STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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 10/14/19 through 10/17/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #H99911.	E 000		
F 000	INITIAL COMMENTS There was no deficiency cited as result of coplaint investigaton, Event ID H99911, 10/17/19.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		11/14/19

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

Electronically Signed | 10/30/2019

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to provide a dignified feeding experience by standing beside the bed to feed meals to 2 of 2 residents reviewed for dignity. (Resident # 60 and Resident # 42). Findings included: 1.Resident # 60 was admitted to the facility on 9/17/19 with diagnoses that included hemiplegia and hemiparesis, cerebral infraction effecting the right dominant side, dysphagia and aphasia. Review of the admission Minimum Data Set (MDS) dated 9/24/19 indicated resident was cognitively impaired and was total dependent with one to two-persons physical assistance with activities of daily living (ADL). Review of Resident # 60's care plan dated 9/18/19 reveals a focus area of feeding regarding needing total assistance with meals. The goal was for staff to assist resident with feeding to	F 550	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. F550 1. For the resident□s affected, the following corrective action was taken. The CNA/s who failed to provide a dignified feeding experience by standing beside the bed to feed meals to resident #42 and #60 was counseled by the DON on 10/17/19 regarding how to provide a	

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F 550	Continued From page 2	F 550		

promote optimum nutrition and hydration. The interventions included setting up the tray, assisting resident with meals and fluids and reporting to nursing any difficulties related to chewing and swallowing.

Record review indicated Resident# 60 was on a cardiac diet, pureed texture with nectar thick liquid.

During a continuous observation on 10/14/19 from 8:35 AM to 8:45 AM, Resident # 60 was being assisted with eating while in her bed by Nurse aide (NA). NA was standing beside the resident's bed while assisting the resident with her breakfast tray. A wooden chair was noted in the room, near the wall behind the NA. The observation continued until the resident had completed consuming her meal and the NA brought the tray out of the room to be placed on the tray rack.

During an interview on 10/14/19 at 8:50 AM, NA # 4 indicated she wasn't sitting while assisting Resident # 60, but she usually does. The NA stated it was more convenient to feed residents standing up. The NA further stated she should have pulled the chair closer to the bed and should have sat down to feed the resident.

During an interview on 10/17/19 at 11:18 AM, the Director of Nursing (DON) stated the residents care needs were listed in the care guide for each resident. The care guides were available on the NA's tablet and used for documenting care provided. The DON indicated during orientation and at least once a year, information regarding assisting resident with meals was reviewed in training. The NA's were provided in-service

dignified experience when assisting a resident with meals.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents who require assistance with meals have the potential to be affected by the alleged deficient practice. On the following dates, (10/18/19, 10/21/19, 10/22/19 and 10/24/19), the DON, ADON, and Floor Supervisor observed staff assisting residents with meals to audit for staff feeding residents while standing up.

3. Systemic changes

In-service education was provided to all full time, part time, and as needed staff. Topics included:

" All staff when assisting residents with meals shall be seated.
" In order to ensure a resident has a dignified eating experience, staff cannot stand-up over the resident when assisting them with eating their meals.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected

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F 550	Continued From page 3 recently. The DON stated her expectations were for staff to be sitting down during a meal, talking and trying to encourage a resident to eat and not to be standing. 2. Resident # 42 was admitted to facility on 5/20/19 with diagnosis that included dementia, chronic embolism, thrombosis of deep veins of left proximal lower extremity and osteoporosis. Review of the most recent quarterly Minimum Data Set (MDS) dated 8/27/19 revealed the resident was assessed with adequate hearing and clear speech. The MDS indicated resident was cognitively impaired and was total dependent with one-person physical assistance with activities of daily living (ADL) related to transfer, bed mobility, personal hygiene, dressing, toilet use and bathing. Resident was assessed as needing supervision with set up help only for eating. Review of Resident # 42's care plan dated 8/27/19 reveals a focus area related to ADL self-care performance deficit due to confusion and dementia. The goal was to improve resident's current level of functioning related to ADL's. The interventions included anticipating resident needs. The resident was able to self-feed independently and needed only set up assistance during meals. The food was to be placed in clear bowls on the tray, Record review indicated Resident# 42 was on a regular diet with regular texture and thin liquid. During a continuous observation on 10/16/19 from 8:15 AM to 8:40 AM, Resident# 42 was observed lying in bed. Nurse Aide (NA) # 5 (who was assigned to the resident), brought the	F 550	and/or in compliance with regulatory requirements. The DON, ADON, and Floor Supervisor or designee will monitor procedures for resident□s dignity with meals weekly x 2 weeks then monthly x 3 months using the Residents dignity Quality Assurance monitor. Monitoring will include auditing staff for sitting down when assisting a resident to eat their food. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager	

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F 550	Continued From page 4	F 550		

resident's meal tray and placed it on the resident's bedside table. The NA assisted the resident with positioning on the bed and setting up the breakfast tray for the resident. NA # 5 was observed feeding the resident while standing beside the resident's bed. A chair was noted in the room, on the opposite side of the resident's bed. The observation continued until the resident had completed consuming her meal and the NA brought the tray out of the room to be placed on the tray rack.

During an interview on 10/16/19 at 8:45 AM, NA#5 indicated resident was total dependent with one person physical assist with ADL. NA stated resident was assisted with feeding and needed to be encouraged to consumed meals. NA further stated she should have pulled the chair over and sat down to feed the resident. NA indicated she should not be standing beside the resident during feeding.

During an interview on 10/17/19 at 11:18 AM, the Director of Nursing (DON) stated the residents care needs were listed in the care guide for each resident. The care guides were available on the NA's tablet and used for documenting care provided. The DON indicated during orientation and at least once a year, information regarding assisting resident with meals was reviewed in training. The NA's were provided in-service recently. The DON stated her expectations were for staff to be sitting down during a meal, talking and trying to encourage a resident to eat and not to be standing.

During an interview on 10/17/19 at 2:26 PM, the Administrator stated his expectation were for staff was to sit and engage the resident appropriately

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F 550	Continued From page 5 during feeding while following the safety precautions.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other	F 565		11/14/19

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F 565	Continued From page 6 residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to respond to group grievances regarding dietary concerns that were reported in the monthly resident council meetings for 4 of the 5 months reviewed (May 2019, June 2019, July 2019 and September 2019). Findings included: 1. During a resident council meeting on 10/15/19 at 10:00 AM, the residents in the resident council reported not all grievances were acted on promptly by the facility and there were no explanations given as to the reason the grievances were not resolved. A resident reported the Activities Director (AD) documented the issues and discussed the ongoing concerns during each meeting. Several of the members indicated the AD explained during the meetings that the issues were passed along to the appropriate staff to ensure resolution of the issues. Residents indicated that they felt their concerns expressed in the meeting were not addressed by the dietary staff. The Resident Council minutes dated 5/23/19 revealed residents with food concerns. The residents were assured that their concerns were forwarded to dietary. The minutes did not indicate the type of food concern or include the residents name with the concerns. The Resident Council minutes dated 6/26/19 read in part "no new business forward other than personal food concerns".	F 565	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. F565 1. For the resident□s affected, the following corrective action was taken. There were no resident□s numbers given in the statement of deficiencies. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who attend resident council have the potential to be affected by the alleged deficient practice. On 10/30/19 a resident council meeting was held and all residents were encouraged to attend. Any concerns received in the meeting were written on the resident council communication form and at the end of the meeting, the concerns were given to the Administrator to review and distribute to the appropriate department head. The	

