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 01/29/2020

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
F 000	INITIAL COMMENTS On 1/27/20 through 1/29/20, an unannounced complaint investigation survey was conducted. Event #IVNE11. 3 of the 14 allegations were substantiated with citations at F 584, F 585, F 732 and F 761.	F 000		
F 584 SS=D	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	F 584		2/26/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 1 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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews, the facility failed to clean a resident's wheelchair for 1 of 3 residents reviewed for environment (Resident #1). Findings included: Resident #1's 5-day Minimum Data Set (MDS) dated 12/31/19 revealed the resident was severely cognitively impaired. The resident required limited assistance with bed mobility, transfers, walking in corridor, and locomotion. He required extensive assistance with dressing, toilet use and supervision with eating and personal hygiene. Resident #1's room was observed on 1/27/20 at 9:10 AM. The resident's wheelchair was observed in the corner of the room. The blue seat cushion of the wheelchair had a circular area of a dried brown substance covering about 40 percent of the wheelchair's cushion. There were also a few small, brown flakes on top of the brown, dried substance on the cushion of the wheelchair.	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. For resident #1, the wheel chair and cushion were cleaned and disinfected by housekeeping on 1/27/20. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 584	Continued From page 2 On 1/27/20 at 10:04 AM environmental services staff member #1 was observed cleaning Resident #3's room and taking the trash out of the resident's room. The environmental service staff member #1 (who was cleaning Resident #1's room at 10:04 AM) was interviewed on 1/27/20 at 10:10 AM. She stated she cleaned residents' rooms throughout her shift. She would go back to each room and take out the trash in the afternoon and clean if needed. The nursing assistant (NA) would tell her if they needed anything cleaned and she would do it. She was unsure who was supposed to wipe down the wheelchairs, but she would do it if the wheelchair needed it. Nursing Assistant #5 was interviewed on 1/27/20 at 10:35 AM. She stated the resident used the toilet and needed more help but now could do it (get to the bathroom) on his own. She stated she checked on the resident this morning. She stated the resident had no concerns. She stated she didn't know when he received bathing/got up in the morning as she was new to this hall. Nurse #1 was interviewed on 1/27/20 at 12:06 PM (assigned the resident on 1/27/20 on day shift). She stated the resident was having diarrhea. If there was something obviously dirty in the resident room, then she would notice it. She hadn't noticed anything obviously dirty in the resident's room. She was unsure who washed the resident's wheelchair. Environmental services staff member #1 was interviewed on 1/27/2020 at 3:58 PM. She stated she wiped the resident's wheelchair down earlier today. The seat of the wheelchair had a brown substance on it. It looked like the resident had an	F 584	All residents who sit in wheel chairs or utilize cushions have the potential to be affected by the alleged deficient practice. The Floor CNA□s and nursing supervisor audited all wheel chairs, Broda chairs, Gerichairs, and cushions for soiling and need to be cleaned. Those chairs or cushions that were noted soiled were cleaned or replaced by floor CNA□s on 1/29/20. 3. Systemic changes In-service education was provided to all full time, part time, and as needed Housekeeping, RN□s, LPN□s, Med Aides, CNA□s, and Med Tech□s. Topics included: "The policy and procedure for disinfecting equipment This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above 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 ADON or designee will monitor needs for equipment disinfection weekly x 4	

