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L 076	.2305(A) QUALITY OF CARE 10A-13D.2305 (a) The facility shall provide necessary care and services in accordance with medical orders, the patient's comprehensive assessment and on-going plan of care. This Rule is not met as evidenced by: Based on observation, record review and staff interview to assess of a change in mobility to a resident receiving restorative services for 1 of 1 sampled resident (Resident #10) who developed a left upper body impairment. The findings included; Resident #10 was admitted to the facility on 11/9/17 with a diagnosis that included A-Fib, CHF, Parkinson's disease, Dysphagia. Review of Resident #10 Admission Facility Assessment (FA) dated 11/9/17 revealed Resident #10 had no contractures. Review of Resident #10 restorative nursing referral dated 6/19/18 revealed service was to begin as soon as possible (ASAP). The note indicated a short-term goal that stated provide assistance to prescribed exercise with use of 3 pounds (lbs.) for bilateral upper extremities and 2 lbs. to bilateral lower extremities as tolerated per exercise sheet. Review of Resident #10 Restorative note dated 11/5/18 revealed a monthly summary for October. The note sated Resident #10 participated in the Restorative 1:1 exercise program. Resident #10 completes the exercises as directed by physical	L 076		

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therapy (PT). The note continued with however Resident #10 limited the use of his eft shoulder due to discomfort. At times he cannot participate due to his hallucinations.

Review of the facilities incident log for the month of October 2018 revealed no incident documented for Resident #10.

Observation of Resident #10 on 11/6/18 at 8:15am revealed the resident to be lying in bed. The resident has a trapeze bar above his bed. The resident was further observed to have bunny boots to both feet. Resident #10's left hand appeared to be swollen along the knuckles and fingers.

Review of Resident #10 nursing note dated 11/1/18 (15:46) revealed he complained of left hand pain of the ring finger and middle finger with some edema noted. The note continued with continue to monitor for any changes or concerns. Administer Tylenol extra strength (ES) 500 milligrams (mg) x 2 tabs given at 1208 with effectiveness pending. An Ice pack was applied to right hand and the spouse requested an x-ray of Resident #10 right hand. The note continued with Tylenol 500mg x 2 tabs given at 1208 non-effective at this time, 1305.
Review of nursing note written by Nurse #4 dated 11/1/18 stated a mobile X-Ray was completed. The note continued that 2 views were taken of Resident #10's left hand. The note indicated Resident #10's 3rd and 4th digits had pain and swelling, and family requested an X-Ray. The noted stated, "residents hand is very contracted, and he completed X-Ray as best he could, but the views would be limited." The note stated that the writer was informed.

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Review of Resident #10 's radiology report dated 11/1/18 at 11:27pm revealed results of no acute fracture or dislocation. The conclusion revealed no gross osseous abnormality and degenerative changes. The conclusion continued with recommendations to repeat x -ray or CT if continued concern given the limited views to exclude a fracture. The note has been signed by the MD with no date to determine date of observation.

Interview with the Restorative Director on 11/7/18 at 1:38pm revealed restorative orders would come from the therapy department although nursing could also make referrals. Although nursing could refer she would still obtain an order and direction for care from the therapy department. She revealed Restorative Aid #1 was assigned to Resident #10 and performed the goals implemented by therapy upon discharge. She stated Resident #10's restorative services began on June 18, 2018 for exercise of the upper and lower extremities. Resident had hallucinations that sometimes interfered with therapy. She revealed it was her expectation that restorative aids communicate changes in resident's mobility that would interfere with restorative goals.

Interview with Restorative Aide #1 on 11/7/18 at 1:41pm revealed he had been working with Resident #10 with 1:1 exercise for about 3 months. She stated Resident #10 exercises included lifting 3 lbs. weights to upper and lower extremities. He stated that Resident #10 had pain in his left shoulder occasionally that would make restorative difficult on occasion. He further stated they completed more with his right arm because of this difficulty. Restorative aid stated he noticed during the weekend that Resident #10

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had was contacted and not able to use his hand for exercise. He sated when he attempted to put Resident#10 on the work out machine for upper body that he couldn't grab with his left hand. He stated he had to help Resident#10 by opening his hand and putting on the machine for him. Restorative Aid #1 indicated that he had not notified the Restorative Director or therapy about Resident #10 change in upper mobility.