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F 565	Continued From page 7 The resident council minutes dated 7/25/29 revealed there were no concerns other than personal food concerns that were forwarded to the dietary. The resident council minutes dated 9/26/19 revealed several residents with personal food concerns that were forwarded to the dietary department. The facility grievance logs from January to September 2019 revealed no grievances related to Resident Council minutes. An interview was conducted with the Social Worker (SW) on 10/15/19 at 2:22 PM. SW stated she was the grievance officer and receives the grievances. The grievances were forwarded to the appropriate department for interventions to be put in place. SW stated once the interventions were put in place, she follows up to ensure the interventions were appropriate and resolution was reached. Oral and written response was provided to the residents and family members. SW indicated she was responsible only for individual grievance and does not complete any resident council grievances as she does not regularly attend resident council meeting. SW stated the activity director (AD) was responsible for resident council grievances. During an interview on 10/15/19 at 2:17 PM, the AD stated any concerns or grievances that were expressed in the resident council were written and forwarded to the respective departments. The departments were responsible for the interventions and follow up. AD indicated she does not maintain a grievance log for resident council concerns. Related to dietary concerns,	F 565	resident concerns were addressed and documented on the resident council communication form and reported back to the resident within 7 days of the resident making the concern. This process was completed on 11/06/19. 3. Systemic changes In-service education was provided to the Administrator and Activities Director by the Nurse Consultant. Topics included: " Policy RCP-101 Resident council " Use of the resident council communication form " Responding back to residents with concerns from resident council meetings within 7 days of receiving their concern and documenting response on the resident council communication form. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 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 or designee will monitor resident council response to concerns monthly x 3 months using the Resident council Quality Assurance monitor.	

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F 565	Continued From page 8 AD stated as residents expressed personal dietary concerns in the meeting, these were forwarded to the dietary department via email. AD indicated no grievances were written as they were personal food choices and that the dietary department does address resident's concerns promptly. During an interview on 10/17/19 at 10:29 AM, the Dietary Manager (DM) explained she sometimes receives email from AD or a piece of paper with the resident's name that had dietary requests. DM indicated the dietary department had not received any grievances related to residents' dietary concerns for past few months. DM stated in September 2019 she did received an email from AD regarding a resident's request to change meal options, which was addressed by the dietary staff. She further stated she received monthly emails from the AD regarding meal of the month that was discussed with the resident's council minutes. The Dietary manager was unable to provide any documentation that concerns were received and addressed. She was unaware of what the resident council concerns were related to dietary department. During an interview on 10/17/19 at 11:53 AM, the administrator stated group grievances can be stated or written by the residents. Depending on the concern or grievance, these should be forwarded to the appropriate department. The departments were supposed to provide appropriate intervention and provide documentation to the AD for resident council grievances. The resolutions were then given to the members of the Resident Council. Administrated stated he expects that these procedures were followed.	F 565	Monitoring will include ensuring resident concerns are documented on the resident council communication form and responded back to in 7 days. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager	

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F 584 SS=B	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); §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	F 584		11/14/19

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F 584	Continued From page 10 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview the facility failed to maintain the walls of the resident's room in good repair for 2 of 18 resident rooms reviewed for environmental conditions (Rooms 308 and 312). Room 308 had a hole in the dry wall and Room 312 had a cracked panel near the resident's bed. Findings included: 1. An observation on 10/14/19 at 11:25 AM of Room 308, revealed a large (approximately palm size) hole in the wall near the resident's bed behind his oxygen concentrator unit. Resident indicated he was unaware that the dry wall broken. Review of the repair requisition dated 10/8/19 for Room 308 read in part "hole in sheet rock on bedside (beside condenser)". An interview with the housekeeping staff #1 was conducted on 10/16/19 at 9:10 AM, The housekeeping staff stated any repairs observed during room cleaning process was reported to the maintenance director. Housekeeping staff indicated she was responsible for cleaning Room #308, but she had not noticed or reported the hole in the wall. During an interview on 10/16/19 at 10:25 AM, Nurse aide (NA) # 6 stated she had observed the hole in the wall few days ago (unsure of the date). NA# 6 indicated the work order for the maintenance was completed and placed in the	F 584	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. F584 1. For the resident□s affected, the following corrective action was taken. Room # 308, repairs to the palm sized hole in the sheet rock behind the oxygen concentrator was completed by the Maintenance Director on 10/16/19. Room # 312, the reinforcement board near the resident□s bed was repaired by the Maintenance Director on 10/16/19. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents□ rooms have the potential to be affected by the alleged deficient practice. Beginning on 10/28/19, the Maintenance Director audited all resident rooms in the facility for holes in the sheet	