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F 584	Continued From page 3 (stool) accident on the cushion part of the wheelchair. She stated she tried to "watch out" for this and make sure his wheelchair was clean. The business office manager was interviewed on 1/28/20 at 8:48 AM. She stated there was a meeting where the resident's family was upset because the resident's wheelchair was dirty. The family also had concerns about medication for the resident's diarrhea. She thought the meeting was on 1/8/20 or 1/9/20. She stated the resident's family grabbed her to see the dirty wheelchair first (unknown date; suspect this was before the meeting on 1/8/20 or 1/9/20). She stated on the cushion of the wheelchair, there was a spot of a dried, brown substance. The resident's family member also grabbed the administrator to see the wheelchair and the administrator told them that he would have someone clean the wheelchair. Resident #1's family was interviewed on 1/27/2020 at 3:39 PM. He stated the resident's wheelchair had stool on it again on Sunday (1/26/20). Resident #1's family was interviewed again on 1/28/20 at 10:14 AM. He stated the resident's wheelchair had a brown substance on the seat cushion for 6 days. He stated on 1/6/20, he got the administrator and the business office manager and showed them. The administrator got them (the facility) to clean the wheelchair. Then on 1/11/20 through 1/14/20, the resident's wheelchair had a brown substance on the cushion again on each of these days, which looked like feces. He stated he did not file a formal grievance but did tell staff (did not state who he told) about the dirty wheelchair. He stated	F 584	weeks then monthly times 2 months using the Equipment disinfection Quality Assurance monitor. Monitoring will include auditing all 5 wheel chairs or other equipment for cleanliness. 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	Continued From page 4	F 584		

the staff did not do anything. He stated on Saturday (1/25/20) the resident's wheelchair was clean. However, on Sunday 1/26/20, there was a brown substance that appeared to be feces on the wheelchair seat again. He stated he spoke to the administrator on 1/20/20 about his concerns and nothing was done about his concerns.

Nurse #4 was interviewed via phone on 1/28/2020 at 2:13 PM. She stated the resident needed assistance with getting up. The resident gets up on his own without their knowledge. The resident would not tell staff when he was going to get up. She has never known his wheelchair or room to be dirty.

The administrator was interviewed on 1/28/2020 at 2:56 PM. He stated there was a time the resident's family came to him because resident's #1 wheelchair was dirty. The wheelchair was soiled but he was unable to say what the substance was. He stated that environmental services staff cleaned the wheelchair. He stated he spot checked the resident's wheelchair for a few days after that and it was fine.

The Director of Nursing was interviewed on 1/28/20 at 4:23 PM. She stated she looked at the resident's wheelchair this morning and the wheelchair wasn't dirty.

The administrator was interviewed on 1/29/20 at 12:10 AM. The NAs would clean the wheelchairs. If a wheelchair sat overnight and it was cleaned the next day and the resident wasn't using the wheelchair, then that was acceptable. He stated he would expect for the wheelchair to be cleaned before the resident utilized it.

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F 585	Continued From page 5	F 585		
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. §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	F 585		2/26/20

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F 585	Continued From page 6	F 585		

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 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

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F 585	Continued From page 7 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 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews, the facility failed to file a grievance for a reported missing cell phone for 1 of 3 residents reviewed for misappropriation of property (Resident #1). Findings included: A policy titled: "Introductions form" (no date) in resident #1's admission packet revealed that "if you have filed a complaint with any of the above individuals and have not gotten a satisfactory response, we encourage you to call our corporate hotline." The document included a list of key individuals and their contact information for a complaint, which included the administrator and business office manager's contact information. There were no grievances filed for this resident regarding a missing cell phone. Resident #1 was admitted to the facility on	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 2/4/20, the Business Office Manager notified resident # 1□s responsible party of the resolution regarding a grievance	

