnosis. She stated Resident #56 had always been schizophrenic and bipolar and had always been on psychoactive medication. She stated although Resident #56 had a significant change in January for ADLs, a significant change should have been done for schizophrenia after the resident was discharged from the hospital and she said she failed to do one. She stated a PASARR should have been submitted because of the 12/18/18 diagnosis of schizophrenia. During as interview on 8/29/19 at 11:20 AM, the Administrator revealed there was nothing in Resident #56's diagnosis history from the previous facility, which required a PASARR Level II. She stated after it was determined Resident #56 had a new diagnosis of schizo-affective disorder that could have possibly affected her outcome level of care, a change for a PASARR should have been submitted.	F 645	All residents identified as not having up to date PASRR reviews since either being newly diagnosed and/or having a Significant Change MDS completed, had new requests for new reviews submitted via NCMUST. This was completed by Stacy Ricks on 09/16/19. Systemic Changes All residents who receive a diagnosis of a Serious Mental Illness or Intellectual Disabilities/Mental Retardation have the potential to be impacted. Beginning on 09/16/19, the facility MDS coordinator will begin running and reviewing a New Diagnosis Report from Point Click Care weekly in order to identify any resident who has been diagnosed with a Serious Mental Illness or Intellectual Disabilities/Mental Retardation during the past 7 days. Any resident who has received a Serious Mental Illness or Intellectual Disabilities/Mental Retardation diagnosis during the past 7 days will be reviewed to validate that a request for new review has been submitted to NCMUST. Any resident who has not had a new request for review since receiving recent diagnosis as stated above will have one sent to NCMUST by the facility Social Services Director. On 09/16/19, the Regional Minimum Data Set Consultant completed an in service training for the facility Director of Nursing, Social Services Director and Minimum Data Set Coordinator that included the	

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F 645	Continued From page 9	F 645		

importance of thoroughly reviewing each resident□s medical record in order to identify whether or not the resident has a diagnosis of a severe mental illness or intellectual disability/mental retardation. The education also included the importance of ensuring that the state mental health authority is notified via NCMUST of all residents who have received these diagnoses and/or if these residents have a significant change in status.

This information has been integrated into the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
On 09/16/19, the Director of Nursing or Minimum Data Set Nurse will begin auditing residents who have a diagnoses of a severe mental illness or intellectual disabilities/mental retardation to ensure that state mental health authority is notified via NCMUST system anytime that they have a significant change in status or are newly diagnosed with above diagnoses, using the quality assurance survey tool entitled PASRR Screening Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements.

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F 645	Continued From page 10	F 645	This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 09/26/19	
F 727 SS=B	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 727		9/26/19

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F 727	Continued From page 11 Based on record review and staff interviews the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 10 of the past 49 days reviewed (7/13/19, 7/14/19, 7/27/19, 7/28/19, 8/10/19, 8/11/19, 8/17/19, 8/18/19, 8/24/19, and 8/25/19). The findings included: A review of the 7/11/2019 through 9/4/2019 staffing sheets was conducted on 8/28/2019. The Daily Facility Staffing sheets for 7/13/19, 7/14/19, 7/27/19, 7/28/19, 8/10/19, 8/11/19, 8/17/19, 8/18/19, 8/24/19, and 8/25/19 indicated "0" (zero) for the registered nurse (RN) on duty. The assignment sheets for 7/13/19, 7/14/19, 7/27/19, 7/28/19, 8/10/19, 8/11/19, 8/17/19, 8/18/19, 8/24/19, and 8/25/19 did not indicate an RN had been scheduled. On 8/28/2019 at 2:27 PM, an interview was conducted with the nursing secretary who stated she wrote the staffing schedule. The secretary further stated the facility had not had a RN available to work every other weekend for a long time, and a RN had not work the weekends listed. On 8/28/2019 at 2:25 PM, an interview was conducted with the Director of Nursing (DON) who stated staffing had been a challenge. The DON stated the facility had been using some agency staff but had not been able to find an agency RN to cover every other weekend. The DON stated a RN was not scheduled daily for 8 hours per day. On 8/28/2019 at 3:51 PM, an interview was	F 727	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F727 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to staff Registered Nurse coverage for 8 consecutive hours daily. 1. Corrective action for resident(s) affected by the alleged deficient practice: At least eight consecutive hours of registered nurse staffing will be maintained daily by 9/26/19. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 9/09/19 staffing sheets were reviewed by the Director of Nurses from 9/01/19 through 9/08/19 to monitor that at least eight consecutive hours of registered nurse staffing was in place daily. 0 out of 7 days had at least 8 consecutive hours of registered nurse hours in place. An on call process to maintain eight consecutive	