Interview with the Rehab Director on 11/7/18 at 2:45p revealed Residents were referred to therapy either by the physician or requested by the nursing department. She recalled Resident #10 being on caseload a while back for positioning. She revealed she did not recall Resident #10 having any contracture development at the time of the assessment. During an observation of Resident #10 at 2:48pm the Rehab Director revealed Resident #10's hand was swollen. She further revealed Resident #10's hand almost appeared like it could be the gout. Upon her examination she described Resident #10's middle finger as being tight and fused with the rest of his hand. She further stated that she was not sure if it was a contracture due to Resident #10 not being fully aroused at the time of her observation.

Interview with PT Director on 11/7/18 at 3:15pm revealed in the instance a resident's status changed while on restorative or had any difficulty with the goals implemented she would expect to be notified immediately. She stated she would expect to be notified so modifications could be made to the resident's goals. She further revealed she would then look at the resident's current status and medical conditions to determine if that would be a reason for the changes. She stated she was unaware that

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Resident #10 was no longer able to participate in his goals as written due to him not being able to open his hand. She further revealed she was unaware of the x-ray report that indicated Resident #10 had a very contracted hand. She stated in the instance Resident #10 had a contracture It would be new.

In an interview with Resident #10's family member on 11/8/18 at 8:59am she revealed she visited with her family member daily. She indicated the injury occurred suddenly about a week. She stated when she had come to visit she had noticed that Resident #10's hand was swollen and a little bruised. She stated Resident#10 hand was not moving and his middle finger was fixed inward. She recalled notifying nursing staff about Resident #10s hand being swollen and requested an x-ray be taken. She further revealed she not been informed as to how the injury may have occurred. She stated she just assumed it was the residents Parkinson's or he might have arthritis. The family member stated the first time the resident was assessed by the Nurse Practitioner (NP) was yesterday 11/7/18. The NP took some notes and concerns about his hand. The family member indicated the resident had hallucinations which is why she preferred for him to be in bed. Resident #10 was unable to get out of bed or out of a chair without assistance.

Interview with Nurse #7 on 11/8/18 at 3:36pm revealed she was the 3 to 11pm nurse supervisor. She sated she was made aware of Resident #10 hand being swollen at change of shift. She stated she was told that Resident #10's one finger was drawn in and they couldn't straighten it out. She stated she had observed Resident #10 hand swollen with no bruising, but it was painful when

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L 076	Continued From page 5 palpated it. She stated she thought she had talked to the NP who observed the resident and provided the order for the x-ray. The X-ray was to determine if the resident had a fracture. She stated that an incident report should have been completed. She stated she had not interviewed staff in regard to the resident's injury and she had not completed an incident report. Interview with Nurse Practitioner (NP) on 11/8/18 at 3:26pm revealed She was not working in the facility last Thursday (11/1/18), Friday (11/2/18), Saturday (11/3/18) or Sunday (11/4/18). She stated that yesterday 11/7/18 was her first day back at the facility. She stated her first time seeing Resident #10s injury was yesterday. She stated she initially thought the resident might have had trigger finger. She sated all the resident's fingers could be moved passively. She stated she referred Resident #10 to therapy for splinting following the visit. The NP revealed no further x-rays had been requested. Interview with the Director of Nursing (DON) on 11/8/18 at 3:50pm revealed it was her expectation that Restorative staff communicate changes in resident's abilities and therapy be notified so the resident can be reassessed.	L 076		
L 078	.2305(C) QUALITY OF CARE 10A-13D.2305 (c) The facility shall not utilize any chemical or physical restraints for the purpose of discipline or convenience, and that are not required to treat the patient's medical condition. An evaluation shall be done to ensure that the least restrictive means of	L 078		

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restraint have been initiated on patients requiring restraints.