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F 585	Continued From page 8 12/24/19 with the current diagnoses of diabetes, hypertension, and chronic kidney disease. Resident #1's 5-day Minimum Data Set (MDS) dated 12/31/19 revealed the resident was severely cognitively impaired. The resident required limited assistance with bed mobility, transfers, walking in corridor, and locomotion. He required extensive assistance with dressing, and toilet use. He required supervision with eating and personal hygiene. The social worker was interviewed on 1/28/20 at 8:36 AM. She stated the business office manager and Director of Nursing (DON) dealt with the resident's family regarding everything. Nothing was brought to her attention because the family didn't want her to be involved in the resident's care. The Director of Nursing was interviewed on 1/28/20 at 8:42 AM. She stated the resident hasn't had any missing items. Residents' clothes were usually labeled and there were a lot of residents with cell phones. The resident or family had not reported any missing items. They (the facility) typically don't complete an inventory list of items when residents were admitted. The associate director of nursing (ADON) was interviewed on 1/28/2020 at 4:21 PM. The resident's family had not filed any grievances with her. The business office manager was interviewed on 1/28/20 at 8:48 AM. She stated there was a meeting on 1/8/20 or 1/9/20 (She was unsure of the exact date). They had a meeting because the family wanted the power of attorney to be changed and had concerns about the resident's	F 585	report completed for a missing cell phone on 1/9/20. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with missing property have the potential to be affected by the alleged deficient practice. Between 2/18/20 and 2/26/20, the Social Worker interviewed all current residents with a BIMS 13 or greater for missing items. Residents with a BIMS of 12 or lower, their responsible party was contacted by the Social Worker and interviewed for missing property. Any reported missing items were immediately investigated by the Administrator and a grievance form completed. This will be completed on 2/26/20. 3. Systemic changes On 2/18/20 in-service education was completed by the Administrator to the Administrative team including the Social Worker, DON, ADON, Supervisor, Business Office Manager, Activities Director, Receptionist, Maintenance, Admissions Coordinator, and Rehab Director on the importance of reporting missing items and completing a grievance report and follow up with the responsible party or Resident. The in-service topics also included: "Prompt resolution of all grievances "Facility procedure and time line for	

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F 585	Continued From page 9 care. She stated the day the social worker, another staff member, and herself met with the family, they (the family) said Resident #1 was missing a cell phone. She stated she went to the resident's room and looked for the cell phone. She added that she went with the resident's family member to look for the cell phone (date unknown). The cell phone was mentioned again to her and she told the family they could not find the cell phone on 1/8/19 (the day of the meeting). The resident's family lead her to believe that the resident misplaced the cell phone. She didn't file a grievance for the cell phone. She tried to handle the situation and had looked for the cell phone. She told the family she would keep an eye out for it. The resident's family did not want any interaction with the social worker. She stated she probably should have filed a grievance for the cell phone, but she thought the concern was resolved as she never heard anything about the issue after she spoke with the family about it. The resident's family was interviewed on 1/28/20 at 10:14 AM. He stated on 1/4/20, the resident still had a cell phone at the facility as the resident had called him about getting to the bathroom. He stated the resident had a cell phone and a cell phone charger. He noticed the cell phone was missing on 1/7/20 and he told the facility (he didn't say who he told). He stated that nothing was done about the missing cell phone. The Administrator was interviewed on 1/28/2020 at 2:56 PM. He never knew of a cell phone missing for Resident #1. He stated the family could have filed a grievance at any time, which are made available at the facility. If a resident had an issue that wasn't taken care of immediately a grievance would be filed. He stated generally they	F 585	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 5 residents for concerns regarding missing property and if the grievance was promptly addressed according to facility policy. This will be completed weekly times 2 weeks then monthly times 3 months. 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 585	Continued From page 10 would write grievance for missing items unless it was found immediately. The Administrator was interviewed on 1/29/2020 at 12:03 PM. He stated the business office manager just told him about the missing cell phone (during the survey). He stated he would expect for a missing item to be searched for and located (if possible). If the item was not able to be located, then he would expect for a further investigation to be completed and the findings to be reported to the family. If the item was money or an item of value, then they would follow up with the police. For a missing cell phone, they would complete a grievance and talk with the family. Depending on what the family wanted to do, they could replace the item. He stated he was the abuse coordinator at the facility.	F 585		
F 732 SS=B	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.	F 732		2/26/20

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F 732	Continued From page 11 (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 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 facility record reviews and staff interviews, the facility failed to post an accurate and complete daily nurse staffing information for 11 of 92 days of staffing information reviewed (11/04/19, 11/8/19, 11/11/19, 11/20/19, 11/28/19, 12/4/19, 12/11/19, 12/28/19, 1/21/20, 1/25/20 and 1/27/20). Findings included: 1a. Review of the 1/27/20 posted nursing staff information on 1/28/20 revealed the resident census was documented as 81 residents for the 3:00 PM to 11:00 PM shift and the 11:00 PM to 7:00 AM shift. Interview on 1/28/20 at 10:00 AM with the Admissions Assistant revealed the resident census on 1/27/20 was 80 during the morning	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. F 732 1. For the resident□s affected, the following corrective action was taken.	