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F 584	Continued From page 11 maintenance box. NA was unsure why it was not yet repaired. As the facility maintenance director was unavailable to be interviewed the corporate maintenance director was interviewed on 10/16/19 at 2:20 PM. The corporate maintenance director stated he was unsure why the hole in the wall of Room #308 was not fixed when the work order was placed. During an interview on 10/16/19 at 11:00 AM, the Director of nursing (DON) stated the housekeeping staff would notify the maintenance staff if any maintenance concerns were observed during the room cleaning. DON further stated the nursing staff need to complete a work order slip to notify maintenance of any building or equipment concerns. During an interview with the administrator on 10/17/19 at 2:49 PM, he stated all maintenance work should be reported and addressed at the earliest possible time frame. 2. An observation on 10/14/19 at 1:35 PM of Room 312, revealed the reinforcement board on the wall near the resident's bed was cracked. The crack was about half of the reinforcement board. During an interview on 10/16/19 at 9:18 AM, Nurse#4 stated she had not observed the crack on the reinforcement board, hence did not complete the work order for the maintenance staff. As the facility maintenance director was unavailable to be interviewed the corporate maintenance director was interviewed on	F 584	rock and cracks in the reinforcement board. Any areas identified requiring correction will be completed by 11/14/19. 3. Systemic changes In-service education was provided to the Maintenance Director by the Administrator: " When receiving repair requisitions, all efforts should be made to complete the repair work within 3 days. If the repair work cannot be completed within 3 days, notify the administrator for approval to extend the repair time or to make other arrangements for outside vendors to be contracted for repairs to be made. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 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 Maintenance Director or designee will monitor timeliness of maintenance repair task. Audit will be completed weekly x 2 weeks them monthly x 3 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as	

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	345496	A. BUILDING _____ B. WING _____	C 10/17/2019

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F 584	Continued From page 12 10/16/19 at 2:20 PM. The corporate maintenance director stated, the reinforcement board was the fiber glass reinforcement panel (FRP) usually placed on the wall near the resident bed to prevent any damage to the dry wall when the bed was lowered or raised. He stated the bed's head board had a lever could raise / lower the bed and when bed was placed too close to the wall, could damage the wall. He stated the reinforcement panel needs to be replaced. During an interview on 10/16/19 at 11:00 AM, the Director of nursing (DON) stated the housekeeping staff would notify the maintenance staff if any maintenance concerns were observed during the room cleaning. DON further stated the nursing staff need to complete a work order slip to notify maintenance of any building or equipment concerns. During an interview with the administrator on 10/17/19 at 2:49 PM, he stated all maintenance work should be reported and addressed at the earliest possible time frame.	F 584	appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		11/14/19

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F 585	Continued From page 13 §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations	F 585		

