STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 The State Agency (SA) conducted an annual recertification survey from 6/4/19 to 6/7/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid and extended the survey, due to an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), related to unsecured medications and resident supervision. The SA identified an IJ and SQC on 6/5/19, which began on 4/26/19, when the A-wing medication "Cart 1" drawer was identified by facility staff as not locking properly, which contained significant medications accessible to residents. The facility was aware the drawer would not lock on 4/26/19, and failed to remove/secure the medications and/or replace the cart until 6/5/19. The facility also failed to supervise cognitively impaired residents to ensure they did not have access to the unsecured medications that were in the A-Wing medication drawer, which did not lock. Resident #41, a severely cognitively impaired resident, was observed on 6/4/19 at 6:45 PM, to open the unlocked drawer of A-Wing medication "Cart 1", which contained 25 Nitroglycerin tablets, Insulin, and other medications. The cart was in the middle of the hallway, with the drawers facing toward the center of the hallway, and the Medication Nurse was not present. Resident #41 demonstrated the ability to easily open the bottle, which had contained the Nitroglycerin tablets. The failure of the facility to secure the medication cart, and to supervise cognitively impaired residents to prevent access to significant medications, from 4/26/19 until 6/5/19, placed	F 000		

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

Electronically Signed | 07/08/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Resident #41 and other mobile residents, with severely impaired cognition, in a situation that was likely to cause serious injury, harm, impairment, or death. The facility's Administrator was notified of the IJ and SQC on 6/5/19 at 6:50 PM. The IJ and SQC existed at: 42 CFR(s) 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) IJ existed at: 42 CFR(s) 483.45(g)-(h) Label/Store Drugs and Biologicals (F761) The facility provided a credible Removal Plan on 6/6/19, in which the facility alleged all corrective actions were completed as of 6/5/19, and the IJ removed as of 6/6/19. The SA validated the Removal Plan on 6/7/19, and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s) 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices (F689), and 42 CFR(s) 483.45(g)-(h) Label/Store Drugs and Biologicals (F761), were lowered to a "D" level, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The SA also cited deficiencies at F585, F641, F645, F656, F677, F755, F759, F760, F803, F804, and F925. The facility census was 86, and the facility was	F 000		

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F 000	Continued From page 2 licensed for 119 beds at the time of survey.	F 000		
F 585 SS=E	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	F 585		7/12/19

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F 585	Continued From page 3 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 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	F 585		

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F 585	Continued From page 4 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 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, Grievance Log review, resident interview, staff interview, Resident Council meeting interviews, and facility policy review, the facility failed to resolve food grievances voiced by six (6) residents in the Resident Council meeting, of 86 residents in the facility, Residents #1, #4, #23, #65, #70, and #83. Findings Include: Record Review of the facility policy, titled "Grievances", undated, revealed the facility will assist residents, their representatives, other family members, or advocates, in filing grievances or complaints when such requests are made. Any resident, his or her representative, family member, or advocate may file a grievance concerning his or her treatment, medical care, behavior of other residents, staff members, theft of property without fear of discrimination, threat or	F 585	Preparation and Submission of this plan of correction by Columbia Rehabilitation and Healthcare Center does not constitute an admission or agreement by the Provider of the truths of the facts alleged or the correctness of the conclusion set forth on this statement of deficiencies. The plan of correction is prepared and submitted solely pursuant the requirement under state and federal laws. F585 1. Resident #1 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #4 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #23 interviewed by Dietary	

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F 585	Continued From page 5 reprisal of any kind. Grievances or complaints may be made orally or in writing to the Social Worker, and may be filled anonymously. Upon receipt of written grievance, the social worker or relevant department head will investigate the allegation and report the findings to the Administrator within 72 hrs to determine what corrective actions, if any, need to be taken. The resident, or the person filing the grievance on behalf of the resident, will be informed verbally and in writing (if requested) of the findings of the investigation and the actions that will be taken to correct any identified problems. Record Review of the facility's "Resident Rights" procedure, undated, revealed the resident is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has rights of action for damages or other said relief for deprivations or infringements of rights to adequate and proper treatment and care established by applicable statue, rule regulation, or contract, and to recommend changes in policies and services to facility staff and/or outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal. Record Review of the resident Council minutes from December 2018 through June 2019, revealed the resident's talked to The Dietary Manager on 12/8/2018, about the chicken that was hard, uncooked and/or burnt. They discussed the menu and residents not asked about food preference on 1/22/2019. Record Review of the Facility's Grievance log from August 2018 through June 2019, revealed	F 585	Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #83 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #70 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #65 no longer resides in the facility as of 6/19/19. Concerns identified were addressed/corrected by Dietary Manager on 7/2/19. 2. Current residents in the facility who receive meals from the dietary department are at risk of being affected by deficient practice. Cognitive residents with Brief Interview for Mental Status (BIMS) score of twelve (12) or higher were interviewed by Dietary Manager regarding their level of satisfaction with Dietary Services on 7/2/19; concerns noted were addressed/corrected by 7/3/19. 3. Dietary Manager in-serviced dietary department staff on food palatability on 7/2/19. Administrator in-serviced management staff on proper grievance procedures and accurately recording council minutes pertaining to concerns voiced in resident council on 7/2/19. Dietary Manager was invited, by the Resident Council President, and will attend Resident Council and address dietary concerns on a monthly basis. Dietary Manager will also interview five (5) residents on food satisfaction on a	

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F 585	Continued From page 6 residents complained of dietary concerns on 8/9/2018, 10/8/2018, 11/9/2018, 11/12/2018, 11/13/2018, 12/28/2018, and 4/29/2019. There was no documented evidence that the facility resolved the grievances. During an observation on 06/04/19 at 6:20 PM, of the dinner meal, Resident #65 complained that the sandwich bread was really hard and had no meat. Resident #65 complained of the taste and said he would not give this to a dog. During interview on 06/05/19 at 2:15 PM, the six (6) Resident Council members revealed they had complained about the food every month for a year. The Council Members also said the Dietary Manager was present for all Resident Council meetings. The Council Members said the Activity Director and the Assistant takes the minutes during the council meeting. During an interview on 06/05/19 at 2:22 PM, Resident #1, the Council President, revealed the Council had complained every month about the food being cold, burnt, and/or the meat is always hard. Resident #1 stated the complaints were not always documented in the minutes. During an interview on 06/06/19 at 3:00 PM, the Activity Director confirmed the residents have complained about the food every month. The Activity Director said she don't know why the residents' complaints about the food was not always put in the minutes. The Activity Director also stated that she has observed cold and burnt food served during meal times. During an interview on 06/06/19 at 9:18 AM, the Dietary Manager revealed she attended all of the	F 585	monthly basis, beginning 7/12/19 and on-going. Administrator in-serviced Dietary Manager on following up on food related grievance issues in a timely manner on 7/2/19. Meal monitoring program initiated on 6/12/2019 and completed daily by Registered Nurse (RN) Supervisor or Licensed Practical Nurse (LPN) Charge Nurse. 4. Beginning on 7/12/19, the Administrator will interview five (5) residents in regards to food satisfaction weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. Administrator will review concerns/grievances and log in daily stand-up meeting for discussion, follow up and resolution. Concerns identified will be acted upon immediately. The Administrator will report findings of the food satisfaction interviews and grievances/log to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator will be responsible for on-going monitoring and compliance.	

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F 585	Continued From page 7 Resident Council meetings. The Dietary Manager stated that the resident's had complained about the food being burnt, or cold, and does not taste good. The Dietary Manager said she was working on correcting the issues. During an interview on 06/6/19 at 10:13 AM, the Social Worker confirmed the residents had complained about the food not tasting good and/or cold for several months. The Social Worker stated the Dietary Manager reported the complaints were resolved. The Social Worker said she had not been talking to the residents to see if the complaints were resolved. The Social Worker said she will follow up with the residents as of today to make sure the complaints were addressed and/or resolved. Record Review of the most recent Minimum Data Set (MDS) of the Resident Council members that were present during interview, revealed the following Brief Interview for Mental Status (BIMS) scores: Resident #1 (BIMS=15), Resident #4 (BIMS=13), Resident #23 (BIMS=15), Resident #65 (BIMS=15), Resident #70 (BIMS=13), Resident #83 (BIMS=13). BIMS 0-6 indicates severe cognitive impairment, BIMS 7-12 indicates moderate cognitive impairment, and BIMS of 13-15 indicates no cognitive impairment.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review,	F 641	F641	7/12/19

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F 641	Continued From page 8 and staff interview, the facility failed to accurately code a Quarterly Minimum Data Set (MDS) related to wounds/Stage 3 pressure ulcer, for one (1) of 22 records reviewed, Resident #46. Findings include: Review of an untitled document on the facility's letterhead, provided and signed by the facility's Administrator, dated 6/7/19, revealed that the facility follows the guidelines set forth by the Resident Assessment Instrument (RAI) Manual for coding the MDS. Review of Resident #46's Quarterly MDS with an Assessment Reference Date (ARD) of 5/3/19, revealed that Resident #46 was coded for a Stage 3 pressure ulcer in the M0300 section of this MDS. Review of a facility document titled, "Skin & Wound Evaluation V5.0," dated 5/1/2019, revealed that Resident #46 had a venous ulcer to the lateral left calf. The wound evaluation did not document a Stage 3 pressure ulcer. Review of the untitled document, dated 6/5/2019, provided by the facility's Treatment Nurse, Licensed Practical Nurse (LPN) #8, revealed that Resident #46 was assessed on 5/9/2019, as having two (2) venous ulcers to the left calf. There was no pressure ulcer(s) indicated on this report. LPN #8 verified this information came from the most recent wound care report. During an interview, on 6/7/2019 at 10:33 AM, LPN #8/Treatment Nurse, revealed that Resident #46's Stage 3 pressure ulcer had been resolved in February 2019. LPN #8 stated that the last	F 641	1. Minimum Data Set (MDS) quarterly assessment of Resident #46 was modified on 6/7/19 by Registered Nurse (RN) #2 to reflect correct status of wound/accurate assessment. Treatment Administration Record (TAR) was corrected on 6/7/19 by discontinuing treatment orders for pressure ulcer in question by Assistant Director of Nursing. 2. Current residents in the facility with wounds are at risk of being affected by deficient practice. Current residents with wounds were audited for accuracy of the MDS related to the Treatment Administration Record (TAR) by MDS and Treatment Nurse. This audit completed by MDS nurses on 7/3/19. Discrepancies noted corrected on 7/3/19 by MDS. 3. Registered Nurse (RN) #2 was in-serviced by Regional Case Mix Specialist in accordance to Resident Assessment Instrument guide about accuracy of assessments on 6/7/19. On 6/20/19, facility nursing staff were educated by Assistant Director of Nursing in regards to requirement of facility to ensure assessments accurately reflect resident status. 4. Beginning on 7/12/19, an audit of five (5) residents with wounds MDS assessments will be conducted weekly for four (4) weeks, monthly for two (2) months and quarterly thereafter by Director of Nursing/Assistant Director of Nursing to validate accuracy of the MDS assessment versus the treatment record	

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F 641	Continued From page 9 wound evaluation indicating that Resident #46 had a Stage 3 pressure ulcer, was completed on 2/8/2019. During an interview, on 6/7/19 at 11:44 AM, Registered Nurse (RN) #2/MDS Coordinator confirmed that a Stage 3 pressure ulcer was coded on Resident #46's Quarterly MDS, with an ARD of 5/3/19. RN #2 stated that there was only two (2) venous ulcers to the left lower extremity on the weekly skin report and weekly wound evaluation report. RN #2 stated that the coding of the Stage 3 pressure ulcer was incorrect. During an interview on 6/7/2019 at 11:50 AM, RN #3/MDS Coordinator, confirmed that the Quarterly MDS completed on 5/3/19, was coded incorrectly for a Stage 3 pressure ulcer. RN #3 confirmed that Resident #46 did not have a pressure ulcer and that two (2) venous ulcers to the left lower extremity were documented on the weekly skin and wound evaluation reports. Review of the Face Sheet revealed Resident #46 was admitted by the facility on 3/6/2018, with diagnoses to include Venous Insufficiency (Chronic)(Peripheral) and Chronic Diastolic (Congestive) Heart Failure.	F 641	and physician order. A report will be submitted to the Quality Assurance Performance Improvement committee by the Director of Nursing monthly for three (3) months for further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)	F 645		7/12/19

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F 645	Continued From page 10 (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the	F 645		

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F 645	Continued From page 11 hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to submit a Level II recommendation within 30 days from the Level I Preadmission Screening and Resident Review (PASARR) screenings for Resident #4 and Resident #14; and failed to submit a Level I Pre-Admission Screening (PAS) for Resident #6 within 30 days; and failed to submit a Level 1 PAS with an accurate diagnosis for Resident #86. This affected four (4) of eight (8) resident reviews for PASARRs. Findings include: A review of the "Division of Medicaid Pre-Admission Screening (PAS) Instruction Manual", revised January 24, 2013, revealed that	F 645	F645 1. On 7/2/19, Pre-admission Screening (PASSR) was resubmitted for Resident #4 by Business Office Manager. On 7/2/19 PASSR was resubmitted for Resident #14 by Business Office Manager. On 7/2/19 PASSR was resubmitted for Resident #6 by Business Office Manager. On 7/2/19 PASSR was resubmitted for Resident #86 by Business Office Manager. Case numbers were obtained for verification by 7/2/19 for these four (4) PASSRs. 2. Current residents in the facility are at risk of being affected by the deficient practice. An audit was completed by Social Services Director on 6/19/19 to ensure that current residents are in	