This Rule is not met as evidenced by:
Based on observations, record review, resident, and staff interviews the facility failed to maintain an environment that was free from physical restraints for 1 of 2 residents (Resident #23) who were in chairs with tray-tops attached, which prevented the resident from getting out of the chair.

The findings included:

Resident #23 was admitted to the facility on 04/04/12 with diagnoses that included dementia, compression fractures, poor safety awareness and a history of falls.

Review of the most recent annual assessment (dated 9/5/18) revealed Resident #23 was severely cognitively impaired, able to ambulate with assistance and had some anxious and angry behaviors. Additional review of the medical record revealed his most recent fall was 07/30/18 and he did not sustain an injury at that time. Resident #23 was also found ambulating in the hallway unassisted on 9/26/18 and 9/27/18, but he did not fall.

Resident #23's Care Plan, most recently updated on 09/10/18, stated a physical restraint was in place. The goals for this problem were to have the least restrictive restraint for the least amount of time, and that he would have systematic and gradual reduction of restraint necessity. Approaches included but were not limited to restorative ambulation twice daily, toileting every 2 hours and gradually replacing restraint use with

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safety monitoring measures as soon as possible.

No restraint assessments could be found in Resident #23's clinical record.

Resident #23 was observed in the Seay Unit dayroom on 11/6/18 at 10:50 AM. Resident #23 was sitting in a chair with a tray-top locked in place. The chair did not have wheels and the seat was slanted lower toward the back of the chair.

On 11/6/18 at 3:50 PM, Resident #23 was observed in the dayroom in the same chair with the tray-top in place. The resident was pushing and pulling on the tray-top, feeling all around the edges of the tray-top and then pushing and pulling on it repeatedly. At the same time, Resident #23 was moving the chair with a slight hopping motion with his upper body while simultaneously pressing the heels of his tennis shoes against the floor. With this motion the resident was able to turn the chair to the left and reach out to another resident, then he propelled himself approximately 2 feet from the wall and turned the chair to the right about 110 degrees.

On 11/7/18 at 8:20 AM, Resident #23 was up in the dayroom sitting quietly in the chair with the tray-top in place.

On 11/7/18 at 11:45 AM, Resident #23 was again observed in the dayroom sitting in the chair with the tray-top in place. The resident was pushing and pulling on the tray-top while using the force of his body and legs to turn and move the chair that did not have wheels.

Nursing Assistant (NA) #1 was interviewed about Resident #23 at 11:48 AM on 11/7/18. NA #1 said, "Sometimes he's all over this room. If we didn't

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have him in this chair he would be up walking around. He can walk but he would fall maybe." She revealed that the resident was unable to release the tray-top.

On 11/8/18 at 8:30 AM, Resident #23 was observed in the dayroom, sitting in the chair with the tray-top in place. His breakfast tray was in front of him and he was eating.

At 8:56 AM on 11/8/18, Nurse #5 stated Resident #23 had always been a wanderer and the resident was in the chair with the tray-top for his safety. When asked how long the tray-top chair had been used to keep him safe, Nurse #5 said Resident #23 had been "using the chair at least a couple of years." She stated the resident had also been known to be aggressive with staff at times but not with other residents.

At 9:09 AM on 11/8/18, NA #2 asked the resident if he was finished with his breakfast. The NA removed the breakfast tray and the resident continued in the chair with the tray-top in place.

On 11/8/18 at 9:30 AM, Resident #23 was in the chair with the tray-top in place. He was sitting quietly with his hands folded on the tray-top and he was whistling.

At 10:20 AM on 11/8/18, Resident continued in the dayroom, in the chair with the tray-top in place and he appeared to be asleep.