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F 585	Continued From page 14	F 585		

by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than

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F 585	Continued From page 15 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews, and record review, the facility failed to document and resolve individual grievances for 1 of 1 resident reviewed for grievances. (Resident # 60). Findings included: Resident # 60 was admitted to the facility on 9/17/19 with diagnoses that included hemiplegia and hemiparesis, cerebral infraction effecting the right dominant side, dysphagia and aphasia. The admission Minimum Data Set (MDS) dated 9/24/19 indicated resident was cognitively impaired and was total dependent with one to two-persons physical assistance with activities of daily living (ADL). Resident # 60's care plan dated 9/18/19 reveals a focus areas of increased risk of falls related to deconditioning, gait problems and unaware to safety needs and actual fall. The goal to minimize falls with no major or minor injuries. The interventions included anticipating resident's needs, assisting resident to bed when tired and frequent monitoring throughout shifts. Resident to be offered to be put to bed after therapy and staff to reinforce safety reminders frequently. The nursing notes dated 9/27/19 revealed resident was noticed on the floor after returning from therapy. Resident # 60 had a small slit over the right eyebrow and steri strip was applied. The resident was sent to emergency room upon family request. Resident returned to facility later at 9:15	F 585	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. F585 1. For the resident□s affected, the following corrective action was taken. On 10/15/19, the Social Worker notified resident # 60□s responsible party of the resolution regarding a grievance reported on 9/27/19. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who voice a grievance have the potential to be affected by the alleged deficient practice. On 10/15/19, the Social Worker audited all grievances reports received from 08/01/2019 through present to identify any grievance that did not indicate that a verbal or written resolution	

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F 585	Continued From page 16 PM after evaluation. Facility grievance logs were reviewed from January 2019 to September 2019. There were no grievances for the month of September. During an interview on 10/14/19 at 1:15 PM, Resident # 60's responsible party (RP) stated on 9/27/19 at 11:30 AM, the family was notified about resident's fall from her wheelchair. RP stated when he arrived at the facility an hour later, he had some concerns related to resident care after the fall and spoke with the social worker (SW) about their concerns. Upon the family's request the resident was sent to the hospital. RP stated he reported his grievance to the SW and did not receive any resolution since 9/27/19. During an interview on 10/15/19 at 2:22 PM, SW stated she was the grievance officer. SW indicated Resident# 60's RP did approach her related to resident's care after the fall. The assigned nurse had provided appropriate treatment and vital signs were checked. SW stated therapy and nursing staff had interventions in place related to the resident's fall. The resident was sent to the hospital upon family request. SW indicated as the resident was sent to the hospital, she assumed the family's concern was resolved and no grievance was filled. She stated she had met with the RP multiple times after the incident and the RP had not expressed any concerns regarding the resolution. She stated she had not filled any grievance related to the resident's family members concern. During a telephone interview on 10/15/19 at 3:32 PM, the resident's RP stated he was informed about the resolution to his grievance 30 minutes	F 585	and summary was offered and given to the grievant if accepted. 3. Systemic changes On 10/28/19 in-service education was completed by the QA Nurse Consultant to the Administrator, Social Worker, Director of Nursing and Assistant Director of Nursing on the grievance resolution process. The in-service topics included: " Prompt resolution of all grievances " Facility procedure and time line for addressing grievances " Offering the grievant a verbal or written resolution and summary This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 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 this issue using the Quality Assurance for monitoring grievance resolution. The monitoring will include auditing 100% of all grievances for two weeks to ensure the grievance was promptly addressed and the offering of a verbal or written resolution and summary according to	

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F 585	Continued From page 17 ago. RP further stated initially when he had expressed his concerns to the SW on 9/27/19, he had requested for certain documents. RP indicated Resident # 60 had returned to the facility on 9/27/19 late in the evening when the administrative staff and SW had left the facility for the week. RP stated he had not received the documentation and resolutions related to the incident. RP stated his preference was for the facility be proactive in providing the information he requested before he expressed his concerns with the onsite State surveyors. During an interview on 10/17/19 at 11:53 AM, the administrator stated the individual grievances can be stated or written by the residents, family members or any concerned party. Depending on the concern or grievance these should be forwarded to the department. The departments were supposed to provide appropriate intervention and provide the documentation to the SW. The resolutions were provided orally and in written to the concerned person so that the resolution was to their satisfaction. The administrator indicated he does review the resolutions prior to them been given to responsible party. Administrated stated he expects that these procedures were followed.	F 585	facility policy. Then the Administrator will monitor 3 grievances monthly for 3 months for prompt resolution and the offering of a written resolution and summary. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager	
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.	F 761		11/14/19