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F 727	Continued From page 12 conducted with the Administrator who stated she did not have a waiver for the RN hours and did not always have a RN for 7 days of the week. The Administrator stated they had been trying to recruit nurses first and they would continue to pursue hiring a RN in this rural area, and they would also continue to pursue applying for a waiver for RN staffing.	F 727	hours of registered nurse staffing daily and use of a contracted agency for registered nurses will be developed and in use by 9/26/19. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 8/29/19, the Nurse Consultant educated the Administrator and Director of Nurses on the requirement of the facility to staff registered nurse coverage for at least 8 consecutive hours daily and on 8/29/19 the Administrator educated the nursing scheduler on the requirement to staff registered nurse coverage for at least 8 hrs. daily. Coverage by a Registered nurse for a least eight consecutive hours will be maintained by 9/26/19. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses will monitor compliance utilizing the F272 Quality Assurance Tool weekly for staffing of registered nurse hours daily x 2 weeks then monthly x 3 months. The Director of Nursing will monitor staffing for compliance with the requirement for at least 8 hours of registered nurse staffing daily. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program	

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F 727	Continued From page 13	F 727	reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 9/26/19	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		9/26/19

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F 732	Continued From page 14 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to include the daily census on the staff posting for 47 of 48 days reviewed for sufficient staffing. The findings included: An observation of the daily staff posting on 8/26/2019 revealed the facility census was left blank. The number of staff and hours worked were completed. On 8/27/2019 the daily staff posting revealed the census number was 101 for the 7:00 AM to 3:00 PM shift. A review of the daily staff posting sheets from 7/11/2019 through 8/27/2019 revealed the facility census was not documented on any posting sheets except for the 8/27/2019 posting sheet. On 8/28/2019 at 4:12 PM, an interview was conducted with the nursing secretary who stated she was responsible for filling out the daily posting sheet. The secretary stated she did not know she was supposed to include the daily census and had been doing the posting sheets for so long she hadn't even noticed the census line was blank.	F 732	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F732 Posted Nursing Staffing Information The facility failed to include the census on the daily posting sheet on 47 out of 48 days. The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: Immediate education was provided to the nursing secretary by the Administrator on 8/28/2019 regarding the items that should be posted on the daily staffing sheet and how to properly fill out the sheet. The procedure for implementing the acceptable plan of correction for the specific deficiency cited:	

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F 732	Continued From page 15 On 8/28/2019 at 3:51 PM, an interview was conducted with the Administrator who stated she had filled out the daily posting sheets for 8/27/2019 and 8/28/2019, and that is why the census was included on those sheets. The Administrator stated she expected the daily staff posting to include the facility census and she had just educated the nursing secretary on where to find the census, so she could include it on the daily posting sheets.	F 732	On 8/28/2019 the Administrator audited 2 months of daily posting staffing sheets and noted that the census was missing for 58 out of the 60 days. Education was provided to the nursing secretary and education will be provided to all managers on duty on how to properly fill out the daily posting staffing sheet. This education will be provided to all managers on duty by 9/19/2019. An audit of the 2 weeks of staffing sheets was performed by the Administrator on 9/16/2019. These sheets were dated 09/1/2019 to 9/14/2019. 100% of all staffing sheets audited were filled out correctly. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Two weeks of daily staffing sheets were monitored on 9/16/2019. Additionally, 3 staffing sheets will be audited weekly times 4 -to include at least one weekend daily posting sheets and then once per week for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for	

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F 732	Continued From page 16	F 732	implementing the acceptable plan of correction: The Administrator Date of Compliance: 9/26/19	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 4 resident (Resident #54) observed during medication pass. The findings included: Resident #54 was admitted to the facility on 8/11/2016 with diagnoses to include diverticulosis of the large intestine and depression. A review of resident #54's current Physician orders included escitalopram 15 mg (milligrams) daily for depression, and MiraLAX powder 17 grams daily for bowel regimen. On 8/27/2019 at 8:43 AM, the Medication Aid (MA) was observed to dispense medications to Resident #54. The medications given were escitalopram 5 mg (milligrams), losartan 100 mg, Sinemet 25-100 mg ½ tab, gabapentin 300 mg,	F 759	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F759 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to have a medication error rate of less than five percent. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident # 54, on 8/28/19, the medication aide was educated by the Director of Nurses and Nurse Consultant	9/26/19

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F 759	Continued From page 17 clonazepam 0.5 mg, a multivitamin tablet and Systane eye drops. During a medication reconciliation (medications given are compared to what was ordered), it was discovered escitalopram was not dispensed as 15 mg, as only 5 mg were given. A review of Resident # 54s Medication Administration Record (MAR) after the medications pass revealed MiraLAX powder was dispensed at the 9:00 AM dose time with the other medications. On 8/27/2019 at 10:29 AM, an interview was conducted with the MA, who stated she gave the escitalopram as 5 mg because that was what was ordered. The MA pulled resident # 54s medication packaging from the medication cart drawer and stated she did not understand why there was one packaging labeled as 5 mg and one labeled as 10mg. The MA was asked to read the line below the dosage on the 5 mg package which read to give with a 10mg tablet to make 15 mg. The instructions on the 10 mg package read to give with a 5 mg table to make 15 mg. The MA stated she did not understand what those instructions meant. The MA stated she did not usually work on this hall and was not familiar with the resident's medications. The MA further stated she gave Resident # 54s MiraLAX at the same time as all the other medications. When the MA was informed the MiraLAX was not witnessed, the MA stated she gave everyone else on the floor MiraLAX and thought she gave it to resident #54. On 8/28/2019 at 10:26 AM, an interview was conducted with the Director of Nursing (DON)	F 759	on the correct procedure for administering medications to include verification of the order with the medication label prior to administration, verification that all medications are administered as ordered and documented appropriately per facility policy along with facility policy on medication error reporting. The medication aide was observed on 9 /10/19 by the Director of Nurses and complied with facility policy with no medication errors observed and medications appropriately documented. The medication aide was able to verbalize facility policy on reporting of medication errors. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 9/10/19 the Director of Nurses/Unit Manager observed med pass administration for compliance with facility policy related to include verification of the order with the medication label prior to administration, verification that all medications are administered as ordered and documented appropriately per facility. Results: 0% error rate. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 8/29/19, the Director of Nurses/Unit Manager began education of all full time, part time and as needed nurses and medication aides on the prevention of medication errors and medication safety	