NA #3, who was assigned to Resident #23, was interviewed on 11/8/18 at 10:35 AM. NA #3 stated he had gotten Resident #23 dressed around 7:30 AM and had last toileted the resident prior to taking him to the dayroom for breakfast. The resident had been placed in the chair at that time

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L 078	Continued From page 9 and the tray-top locked in place for his safety. At 10:45 AM on 11/8/18 Resident #23 was still in the chair with the tray-top in place. He was participating in a sing-along by whistling. At 11:00 AM on 11/8/18, NA #3 and another staff member got Resident #23 out of the chair and assisted the resident in walking to the dining room. Care Plan Coordinator #1 was interviewed on 11/8/18 at 2:35 PM. She confirmed that no restraint assessments had been completed for Resident #23. The facility was unable to provide evidence of any less restrictive measures or systematic reduction in the use of the restraint for Resident #23 even though it was a goal stated in his Care Plan. On 11/8/18 at 2:37 PM, the Director of Nursing (DON) was interviewed. The DON stated that Resident #23 was using the restraint (tray-top locked in place) for his safety, and that staff would get him out of it at intervals to walk him or toilet him before taking him back to the chair. On 11/8/18 at 3:05 PM, the DON was again interviewed. She stated Resident #23 was being re-evaluated for the use of the restraint and the chair with the tray-top had been put in the trash.	L 078		
L 089	.2306(B) MEDICATION ADMINISTRATION 10A-13D.2306 (b) The facility shall ensure that each patient's drug regimen is free from drugs used in excessive dose or duplicative therapy, for excessive duration or without indications for the prescription of the drug. Drugs shall not be used	L 089		

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L 089	Continued From page 10 without monitoring or in the presence of adverse conditions that indicate the drugs' usage should be modified or discontinued. As used in this Paragraph: (1) "Excessive dose" means the total amount of any medication (including duplicate therapy) given at one time or over a period of time that is greater than the amount recommended by the manufacturer for a resident's age and condition. (2) "Excessive Duration" means the medication is administered beyond the manufacturer's recommended time frames or facility-established stop order policies or without either evidence of additional therapeutic benefit for the resident or clinical evidence that would warrant the continued use of the medication. (3) "Duplicative Therapy" means multiple medications of the same pharmacological class or category or any medication therapy that replicates a particular effect of another medication that the individual is taking. (4) "Indications for the prescription" means a documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations. (5) "Monitoring" means ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to: (A) Ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal; (B) Detect any complications or adverse consequences of the condition or of the treatments; and (C) Support decisions about modifying, discontinuing, or continuing any interventions.	L 089		

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This Rule is not met as evidenced by:
Based on record reviews and staff and consultant pharmacist interviews, the facility failed to initiate and observe a stop date for a controlled substance medication prescribed for a limited period of time. This occurred for 1 of 1 resident reviewed who received a controlled substance medication requiring a medication stop date (Resident #3).

The findings included:

Resident #3 was admitted to the facility on 6/22/18. Her cumulative diagnoses included depression and anxiety.

A review of Resident #3 ' s current medications included a physician ' s order dated 9/10/18 for 0.5 mg lorazepam (an antianxiety medication) to be given as one tablet by mouth twice daily as needed (PRN) "times 30 days." Further review of the details input into the computer system for this order revealed no stop date was designated for this order.

A review of the resident ' s October 2018 Medication Administration Record (MAR) revealed the resident continued to receive the lorazepam past the 30-day stop date (10/10/18) included in the physician ' s order. She received at least one dose of lorazepam on each of the following dates: 10/11/18, 10/12/18, 10/13/18, 10/14/18, 10/15/18, 10/17/18, 10/18/18, 10/19/18, 10/22/18, 10/23/18, and 10/24/18.

A review of the resident ' s November 2018 Medication Administration Record (MAR) also revealed the resident continued to receive the

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lorazepam past the 30-day stop date (10/10/18) included in the physician ' s order. She received one dose of lorazepam on 11/3/18.