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	345496	A. BUILDING _____ B. WING _____	C 01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 12 and the census changed to 84 due to 4 admissions on 1/27/2020. The Admission Assistant stated on 1/27/20, 1 resident was admitted at noon, 1 resident was admitted at 3:30 PM, 1 resident was admitted at 5:00 PM, and 1 resident was admitted at 6:15 PM. b. Review of the retained posted nursing staffing records revealed: Staff posting dated 11/4/19 revealed under the columns for the number and hours of registered nurses on duty during the entire day was entered as "0[zero]." Review of the payroll report for 11/4/19 revealed one (1) registered nurse worked 8:00 AM to 5:00 PM. No posted staffing forms were retained for 11/8/19, 11/11/19, 11/20/19, 11/28/19, 12/4/19, 12/11/19, 12/28/19 and 1/21/20. The posted staffing form for 1/25/20 was incomplete. There was no documentation under the columns for the census, number of registered nurses or hours on duty for 7 PM -7 AM and there were no hours for licensed staff during the 11 PM-7 AM shifts. Interview on 1/29/20 at 12:08 PM with the Director of Nurses (DON) stated the HR payroll staff completed the daily staff posting for all shifts, but no one had been assigned to make changes or modifications to the information once the information was completed and posted in the morning. The DON stated she was responsible for retention of the posted staffing and staff would place the prior day's staff posting in her mailbox and at the time of the survey there were months of posted staffing in her mailbox that had not been filed.	F 732	No specific resident was mentioned. The daily staffing records for 11/4, 11/8, 11/11, 11/20, 11/28, 12/4, 12/11, 12/28/2019, 1/21, 1/25, and 1/27/2020 were verified and corrected to include all required information accurately. This was performed on 2/17/20 by the Director of Nursing. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. The Director of Nursing reviewed the Daily Nursing Staff Posting Sheet from 01/29/2020 to 02/17/2020 to ensure that it included all required information accurately, which includes: "Facility name "Current Date "Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: 1. Registered Nurses 2. Licensed Nurses 3. Certified Nursing Assistants "Resident Census The required staffing information is posted daily in a clear and readable format. It is located in a prominent place readily accessible for residents and visitors. This was completed by 02/17/2020. 3. Systemic Changes	

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F 732	Continued From page 13	F 732	On 2/14/20 the Nurse Management team began in servicing the full time, part time and prn RN□s and LPN□s, Administrator, and Nursing Secretary. Topics included: The daily nursing staffing data must be posted daily at the beginning of each shift. The staffing data must include the following components: " Facility name " Current Date " Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: 1. Registered Nurses 2. Licensed Nurses 3. Certified Nursing Assistants "Resident Census The required staffing information is posted daily in a clear and readable format. It is located in a prominent place readily accessible for residents and visitors. Any in-house staff member who did not receive in-service training by 2/26/20 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 732	Continued From page 14	F 732	4. The facility plans to monitor its performance by: The Director of Nursing will monitor this issue using the Staff Posting Survey Audit Tool. This audit will monitor the daily nursing staffing posting requirement for accurate staffing data weekly for 2 weeks then monthly for 3 months or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		2/26/20