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F 759	Continued From page 18 who stated she expected the nurses to read the medication instructions and give medications as ordered. The DON further stated she expected the nurses to only chart the medications when they were given.	F 759	to include facility policy of all orders with medication labels prior to administration, verification that all medications are administered as ordered and documented appropriately and medication error reporting. The in-service will be completed by 09/19/19 at which time all nurses and medication aides must be in-serviced prior to working. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses/Unit Manager will monitor for compliance with facility policy on medication administration and the prevention of medication errors by randomly observing two nurse and 2 medication aide medication passes to include all shifts and weekends, weekly x 2 and monthly x 3. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 9/26/19	
F 761	Label/Store Drugs and Biologicals	F 761		9/26/19

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F 761 SS=D	Continued From page 19 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 and staff interviews the facility failed to lock unattended medication carts for 2 of 4 medication carts observed (100 hall medication cart and 400 hall medication cart). The findings included: 1. On 8/27/2019 at 8:10 AM, a continuous observation was conducted of the unattended 100 hall medication cart in the 100 hallway near	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	

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F 761	Continued From page 20 room 103. The locked mechanism on the cart was in the (out) unlocked position. The nurse was not visible at the medication cart. One nursing assistant was at the other end of the 100 hallway picking up breakfast trays from resident rooms. On 8/27/2019 at 08:17 AM, nurse #1 came to the cart from a closed door across the hall from the cart and an interview was conducted immediately following. Nurse #1 stated she ran out to her cart earlier to get something and forgot to lock it when she went back into the resident room. The nurse stated she usually locked her cart when she left it. On 8/27/2019 at 9:49 AM, an interview was conducted with the Administrator who stated she expected the nurses to lock the medication carts when they were not in site or reach of the cart. 2. On 8/27/2019 at 8:42 AM, an observation was conducted of medication aide (MA #1) as she left the 400 hall medication cart facing out to the hallway next to room 402, in the unlocked position. The MA was not visible from the front of the unlocked medication cart. The MA returned to the medication cart shortly after leaving and stated she normally locked the cart when she left it. On 8/27/2019 at 9:49 AM, an interview was conducted with the Administrator who stated she expected the nurses to lock the medication carts when they were not in site or reach of the cart.	F 761	deficiencies cited have been or will be corrected by the dates indicated F761 Label/Store Drugs and Biologics The facility failed to lock unattended medication carts for 2 of 4 medication carts observed. (100 hall and 400 hall medication carts) The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: On 8/27 /19 the Administrator and Staff Development Coordinator educated the nurses assigned to the 100 and 400 hall carts on following facility policy on appropriately securing/locking mediation carts and then audited all medication carts to assure that the medications carts were appropriately locked/secured with no carts being found unlocked/secured. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 8/28 /18 the Director of Nurses and Staff Development Coordinator audited all medications carts to assure facility policy was in place for locking/securing the carts with all carts appropriately locked/secured. All carts were locked/secured following facility policy. On 8/29 /18, the Director of Nurses/Staff Development Coordinator began education of all FT, PT, PRN Nurses, Agency Nurses and Medication Aides on facility policy related to medication safety that included securing /locking medication carts. Any nurse or medication aid who does not complete the education by 9/19/18 will not be scheduled to work until the education has been completed. This	

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F 761	Continued From page 21	F 761	training has been incorporated into the new hire orientation process for all licensed nurses and nursing assistants. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: A quality assurance audit will be completed by the Director of Nurses/Unit Manager to assess that medication carts are appropriately locked/secured. The Director of Nursing /Unit Manager will conduct three random medication cart audits on 3 shifts, 7 days a week to ensure that medication carts are locked when not in use and the licensed nurse/medication aide is not at the cart. Medication cart audits will be conducted 3 times weekly for 2 weeks, then monthly for 3 months for compliance with facility policy on securing/locking medication carts when not in attendance by staff. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for	

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F 761	Continued From page 22	F 761	implementing the acceptable plan of correction: The Administrator Date of Compliance: 9/26/19	