An interview was conducted on 11/8/18 at 10:05 AM with the facility ' s Clinical Coordinator. The Clinical Coordinator was identified as having input the 9/10/18 physician ' s order for Resident #3 ' s lorazepam into the computer system. Upon request, the Clinical Coordinator reviewed the 9/10/18 order for Resident #3 ' s lorazepam. The Clinical Coordinator reported since her name was the only name listed on this order in the computer system, she may have been the person who put the order into the system. The Clinical Coordinator explained further by stating a 2nd nurse usually would have filled in the computer field for a "stop date," but there was no documentation to indicate it was done and she acknowledged there was no stop date put into the computer system. When asked, the Clinical Coordinator confirmed the resident was receiving the lorazepam past the medication stop date (30 days) indicated by the physician ' s order. She added, "I guess we need to re-think how we do that."

An interview was conducted on 11/8/18 at 10:40 AM with the facility ' s consultant pharmacist. Upon review of the Resident #3 ' s physician ' s order for the lorazepam and the October and November 2018 MARs, the pharmacist stated, "There should be a stop date."

An interview was conducted on 11/8/18 at 2:00 PM with the facility ' s Director of Nursing (DON). During the interview, the concern related to Resident #3 continuing to receive lorazepam beyond the time frame specified in the physician ' s order was discussed. The DON reported she

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L 089	Continued From page 13 would expect to have a stop date put on a medication ordered for a limited time, or alternatively, to have a system in place to monitor the medication to ensure it did not continue past the intended time frame. She stated, "We can look at this and get a system in place."	L 089		
L 092	.2306(D)(2) MEDICATION ADMINISTRATION 10A-13D.2306 (d)(2) The requirements for self-administration of medication shall include the following: (A) determination by the interdisciplinary team that this practice is safe; (B) administration ordered by the physician or other person legally authorized to prescribe medications; (C) instructions for administration printed on the medication label; and (D) administration of medication monitored by the nursing staff and consultant pharmacist. This Rule is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assess a resident's ability to self-administer medications for 1 of 1 residents (Resident #9). The findings included; Review of facility policy titled, "Self-Administration of Medication" revised 10/18. The policy stated, "Residents admitted to the facility, have the right to self-administer their medications, provided the resident has been determined by the interdisciplinary team competent to do so, and there is a MD (Medical Doctor) order." Resident #9 was admitted to the facility on 1/9/18 with a diagnosis that included Amnesia,	L 092		

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L 092	Continued From page 14 Hypertension, Hypokalemia, Hyperlipidemia, Edema, COPD, Vitamin D Deficiency, unspecified Dementia with behavioral disturbance, low back pain, Arthritis, Major depressive disorder, single episode and Stage 3 Kidney Disease. Review of the most recent Facility Assessment (FA) dated 1/9/18 revealed Resident #9 had short term memory (STM) loss with confusion. Review of Resident #9 care plan revealed no goals or interventions for self-administration of medications. Review of Resident #9 care plan revealed a "problem" of, Cognitive loss/Dementia: Resident noted to have STM deficits and confusion and on admission assessment MD ordered Neurology consult and SLUMS (Saint Louis University Mental Status Examination). The goal stated Resident #9 would perform self-care activities within her individual capabilities. The approaches included Provide Resident #9 with cueing and oversight support for performance of activities of daily living. Review of interdisciplinary note dated 10/22/18 stated resident had occasional confusion and forgetfulness. Review of Interdisciplinary note dated 10/24/18 stated Resident #9 was alert and oriented to self. The note continued with she was occasional confused and had memory lapses. Review of interdisciplinary note dated 10/31/18 revealed Resident #9 was altered with episodes of confusion. Observation on 11/17/18 at 9:55am revealed	L 092		

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L 092	Continued From page 15 Resident #9 to be seated on the edge of her bed in front of her bedside table. The resident was further observed to have an empty breakfast plate in front of her. Resident revealed she enjoyed her breakfast and lifted a medication cup with multiple pills and shook them. Resident #9 stated she was going to take her medication now. During an interview with Resident #9 on 11/17/18 at 10:05 revealed she was left her pills because she didn't want to take them until she finished eating. She stated the nurse left them for me and I took all of them. Interview with Nurse #6 on 11/17/18 at 10:08am revealed she had thought Resident #9 had taken all the pills when before she left the room. Nurse #6 revealed she provided Resident #9 with Zoloft, Cozaar, Klor-Con, Vasculera, Wellbutrin, Vitamin D3, Bumetanide, a Multivitamin and Mybetriq. She stated she should have not left the resident by herself with the pills. She further revealed she should have not marked the pills as administered until she saw the resident take them. Interview with Director of Nursing (DON) on 11/8/18 at 3:50pm revealed it was her expectation that staff watch the resident take the pills before signing the MAR that indicates they had been taken. She further revealed it was her expectation that a resident be assessed for ability to self-administer. The DON stated Resident #9 would not have the cognition to self-administer medications.	L 092		
L 134	.2605(A) DRUG STORAGE AND DISPOSITION 10A-13D.2605 (a) A facility shall ensure that drug storage areas are clean, secure,	L 134		

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L 134	Continued From page 16	L 134		

well lighted and well ventilated; that room temperature is maintained between 59 degrees F. and 86 degrees F.; and that the following conditions are met:

This Rule is not met as evidenced by:
Based on observations and staff and consultant pharmacist interviews, the facility failed to store medications at the refrigeration temperature specified by the manufacturer in 1 of 3 Medication Storage Rooms observed (2nd floor C/D Med Room); and, failed to discard expired medications stored in 2 of 4 medication carts (1B and 1D med carts) and in 1 of 3 Medication Storage Rooms (2nd floor ABC Med Room).

The findings included:

1) Accompanied by Nurse #1, an observation was made of the 2nd floor C/D Medication Room on 11/7/18 at 10:20 AM. The thermometer in the refrigerator read -2o Fahrenheit (o F). On 11/7/18 at 10:22 AM, the Assistant Director of Nursing (ADON) joined the nurse in the med room to confirm the refrigerator temperature observed. When asked if she would like to confirm this temperature with another thermometer, the ADON left the med room to obtain another one. As an inventory of the medications stored in the refrigerator was taken, a second thermometer was observed to be placed on another shelf of the refrigerator. This thermometer indicated the refrigerator ' s temperature was 32o F. When the ADON returned to the med room, she confirmed the second thermometer ' s temperature reading.

An interview was conducted with the ADON on 11/7/18 at 10:27 AM. Upon observing the temperature reading of the thermometers and

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L 134	Continued From page 17 feeling the temperature of the medications stored in the refrigerator, the ADON acknowledged the medications from the refrigerator felt colder than usual. The medication contents of the refrigerator at the time of the observation included the following: --2 partial boxes of 20 mcg/2 ml Perforomist nebulization solution (an inhalation medication used in the treatment of asthma or chronic obstructive pulmonary disease); --1 unopened box containing 60 vials of 15 mcg/2 ml Brovana nebulization solution (an inhalation medication used in the treatment chronic obstructive pulmonary disease). The manufacturer ' s label read, in part, "Keep refrigerated or store at room temperature for up to 6 weeks." Two pharmacy auxiliary stickers placed on the box read, "Keep in refrigerator. Do not freeze (written in capital letters);" --1 unopened 2.5 milliliter bottle of 0.005% latanoprost ophthalmic solution (an eye drop used for the treatment of glaucoma); --1 opened multi-dose vial of Tuberculin PPD dated 10/29/18 (an injectable medication used as a diagnostic test for exposure to tuberculosis). A review of the manufacturers' product information for the individual medications stored in the C/D Medication Room refrigerator included the following storage requirements: -- Perforomist vials may be stored in a refrigerator (36o - 46o F); -- Brovana solution for nebulization may be stored in a refrigerator (36o - 46o F); -- Intact bottles of latanoprost ophthalmic solution should be stored under refrigeration at 36o - 46o F; --Tuberculin PPD injectable solution should be stored at 36o - 46o F; do not freeze.	L 134		

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L 134	Continued From page 18 An interview was conducted on 11/8/18 at 8:06 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated the ADON had informed her about the med room refrigerator temperature in the 2nd floor C/D med room refrigerator and told her the medications were very cold when checked. She reported this refrigerator was identified as being fairly old so the facility decided to purchase a new refrigerator (on 11/7/18) for the med room. The DON stated the facility consulted with their pharmacist and returned the affected medications to the pharmacy. Upon inquiry, the DON stated refrigerated medications should be stored in the refrigerator at 36o - 46o F. 2) Accompanied by Nurse #3, an observation was made of the 1B medication cart on 11/7/18 at 3:23 PM. One bubble pack medication card containing 28 tablets of 0.125 milligrams (mg) hyoscyamine sublingual tablets was stored on the medication cart. The pharmacy label on the medication card included the following phrase, "Discard date on pkg (package)." The expiration date printed on the foil back of each bubble containing a tablet indicated the expiration date of the tablets was 8/12/17. An interview was conducted on 11/8/18 at 8:06 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she would expect expired meds to be pulled from the medication carts and medication rooms. 3) Accompanied by Nurse #4, an observation was made of the 1D medication cart on 11/7/18 at 3:43 PM. One bubble pack medication card containing 23 tablets of 325 milligrams (mg) ferrous sulfate tablets was stored on the	L 134		

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L 134	Continued From page 19 medication cart. The pharmacy label on the medication card included the following phrase, "Discard date on pkg (package)." The expiration date printed on the foil back of each bubble containing a tablet indicated the expiration date of the tablets was 6/8/18. An interview was conducted on 11/8/18 at 8:06 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she would expect expired meds to be pulled from the medication carts and medication rooms. 4) Accompanied by Nurse #2, an observation was made of the 2nd floor ABC Medication Room on 11/7/18 at 10:00 AM. One unopened, multi-dose vial of Engerix-B (an injectable vaccine for hepatitis B) with a manufacturer expiration date of 10/8/18 was stored in the med room refrigerator. Nurse #2 confirmed the vaccine was past the manufacturer ' s expiration date. An interview was conducted on 11/8/18 at 8:06 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she would expect expired meds to be pulled from the medication carts and medication rooms.	L 134		
L 156	.2701(E) PROVISION OF NUTRITION & DIETETIC SVCS 10A-13D.2701 (e) The facility shall ensure that menus are followed which meet the nutritional needs of patients in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences which are incorporated by reference, including subsequent amendments.	L 156		

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L 156	Continued From page 20 Copies of this publication may be obtained by contacting The National Academy Press, 500 Fifth St. N.W., Washington, D.C. 20001 or accessing it at http://www.nap.edu/catalog.php?record_id=1349. Menus shall: (1) be planned at least 14 days in advance, (2) provide for substitutes of similar nutritive value for patients who refuse food that is served, and (3) be provided to patients orally or written through such methods as posting and daily announcements. This Rule is not met as evidenced by: Based on observation, staff interviews and review of facility menus, the facility failed to serve portions of foods planned on the facility's menu for 7 of 10 foods being served during 1 of 1 tray line observation. The findings included: Review of the facility's planned lunch menu for 11/8/18 included the following portion sizes were to be served; 4 ounces of Chopped Chicken 4 ounces of sliced Beets 4 ounces of whole Peas 5 ounces of Pureed Chicken 5 ounces of Pureed Beets 5 ounces of Pureed Spinach 8 ounces of Pureed Soup On 11/08/18 from 11:43 to 11:46 AM, Dietary Staff (DS) #1 was observed at the kitchen's tray line plating foods for resident lunch meal tray line service while Registered Dietician (RD) #1 identified the amount of each scoop being used.	L 156		

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L 156	Continued From page 21 The RD identified that DS #1 was using the following sized scoops: 3 ounce scoop for the Pureed Chicken 3 ounce scoop for the Pureed Beets 3 ounce scoop for the Pureed Spinach and 3 ounce scoop for the Pureed Soup During this time DS #1 was also plating the Chopped Chicken, sliced Beets and the whole Peas using large serving spoons instead of portion measured scoops. DS #1 was observed plating one spoonful each of the Chopped Chicken, sliced Beets and the whole Peas or one scoop each of the Pureed Chicken, Pureed Beets, Pureed Spinach and Pureed Soup. On 11/08/18 at 11:45 AM, DS #1 continued to plate food while RD #1 was interviewed. When asked why the large spoons were being used and the amount being served with the spoons, the RD stated she did not know how much each spoonful provided and then replaced the spoons with 4 ounce scoops. On 11/08/18 at 11:46 AM, DS #1 was interviewed about her serving sizes as she continued to plate the food. DS #1 said, "I give one scoop of each." When asked why she had been using the large serving spoons, DS #1 said, "With a spoon you can drain off the liquid." Continued observation on 11/08/18 from 11:46 AM to 11:47 AM, with RD #1 and the Dietary Manager present, revealed DS #1 plating one 3 ounce scoop when she served Pureed Chicken, Pureed Beets, Pureed Spinach and Pureed Soup on resident meal trays. On 11/08/18 at 11:47 AM, it was pointed out to RD #1 and the Dietary Manager that DS #1 was plating only one 3 ounce scoop of the identified	L 156		

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L 156	Continued From page 22 foods. RD #1 then instructed DS #1 to serve one and one half 3 ounce scoops when plating Pureed Chicken, Pureed Beets, Pureed Spinach and Pureed Soup. During an interview at 11:49 AM on 11/08/18, RD #1 said the correct serving sizes scoops should be used during meal service. The Dietary Manager stated that she would provide portion control training to the Dietary staff.	L 156		
L 166	.2701(O) PROVISION OF NUTRITION & DIETETIC SVCS 10A-13D.2701 (o) Food services shall comply with Rules Governing the Sanitation of Restaurants and Other Foodhandling Establishments (15A NCAC 18A .1300) as promulgated by the Commission for Public Health which are incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food under sanitary conditions. Copies of these Rules can be accessed online at http://www.deh.enr.state.nc.us/rules.htm. This Rule is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment and floors in sanitary condition by failing to clean the char-griller grate and 3 of 5 roasting pans and by failing to prevent the build-up of grease and food debris on the floor in the kitchen. The findings included: 1. The initial tour of the kitchen began at 9:25 AM on 11/06/18. The Dietary Manager (DM) and the	L 166		

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L 166	Continued From page 23 Assistant Dietary Manager (ADM) were present during the tour and the following was observed: a. At 9:38 on 11/06/18, roasting pans were stacked front side down on a storage rack. Black dried food residue 1/8 to ¼ inch thick was observed all around the pans under the rim on 3 of the 5 roasting pans. During an interview at 9:39 AM on 11/06/18, the Dietary Manager indicated the pans were gradually being replaced and said, "but these need to be cleaned." b. At 9:41 on 11/06/18, the char-griller grate had a build-up of hardened carbon and all across the front tray of the char-griller were blackened bits of food particles and grease. At that time the Dietary Manager estimated that in some areas the carbon build-up was ¼ inch thick on the grill. At 9:45 on 11/06/18, the Assistant Dietary Manager (ADM) was interviewed about when the grill was last used. The Assistant Dietary Manager stated it had been used for dinner the previous evening and "should have been cleaned up last night before anyone left to go home." When asked about who was responsible for cleaning the equipment, the ADM responded that all staff were responsible. He said there was a cleaning schedule but he was unable to find the current or last week's schedule to see when the grill was last cleaned. c. On 11/06/18 at 9:50 AM, there was a film of grease on the floor and at the baseboards there was dried food debris and grease build-up. The black grease/food debris build-up was ¾ to 1 inch wide along the baseboards and the Dietary Manager estimated it to be 1/8 inch thick in some	L 166		

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L 166	Continued From page 24 places. At the same time under a storage rack, food spillage was observed on the floor that was dry and in a splatter pattern that was approximately 1 ½ feet in diameter. During an interview on 11/07/18 at 1:50 PM the Dietary Manager said staff had cleaned the floor and taken a scraper to remove the build-up at the baseboards. She said the floors were supposed to be mopped three times a day after each meal. The DM said "They moved stuff out and scrubbed. I think they have a better idea of what is expected of them now."	L 166		