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F 761	Continued From page 15 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, staff interview, facility record review and review of the manufacturer's medication storage specifications, the facility failed to date medications when opened, failed to discard expired insulin and failed to properly store an unopened insulin pen in 2 of 2 medication carts. (Unit 100 and right side of Unit 300 and Unit 200 and left side of Unit 300). Findings included: The review of manufacturer's storage specifications revealed: " Levemir Flexpen(insulin) once opened should be disposed after 42 days, even if there was insulin left in it. " All forms of Lantus (insulin)are good for up to 28 days once they are opened, after which any unused portions must be discarded. " Novolog Flexpen (insulin) after opened and not used within 28 days must be discarded. " All unopened Novolog Flexpen must be stored in a refrigerator and protected from light. " Travoprost ophthalmic drops must be discarded 4 weeks after being opened.	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 # 5, the 4 affected insulin pens (for residents #1, 4, 6, and 7) and Timolol (for resident #5) eye drops were discarded. The 2 Fluticasone sprays were discarded. The Travoprost eye drops (for resident #3) were discarded. This was completed on 1/28/20 by Nurse #5.	

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F 761	Continued From page 16 Review of the in-service training records revealed drug storage training was completed on 10/17/19 and 11/6/19. Record review of medication storage audits revealed audits were completed on 10/17/19, 10/21/19, 10/28/19, 11/4/19 and 12/8/19. a. Observation on 1/28/20 at 4:35 PM of the medication Cart for Unit 100 and right side of Unit 300 revealed: " Levemir Flexpen was opened and undated for Resident #1. " Lantus pen for Resident #4 was opened and undated. " Timolol 0.5% Ophthalmic drops for Resident #5 was opened and undated. " Novolog Flexpen was opened for Resident #6. The date on the label affixed to the Flexpen was 12/28/19 as opened. As of 1/28/20, there were more than 28 days after the initial opening of the Novolog Flexpen. " Novolog Flexpen was not opened for Resident #7. " Two (2) bottles of Fluticasone propionate nasal spray were open and not dated. The resident names were smeared and was difficult to obtain resident names. " Travoprost ophthalmic drops for Resident #3 was opened and undated. During an interview with Nurse #5 on 1/28/20 at 4:50 PM Nurse #5 stated it was the responsibility of the nurse who opened a new bottle of medication and/or insulin to write the date it was opened. Nurse #5 stated she knew unopened insulin pens should be refrigerated and was not sure why the unopened insulin pen was stored in the cart. b. Observation on 1/28/20 at 4:59PM of the	F 761	For Nurse # 6, the Fluticasone (for resident #8) and 3 tubes of Diclofenac-sodium topical gel (for residents #9, 10, and 11) was discarded. This was completed on 1/28/20 by Nurse #6. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who use multi dose insulin, eye drops, nose sprays, and topical gels have the potential to be affected by the alleged deficient practice. The Nurse Management Team audited all three medication carts for undated or expired medications. This was completed on 1/28/20. If any expired 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 medication room. " Dating all multi use eye drops with the date open and other multi-use products with a recommended expiration	

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F 761	Continued From page 17 medication Cart for Unit 200 and left side of cart for Unit 300 revealed: " Fluticasone propionate nasal spray was open and not dated for Resident # 8 " Three (3) tubes of Diclofenac sodium topical gel was open and undated. Diclofenac sodium topical gel was prescribed for Resident # 9, Resident #10 and Resident #11. Interview with Nurse #6 occurred on 1/28/20 at 5:15 PM. Nurse #6 stated it was the responsibility of the nurse who opened a new medication to document the date the medication was opened. Interview on 1/28/20 at 5:30 PM with the Director of Nurses (DON) stated nurses get in a hurry and forget to date medications when initially opened. Continued interview with the DON stated her nurses were educated to date medication when initially opened and audits were completed as a result of the last recertification survey ending 10/17/19.	F 761	date after opening. " McNeill□s Pharmacy Recommended drug storage guidelines " Flonase (Fluticasone) nose spray and 3 tubes Voltaren (Diclofenac-sodium topical gel) must be used by the expiration date on the product. Expiration is not dependent on the date open. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff nurses and Med Tech□s 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 or designee will monitor medication storage for date open documentation and expiration dates weekly x 8 weeks then monthly x 2 months using the Drug Storage Quality Assurance monitor. Monitoring will include auditing all 3 medication carts for undated or expired medication. 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	

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F 761	Continued From page 18	F 761	Manager, and the Dietary Manager	