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F 645	Continued From page 12 a Level II Referral would be completed if a person had a mental illness or diagnosed with mental retardation and/or a developmental disability. The manual also revealed that referrals must be made even if a physician certified that, in his/her opinion, a Level II evaluation was "not indicated at this time". Resident #4 and Resident #14 Record Review of Resident #14's PAS, dated 4/24/19, revealed a Level II was indicated, but had not been completed and submitted as of 6/4/19. Resident #4 was admitted to the facility on 5/11/17, and re-entered the facility on 2/25/19, per the Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/31/19. This MDS indicated Resident #4 had a diagnoses to include; Bipolar Disorder, Alcohol Abuse and Cocaine Abuse. Record review revealed Resident #14's PAS, completed on 4/24/19, revealed a Level II was indicated, but had not been completed and submitted as of 6/4/19. During an interview on 06/07/19 at 2:25 PM, the Social Worker confirmed the PAS was done, but the level II's were not sent to ASCEND. The Business Office Manager did not know she was suppose to send them. The Social Worker said the Level II screen was sent to ASCEND on 6/5/2019. On 06/07/19 at 09:50 AM, interview with the Social Service Director (SSD), revealed the Business Office Manager did not submit the Level I findings that indicated a Level II assessment.	F 645	compliance with PASSR requirements including a case number for verification. Beginning 6/19/19, a clean-up project was initiated to ensure Pre-admission Screenings were completed and on file in the Business Office. Twenty-seven (27) status changes needed and four (4) indications of Level II were found as a result of the audit. All status changes have been completed, and all Level II s have been scheduled with Ascend as of 7/12/19. 3. A tracking log was developed by the Administrator to include PASSR completion date and case number for verification after submission, beginning 6/19/19; log will be kept by Business Office Manager and Social Services Director. On 7/2/19, Social Services Director, Minimum Data Set (MDS) Registered Nurse (RN), Business Office Manager and Medical Records Licensed Practical Nurse (LPN) were in-serviced by Administrator on requirement of facility to submit PASSR assessment to determine further support and care needs for residents. 4. Beginning on 7/12/19, PASSR tracking log will be reviewed by the Administrator weekly for four (4) weeks for completion including case numbers, then monthly for two (2) months and quarterly thereafter. The Administrator will report findings monthly for three (3) months to the Quality Assurance Performance Improvement committee for further recommendations. The Administrator is responsible for	

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F 645	Continued From page 13 The SSD stated that the Business Office Manager was not aware these had to be submitted this week. In a statement, on letterhead, provided by the Regional Reimbursement Specialist on 6/5/19, revealed on 4/24/19, a PAS was entered into the computer system for Resident #4 and Resident #14. Both had attestations stated a Level II is indicated at this time, but the PAS were never submitted. Resident #86 A review of Resident #86's PAS, dated 12/07/16, revealed the facility documented in Part B - Level II Referral Criteria was marked "No", for the question "person has a diagnosis of Mental Retardation" and "No", for the question "person has a diagnosis of a major mental illness". The attestation on the PAS was marked, "A Level II evaluation is not indicated at this time" and signed by the physician on 12/09/2016. A review of Resident #86's medical diagnoses revealed "profound intellectual disabilities", dated 2/8/2019; "unspecified psychosis" dated 5/18/2001; "bipolar disorder", dated 4/26/2010; and "delusional disorder", dated 10/09/2010. A review of Resident #86's MDS with an ARD of 5/22/2019, revealed Section A1500 was documented "0", which indicated the resident was not considered, by the state level II PASRR process, to have a serious mental illness and/or intellectual disability. A review of Resident #86's "Admission Record" indicated her initial admission date was	F 645	on-going monitoring and compliance.	

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F 645	Continued From page 14 5/18/2001, with a readmit date of 01/04/2018. In an interview on 06/06/19 at 3:40 PM, the Administrator (ADM) said the Business Office starts the PAS before admission. An interview with Licensed Social Worker (LSW), at the same time, revealed the Pre-Admission Screening Application for Long Term Care information was electronically entered by Medical Records after nursing and the Social Services completed the form. The LSW said Medicaid then decides who needs a Level II. The ADM confirmed this was the facility policy for completing the PAS. An interview on 6/7/2019 at 11:02 AM, with the LSW, confirmed Resident #86 had a major mental illness and developmental diagnosis that should have triggered a PASARR Level II. The LSW confirmed Resident #86's PAS was blank and was marked "no" on the Part B section for mental illness. The LSW said she would have marked "yes" if she had filled out the form and would expect Resident #86 to have a Level II referral. Resident #6 Review of Resident #6's PAS Summary and Physician Certification document or (Electronic PAS), dated 4/23/219, revealed that Resident #6 had an active medical condition of Bipolar Disorder, Depression (Major), and Anxiety Disorder. The PAS indicated in Part B of the General PASARR section that Resident #6 did not have a diagnosis of a major mental illness. The PAS indicated in the Electronic Attestation section that a Level II evaluation is not indicated at this time. The PAS also indicated a signature from the physician.	F 645		

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F 645	Continued From page 15 Review of the untitled document on the facility's letterhead, dated 6/5/19, revealed that on 4/23/2019, the PAS was entered for Resident #6. The document also indicated, "The attestation stated a Level II screening is not indicated at this time." The document also indicated, "The PAS was submitted on 06/05/2019." The document was signed by Registered Nurse (RN) #4, the facility's Regional Re-imbursement Specialist. Review of the facility's medical records document titled, "Diagnosis Report," dated 6/6/2019, revealed that Resident #6 was admitted to the facility with diagnoses to include: Major Depressive Disorder (Recurrent) (Unspecified) dated 1/23/2018, Bipolar Disorder (Unspecified) dated 01/23/2018. The diagnosis report also indicated that Resident #6 was given the following diagnoses: Major Depressive Disorder (Recurrent) (Mild) dated 11/12/2018, and Generalized Anxiety Disorder dated 11/15/2018. During an interview, on 6/5/2019 at 3:59 PM, the facility's Regional Re-imbursement Specialist/RN #4, stated that the PAS was past the 30-day requirement for submission. RN #4 stated that the PAS was completed, signed by the physician, and entered into the computer on 4/23/2019. RN #4 stated that the PAS revealed that Resident #6 did not require a Level II screening. RN #4 stated that the PAS was finally submitted on 6/5/2019. During an interview, on 6/6/2019 at 10:05 AM, the facility's Social Services Director (SSD), revealed that the SSD is only responsible for a portion of a completed PAS. The SSD stated that the PASARR must be completed to determine if the resident has a Level II exemption. The SSD stated that the exception should have been	F 645		

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F 645	Continued From page 16 marked for major mental illness in Part B and not severe physical illness in Part A. The SSD stated, "I'm going to look for the original PAS, and see what it says." The SSD confirmed the resident had a Bipolar Disorder mental illness diagnosis. Review of the Face Sheet revealed Resident #6 was admitted by the facility on 1/23/2018, and re-admitted on 8/16/2018, with diagnoses to include Acute on Chronic (Congestive) Heart Failure and Recurrent Major Depressive Disorder with Unspecified complications.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		7/12/19

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F 656	Continued From page 17 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan related to nail care for Resident #11, and related to medication administration for Resident #1. This affected two (2) of 18 resident comprehensive care plans reviewed. Findings include: Review of a facility policy titled, "Goals and Objectives, Care Plans" dated April 2009, revealed: Care Plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. A review of facility policy titled, "Using the Care	F 656	F656 1. Resident #11 was assessed in regards to care plan not being followed by Registered Nurse (RN) Supervisor with no adverse findings on 6/6/19. Resident #1 s physician orders were reconciled against Medication Administration Record (MAR) on 6/4/19 Registered Nurse (RN) Supervisor. Physician was notified of results by Registered Nurse (RN) Supervisor, which included various missing medications; hold order was obtained from Medical Doctor on 6/4/19. An incident report was completed, by Risk Manager Registered Nurse (RN) on 6/5/19, due to borrowing of medication from another resident by Licensed Practical Nurse (LPN) Charge. Disciplinary action was taken with Licensed Practical Nurse (LPN) whom	

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F 656	Continued From page 18 Plan", dated August 2006, revealed: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. The Nurse Supervisor uses the care plan to complete the Certified Nurse Aide (CNA's) daily/weekly word assignment sheets and/or flow sheets. CNA's are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met, or expected outcomes that have not been achieved. Resident #1 Review of Resident #1's Care Plan, initiated 9/17/18, through a review dated of 6/4/19, revealed the resident has Diabetes Mellitus. Interventions included: Diabetes medication as ordered by the doctor. A care plan, initiated 9/8/17 through the target date of 6/4/19, documented the resident had a risk related to history of pneumonia, cough, congestive heart failure and Chronic Obstructive Pulmonary Disease, with an intervention to administer medications as ordered. Review of physician's orders dated 2/13/19, revealed Resident #1 had orders for Levemir Solution 100 units/milliliter (ml). Inject 50 units subcutaneously at bedtime and 15 units in the mornings (at 6:30 AM). Orders also revealed to use Flonase Suspension 50 microgram (mcg) ACT one (1) spray in each nostril every 12 hours (scheduled for 9 AM and 9 PM), initiated 2/22/18. An observation and interview on 06/04/19 at 7:30 PM, revealed Licensed Practical Nurse (LPN) #3 began to pull Resident #1's medications for the	F 656	administered the borrowed medications. Medications were ordered for Resident #1, and were received on 6/5/19. Resident #11 s nail care was performed on 6/6/19 by LPN. 2. Current residents in the facility are at risk for the deficient practices. On 6/10/19, Licensed Practical Nurse Staff Development Coordinator completed a Medication Administration Record (MAR) to cart review. Medications were obtained for MARs with discrepancies to facilitate compliance. On 6/14/19, contracted pharmacy services Quality Assurance Registered Nurse (RN) completed internal MAR-to-cart review to ensure medications are available for administration. An audit was conducted of the condition of fingernails of active residents on 6/6/19 by Licensed Practical Nurse (LPN) and Registered Nurse (RN) Supervisor. Any adverse findings were corrected during the audit by Licensed Practical Nurse (LPN) and Registered Nurse (RN) Supervisor 6/6/19. 3. In-service was conducted by contracted pharmacy services Registered Nurse (RN) on 6/13/19 to educate licensed nursing staff on ordering medication and medication administration. Nail Care has been added to the electronic Activities of Daily Living (ADL) charting system and Diabetic Nail care was added to the MAR for diabetic residents on 7/8/19 by the Director of Nursing/Assistant Director of Nursing. Facility nursing staff were in-serviced on 6/20/19 by LPN Staff	

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F 656	Continued From page 19 8:00 PM medication pass. LPN #3 opened the top drawer on the Medication cart and pointed into the drawer and stated Resident #1 did not have any Levemir Insulin or Flonase nasal spray. She stated that Resident #1 went out on pass for a couple weeks with family and she did not bring her Levemir Insulin or Flonase back from pass. Further interview on 06/05/19 at 10:35 AM, with LPN #3, revealed she borrowed insulin from another resident and gave it to Resident #1 on Monday night (6/3/19). She stated she had documented administration of the Flonase prior in error. She stated she didn't follow the care plan to give medication, because the medication wasn't available. An interview on 06/04/19 at 8:33 PM, with Resident #1, revealed she had not received her Levemir Insulin or Flonase nasal spray since she'd been back from pass, five (5) days prior. She stated she'd left medication with her family in North Mississippi; six (6) hours away. Record Review of Resident #1's Electronic Medical Record (EMAR) for June 2019, revealed the resident did not receive Levemir 50 units of Insulin on June 4,2019. On June 5, 2019, Resident #1's Blood glucose reading was 239. There were no adverse effects documented for the missed dose of insulin. Review of the EMAR for June 2019, revealed Flonase was documented as not given, per orders, on 6/4/19 for the 9:00 PM dose. Resident #11 Review of Resident #11's Care Plan, last revised on 3/28/18, revealed Resident #11 participated in	F 656	Development Coordinator in regards to requirement to meet residents Activities of Daily Living including nail care, and that care plans for appropriate residents are to be followed. 4. Beginning on 7/12/19, Director of Nursing/Assistant Director of Nursing will complete MAR to cart reviews on ten (10) residents per week with any negative findings addressed immediately. Beginning 7/12/19, Staff Development Coordinator Licensed Practical Nurse (LPN) will complete five (5) medication pass observations to ensure medications are administered appropriately and according to Physician orders/care plan. Audits will be conducted weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. RN Supervisor will complete ten (10) residents who are dependent on staff for nail care weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter to determine if nail care is being provided per the care instructions The Director of Nursing will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	

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F 656	Continued From page 20 Activity of Daily Living (ADL)s within limitations, with interventions for personal hygiene and assistance of one (1) staff member. Observation on 06/04/19 at 7:19 PM, revealed Resident #11's finger nails dirty, with some long nails and some short. Resident #11 stated, "My nails need to be done. It is an issue for me when I play the piano". Resident #11's right pinky nail, ring finger, and right middle fingernails were approximately 3/4 inches long and the forefinger nail was approximately 1/2 inch long. The left hand had several nails broken, with some being short and others being longer. Nails were jagged on both hands. The resident stated, "I like my nails longer, but they need to be done closer to the same size on both hands. It effects my piano playing". An interview on 06/06/19 at 10:27 AM, with Resident #11, revealed "My nails hurt. My pinky was long and it broke off and it hurts. I don't want to cut them off short, but I do want them clean and shaped the same length. I play my piano and it bothers me that they are in this shape". An interview on 06/06/19 at 12:28 PM, with RN #2/ MDS/Care Plan Nurse revealed she considered personal care on the ADL Care plan as being oral care, nail care, shaving, and showering. She stated, "If a care plan is written, I expect the staff to follow it, based on standards of care. It could be a dignity issue for nails to be un-kept". An interview on 06/06/19 at 12:28 PM, with RN #2 MDS/Care Plan Nurse, revealed "If a care plan is written I expect the staff to follow it based on standards of care".	F 656		

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F 656	Continued From page 21 An interview on 06/06/19 at 12:30 PM, with RN #3/ MDS Coordinator revealed she expected if a care plan is developed, that nurses and CNA's would follow the care plan in caring of the residents based on standards of care. An interview on 06/07/19 at 10:40 AM, with the Director of Nursing (DON) revealed she agreed nail care fell under personal care on the ADL Care Plan. She stated she expected the care plan should be followed by staff, and the resident's Care Plan was not followed for nail care for Resident #11, or medication administration for Resident #1.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility staff interview, and record review, the facility failed to provide nail care for one (1) of 18 residents reviewed, Resident #11. Findings include: Review of the facility policy, "Fingernails/Toenails, Care of", dated February 2018, revealed: The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infection. Nail care includes daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring	F 677	F677 1. Resident #11 s nail care was performed on 6/6/19 by Licensed Practical Nurse (LPN). 2. Current residents in the facility who are dependent on staff for nail care are at risk for the deficient practice. An audit was conducted of the condition of fingernails of active residents on 6/6/19 by Licensed Practical Nurse (LPN) and Registered Nurse (RN) Supervisor. Any adverse findings were corrected during the audit by Licensed Practical Nurse (LPN) and	7/12/19

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COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

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F 677	Continued From page 22 his/her skin. In an observation and interview on 06/04/19 at 7:19 PM, Resident #11's fingernails were dirty and uneven in length. Resident #11 stated, "My nails need to be done. It is an issue for me when I play the piano. It bothers me when I try and play the piano". Resident #11's right pinky, right ring finger, and right middle fingernails were long; approximately 3/4 inches in length. The forefinger nail was approximately 1/2 inch long. The left hand had several nails broken and uneven in length. Nails were jagged on both hands. The resident stated, "I like my nails longer, but they need to be done closer to same size on both hands". An interview with Resident #11, on 06/06/19 at 10:27 AM, with Registered Nurse (RN) #1 present, revealed her nails hurt. She stated her pinky was long, and had broken off, and it hurt. She stated she didn't want the nails cut off short, but did want them clean and shaped the same length. She stated she played the piano and it bothered her that her nails were in that shape. An interview on 06/06/19 at 10:35 AM, with RN #1, revealed the nurses are supposed to cut the resident's nails on the weekend. She stated she could see that Resident #11's nails were uneven, jagged, and somewhat unclean. An interview on 06/06/19 on 12:31 PM, with RN #4, revealed the facility was implementing a new schedule, where the diabetic residents nail care will be placed on the Electric Medical Record (EMAR) for the nurses to do, and the nail care the CNA can do will be placed on the "point of care" for them to check off that nail care was	F 677	Registered Nurse (RN) Supervisor. 3. Beginning on 6/20/19, nursing staff were in-serviced by Licensed Practical Nurse (LPN) Staff Development Coordinator in regards to requirement of providing nail care for residents. 4. Beginning on 7/12/19, Registered Nurse (RN) Supervisor will complete an audit on ten (10) residents for nail care weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. The RN Supervisor will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	

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F 677	Continued From page 23 completed. RN #4 stated this was schedule at some of the facilities, but not at this one yet. An interview on 06/07/19 at 10:35 AM, with the DON, revealed Resident #11's sisters do her nails sometimes and she had supplies in her room for when they visited. The DON stated that Resident #11 liked her nails long, and she guessed it just fell through the crack and they weren't done. The DON stated the Activity Department does nails monthly and she didn't know how it fell through the crack for the nails not being done, including trimmed or cleaned.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, facility staff and consulting staff interviews, record review, and facility policy review, the facility failed to provide adequate supervision for a severely cognitively impaired resident, to ensure the resident did not have access to medication from an unsecured medication cart, for one (1) of five (5) residents reviewed for accidents and hazards, Resident #41. On 6/4/19 at 6:45 PM, Resident #41 was observed opening the drawer of the A Wing medication cart (Cart #1), which contained the significant medications Insulin and Nitroglycerin	F 689	F689 1. On 6/4/19, Resident #41 was immediately redirected from malfunctioning medication cart by Registered Nurse (RN) #3. Medication cart was locked in the medication room once medication pass was completed. Contracted pharmacy service provider replace malfunctioning cart on 6/5/19. 2. Current residents in the facility have the potential to be affected by the deficient	7/12/19

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F 689	Continued From page 24 tablets, along with other medications. The failure to provide adequate supervision, to ensure Resident #41 and the other five (5) residents identified with severe cognitive impairment, did not have access to remove medications from an unsecured medication cart, placed these residents in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 4/26/19, when facility staff became aware that the medication cart had a drawer that would not lock and did not correct the situation. Resident #41, a resident with severe cognitive impairment, was observed to open the unsecured medication cart drawer, with accessible medications, on 6/4/19. On 6/5/19 at 6:50 PM, the State Agency (SA) notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Removal Plan on 6/6/19, in which the facility alleged that all corrective actions were completed as of 6/5/19, and the IJ removed as of 6/6/19. The SA validated the Removal Plan on 6/7/19, and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CRF(s) 483.25 (d)(2)-Supervision, F689, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include:	F 689	practice. Staff was in-serviced beginning on 6/5/19 by Licensed Practical Nurse (LPN) Staff Development Coordinator regarding requirement of facility to provide a safe environment for residents. No staff permitted to work until in-serviced. 3. Licensed nurses were educated by Licensed Practical Nurse (LPN) Staff Development Coordinator on 6/5/19 to notify Administrator/Director of Nursing immediately if a medication cart or other unsafe condition exists. In-service was conducted by contracted pharmacy services representative to educate licensed nursing staff on accuracy of ordering medication and correct medication administration on 6/13/19. 4. Beginning 7/12/19, medication carts will be checked on a weekly basis for four (4) weeks, then monthly for two (2) months and quarterly thereafter - by the Administrator/Director of Nursing/Maintenance Director to ensure they are locking without issue. Any cart identified as not locking will be placed in the medication room and medications will be walked to the resident until cart can be replaced. Administrator will report findings of audits to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for on-going monitoring and compliance.	

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F 689	Continued From page 25 A review of the facility's policy titled "Security of Medication Cart", revised 4/2007, revealed the nurse must secure the medication cart during the medication pass to prevent unauthorized entry. A review of the facility's policy titled, "Safety and Supervision of Residents", with a revision date of July 2017, revealed: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Observation on 6/4/19 at 6:45 PM, revealed Resident #41 opened the uppermost right top medication cart drawer as the surveyor was walking down A-wing 100 hallway. The primary medication nurse was not present, or in sight of, the medication cart at this time. Registered Nurse (RN) #3 was walking down the hallway and met the resident at the medication cart and redirected his right hand away from the cart. Shortly after, the primary medication nurse and the Director of Nursing (DON) came to the cart. The primary medication nurse verified that the drawer contained the following medications: three (3) insulin pens, one (1) Scopolamine patch, one (1) tube of Glucagon, one (1) 2.5 milliliter (ML) bottle of Latanoprost eye drops, one (1) bottle of Prednisone eye drops, one (1) bottle of Original eye drops, one (1) bottle of Nitroglycerin 0.4 milligram (MG) tablets (which contained 25 tablets), six (6) 2 ML vials of Zofran, one (1) 20 ML bottle of 1 percent (%) Lidocaine with approximately 15 ML remaining in the bottle, and one (1) tube of oral pain relief medication. On 6/4/19 at 8:30 PM, an interview with the DON	F 689		

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F 689	Continued From page 26 revealed, "We have been trying to get that medication cart fixed for the past month or so." On 6/4/19 at 8:40 PM, an interview with Licensed Practical Nurse (LPN) #10 revealed the facility had been having trouble with this medication cart drawer since she started to work at this facility, in April 2019. Review of the Electronic Medication Administration Records (MARs) revealed LPN #10 first documented medication administration on 4/26/19 for the 100 hall. On 6/5/19 at 8:50 AM, an interview with the Director of Nursing (DON) revealed, RN #3 moved the resident's hand away from the medication cart. The DON also stated the medication cart lock had been broken for at least the past two (2) weeks. She stated the medication carts are usually kept in the medication room or in the hallway with the lock turned towards the wall. She also stated Resident #41 could have gotten an alcohol pad from the medication cart, because he is cognitively impaired. The DON stated there was some Insulin in the drawer, but it was in a bag, and the eye drops were in a box. She stated the resident could have taken the Nitroglycerin from the drawer and could have been sent to the hospital. Observation and interview on 6/5/19 at 9:00 AM, revealed Resident #41 lying in bed awake and getting ready to receive Activities of Daily Living (ADL) care. This Surveyor asked Resident #41 to make a fist and he stated, "Do you mean make a fist like this" and proceeded to open and close both of his hands demonstrating a fist five (5) times very quickly. He demonstrated the ability to follow a command.	F 689		

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F 689	Continued From page 27 Observation on 6/5/19 at 9:30 AM, revealed LPN #9 pulled on each medication drawer of the A-wing medication cart, while it was in the locked position. Only the uppermost top right drawer would open. The same medications, including Insulin and Nitroglycerin tablets, remained in the unsecured medication drawer at this time. During observation, on 6/5/19 at 9:35 AM, LPN #9 emptied the Nitroglycerin tablets from the bottle (from the unsecured medication cart) into a plastic 30 Cubic Centimeter (CC) medication cup. LPN #9 approached Resident #41 and asked the resident to open the empty Nitroglycerin bottle. The resident twisted the cap off of the Nitroglycerin bottle easily. This was demonstrated in the presence of two (2) surveyors. Observation on 6/5/19 at 10:05 AM, revealed LPN #9 counted the Nitroglycerin tablets that were in the bottle from the top right drawer of A-wing medication cart. There were a total of 25 0.4 MG tablets in the bottle. Interview on 6/5/19 at 10:55 AM, revealed LPN #9 had not redirected any resident away from the medication cart before. She denied any problems with residents getting into the medication cart. LPN #9 stated no resident has been harmed from any medications and she has not seen any medications in any resident hands. She also stated, she was just made aware of the medication cart not locking as of last week. She stated she had called the pharmacy this past weekend and told them the top right medication cart drawer had problems with locking and the response was they would have to give her a call back. LPN #9 stated the pharmacy had not	F 689		

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F 689	Continued From page 28 called her back as of today (6/5/19). She stated she had told her Charge Nurse, LPN #4 or LPN #5 about the medication cart drawer not locking; she was not sure which one of those Charge Nurses she had told. LPN #9 stated she never had gotten a chance to report the drawer not locking to the DON, because she had just discovered it over the weekend. On 6/5/19 at 11:05 AM, an interview with RN #6 revealed she had not had any residents attempting to open her medication cart. She stated she tried to anticipate what the residents need to help prevent the residents from trying to get a medication themselves. On 6/5/19 at 11:15 AM, an interview with the DON revealed she had not had any problems with residents trying to get into medication carts. She stated she was about to intervene when she had seen Resident #41 open the medication cart drawer. The DON stated that if the medication cart would have been turned around towards the room, the resident would not have been able to open the drawer. On 6/5/19 at 11:28 AM, an interview with RN #5 revealed the nurses try to keep the medication cart within eye's view. She stated the nurses started calling last week to let the pharmacy know that the lock was broken on the A wing medication cart. On 6/5/19 at 11:40 AM, an interview with the DON revealed the facility should receive a new medication cart tonight from Omnicare. (Medications still remained in the cart at this time).	F 689		

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F 689	Continued From page 29 On 6/5/19 at 3:04 PM, an interview with LPN #10, via telephone, revealed the medication cart drawer had been broken for a couple of weeks. She stated she told the pharmacy people about the medication cart being broken. She also stated she had gone to the DON. LPN #10 stated the DON told her to call the pharmacy initially, and she had started calling them last week. She also stated Maintenance attempted to fix the medication cart the day before (referring to 6/4/19). LPN #10 stated she was on the hallway and had just came out of room 102. She stated the medication cart was parked between room 101 and room 102. She also stated she was able to see the resident in room 102 and the medication cart at the same time. On 6/5/19 at 3:15 PM, LPN #10 disconnected the telephone call. On 6/5/19 at 3:18 PM, LPN #10 called back to continue the interview. During this interview LPN #10 stated, "Yes, I said it had been broken, and I think I told you since April 25th" (referring to how long the A-wind medication cart 1 had been broken). LPN #10 stated the cart was broken when she first started working (verified by the initials on the Electronic Medication Administration record as 4/26/19). She stated when she first identified the lock was broken, she asked Maintenance if they could fix the lock. She stated Maintenance said they do not look at medication carts; she would have to call the people they (referring to the medication carts) had come from. She also stated the DON told her to call the pharmacy. LPN #10 stated she would keep the medication cart in view and/or turn it around. She stated when the surveyors had come to the facility, she was just finishing her medication pass. She then stated, she was able to see the medication cart, but could not see the resident. She also stated she had seen RN #3	F 689		

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intervene, but she (LPN #10) did not. LPN #10 then stated, the lock was facing her and she could see the lock. She stated the medication cart was close to rooms 101 and 102 and it was facing towards the middle of the hallway. She stated the resident could have side effects if he had taken some of the medications. She also stated the resident could have heart problems and could have died. LPN #10 stated if she was giving medications to a resident and had the privacy curtain pulled, she would pull the medication cart to the door and she could hear if someone opened the drawer to the cart. She stated they would have to totally move the cart. She also stated, "We have to keep the medications separated", so she could not have moved the medications to another drawer. She stated sometimes the other drawers would not lock and it's possible the resident could have gotten into another unlocked drawer. LPN #10 stated she tried several times to get the medication cart drawer fixed.

On 6/5/19 at 4:08 PM, an interview with the DON revealed the staff reports to maintenance or puts the problem in the maintenance book for any broken equipment. She stated the Maintenance Supervisor or Maintenance Staff #2, are always on call even for equipment that need to be reported immediately.

On 6/5/19 at 4:35 PM, an interview with Maintenance Staff #2 revealed he first became aware of the medication cart lock being broken on 6/4/19. He stated as he was walking down the hallway, he was flagged down by RN #1 to talk to the pharmacy. Maintenance Staff #2 stated Omnicare staff asked him to check out the lock on the medication cart. He stated he and the

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F 689	Continued From page 31 Maintenance Supervisor were unable to fix the medication cart lock. He stated he called back and the lady on the phone stated she would send a technician out to the facility. He stated he had gotten the lady's first name but he was unable to get her last name. He also stated he does not know if the pharmacy sent the technician out to the facility or not. On 6/5/19 at 4:40 PM, an interview with the Maintenance Supervisor, revealed, Maintenance Staff #2, told her about the medication cart not being able to be locked on 6/4/19. She stated, they (referring to her and her assistant) tried to work on it (referring to A-wing medication cart 1 lock) and could not get it fixed. She stated Maintenance Staff #2 called Omnicare. She stated the top right drawer would not lock. During an interview on 6/5/19 at 4:45 PM, Maintenance Staff #2 revealed the A-wing medication cart (Cart #1) measured 40 and ¼ inches in height. This was observed to be easily accessible to any resident, even a resident who used a wheelchair. On 6/5/19 at 5:47 PM, an interview with Consultant Pharmacist #2, revealed Omnicare (pharmacy) was first notified on Monday (6/3/19), of the facility having a medication cart that would not lock. She stated the facility emailed Pharmacy Staff #1 on Monday, 6/3/19, at 5:08 PM. She also stated she was not aware that the medication cart had been broken for two (2) weeks. She stated she called the facility Tuesday 6/4/19, to see if the maintenance man could fix the cart. She also stated if a resident took 25 0.4 MG Nitroglycerin tablets, she believed they would have a headache and Hypotension. She also	F 689		

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F 689	Continued From page 32 stated that 25 Nitroglycerin tablets would be a higher than indicated dose. She stated it is not an indicated dose, and could lead to Hypotension, Headache, and falls. On 6/5/19 at 5:57 PM, an interview with the Medical Director revealed she was made aware of this incident (A-wing medication "Cart 1" drawer lock being broken) today when she walked through the door at 2:00 PM. She stated there was a plan of correction in place. She also stated the Pharmacist is a major issue here at the facility. She stated if a resident had taken 25 of the 0.4 Mg Nitroglycerin tablets that could cause death. On 6/6/19 at 12:04 PM, an interview with RN #3 revealed she was making rounds and when she headed back, that's when she took the resident's hand and said, "No, no, no, we can't do that" (referring to Resident #41 opening the medication cart drawer). She stated Resident #41 said all he wanted was a pencil. RN #3 also stated she was headed back from the end of A-wing hallway to the nursing station. She stated the DON was coming from the opposite direction. RN #3 stated she had not had to redirect a resident away from a medication cart before. She also stated she does not remember any other resident opening the medication cart before. She stated she does not have a clue as to how long the medication cart lock had been broken. On 6/6/19 at 12:15 PM, observation revealed LPN #7 moved a Medication cart, just like the cart that had the broken drawer, to the middle of A-wing hallway between rooms 101 and 102. The medication drawers faced the center of the hallway, just as positioned on 6/4/19, when the	F 689		

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F 689	Continued From page 33 resident was observed opening the medication cart drawer. The surveyor sat at the nursing desk on A-wing and the medication cart drawers were not visible from the nursing station with the medication cart being in this position. On 6/6/19 at 3:22 PM, an interview with Consultant Pharmacist #1 revealed there is some form of medication audit done monthly. He stated carts are checked basically once a quarter. He stated he was not aware and cannot recall the A-wing medication cart drawer being unable to be locked. On 6/7/19 at 11:32 AM, an interview with RN #3 revealed the staff could have supervised and redirected the resident to prevent this incident from occurring. On 6/7/19 at 1:28 PM, an interview with the Administrator revealed the DON notified him of the incident (A Wing top right medication cart drawer not locking) on 6/4/19. He stated the expectation is not that the staff wait to report these types of issues. He stated he must be made aware for the safety and well-being of the residents. The facility identified five (5) residents, who had severe cognitive impairment and who were mobile in the facility. The facility provided the following Removal Plan: Brief Summary: At approximately 6:50 PM on June 5, 2019, the facility was notified by the annual survey team that the facility was being placed in Immediate Jeopardy, due to the Facility on June 4, 2019 at	F 689		

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F 689	Continued From page 34 approximately 6:45 PM, failed to adequately supervise to prevent a severely cognitively-impaired resident from opening a medication cart drawer where multiple medications, including 25 Nitroglycerin 0.4 milligram (mg) tablets were located. The facility failed to store medications safely to prevent a cognitively impaired resident from having access to the medication cart, and the medication cart drawer would not lock. Licensed Practical Nurse (LPN) #10 stated the cart did not lock properly and has malfunctioned since she started to work in the Facility on April 26, 2019, at approximately 7:00 AM. On the evening of June 4, 2019, Resident #41 was witnessed by a surveyor opening the malfunctioning drawer where medication was located. The cart was locked in the medication room once medication pass was completed. (The name of the Pharmacy Vendor) was contacted on June 3, 2019 and a new cart was requested. The replacement cart arrived at the Facility on June 5, 2019, and medications were transferred from the malfunctioning cart to the properly locking replacement cart. Corrective actions included: 1. On June 4, 2019 at approximately 6:45 PM, Resident #41 was observed opening the malfunctioning drawer. This incident was witnessed by RN #3 and LPN #7. RN #3 immediately redirected resident. This incident was also witnessed by the annual survey team. The primary LPN #10 assigned to the cart was not present. 2. On June 5, 2019 at approximately 1:00 PM, a new medication cart was delivered to the Facility. Medications were exchanged from the old cart into the new properly locking cart.	F 689		

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F 689	Continued From page 35 3. On June 5, 2019 at approximately 2:00 PM, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the RN Supervisor (RN) #1, and the Minimum Data Set (MDS) RN #2, audited medication carts regarding proper locking and storage. No issues were identified. 4. On June 5, 2019 at approximately 2:30 PM, the Administrator held a Quality Assurance Performance Improvement (QAPI) meeting to discuss action plan and resolution steps. The members of the committee discussed the medication cart malfunction, proper storage of medication, necessary steps in reporting issues and an audit tool developed as a tracking mechanism to ensure medication carts are in proper working order. The Members in attendance were the Administrator, DON, ADON, Medical Director, Social Services Director, Dietary Manager, Activities Director, Director of Therapy, Staff Development Coordinator LPN #7, Maintenance Director, Business Office Manager, Human Resources Generalist, Housekeeping Manager, MDS RN #2, LPN #4, LPN #5, Risk Manager RN, and the RN Supervisor (RN #1). 5. On June 5, 2019 at approximately 3:00 PM, the Staff Development Coordinator LPN #7 in-serviced Licensed Nursing Staff on the daily audit tool used to validate that all medication carts are in proper-working order, proper storage of medication to maintain a safe environment, and proper procedure for unavailable medications. 6. No nursing staff will be permitted to work until in-serviced.	F 689		

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F 689	Continued From page 36 7. The facility alleges that all corrective actions to remove the immediate jeopardy was completed as of June 5, 2019, and the immediate jeopardy removed as of June 6, 2019. The SA validated the facility's Removal Plan and determined the facility had taken the following actions to correct the IJ: 1. Based on observations record review and staff interviews the State Agency (SA) validated Resident #41 had severe cognitive impairment and was observed opening the drawer of an unsecured medication cart. The SA validated the resident was redirected by RN #3. 2. The SA validated by interview with the Director of Nurses (DON) and observation on 6/6/19, that a new cart had been delivered and medications were exchanged from the old cart into the new cart on 6/5/19, and the cart properly locked. 3. The SA validated by interview with the DON that an audit was completed on 6/5/19, that all carts locked appropriately. The SA found no other carts that malfunctioned. 4. The SA validated through review of the sign-in sheet and interview with the Administrator, that a QAPI meeting was held on 6/5/19, with all stated members, in regards to the malfunctioning medication cart, storage of medications, reporting requirements if there's a malfunction, and a tracking/audit tool for ensuring medication carts were in proper working order. 5. The SA validated through random interviews with nursing staff and review of in-service sign in sheets, that the Staff Development Coordinator,	F 689		

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F 689	Continued From page 37 LPN #7, initiated in-services regarding use of the audit tool, proper storage of medication to maintain a safe environment for residents, and procedures for medications not available. 6. The SA validated through interview with random nursing staff that no staff was allowed to work until they were in-serviced. 7. The SA validated that all corrective actions to remove the Immediate Jeopardy were completed on 6/5/19, and the Immediate Jeopardy removed as of 6/6/19.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		7/12/19

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F 755	Continued From page 38 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to ensure medications were not borrowed from other residents and that medications were available for administration for one (1) of five (5), Residents, Resident #1. Medications not available included Insulin and Flonase; medication borrowed included Insulin. Findings include: Record Review of a facility document on letterhead, signed by the Administrator and dated 6/5/19, revealed the facility did not have a designated policy on borrowing medications amongst residents. However, a policy "5.2 Receipt of Interim/Stat/Emergency Deliveries", dated 2013, revealed: "4. Facility should not borrow medication from another resident". Review of a documented procedure, signed by the Administrator and dated 6/5/19, and placed on company letter head, revealed, "It is the policy of the facility to do the following when medication is unavailable: 1. the nurse shall check the omnicell for the appropriate medication in need 2. If the medication is not available, the nurse shall call Medical Director for a hold order, or alternate	F 755	F755 1. Resident #1 s physician orders were reconciled against Medication Administration Record (MAR)s on 6/4/19 by Registered Nurse (RN) Supervisor. Physician was notified of results, which included various missing medications a hold order was obtained from Medical Doctor (MD) on 6/4/19 by Registered Nurse (RN) Supervisor. An incident report was completed, by Risk Manager Registered Nurse (RN) on 6/5/19, due to borrowing of medication from another resident. Nurses identified as failing to follow proper protocols were disciplined according to facility policy by Director of Nursing on 6/5/19. Medications were ordered by Licensed Practical Nurse (LPN), and were received on 6/5/19. 2. Current residents in the facility are at risk for the deficient practice. On 6/10/19, LPN Staff Development Coordinator completed a Medication Administration Record (MAR) to medication cart review to ensure medications were available for administration per physician orders. Medications were obtained from	

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F 755	Continued From page 39 medication order 3. If Medical Director is unavailable, the nurse shall contact the Nurse Practitioner for appropriate orders." An observation on 06/04/19 at 7:30 PM, revealed Licensed Practical Nurse (LPN) #3 pulled Resident #1's medications for the 8:00 PM medication pass. LPN #3 stated Resident #1 does not have any Levemir Insulin or Flonase to administer. An interview on 06/04/19 at 8:33 PM, with Resident #1 revealed, "I missed my Levemir Insulin, Flonase, and Symbicort medication since I've been back from pass. I haven't gotten those medications since five (5) days ago. I left them with my family in North Mississippi and they are six (6) hours away and cannot bring them back". Further interview with Resident #1 on 06/07/19 at 06:15 PM, revealed "I am seriously concerned about the Insulin issue. I always run out of Insulin". Review of the medical record revealed Resident #1 was on leave with family and returned to the facility on 6/1/19. Review of the current physician's orders revealed Resident #1's orders included Levemir Sol 100 units/milliliter (ml) 50 units Subcutaneously (SQ) at bedtime (scheduled for 9:00 PM) and 15 units SQ in the mornings (scheduled for 6:00 AM), initiated 2/13/19; and Flonase Suspension 50 microgram (mcg) ACT one (1) spray in each nostril every 12 hours (scheduled for 2100), initiated 2/22/18. A review of facility electronic physician's order, dated 6/5/19 at 12:01 PM, revealed: Hold Levemir	F 755	contracted pharmacy for MARs found to have discrepancies to facilitate compliance with appropriate medication pass. On 6/14/19, contracted pharmacy services Registered Nurse (RN) completed internal MAR to cart review to ensure medications are available for administration. Medications noted not available as a result of the audit were ordered and received on 6/14/19 by Licensed Practical Nurse. 3. In-service was held by contracted pharmacy representative to educate licensed nursing staff on ordering medication procedures and medication administration on 6/13/19. 4. Director of Nursing/Assistant Director of Nursing will complete MAR to cart reviews on (10) residents per week with findings recorded on MAR to cart check form beginning 7/8/19 for four (4) weeks, then monthly for two (2) months and quarterly thereafter to ensure that medications are available for administration. Director of Nursing will report findings of audits to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	

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F 755	Continued From page 40 and Flonase until available from pharmacy. Use sliding scale and monitor for signs/symptoms of hyperglycemia, effective 6/4/19, one (1) time only for one (1) day. (This order did not cover 6/1/19-6/3/19.) Review of the Electronic Medication Record (EMAR), dated 6/4/19, revealed Levemir Insulin and Flonase Nasal Spray was not signed as administered for Resident #1 for the 9:00 PM dose. Review of the EMAR for June 2019, revealed Resident #1's blood glucose (BG) levels were checked three (3) times daily. The BG level for 6/5/19 at 6:30 AM, after non-receipt of Insulin on 6/4/19 at 9:00 PM, read 239 with six (6) units of sliding scale insulin administered. The other BG levels ranged from 108 to 318. There were no documented adverse effects for Resident #1, related to BG levels. Review of a document, provided by the facility, titled "Refill Reorder Form", revealed Levemir was reordered on 6/2/19, and Flonase was reordered on 6/3/19, for Resident #1. Review of a facility document titled "Delivery Receipt", revealed Levemir's ship date as 6/4/19, and not delivered to facility until 6/5/19 at 12:30 PM; and Flonase's ship date as 6/5/19, and not delivered to facility until 6/519 at 12:30 PM. A review of a facility document titled "24 hour report", revealed Resident #1's medication was not identified as needing ordered on the 24 hour communication sheet (from 6/1/19-6/4/19). In an interview on 06/04/19 at 7:30 PM, LPN #3	F 755		

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revealed, "Resident #1 went out on pass for a couple weeks with family and she did not bring her Levemir Insulin or Flonase back from pass". LPN #3 stated, "I borrowed Levemir Insulin on Monday night (6/3/19) to give Resident #1 from another resident. I gave it to Resident #1 on Monday night. I did not give the Flonase because I did not have it in the facility. However, I guess I just got busy and signed the Electronic Medication Record Administration (EMAR) by mistake that I gave it". Further interview with LPN #3 on 06/04/19 at 8:25 PM, revealed, "As I stated earlier, Resident #1's Levemir Insulin and Flonase was not here tonight for me to give, but I borrowed Levemir Insulin and gave it to Resident #1 on Monday night. I know I'm not supposed to borrow Insulin, but she has high blood sugars. I was probably going too fast and marked the EMAR by mistake for giving the Flonase".

An interview on 06/04/19 at 8:13 PM, with LPN #4/ Charge Nurse (7 AM-7 PM), regarding the Levemir Insulin being borrowed and the Flonase not being in the facility revealed, "This is the first time I've been told the medications are missing. They usually make me a list of the medications that they need and I order it". LPN #4 verified Resident #1 returned from pass on 6/1/19. LPN #4 stated that prior to 6/5/19, the last time the Flonase was ordered was 3/4/19, and the last time the Levemir Insulin was ordered was 5/2/19".

During an interview on 06/04/19 at 8:26 PM, LPN #4 revealed she pulled the fax sheets that were sent to Omnicare Pharmacy to be filled, and it revealed Flonase was ordered from the pharmacy on 6/3/19, and Levemir Sol Insulin was ordered on 6/2/19. Further interview on 06/05/19 at 9:10 AM, with LPN #4, revealed she was told by the

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F 755	Continued From page 42 ADON that if a medication is ordered, and it is not available in the Omnicell machine, they are supposed to send the resident out to the hospital for the medication. LPN #4 revealed that there is no physician's order for Resident #1 to be sent out for Flonase or Levemir Insulin after missing her medication from 6/1/19 through 6/4/19. An interview on 06/04/19 at 8:29 PM, with LPN #5 revealed, "It takes two (2) days for medications to come in to the facility once they are ordered, if they are ordered after a certain time of day". LPN #4 was present during the interview, and stated,"That is correct, it does take two (2) - three (3) days to get our meds sometimes. The process for checking in medications is the 7 PM-7 AM nurse checks the medications in and they are to tell the charge nurse on days, or the nurse they count off with, that a medication is missing or needing to be ordered. They are also to tell them if the medication did not come in after it was ordered". An interview on 06/04/19 at 8:30 PM, with LPN #3, revealed she reported to LPN #2, the 7 AM-7 PM nurse, that the Levemir Insulin and Flonase was not at the facility. In a further interview, on 06/04/19 at 8:35 PM, LPN #3 stated, "Resident #1 did not miss her Levemir Insulin last night. I borrowed it from another resident and gave it to her". An interview on 06/05/19 at 9:40 AM, with LPN #4, revealed, "Resident #1 receives Levemir Insulin from a multi dose vial. She stated that LPN #3 did state to her last night that she borrowed Levemir Insulin from another resident and administered it to Resident #1.	F 755		

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F 755	Continued From page 43 An observation of the Medication Cart on 06/04/19 at 8:34 PM, revealed Symbicort was on the medication cart and available for administration to Resident #1, but Levemir and Flonase were not on the cart. An interview on 06/04/19 at 8:45 PM, with the Director of Nursing (DON) revealed they couldn't use the local pharmacy as an after hours pharmacy. She stated they had been told by the pharmacy that the facility had to use the pharmacy that they used. The DON stated she didn't know why they couldn't use the local pharmacies that were open 24 hours per day. An observation on 06/05/19 at 2:32 PM, of the medication cart, revealed that Resident #1's Levemir Insulin and Flonase had arrived from pharmacy, and was located on the mediation cart at this time. In an interview on 06/05/19 at 12:10 PM, LPN #4 revealed, "As of now, we do not have a policy as to what to do when the medications are not in the facility to give the residents. Administration is working on a policy now with pharmacy and corporate about creating a policy". In an interview on 06/05/19 at 12:30 PM, the DON stated they were still having trouble with getting medications from the pharmacy. She stated she drove to a pharmacy in a nearby town to get Resident #1's medications, but they weren't ready. She stated the Pharmacist told her the medications would be there sometime today, because they had to come from the Pharmacy in (name of town). She stated the pharmacy said that they tried calling the facility last night to tell them the medication would not be ready, and no	F 755		

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one answered the call. The DON stated, "I was at the facility until midnight last night, and nobody called the facility from the pharmacy. We have major issues in getting our mediations for our residents".

In an interview on 06/05/19 at 3:43 PM, LPN #6 revealed, "I borrowed the Levemir Insulin from another resident to give to Resident #1". She stated she borrowed it and gave it to the resident, because she knew how high the resident's sugars could be and she needed the medication. She stated she knew it was the weekend (6/1-6/2) and the pharmacy wouldn't have been able to deliver the Levemir Insulin. She stated they have trouble getting medication sometime, especially on the weekends. She stated she did not give the Flonase, but signed the EMAR as given, in error. She stated, "I was in a hurry I guess, and just checked it off that I gave the Flonase, but it wasn't there to give".

In an interview on 06/06/19 at 2:30 PM, the Pharmacist with the contracted vendor revealed, "I do not know of any instances right off the bat where the facility didn't receive Resident #1's Levemir or Flonase, if it was ordered". The Pharmacist stated the facility should have a schedule posted at the nurse's desk with cutoff times for ordering medications. The Pharmacist stated the delivery contract with the facility did not guarantee delivery. He stated they try to have a four (4) hour turn-around time, but again, no guarantee. The Pharmacist stated the facility has a Pixel machine that contains 250 medications in it, but no Insulin, because a refrigerator is not linked to their Pixel. The Pharmacist stated, "We make one (1) delivery to the facility a day. If they miss the cut off time with ordering a medication,

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F 755	Continued From page 45	F 755		

we have a system that if a medication is called or faxed into the pharmacy after hours, we call our on-call pharmacist and they will go in and fill the medication, if we have it in stock. The pharmacist will then try and catch a driver to deliver it to the facility. If we don't have the medication in stock, the on-call pharmacist will call it in to a 24 hour back up pharmacy, and someone from the facility will have to go pick it up. But, it is the facility's responsibility to call us and say they have faxed a medication they need immediately. If they don't call, then we will process the order the next day. He stated the back-up pharmacy is chosen by the contract vendor. The Director of Nursing and LPN #7 were present in the room for the call with Pharmacist and both the DON and Staff Development stated that the information given by the Pharmacist is not what they are experiencing at the facility, as far as getting medications to the facility in a timely manner.

An interview on 06/06/19 at approximately 3:30 PM, with the Consultant Pharmacist for the facility, revealed the Pharmacist was not aware of the facility not getting medications timely, unless it was back-ordered. The Pharmacist stated he visited the facility monthly and checked carts, medication rooms, and followed med passes with nurses. The Pharmacist stated he had not came across any medication for a resident that was not available at the facility for administration, to his knowledge, and no nurse had ever told him of any issues where they couldn't get medication in a timely manner.

An interview on 06/06/19 at 5:45 PM, with the Medical Director revealed he wasn't called about Resident #1 not having Levemir or Flonase until late yesterday, he didn't recall the exact time, but

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F 755	Continued From page 46 knew it was late. The Medical Director stated he told the nurse to hold Flonase and Levemir and to cover with sliding scale if needed. He stated, "I don't know why they just didn't call me. If medications are not available, I expect a nurse to call me and I will give orders for a substitute medication or call a substitute pharmacy". The Medical Director stated he has had problems with this pharmacy on a couple of instances regarding getting medication, and had gone to administration about the issue. He stated he believed they were in the process of getting a new Pharmacy vendor. He stated borrowing the Insulin from another resident and giving it to Resident #1 and not giving the Flonase is unacceptable; it was definitely a medication error to not have the Flonase or Levemir to administer. He stated that nurses charting medications as given when they are not at the facility, is unacceptable also. An interview on 06/07/19 at 9:38 AM, with LPN #2 revealed, "I work 7a-7p and LPN #3 works 7p-7a. LPN #3 never reported off to me that the Levemir nor Flonase was not in the facility. Resident #1 actually told me that the Flonase was not here, because she had left it in her family's vehicle when they brought her back from pass. Resident #1 never said anything about the Levemir not being here. I know I was supposed to go call her daughter and see if we could get the Flonase back, because I knew it had a lot in the bottle when she left, but I forgot and that's my fault". An interview on 06/07/19 at 10:46 AM, with the DON revealed, "You're not supposed to borrow medication from resident to resident. Borrowing would effect a resident's supply, especially with a multivial medication. It was a medication error	F 755		

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F 755	Continued From page 47 with the resident not getting the Levemir Insulin on 6/4/19, and Flonase on other days. The nurses signing that they gave the Flonase is inaccurate documentation. A review of a facility document titled "Disciplinary Action Report", dated 6/5/19, revealed LPN #3 and LPN #6 received disciplinary action for borrowing medications. An interview on 06/07/19 at 1:12 PM, the Administrator stated, "I was made aware of the medication error on 6/4/19, after it was discovered. I understand what was done with the nurses borrowing the Levemir and I don't think the most appropriate decision was made however, the nurses borrowed the Insulin from another resident who had been discharged from the facility, so at least the resident did not go without her Insulin. It was a new flexpen of Insulin that the facility purchased (Medicare Part A) for the resident that had never been opened delivered on 5/29/19, because the resident discharged on 5/31/19". The Administrator stated that he/she was told that the nurses documented Resident #1 received Flonase from 6/1/19-6/ through 6/4/19, when the issue was identified that the Flonase was not available, and both nurses have voiced they accidentally documented that it was given, but it was not given. The Administrator stated that disciplinary actions were being taken with those nurses at this time. In an interview on 06/07/19 at 1:45 PM, with the DON revealed, "I don't think we have a policy per say for borrowing medications from one resident to another or for medication errors and who they are supposed to report to".	F 755		

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F 759	Continued From page 48	F 759		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to maintain a medication error rate below 5 percent (%), for two (2) of 26 medication opportunities observed, resulting in a 7.69 % medication error rate. This involved Resident #1, who did not receive Levemir Insulin and Flonase nasal spray. Findings include: A review of facility policy titled, "Medication Error Reporting Protocol; Identifying and Managing Medication Errors and Adverse Consequences", dated 7/23/18, revealed: Staff and Practitioners shall try to prevent medication errors and adverse medication consequences, and shall strive to identify and manage them appropriately when they occur. Observation of medication pass on 6/4/19 at 7:30 PM, revealed Licensed Practical Nurse (LPN) #3 did not have Levemir Insulin and Flonase nasal spray to administer to Resident #1. Medication passes monitored on 6/4/19, 6/5/19, and 6/6/19, revealed 26 medications opportunities to be administered, with those two (2) medications not	F 759	F759 1. Medical Doctor (MD) was notified of Resident #1 s missing and unavailable medications by Registered Nurse (RN) Supervisor on 6/4/19. Medical Doctor (MD) provided hold orders for missed and unavailable medications on 6/4/19 and also gave new order to use accu-check with sliding scale. Nurses identified as failing to follow proper protocols were addressed according to facility policy Director of Nursing on 6/5/19. 2. Current residents in the facility are potentially at risk for the deficient practice. On 6/10/19 LPN Staff Development Coordinator completed a Medication Administration Record (MAR) to cart review to ensure medications were available for administration. Medications were obtained from contracted pharmacy for Medication Administration Records (MAR)s found to have discrepancies to facilitate compliance with appropriate medication pass. 3. Beginning on 6/4/19, licensed nurses were in-serviced on procedures for unavailable medication by the Licensed	7/12/19

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F 759	Continued From page 49 available and not administered to Resident #1, creating a 7.69% medication error rate for the facility. Review of a facility document titled "Medication Error", dated 6/7/19, revealed Resident #1 returned from therapeutic pass 6/1/19. Resident #1 was prescribed Flonase twice daily (BID). Resident #1 stated she left the medication at a family residence. Flonase was signed as if given on 6/1/19 at 9:00 PM by LPN #6, signed for 9:00 AM on 6/2/19 by LPN #9, signed for 9:00 PM on 6/2/19 by LPN #6, on 6/3/19 for 9:00 AM by LPN #2, signed for 9:00 PM on 6/3/19 by LPN #3, signed on 6/4/19 for 9:00 AM by LPN #2. The document also revealed that on 6/4/19, LPN #3 noted the Levemir medication error. The physician was notified of resident being out of Levemir; resident refused to go to hospital; and the Medical Director instructed to hold the Levemir and use sliding scale. Review of the current physician's orders revealed Resident #1's orders included Levemir Sol (Solution) 100 units/milliliter (ml) 50 units Subcutaneously (SQ) at bedtime (scheduled for 9:00 PM) and 15 units SQ in the mornings (scheduled for 6:00 AM), initiated 2/13/19; and Flonase Suspension 50 microgram (mcg) ACT one (1) spray in each nostril every 12 hours (scheduled for 9:00 PM), initiated 2/22/18. Review of the Electronic Medication Administration Record (EMAR), revealed no documentation that Resident #1 received Levemir insulin or Flonase Nasal Spray for 6/4/19 for the 9:00 PM dose. Review of the EMAR from 6/1/19 through 6/5/19,	F 759	Practical Nurse (LPN) Staff Development Coordinator to ensure procedures are followed for obtaining medications and documentation. On 6/14/19, contracted pharmacy services Registered Nurse (RN) completed internal MAR to cart review to ensure medications are available for administration. In-service for nurses was conducted by contracted pharmacy provider on 6/19/19 regarding medication ordering procedures and accuracy of medication administration. 4. Beginning on 7/12/19, Registered Nurse (RN) Supervisor/Staff Development Coordinator Licensed Practical Nurse (LPN) will complete (5) medication pass observations weekly for four (4) weeks, then weekly for two (2) months and quarterly thereafter to ensure medications are available per physician orders for administration and procedures are followed. Results will be recorded on medication pass observation check list. Any discrepancies will be brought to Director of Nursing/Assistant Director of Nursing upon occurrence. The Director of Nursing will report findings of audits to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	

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F 759	Continued From page 50	F 759		

revealed Resident #1's Blood Glucose levels ranged from results 108 to 318, with the result of 239 on 6/5/19, after Resident #1 missed the 9:00 PM dose of Insulin on 6/4/19. There were no adverse effects documented for Resident #1, regarding the missed medication.

A review of Physician's orders revealed no order to hold the Insulin and Flonase in the computer until 6/5/19 at 12:01 PM, which was obtained by Registered Nurse #1.

An interview on 06/04/19 at 8:33 PM, with Resident #1, revealed she had missed her Levemir Insulin and Flonase nasal spray since she returned to the facility from a visit with her family (6/1/19).

In an interview on 06/04/19 at 7:30 PM, LPN #3 stated, "Resident #1 went out on pass for a couple weeks with family and she did not bring her Levemir Insulin or Flonase back from pass." LPN #3 stated she borrowed Levemir from another resident and gave to Resident #1 on 6/3/19, but did not give the Flonase because it wasn't available, however, she documented it was given by mistake.

In an interview on 06/05/19 at 3:43 PM, LPN #6 revealed she borrowed Levemir from another resident and gave to Resident #1 (at 9:00 PM on 6/1/19 and 6/2/19), and didn't give the Flonase because it wasn't available. She stated she documented on the EMAR by mistake about the Flonase, because she was in a hurry.

In an interview on 06/06/19 at 10:05 AM, the Director of Nursing (DON) revealed, "The nurse borrowing the Levemir is definitely a medication

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F 759	Continued From page 51 error. The medication not being in the facility for the LPN to administer is a medication error". In an interview on 06/07/19 at 2:32 PM, the DON revealed, "I did not know about the nurses borrowing medications or the medication error until after it was identified Tuesday night (6/4/19). Nobody reported it to me. After I found out about the errors, I did an incident report on it". An interview on 06/07/19 at 10:46 AM, with the DON revealed, "You're not supposed to borrow medication from resident to resident. Borrowing would effect a resident's supply, especially with a multi-vial medication. It was a medication error with the resident not getting the Levemir Insulin on 6/4/19, and Flonase on other days. In an interview on 06/07/19 at 3:20 PM, the DON revealed, "I expect our medication error rate to be at zero (0) for the facility". An interview on 06/06/19 at 5:45 PM, with the Medical Director, revealed she wasn't notified about Resident #1 not having Levemir or Flonase until late the evening before. The Medical Director stated she told the nurse to hold Flonase and Levemir and to cover with sliding scale if needed. She stated borrowing the Insulin from another resident and giving it to Resident #1, and not giving the Flonase is unacceptable. It is definitely a medication error to not have the Flonase or Levemir to administer.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		7/12/19

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F 760	Continued From page 52 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, facility policy review, the facility failed to have insulin available to prevent a significant medication error for one (1) of five (5) residents reviewed, Resident #1. Findings include: A review of facility policy titled, "Medication Error Reporting Protocol; Identifying and Managing Medication Errors and Adverse Consequences", dated 7/23/18, revealed "Staff and Practitioners shall try to prevent medication errors and adverse medication consequences, and shall strive to identify and manage them appropriately when they occur. An observation on 06/04/19 at 7:30 PM, revealed Resident #1 had no Levemir Insulin when Licensed Practical Nurse (LPN) #3 began to pull medications for the 8:00 PM medication pass. Review of Resident #1's current June 2019 physician's orders revealed an order for Levemir Sol (Solution) 100 units/milliliter (ml), give 50 units Subcutaneous (SQ) at bedtime and 15 units SQ at 6:30 AM daily. Review of the Electronic Medication Record (EMAR), dated 6/4/19, revealed Resident #1 was supposed to receive Levemir Sol 100 units/ml-50 units SQ at bedtime (9:00 PM), which was not signed as administered. The EMAR revealed Blood Glucose (BG) reading of 162 at 4:30 PM on	F 760	F760 1. On 6/4/19, Medical Doctor (MD) was notified of Resident #1 s unavailable medications by Registered Nurse (RN) Supervisor. Medical Doctor (MD) provided hold orders for missed and unavailable medications on 6/4/19 and new order obtained to use accu-check with sliding scale. Nurses identified as failing to follow proper protocols were addressed according to facility policy by Director of Nursing (DON). 2. Current residents in the facility are potentially at risk for the deficient practice. On 6/10/19, Licensed Practical Nurse (LPN) Staff Development Coordinator completed a Medication Administration Record (MAR) to medication cart review to ensure appropriate medications were available for administration. Medications were obtained from contracted pharmacy for Medication Administration Records (MAR)s found to have discrepancies to facilitate compliance with medication pass and ensure medications were available for administration. 3. Nurses were in-serviced beginning on 6/4/19 on procedures for unavailable medication by the Licensed Practical Nurse (LPN) Staff Development Coordinator. On 6/14/19, contracted pharmacy services Registered Nurse (RN) completed internal Medication	

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F 760	Continued From page 53 6/4/19, and 239 on 6/5/19 at 6:30 AM. There were no adverse effects documented for Resident #1. A review of a Pharmacy Medication Requisition for Resident #1, revealed Levemir was requested on 6/4/19, with authorization to bill the facility and a delivery form revealed the Levemir was delivered on 6/5/19. An interview on 06/04/19 at 8:13 PM, with LPN #4 Charge Nurse (7a-7p), revealed she was not aware Resident #1's Levemir was missing. She stated, "They usually make me a list of the medications that they need and I order it". LPN #4 verified Resident #1 returned from pass on 6/1/19. LPN #4 verified prior to 6/5/19, the last time the Levemir was ordered was 5/2/19. In an interview on 06/04/19 at 8:26 PM, LPN #4 revealed she pulled the sheets where the nurse's fax medication to be filled to the pharmacy, and it revealed Levemir Sol was ordered on 6/2/19. An interview on 06/04/19 at 8:29 PM, with LPN #5 revealed, "Sometimes It takes two (2) days for medications to come in to the facility once they are ordered, if they are ordered after a certain time of day". Interview with LPN #3 on 6/4/19 at 7:30 PM, and LPN #6 on 6/5/19 at 3:43 PM, revealed they had borrowed Levemir Insulin from another resident and administered to Resident #1 from 6/1/19, until the Levemir arrived for Resident #1 on 6/5/19. During an interview on 06/06/19 at 10:05 AM, the DON revealed, "The nurse borrowing the Levemir	F 760	Administration Record (MAR) to cart review to ensure insulins are available for administration. In-service was conducted by contracted pharmacy services representative to educate licensed nursing staff on accuracy of ordering medication and correct medication administration on 6/13/19. 4. Beginning on 7/12/19, Registered Nurse (RN) Supervisor/Staff Development Coordinator Licensed Practical Nurse (LPN) will complete (5) medication pass observations weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter to ensure insulin availability for applicable residents. Results will be recorded on mediation pass observation check list. Any discrepancies will be brought to Director of Nursing/Assistant Director of Nursing upon occurrence. A report regarding findings of the medication pass observations will be submitted by the DON/ADON to Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Director of Nursing are responsible for on-going monitoring and compliance.	

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F 760	Continued From page 54 is definitely a medication error. The medication not being in the facility for the LPN to administer is a medication error". During an interview on 06/07/19 at 2:32 PM, the DON revealed, "I did not know about the nurses borrowing medications or the medication error until after it was identified Tuesday night (6/4/19). Nobody reported it to me. After I found out about the errors, I did an incident report on it". An interview on 06/07/19 at 10:46 AM, with the DON revealed, medication was not supposed to be borrowed from resident to resident. The DON confirmed the significant medication error with the resident not getting the Levemir Insulin on 6/4/19. In an interview on 06/07/19 at 3:20 PM, the DON revealed, "I expect our medication error rate to be at zero (0) for the facility". An interview on 06/06/19 at 5:45 PM, with the Medical Director revealed she wasn't called about Resident #1 not having Levemir until 6/5/19. She stated that it was definitely a medication error to not have the Levemir available to administer to Resident #1.	F 760		
F 761 SS=J	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		7/12/19

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F 761	Continued From page 55 §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 observation, facility staff and consulting staff interviews, record review, and facility policy review, the facility failed to provide safe medication storage and security of medications in a manner to prevent resident access, as evidenced by a drawer of the medication cart would not lock. As a result, on 6/4/19 at 6:45 PM, Resident #41 was observed opening the drawer of the A Wing Medication "Cart 1," which contained significant medications including Insulin and Nitroglycerin tablets, as well as other medications. The facility was aware of the medication cart lock not functioning for approximately two (2) months prior to this incident, as evidenced by an interview with Licensed Practical Nurse (LPN) #10, who stated the drawer would not lock when she started to work on 4/26/19. Resident #41 was observed opening the unsecured medication drawer on 6/4/19 at approximately 6:45 PM.	F 761	F761 1. On 6/4/19, Resident #41 was immediately redirected from malfunctioning medication cart by Registered Nurse (RN) #3. Medication cart was locked in the medication room once medication pass was completed. Contracted pharmacy service provider was contacted on the evening of 6/4/19 by the Administrator and Regional Vice President to expedite new medication cart delivery and a replacement cart was delivered on 6/5/19. 2. Current residents in the facility have the potential to be affected by the deficient practice. Beginning on 6/5/19, medication carts will be monitored by facility managers throughout the day to ensure residents remain in a safe environment,	

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COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

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F 761	Continued From page 56 The failure to provide adequate storage and locking of medications to ensure Resident #41 and the other five (5) mobile residents, identified with severe cognitive impairment, did not have access to remove medications from an unsecured medication cart, placed these residents in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 4/26/19, when facility staff identified the A-Wing medication "Cart 1" drawer, which contained Insulin and Nitroglycerin tablets, would not lock, allowing cognitively impaired residents to have access. On 6/5/19 at 6:50 PM, the State Agency (SA) notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Removal Plan on 6/6/19, in which the facility alleged that all corrective actions were completed as of 6/5/19, and the IJ removed as of 6/6/19. The SA validated the Removal Plan on 6/7/19, and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s) 483.45(h)(1) F761, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include:	F 761	free of accidents and hazards, and that carts are locked when not in use. Adverse findings will be address and reported to Administrator or Director of Nursing (DON) immediately. 3. Licensed nursing staff was in-serviced on 6/5/19, by LPN Staff Development Coordinator regarding requirement of medication carts being maintained in working order, and storage of medication to maintain a safe environment, which includes ensuring medication carts lock properly. Licensed nurses were educated to notify Administrator/Director of Nursing immediately if a medication cart or other unsafe condition exists. On 6/13/19 contracted pharmacy service provide in-serviced licensed nurses in regards to requirement of safe storage of medications/medication carts locking. Beginning on 6/5/19 facility staff were in-serviced LPN Staff Development Coordinator in regards to requirement of facility to provide a safe environment for residents, including freedom from accidents and hazards. 4. Beginning 6/10/19, medication carts were checked three (3) times weekly to ensure locking without issue and maintaining a safe environment for residents. Beginning 7/12/19, medication carts will be checked on a weekly basis for four (4) weeks, then monthly for two (2) months and quarterly thereafter, by the Administrator/Director of Nursing/Maintenance Director to ensure they are locking without issue. Any cart	

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F 761	Continued From page 57 A review of the facility's undated policy titled, "Security of Medication Cart", revealed the nurse must secure the medication cart during the medication pass to prevent unauthorized entry. A review of the facility's policy titled, "Safety and Supervision of Residents", with a revision date of July 2013, revealed: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. On 6/4/19 at 6:45 PM, an observation revealed Resident #41 opened the uppermost right top medication cart drawer of a medication cart as the surveyor was walking down A-wing 100 hallway. The primary medication nurse was not in sight of the medication cart at this time. Registered Nurse (RN) #3 was walking down the hallway and met the resident at the medication cart and redirected his right hand away from the cart. Shortly after, the primary Medication Nurse and the Director of Nursing (DON) came to the cart. The primary Medication Nurse verified that the drawer contained the following medications: three (3) Insulin pens, one (1) scopolomine patch, one (1) Glucagon tube, one (1) 2.5 milliliter (ML) bottle of Latanoprost eye drops, one (1) bottle of Prednisone eye drops, one (1) bottle of Original eye drops, one (1) bottle of Nitroglycerin 0.4 milligram (MG) tablets (which contained 25 tablets), six (6) 2 ML vials of Zofran, one (1) 20 ML bottle of 1 percent (%) Lidocaine with approximately 15 ML remaining in the bottle, and one (1) tube of oral pain relief medication. During an interview on 6/4/19 at 8:30 PM, the DON revealed, "We have been trying to get that	F 761	identified as not locking will be placed in the medication room and medications will be walked to the resident until cart can be replaced. Administrator will report findings of audits to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for on-going monitoring and compliance.	

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F 761	Continued From page 58 medication cart fixed for the past month or so." In an interview on 6/4/19 at 8:40 PM, Licensed Practical Nurse (LPN) #10 revealed the facility had been having trouble with the "Cart I" medication cart not locking since she started to work at this facility, in April 2019. She verified the cart drawer would not lock her first day on the cart on 4/26/19, and contained medications, which included the Insulin and Nitroglycerin tablets. (Review of the Electronic Medical Records revealed LPN #10 began signing the Medication Administration Record for hall 100 on 4/26/19). In an interview on 6/5/19 at 8:30 AM, the DON stated that RN #3 moved the resident's hand away from the medication cart. The DON also stated, the medication cart lock had been broken for at least the past two (2) weeks. She stated the medication carts are usually kept in the medication room or in the hallway, with the lock turned towards the wall. She also stated Resident #41 could also have gotten alcohol pads from the medication cart, because he is cognitively impaired. The DON stated there was some Insulin in the medication cart, but it was in a bag, and the eye drops were in a box. She stated the resident could have taken the Nitroglycerin tablets and could have been sent to the hospital. On 6/5/19 at 9:00 AM, an observation revealed Resident #41 lying in bed awake and alert. This Surveyor asked Resident #41 if he could make a fist and he stated, "Do you mean make a fist like this" and proceeded to open and close both of his hands demonstrating a fist five (5) times very quickly. Resident #41 was able to follow the command.	F 761		

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F 761	Continued From page 59 On 6/5/19 at 9:30 AM, an observation revealed LPN #9 pulled on each medication drawer of the A-wing medication cart, while it was in the locked position, and only the uppermost top right drawer would open. The medications remained in the unsecured medication drawer. This was done in the presence of two (2) surveyors. Observation on 6/5/19 at 9:35 AM, revealed LPN #9 emptied the 0.4 MG tablets of Nitroglycerin from the bottle into a plastic 30 Cubic Centimeter (CC) medication cup. This nurse then approached Resident #41 and asked the resident to open the empty Nitroglycerin bottle. LPN #9 handed Resident #41 the empty Nitroglycerin bottle and the resident twisted the cap off of the bottle easily. He had no difficulty in removing the cap, therefore allowing access to medication in the bottle. This was done in the presence of two (2) surveyors. Observation on 6/5/19 at 10:05 AM, revealed LPN #9 counted the Nitroglycerin tablets that were in the Nitroglycerin bottle from the top right drawer of the A-wing medication cart, with a total of 25 tablets in the bottle. This was done in the presence of two (2) surveyors. On 6/5/19 at 10:55 AM, interview with LPN #9 revealed she has not had to redirect any resident away from the medication cart before. She stated she has not had any problems with any resident getting into the medication cart. LPN #9 stated she had not seen any medications in any resident hands. She also stated she was just made aware of the medication cart not locking, as of last week. She stated she had called the pharmacy this past weekend and told them the top right	F 761		

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medication cart drawer had problems with locking. LPN #9 stated the pharmacy had not called her back as of today (6/5/19). She stated she had told her Charge Nurse, LPN #4 or LPN #5, about the medication cart drawer not locking. LPN #9 stated she is not sure which of those Charge Nurses she had told. LPN #9 stated she never had gotten a chance to report the cart drawer not locking to the DON, because she had just discovered it over the weekend.

On 6/5/19 at 11:05 AM, an interview with RN #6 revealed she had not had any residents attempting to open her medication cart. She stated she tries to anticipate what the residents need, to help prevent the resident from trying to get a medication themselves. RN #6 also stated she was not aware of any harm to residents from medications or any medications being in a resident's hands.

On 6/5/19 at 11:15 AM, an interview with the DON revealed she had not had any problems with residents trying to get into medication carts. She stated she was about to intervene when she had seen Resident #41 open the medication cart drawer. The DON stated, if the medication cart would have been turned around towards the room, the resident would not have been able to open the drawer.

On 6/5/19 at 11:28 AM, an interview with RN #5 revealed the nurses try to keep the medication carts within eye view. She stated the nurses started calling last week to let the pharmacy vendor know that the lock was broken on the A wing medication cart.

On 6/5/19 at 11:40 AM, an interview with the DON

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F 761	Continued From page 61 revealed the facility should receive a new medication cart tonight from the pharmacy vendor. On 6/5/19 at 3:04 PM, an interview with LPN #10, per telephone, revealed the medication cart drawer had been broken for a couple of weeks. She stated she told the pharmacy people about the medication cart being broken. She also stated she had gone to the DON. LPN #10 stated the DON told her to call the pharmacy vendor initially, and she had started calling them last week. She also stated Maintenance attempted to fix the medication cart yesterday (referring to 6/4/19). LPN #10 stated she was on the hallway and had just come out of room 102. She stated the medication cart was parked between room 101 and room 102. She also stated she was able to see the resident in room 102 and the medication cart at the same time. The call was disconnected at 3:15 PM, and LPN #10 called back to continue the interview. During this interview, LPN #10 stated, "Yes, I said it had been broken and I think I told you April 25th" (referring to how long the A-wind medication cart 1 had been broken). She stated when she first identified the lock was broken, she asked maintenance if they could fix the lock and Maintenance stated they do not look at medication carts; and she would have to call the people they (referring to the medication carts) had come from. She also stated she was told to call the pharmacy vendor by the DON. LPN #10 stated she would keep the medication cart in view and/or turn it around. She stated, when the surveyors had come to the facility, she was just finishing her medication pass. She then stated, she was able to see the medication cart, but could not see the resident. She also stated she	F 761		

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had seen RN #3 intervene, but she (LPN #10) did not. LPN #10 then stated, the lock was facing her and she could see the lock. LPN #10 stated the resident used his right hand and opened the medication cart drawer. She stated the medication cart was close to rooms 101 and 102 and it was facing towards the middle of the hallway. She stated the resident could have side effects if he had taken some of the medications. She also sated the resident could have heart problems and could have died. LPN #10 stated, if she was giving medications to a resident and had the privacy curtain pulled, she would pull the medication cart to the door and she could hear if someone opened the drawer to the cart. She stated they would have to totally move the cart. She also stated, "We have to keep the medications separated", so she could not have moved the medications to another drawer. She stated sometimes the other drawers would not lock and it's possible the resident could have gotten into another unlocked drawer. LPN #10 stated she tried several times to get the medication drawer fixed.

On 6/5/19 at 4:08 PM, an interview with the DON revealed the staff reports to Maintenance or logs the problem in the maintenance book for any broken equipment. She stated the Maintenance Supervisor or Maintenance Staff #2 are always on call, even for equipment that need to be reported immediately.

On 6/5/19 at 4:35 PM, an interview with Maintenance Staff #2 revealed he first became aware of the medication cart lock being broken on yesterday (referring to 6/4/19). He stated as he was walking down the hallway, he was flagged down by RN #1 to talk to the pharmacy vendor.

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F 761	Continued From page 63 Maintenance Staff #2 stated pharmacy staff asked him to check out the lock on the medication cart. He stated he and the Maintenance Supervisor were unable to fix the medication cart lock. He stated he called the pharmacy back and the lady on the phone stated she would send a technician out to the facility. He also stated he does not know if the pharmacy sent the technician to the facility or not. On 6/5/19 at 4:40 PM, an interview with the Maintenance Supervisor revealed Maintenance Staff #2 told her about the medication cart not locking on 6/4/19. She stated they (referring to her and her assistant) tried to work on it (referring to A-wing medication Cart 1's lock) and could not get it fixed. She stated Maintenance Staff #2 called the pharmacy vendor. She stated the top right drawer of the cart would not lock. On 6/5/19 at 4:45 PM, an interview with Maintenance Staff #2 revealed the A-wing medication cart "Cart 1", was 40 and ¼ inches in height. This was observed to be easily accessible to any resident in a wheelchair. On 6/5/19 at 5:47 PM, an interview with Pharmacist #1, revealed the pharmacy vendor was first notified on Monday (6/3/19), of the facility having a medication cart that would not lock. She stated the facility emailed Pharmacy Staff #1 on Monday, 6/3/19 at 5:08 PM. She also stated she was not aware that the medication cart had been broken for two (2) weeks. She stated she called the facility Tuesday 6/4/19, to see if the maintenance man could fix the cart. She also stated if a resident took 25 Nitroglycerin tablets, she believed they would have a headache and Hypotension. She also stated that 25	F 761		

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F 761	Continued From page 64 Nitroglycerin tablets would be a higher than indicated. She stated it is not an indicated dose, and could lead to Hypotension, Headache, and falls. On 6/5/19 at 5:57 PM, an interview with the Medical Director revealed she was made aware of this incident (the A-wing medication Cart 1 drawer lock being broken) today when she walked through the door at 2:00 PM. She stated there was a plan of correction in place. She also stated the Pharmacist is a major issue here at the facility. She stated if a resident had taken 25 of the 0.4 Mg Nitroglycerin tablets, that could cause death. On 6/6/19 at 12:04 PM, an interview with RN #3 revealed she was making rounds and when she headed back, that's when she took the resident's hand and said, "No, no, no, we can't do that" (referring to Resident #41 opening the medication cart drawer). She stated, the resident said, all he wanted was a pencil. She stated she was headed back from the end of A-wing hallway towards the nursing station. She stated the DON was coming from the opposite direction. RN #3 stated she had not had to redirect a resident away from a medication cart before. She also stated she does not remember any other resident opening the medication cart before. She stated she does not have a clue as to how long the medication cart lock had been broken. Observation on 6/6/19 at 12:15 PM, revealed LPN #7 moved a medication cart, just like the cart that had the broken drawer, to the middle of A-wing hallway between rooms 101 and 102 with the medication drawers facing the center of the hallway, just as positioned on 6/4/19, when the	F 761		

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F 761	Continued From page 65 resident was observed opening the medication cart drawer. The surveyor sat at the nursing desk on A-wing and the medication cart drawers were not visible from the nursing station, with the medication cart being in this position, indicating that the cart would have been unsecured without someone directly at the cart. On 6/6/19 at 3:22 PM, an interview with the Consultant Pharmacist revealed there is some form of medication audit done monthly. He stated carts are checked basically once a quarter. He stated he was not aware and cannot recall the A-wing medication cart drawer being unable to be locked. On 6/7/19 at 1:05 PM, an interview with the Administrator revealed the DON notified him of the incident (A Wing top right medication cart drawer not locking) on 6/4/19. He stated staff should not wait to report these types of issues. He stated he must be made aware for the safety and well-being of the residents. The facility provided the following Removal Plan: Brief Summary: At approximately 6:50 PM on June 5, 2019, the facility was notified by the annual survey team that the facility was being placed in Immediate Jeopardy, due to the Facility on June 4, 2019 at approximately 6:45 PM, failed to adequately supervise to prevent a severely cognitively-impaired resident from opening a medication cart drawer where multiple medications, including 25 Nitroglycerin 0.4 milligram (mg) tablets were located. The facility failed to store medications safely to prevent a cognitively impaired resident from having access	F 761		

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F 761	Continued From page 66 to the medication cart, and the medication cart drawer would not lock. Licensed Practical Nurse (LPN) #10 stated the cart did not lock properly and has malfunctioned since she started to work in the Facility on April 26, 2019, at approximately 7:00 AM. On the evening of June 4, 2019, Resident #41 was witnessed by a surveyor opening the malfunctioning drawer where medication was located. The cart was locked in the medication room once medication pass was completed. (Name of Pharmacy Vendor) was contacted on June 3, 2019 and a new cart was requested. The replacement cart arrived at the Facility on June 5, 2019, and medications were transferred from the malfunctioning cart to the properly locking replacement cart. Corrective actions included: 1. On June 4, 2019 at approximately 6:45 PM, Resident #41 was observed opening the malfunctioning drawer. This incident was witnessed by RN #3 and LPN #7. RN #3 immediately redirected resident. This incident was also witnessed by the annual survey team. The primary LPN #10 assigned to the cart was not present. 2. On June 5, 2019 at approximately 1:00 PM, a new medication cart was delivered to the Facility. Medications were exchanged from the old cart into the new properly locking cart. 3. On June 5, 2019 at approximately 2:00 PM, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the RN Supervisor (RN) #1, and the Minimum Data Set (MDS) RN #2, audited medication carts regarding proper locking and storage. No issues were identified.	F 761		

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F 761	Continued From page 67 4. On June 5, 2019 at approximately 2:30 PM, the Administrator held a Quality Assurance Performance Improvement (QAPI) meeting to discuss action plan and resolution steps. The members of the committee discussed the medication cart malfunction, proper storage of medication, necessary steps in reporting issues and an audit tool developed as a tracking mechanism to ensure medication carts are in proper working order. The Members in attendance were the Administrator, DON, ADON, Medical Director, Social Services Director, Dietary Manager, Activities Director, Director of Therapy, Staff Development Coordinator LPN #7, Maintenance Director, Business Office Manager, Human Resources Generalist, Housekeeping Manager, MDS RN #2, LPN #4, LPN #5, Risk Manager RN, and the RN Supervisor (RN #1). 5. On June 5, 2019 at approximately 3:00 PM, the Staff Development Coordinator LPN #7 in-serviced Licensed Nursing Staff on the daily audit tool used to validate that all medication carts are in proper-working order, proper storage of medication to maintain a safe environment, and proper procedure for unavailable medications. 6. No nursing staff will be permitted to work until in-serviced. 7. The facility alleges that all corrective actions to remove the immediate jeopardy was completed as of June 5, 2019, and the immediate jeopardy removed as of June 6, 2019. The SA validated the facility's Removal Plan and determined the facility had taken the following actions to correct the IJ:	F 761		

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F 761	Continued From page 68 1. Based on observations record review and staff interviews the State Agency (SA) validated Resident #41 had server cognitive impairment and was observed opening the drawer of an unsecured medication cart. The SA validated the resident was redirected by RN #3. 2. The SA validated by interview with the Director of Nurses (DON) and observation on 6/6/19, that a new cart had been delivered and medications were exchanged from the old cart into the new cart on 6/5/19, and the cart properly locked. 3. The SA validated by interview with the DON that an audit was completed on 6/5/19, that all carts locked appropriately. The SA found no other carts that malfunctioned. 4. The SA validated through review of the sign-in sheet and interview with the Administrator, that a QAPI meeting was held on 6/5/19, with all stated members, in regards to the malfunctioning medication cart, storage of medications, reporting requirements if there's a malfunction, and a tracking/audit tool for ensuring medication carts were in proper working order. 5. The SA validated through random interviews with nursing staff and review of in-service sign in sheets, that the Staff Development Coordinator, LPN #7, initiated in-services regarding use of the audit tool, proper storage of medication to maintain a safe environment for residents, and procedures for medications not available. 6. The SA validated through interview with random nursing staff that no staff was allowed to work until they were in-serviced.	F 761		

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	255227	A. BUILDING _____ B. WING _____	06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 69 7. The SA validated that all corrective actions to remove the Immediate Jeopardy were completed on 6/5/19, and the Immediate Jeopardy removed as of 6/6/19.	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to	F 803	F803 1. Resident #36 offered the alternate meal	7/12/19

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F 803	Continued From page 70 follow the meal menu for Resident #65 and Resident #36, for two (2) of 18 meal observations. Findings include: The facility policy "Menus", revised 9/2017, noted that menus will be served as written, unless a substitution is provided. This policy stated menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. In a review of the facility menu for week one, on Tuesday evening for dinner listed: Grilled Ham and Cheese Sandwich, Tossed Salad with Dressing, Tater Tots, Summer Fresh Fruit Cup, and Tomato Soup. Resident #65 On 06/04/19 at 6:15 PM, during observation of the dinner meal, Resident #65 stated, "I can't eat this mess, look at what they feed us." He stated, "This bread is hard as a rock." Resident #65's meal ticket listed for Grilled Ham and Cheese sandwich, Tossed Salad with Dressing, Tater Tots, Ketchup, Tomato Soup, Saltine Crackers, and Summer Fresh Fruit Cup. Food was served on paper plates, with disposable cups, spoons and forks. Resident #65 confirmed he did not receive tomato soup or tater tots and did not have ham on his sandwich. Resident #65 stated he would have eaten the ham, tater tots, and the tomato soup if they had given it to him. The bread on the sandwich was hard, dry (not like toast) and did not look presentable or edible. Resident #65 opened his sandwich and no ham was visible, but	F 803	or other foods available by Dietary Cook on 6/4/19, but declined. Resident #65 offered the alternate meal or other foods by Dietary Cook available on 6/4/19, but declined. Dietary staff member was terminated on 6/7/19 by Dietary Manager for failure to follow menu on 6/4/19. 2. Current residents who receive meals from the dietary department are at risk of being affected by deficient practice. Residents with Brief Interview for Mental Status (BIMS) of twelve (12) or greater were interviewed by Dietary Manager regarding their level of satisfaction with Dietary Services on 7/2/19; concerns noted were addressed/corrected by 7/3/19. 3. On 6/6/19, Dietary Manager was in-serviced by Administrator in regards to ensuring menu is followed and residents are notified when changes are made. Dietary department was in-serviced by Dietary Manager on 6/6/19 in regards to following menu. Dietary Manager was invited by Resident Council President, and will attend resident council and address diet concerns on a monthly basis beginning July 2019. Beginning on 6/20/19, licensed nurses, certified nurses aides and department heads were in-serviced by Licensed Practical Nurse (LPN) Staff Development Coordinator in regards of requirement of facility to provide meals per requirement and follow posted menu or notify residents when changes are made. Beginning 6/12/19, the facility implemented a meal	

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F 803	Continued From page 71 cheese was melted to both sides of the hard, dry bread. During an interview 06/04/19 at 6:18 AM, Dietary Cook/Aide #3 stated that all of the sandwiches have ham and cheese, the tomato soup is a misprint for Resident #65's meal ticket, and all residents that were to supposed to have tater tots got them. She confirmed other residents received tomato soup. She confirmed Resident #65 did not have Tomato Soup or Tater Tots on his supper meal tray. Review of the Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/14/19, reveled Resident #65 had a score of 15 on the Brief Interview for Mental Status (BIMS), which indicated he was cognitively intact. Resident #36 Review of Resident #36's current June 2016 physician orders revealed an order for a Regular diet. An observation an interview on 06/04/19 at 6:39 PM, revealed Resident #36 had tomato soup six (6) ounces listed to be served on her tray card. The dinner tray did not have tomato soup on her plate. Resident #36 said she would try the soup if it was on her tray. In an interview on 06/5/19 at 2:25 PM, the Dietary Manager confirmed the menu was to include the tomato soup. She said she thought the meals were correct when they left the kitchen and alternates were available.	F 803	monitor program in which a meal monitor checklist, Meal Monitor, must be completed to ensure accuracy of meals served, completed by Registered Nurse (RN) Supervisor/licensed nurse/department head. 4. Beginning on 7/12/19, Administrator will interview five (5) residents on food satisfaction weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. Dietary Manager will bring concerns/grievances to stand-up for daily discussion. Any concerns will be acted upon immediately. Administrator will report findings during monthly Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. RN Supervisor will bring concerns identified by the daily meal monitor to stand-up for daily discussion. Administrator will report findings during monthly Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for on-going monitoring and compliance.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		7/12/19

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F 804	Continued From page 72 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide Resident #65 with a meal that was palatable, attractive and acceptable in flavor, for one (1) of 18 meal observations; and six (6) Resident Council members, during interview, also complained of food being cold and not palatable. This affected seven (7) of 86 residents in the facility. Findings include: The facility policy "Food: Quality and Palatability", revised on 9/2017, noted the facility would prepare food by methods that conserve nutritive value, flavor and appearance and will be palatable, attractive, and served at a safe and appetizing temperature. This policy also noted foods and liquids are to be prepared and served in a manner, form, and texture to meet resident's needs. Resident #65 On 06/04/19 at 6:15 PM, during the dinner meal observation with Resident #65, he stated, "I can't eat this mess, look at what they feed us." The resident stated the bread was hard as a rock. The	F 804	F804 1. Resident #65 was offered the alternate meal or other foods available on 6/4/19 by Dietary Cook, but declined. On 6/19/19, Dietary Manager and Ombudsman attended resident council meeting, as invited by the Resident Council President, to discuss food related complaints regarding palatability and temperature. 2. Current residents who receive meals from the dietary department in the facility are at risk of being affected by the deficient practice. Residents with Brief Interview for Mental Status (BIMS) assessments of twelve (12) or higher were interviewed by Dietary Manager regarding their level of satisfaction with Dietary Services related to temperature and palatability on 7/2/19; concerns noted were addressed by 7/3/19 by Dietary Manager. 3. On 6/6/19, Dietary Manager was in-serviced by Administrator in regards to ensuring menu is followed and residents are notified when changes are made.	

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F 804	Continued From page 73 bread was hard with no meat. Resident #65 complained of the taste and said he would not give this to a dog. The food was served on paper plates and disposable cups, with disposable spoons and forks. The bread on the sandwich was hard, dry (not like toast). When Resident #65 opened his sandwich, cheese was melted to both sides of the hard, dry bread, without any meat. In an observation on 06/04/19 at 6:18 PM, with Dietary Cook/Aide #3 present, the ham and cheese sandwiches had a dry-looking appearance. Dietary Cook/Aide #3 confirmed that the sandwiches in the metal tray were the ones being served to the residents. Interview with the Dietary Manager, on 06/05/19 at 4:35 PM, revealed there were concerns with one (1) Cook during the evenings. Taste of test trays on 6/6/19 at 12:30 PM, by the State Agency (SA) was acceptable in temperature, but bland with little to no seasoning. No concern with this meal appearance. The Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/14/19, revealed Resident #65 had a score of 15 on the Brief Interview for Mental Status (BIMS), which indicated he was cognitively intact. Resident Council Members During interview on 06/05/19 at 2:15 PM, six (6) Resident Council members revealed they have complained about the food every month for a year. The council Members also said the Dietary Manager was present for all meetings. Resident #1, the Council President, revealed the Council had complained every month about the food being cold, burnt and the meat is always hard.	F 804	Dietary department was in-serviced by Dietary Manager on 6/6/19 in regards to following menu, presentation of food and adequate temperature. Dietary Manager was invited by Resident Council President and will attend resident council and address diet concerns on a monthly basis beginning July 2019. Beginning on 6/20/19, full-time facility-wide staff were in-serviced by Licensed Practical Nurse (LPN) Staff Development Coordinator in regards of requirement of facility to provide meals per requirement and follow posted menu or notify residents when changes are made including palatability, appearance and adequate temperature. Beginning 6/12/19 facility implemented a meal monitor program in which a meal monitor checklist, Meal Monitor, must be completed to ensure accuracy of meals served, completed by RN Supervisor/licensed nurse/department head. The meal monitor, as a part of the meal monitor check list, will sample a tray to test for accuracy according to the menu, palatability and temperature. 4. Beginning on 7/12/19, Administrator will interview five (5) residents on food satisfaction weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. Dietary Manager will bring concerns/grievances to stand-up for daily discussion. Any concerns will be acted upon immediately. Administrator will report findings during monthly Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations.	

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F 804	Continued From page 74 During an interview on 06/06/19 at 3:00 PM, the Activity Director confirmed the residents have complained about the food every month. The Activity Director also stated that she had observed cold and burnt food served during meal times. During an interview on 06/06/19 at 9:18 AM, The Dietary Manager revealed she attended all of the Resident Council meetings and the resident's had complained about the food being burnt, cold, and not tasting good. The Dietary Manager said she was working on correcting the issues.	F 804	RN Supervisor will bring concerns identified by the daily meal monitor to stand-up for daily discussion. Administrator will report findings during monthly Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for on-going monitoring and compliance.	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to have an effective pest control, as evidence by flies for three (3) of four (4) days of survey, to include two (2) of three (3) kitchen observations. All 86 residents have the potential to be affected. Findings include: The facility's policy, "Pest Control", revised May 2008, noted the facility shall maintain an effective pest control program to ensure the building is kept free of insects and rodents. On 06/04/19 at 6:20 PM, during an observation of	F 925	F925 1. Administrator contacted contracted pest control provider on 6/25/2019 to have pest control to begin to treat weekly for pests. Weekly pest control services began on 6/26/19 superseding monthly scheduled pest control services. Maintenance Director replaced fly stations at all egress exits on 6/6/19. 2. Current residents are at risk of being affected by the deficient practice. 3. On 7/2/19, facility staff were educated by Maintenance Director on requirement of facility being maintained in manner that	7/12/19

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F 925	Continued From page 75 the supper meal, Certified Nursing Assistant (CNA) #1 confirmed a fly seen on Resident #65's plate while eating. Resident #65 stated, "We can't eat our food for the flies, they are everywhere". On 06/04/19 at 6:38 PM, during the initial kitchen tour, Dietary Cook/Aide #4 confirmed a fly in the kitchen area. On 06/06/19 at 11:45 AM, during an observation with the Dietary Manager (DM), a fly was visible on the rim of a desert bowl. During an interview on 6/6/19 at 11:45 AM, the DM was asked why it was important not to have flies and pests in the kitchen. The DM stated, "It's unsanitary". The DM did not remove the dessert bowl from the tray line after identifying the fly on the rim of the bowl and continued to let the desert be served. On 06/07/19 at 2:09 PM, observation of a fly on an un-sampled resident's left sleeve of shirt was confirmed by Licensed Practical Nurse (LPN) #1. On 06/07/19 at 1:15 PM, the facility Administrator was asked how he knows he has an effective pest control program? The Administrator responded, "By the absence of pests". The Administrator confirmed that pest control was not effective with the evidence of flies in the kitchen and throughout the facility. Record review revealed Pest Control Invoices dated 12/19/18, 1/10/19, 2/15/19, 3/19/19, 4/25/19, and 5/30/19.	F 925	controls pest. Fly swatters have been placed at the Nurse s stations for employee use beginning 7/2/19. Pest control services will come on a weekly basis for six (6) weeks. 4. Beginning 7/12/19, Maintenance Director will perform rounds weekly for twelve (12) to observe for pests in the facility, and to ensure pest control service are working. Maintenance Director will report findings monthly to the Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. The Maintenance Director is responsible for on-going monitoring and compliance.	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 07/08/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 6/7/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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