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F 761	Continued From page 18 §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 remove two expired insulin pen injectors, failed to provide the date of opening for one opened insulin pen injector, stored in 2 of 4 medication administration carts (200 hall and 100 hall). Findings Included: On 10/14/19 at 8:40 AM, observation of the medication administration cart on 200 hall, with Nurse #3 revealed the following expired medication was found: one Lantus (insulin) Solotar Pen, 100 units/ml (milliliter), 3 ml. Per the label on the injector, the Lantus was opened on 9/13/19. Review of the manufacturer ' s literature/information recommended to discard the Lantus injector 28 days after opening, which would have been on 10/11/19.	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 deficiencies cited have been or will be corrected by the dates indicated. F761 1. For the resident□s affected, the following corrective action was taken. For Nurse # 3, the insulin pen was	

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F 761	Continued From page 19 On 10/14/19 at 8:55 AM, during an interview, Nurse #3 indicated that the nurses, who worked on the medication carts, were responsible to check the expiration date on insulin injectors and remove expired medications from the medication administration cart. The nurse had not checked the expiration date on Lantus Pen in her medication administration cart at the beginning of her shift. The nurse did not administer the expired Lantus insulin this shift. On 10/14/19 at 9:10 AM, observation of the medication administration cart on 100 hall with Nurse #4 revealed the following expired medications were found: one Lantus (insulin) Solotar Pen, 100 units/ml, 3 ml. Per the label on the injector, the Lantus was opened on 9/2/19. Review of the manufacturer ' s literature/information recommended to discard the Lantus injector 28 days after opening, which would have been on 9/30/19; one Novolog Flex Pen (insulin), 100 units/ml (milliliter), 3 ml, with no date of opening. On 10/14/19 at 9:25 AM, during an interview, Nurse #4 indicated that the nurses, who worked on the medication carts, were responsible to mark the date of opening on the insulin pen and remove expired medications from the medication administration cart. The nurse confirmed that Novolog insulin pen was opened. The nurse had not check the expiration date on Lantus injector in her medication administration cart at the beginning of her shift. The nurse did not administer Lantus or Novolog insulin this shift. On 10/15/19 at 10:55 AM, during an interview, the Director of Nursing indicated that all the nurses	F 761	immediately discarded and replaced with a new insulin pen that was promptly labeled with the date open. This was completed on 10/14/19. For Nurse # 4, the insulin pen was immediately discarded and replaced with a new insulin pen that was promptly labeled with the date open. This was completed on 10/14/19. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who use insulin pens have the potential to be affected by the alleged deficient practice. The DON, ADON, and Floor Supervisor audited all 3 medication carts for expired insulin pens or other expired medication. This was completed on 10/14/19. If any expired insulin pens medications were noted they were immediately removed from the carts. 3. Systemic changes In-service education was provided to all full time, part time, and as needed RN□s, LPN□s, and Med Tech□s. Topics included: " Dating all insulin pens once placed on the medication cart. " Reviewing the insulin pen date open every time prior to administering the injection. " Immediately replacing any expired insulin pens or any other expired medication from the cart or med room.	

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F 761	Continued From page 20 were responsible to put date of opening on insulin pens-injectors, check all the medications in medication administration carts for expiration date and remove expired medications. Her expectation was that no expired items be left in the medication carts.	F 761	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 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 DON, ADON, Floor Supervisor or designee will monitor insulin pen storage and expiration dates weekly x 2 weeks then monthly x 3 months using the Drug Storage Quality Assurance monitor. Monitoring will include auditing all 3 medication carts for expired insulin pens or other expired drugs. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager	