STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355047	A. BUILDING _____ B. WING _____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ON BROADWAY	1351 N BROADWAY FARGO, ND 58102

(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 For the standard Medicare/Medicaid recertification survey started on 4/20/15 and completed on 04/23/15, the sample included 5 residents for complete review, 13 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date indicated.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide medically related social services to ensure 2 of 2 sampled residents (Resident #11 and #14) involved in inappropriate behaviors received the necessary services. Failure to reassess the continued behaviors and evaluate measures to eliminate the inappropriate behavior may negatively impact the physical, mental, and psychosocial well-being of each resident. Findings include: Review of the facility policy titled "Behavior, Management of Challenging Resident Behavior" occurred on 04/23/15. This policy, dated 10/8/13, stated, "Policy: It is the policy of Rosewood to	F 250	**F250.** It is the practice of this facility to provide medically related social services to maintain the well-being of each resident in the facility. 1. Behavior assessments will be completed for Resident #11 and #14. Careplans for both residents will be reviewed for appropriate interventions based on the assessment. 2. All residents in the facility would have the potential to be affected by this deficiency. 3. The Director of Nursing/designee will re-educate the Case Management Staff re:	5/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/19/15

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 250	Continued From page 1 assist residents to achieve and maintain their highest level of physical, social and emotional functioning, quality of life and safety through the systematic delivery of services, including the management of negative behaviors which distress and/or disrupt the resident, other residents . . . Definitions: Challenging behaviors may consist of . . . Socially inappropriate behavior . . . inappropriate sexual behavior, disrobing in public . . . Procedure: . . . 5. If behavior included . . . physical attack to other residents or guest, complete risk management report in PointClickCare. . . 6. Case manger will initiate and have completed a behavior assessment within 48 hours of reported new behavior. . . 7. Case manager will review RW [Rosewood] Behavior task in POC [point of care] to gather shift by shift information related to behavior. . . .8. Initiate behavior interventions. . . ." Review of the facility policy titled "Abuse Neglect and Misappropriation of Resident Property Prevention" occurred on 04/23/15. This policy, dated 01/13/15, stated, "Policy: All residents at [sic] have the right to be free from verbal, sexual, physical and mental abuse . . . 5. Investigate: Once reported, the facility conducts a timely, thorough and objective investigation of any allegations of abuse. Part of the investigation includes the consideration of the indicators of possible abuse. The focus is on determining who, what, when, why and how for any occurrence to determine the appropriate course of action and response." - Review of Resident #11's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. The current Minimum Data Set (MDS), dated 04/07/15,	F 250	identification of behaviors and completion of the Behavior Assessment to include careplanning appropriate interventions for the behavior in the plan of care. 4. The Case Management Coordinator will audit for completion of the behavior assessment and appropriate interventions included in the careplan for residents identified with behaviors ~~monthly for 3 months~~ Monthly x 3 months, then quarterly x 2. Audits will be reviewed at the QAPI meeting and with case management staff for continued compliance. 5/29/15 9:49am weekly for 3 weeks then monthly for 3 months then quarterly therapeutic 1x a month, then quarterly #4 changed to read weekly for 3 weeks then monthly for 3 months, and quarterly therapeutic for 2 quarters. ok'd via phone 5/29/15 9:49am Tony Keller L.S.	

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F 250	Continued From page 2	F 250		

identified severely impaired cognition and extensive assistance of one for transfers.

Resident #11's nursing progress notes stated the following:
01/08/15 - 1:12 p.m. "Spoke with [Resident #11] son yesterday regarding the relationship that [Resident #11] has formed with a male resident. His only concern is for [Resident #11] safety. Staff educated to observe and intervene if male resident attempts to assist [Resident #11]."
02/07/15 - 6:15 p.m. "Heard resident's alarm go off, was no longer in dining room where she had been 10 min earlier. Resident found to be in males [sic] room on his bed with him on top of her. Both had there [sic] clothes on. RA [resident assistant] asked residents if they were ok. Resident wanted to get up into her w/c [wheelchair]. Resident assisted to dining room where she remained calm and quiet. RA's did not note any injuries at this time."

An e-mail sent from the nurse manger to facility staff on 02/09/15 at 3:29 p.m. stated, "This weekend [Resident #11] was found on [Resident #14's] bed and [Resident #14] was on top of her (they were clothed) but because of the risk of injury to both of them, we have to know where [Resident #11] is at all times. Do your best to not leave [Resident #11] in the Dining Room or hall without staff supervision because it seems that [Resident #14] waits for this to happen then takes [Resident #11] away."

Resident #11's care plan stated, ". . . Focus: I am at risk for falls secondary to dementia . . . Intervention: A male resident on the floor has a history of trying to wheel me to his room. Please monitor and intervene for safety [initiated

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F 250	Continued From page 3 01/08/2015]. . . . Focus: There is a male res. [resident] on the unit I have shown an attraction for by reaching for his hand and calling him 'honey'. My son is aware of this and agrees this is fine but shares concern with staff that I may try to self-transfer because of this other res. or other res. may try to transfer me which is unsafe for both of us. Intervention: Do your best to not leave me in the Dining Room or hall without staff supervision. I like to spend time with a male res. I have shown an attraction to but for our safety we need to be supervised when together otherwise I may self-transfer or he may try to transfer me which is not safe for either of us. . . . [initiate 02/23/2015]" - Review of Resident #14's medical record occurred on 04/22-23/15. Diagnoses included Alzheimer's disease and delusional disorder. The current MDS dated 02/05/15, identified severely impaired cognition and independent with transfers and locomotion. Resident #14's nursing progress notes stated the following: 02/07/15 - 6:15 p.m. "Observed Behavior: Checked on at this time, had another resident in his room on his bed and he on top of her. He had his belt open and zipper open, both were fully clothed. What was happening before the behavior occurred: Resident in Dining room, visiting. 15 Min. [minutes] before incident. Intervention used: RA entered room, and asked this resident and other resident if they were ok. Calm approach to assist other resident back into her w/c and out to dining room. Resident response to intervention: Stated it was all his fault and stayed in his room the rest of the evening. Will monitor residents closely and staff education provided to prevent	F 250		

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F 250	Continued From page 4	F 250		

future incidents."

Review of a form used daily for nursing report stated the following:
02/08/15 - ". . . [Resident #11] - MONITOR CLOSELY with [Resident #14] has been taken from public areas again. . . .
[Resident #14] ". . . He needs very close monitoring with [Resident #11] as he has removef [sic] her from public areas again . . ."
A report form, dated 04/23/15, stated, "[Resident #14] . . . needs very close monitoring with [Resident #11] as he has removed her from public areas again . . ."

Review of physician progress notes dated 02/12/15 at 8:15 a.m. stated, ". . . [Resident #14] memory is declining and more episodes of confusion. He has a more difficult time remembering people and often thinks he is back in 'army days'. . . . He has taken a recent interest in some female residents. He has started doing more things such as coming out of his room undressed, making sexual comments on occasion. . . Staff have no concerns related to his physical or emotional status at this time. . . Plan: changes/Revisions: None . . ."

An entry on Resident #14's care plan, dated 02/23/15, stated, ". . . I seem to have an attraction to a female res. on the unit who also has dementia but is a high fall risk. Female res. seems to enjoy my company as well. . . . Interventions: Allow me to visit with the female res. I like to spend time with in group settings but do not allow us to be alone together because I may try to transfer her or encourage her to transfer which is not safe for either of us. . . ."

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F 250	Continued From page 5 During an interview on 04/22/15 at 4:00 p.m. the unit case manager (#23) stated after the incident on 02/07/15 staff attempted to increase the activities for the two residents, and keep a close eye on the residents. During an interview on 04/22/15 at 4:45 p.m., a nurse manger (#11) stated staff failed to complete an incident report for the behavior on 02/07/15 and failed to have the incident reviewed by the risk management committee. This nurse manger stated Resident #11 and #14's care plans were updated on 02/23/15 after notifying the resident's family of the incident (16 days after the incident). Resident #11 and #14's medical records lacked evidence of family notification of the incident on 02/07/15. The interdisciplinary team failed to reassess the behaviors and identify all the risks including inappropriate behaviors and falls, implement timely measures, and evaluate the effectiveness of these measures. The facility failed to identify the inappropriate incident within Resident #11 and Resident #14's care plan.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	**F278.** It is the practice of this facility to accurately assess and document resident's status and correctly code the assessment on the MDS. 1. Reviewed documentation for Resident #16 for 3/9/15 and MDS. Correction made to E0100B on MDS for that date. MDS Submitted to CMS and ND DHS.	5/28/15

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F 278	Continued From page 6 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/03/14. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 1 of 1 sampled resident (Resident #16) coded on the MDS as having delusions. Failure to accurately assess and code the MDS may affect the level of care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), November 2014, page E-2 stated,	F 278	2. Review of most recent MDS for all other residents for coding on E0100B did not identify any other assessments where E0100B was coded Yes. 3. The Director of Nursing/ designee will re-educate case management staff on the need to have supporting documentation to code E0100B Yes. 4. The MDS Coordinator/ designee will review supporting documentation for all MDS's with E0100B coded as Yes weekly for the next 4 weeks then monthly for 3 months and quarterly for 1 year.	

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F 278	Continued From page 7 ". . . Review the resident's medical record for the 7-day look-back period. . . . Clarify potentially false beliefs . . . A delusion is a fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . ." Review of Resident #16's medical record occurred on April 22-23, 2015. The quarterly MDS, dated 03/19/15, identified Resident #16 as having delusions. Resident #16's progress notes failed to show a behavior of delusions including staff trying to clarify a false belief in the seven day look-back period. During an interview on 04/23/15 at 9:25 a.m., a social services staff member (#1) confirmed the resident's medical records failed to show they exhibited delusional behaviors during the seven day look-back period.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, review of professional reference, and staff interview, the facility failed to ensure the services of medication administration met professional standards of practice for 3 of 6 sampled residents (Resident #12, #23 and #24) observed during medication administration. Failure to identify a transcription error (Resident #23), clarify a medication order (Resident #24), and ensure the label on the	F 281	**F281** It is the practice of this facility that medications will be administered according to professional standards of practice. 1. Resident #23 MAR was corrected to read 80 mg. Medication had been given as ordered. Resident ~~#24~~ #12 insulin pen was sent to Thrifty White Drug for relabeling at time of observation on 4/21/15. Resident #24 ~~MAR~~ medication corrected to match the physician order at time of observation on 4/21/15. 5/20/15 1:32 pm Verbal correction #12 via phone to Lizy Peterson L.S. Day Resident #24 medication corrected to match physician order... 5/28/15 1:32 pm Lizy Peterson L.S.	5/28/15

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F 281	Continued From page 8 insulin vial matched the medication administration record (MAR) (Resident #12) has the potential to cause negative outcomes to residents. Findings include: Review of the facility policy titled "Medication Administration" occurred on 04/22/15. This policy, revised 06/14/14, stated, ". . . Medication will be administered in a way to ensure the safe and efficient administration of medication . . . OBJECTIVES: . . . To assure the right drug and dose are given to the right resident . . . PROCEDURE: . . . All individual prescription cartridges, bottles, or packages will be clearly labeled with . . . medication name, dosage and direction . . . Medications are to be administered . . . comparing the label on the . . . bottle . . . with the MAR . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 9th Edition, dated 2012, pages 860 and 864 states, ". . . Nurses who administer medications are responsible for [to] . . . Call the person who prescribed the medication for clarification. . . . Compare the label of the medication . . . against the order on the MAR . . . administer the medication in the prescribed dosage . . ." - During observation of medication preparation on 04/21/15 at 9:50 a.m., a licensed nurse (#2) prepared medications for Resident #23. The MAR showed to administer Propanolol (a medication for the heart and/or blood pressure) 80 micrograms (mcg) and the label on the medication dispensing card showed the dose as 80 milligrams (mg). The nurse observed the error, checked the hand-written physician's order	F 281	2. All residents requiring medications have the potential to be affected. Consultant Pharmacist completed a review of all resident charts to identify any potential transcription errors on 5/15/15. 3. The Director of Nursing/designee will re-educate all nurses re: entering medication orders in PointClickCare MAR on 5/19/15. Clinical Support Nurses will utilize red tabs on the chart to double check orders entered by the nurse into PCC for accuracy in transcription. 4. The Quality Nurse/designee will audit 10 orders per week on each floor for 4 weeks and monthly thereafter for 3 months to verify that orders are transcribed to MAR as written, med label matches the MAR and order is clarified if needed. Audits will be reviewed at the facility QAPI meeting for continued compliance.	

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F 281	Continued From page 9	F 281		

and clarified the order as for the 80 mg dose. Review of the current MAR and preceding MARs, dated back to December of 2014, also showed the Propanolol as 80 mcg verses mg.

During interview on 04/23/15 at 8:45 a.m., a supervisory nurse (#16) stated each nurse can enter physician's orders into the computerized medical record; the entry will automatically carry forward from month to month; and each/all nurses that administered the Propanolol since December should have caught the transcription error.

The facility failed to utilize a review process to ensure accuracy of provider orders entered onto the electronic MAR. This may have contributed to not identifying the mis-entry/transcription error over a period of several months.

- Observation during medication pass on 04/21/15 at 8:10 a.m., showed Resident #12 received Levemir insulin. The label on the Levemir FlexPen stated to inject 16 units every night. Resident #12's MAR and physician's orders stated to inject nine units two times a day.

During an interview on 04/21/15 at 08:10 a.m. a staff nurse (#10) confirmed Resident #12's Levemir order had changed on 04/16/15 and the FlexPen should contain a "check chart" label and be sent to pharmacy for a new label.

- Observation during medication pass on 04/21/15 at 8:46 a.m., showed Resident #24 received Ergocalciferol (vitamin D2) 1.25 mg one time a week for 12 weeks. Resident #24's MAR stated vitamin D3 (cholecalciferol) 50,000 units. Resident #12's physician order stated vitamin D

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F 281	Continued From page 10 50,000 units once a week. During an interview on 04/21/15 at 8:10 a.m. a staff nurse (#10) confirmed the MAR did not match the medication label. During an interview on 04/22/15 at 10:50 a.m., a nurse manager (#11) confirmed the medication label should match the MAR. During an interview on 04/23/15 at 10:38 a.m., a consulting pharmacist (#12) confirmed Resident #24 received the correct medication and she also confirmed the medication label should match the MAR.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/03/14. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 12 sampled residents (Resident #3 and #13) observed transferred with a gait belt. Failure to	F 323	**F 323** It is the practice of this facility to provide assistance necessary to prevent accidents for residents. 1. Staff re-education provided by the Director of Nursing/designee on gait belt use for residents #3 and #13 completed on 4/3/15 as well as for all staff 5/19/15 and 5/26/15. 2. All residents requiring assistance have the potential to be affected. 3. The Director of Nursing/designee will provide re-education on appropriate use of gait belts at All Nurse and All CNA in-services on 5/19/15 and 5/26/15.	5/28/15

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F 323	Continued From page 11 use gait belts, or use them properly during transfers placed the residents at risk of accidents and injury. Findings include: Review of the facility policy titled "GAIT BELTS" occurred on 04/23/15. This policy, revised 04/01/15, stated, ". . . PROCEDURE: . . . 2. Place the gait belt around the residents waist and fasten snug enough so it won't slip up around ribs. . . ." Review of the facility's policy titled "Standards of Care" occurred on the morning of 04/23/15. This policy, dated 08/13/15, stated, ". . . A transfer or gait belt will be used for all assisted transfers and ambulation. . . ." - Review of Resident #13's medical record occurred on April 20-23, 2015. The current quarterly Minimum Data Set (MDS), dated 03/18/15, identified extensive assistance of one person with transfers. Resident #13's care plan stated, ". . . Transfers: Assist of 1 using fww (Forward Wheeled Walker) . . ." Observation on 04/21/15 at 9:50 a.m. showed a CNA (#4) assisted Resident #13 with morning cares. The CNA (#4) failed to apply a gait belt and provided supervision only as Resident #8 transferred with her FWW from a rocking recliner to her bed. Observation showed the resident rocked back on her heels in an effort to propel herself forward before rising from the recliner. Observation on 04/22/15 at 9:50 a.m. showed a CNA (#13) applied a gait belt and assisted	F 323	4. The Quality Nurse/designee will audit 10 transfers per week for 4 weeks and monthly thereafter for 3 months to verify that gait belt is used appropriately during transfer. Audits will be reviewed at the facility QAPI meeting for continued compliance.	

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	355047	A. BUILDING _____ B. WING _____	04/23/2015

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F 323	Continued From page 12 Resident #13 with her FWW from her bed to the bathroom. When the CNA (#13) assisted the resident to an upright position and back to a seated position, the gait belt slid up the resident's mid back. - Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, ". . . Focus . . . I have had falls in the past because my blood pressure drops when I stand or change position quickly and I become dizzy. . . . Interventions/Tasks . . . TRANSFERS: I need 1 staff to assist me with my transfers. . . ." Observation on 04/21/15 at 9:08 a.m. showed two CNAs (#19 and #20) applied a gait belt and transferred Resident #3 from her wheelchair to the toilet. The CNA (#20) lifted under the resident's left arm and failed to use the gait belt. During an interview on 04/23/15 at 10:05 a.m., an administrative nurse (#9) confirmed a gait belt should be applied when providing assistance of one person. This staff member stated a gait belt should be applied so only two fingers fit beneath the gait belt.	F 323		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	**F428.** It is the practice of this facility to have the drug regimen of each resident reviewed at least monthly per the regulation. 1. Resident #23 MAR corrected at time of observation to read Propanolol 80 mg. Medication was administered per physician order.	5/28/15

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F 428	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the pharmacist completed a thorough evaluation of the drug regimen for 1 of 6 sampled residents (Resident #23) observed during medication administration. Failure to identify an irregularity and report it to the attending physician and the director of nursing resulted in an inaccurate entry in the medication administration record (MAR) for a period greater than four months. Findings include: During observation of medication pass on 04/21/15 at 9:50 a.m., a licensed nurse (#2) prepared medications for Resident #23. The MAR listed Propanolol (a medication for the heart and/or blood pressure) 80 micrograms (mcg) and the label on the medication dispensing card showed the dose as 80 milligrams (mg). The nurse observed the error, checked the hand-written physician's order and clarified the order as 80 mg dose. Review of the current MAR and preceding MARs, dated back to December 2014, also showed the Propanolol as 80 mcg verses mg. Pharmacy review records lacked evidence the consultant pharmacist identified the irregularity.	F 428	2. Consultant pharmacist completed review of each residents MAR's to identify other potential transcription errors on 5/15/15. Report given to DON. 3. Reviewed regulation with consultant pharmacist on 5/15/15. Nursing staff will also be re-educated by the Director of Nursing/designee on double checking entry of physician orders and checking each time medication is administered that order is entered correctly. 4. Consultant pharmacist will monitor resident MAR's for transcription errors with each monthly review and report discrepancies to the DON. Additional audits are being completed by the Quality nurse or designee to identify transcription errors as identified in F281.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 14 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 and review of the facility's medication storage policy, the facility failed to ensure safe storage of resident medications in 2 of 6 medication carts in the facility. Failure to	F 431	**F431.** It is the practice of this facility to maintain secure storage of resident's medications. 1. Medication carts will be locked when not in view of person administering medications per policy. 2. All nursing units have the potential to be affected by this practice. 3. The Director of Nursing/designee will re-educate nurses that medication carts must be locked when not in clear view of the person administering medications. 4. Quality audits will be completed by the Quality Nurse/designee ten times per week for 4 weeks then ten times monthly for three months to verify that medication carts are locked when not in view of the person administering medications. Audits will be reviewed by the QAPI committee for continued compliance.	5/28/15

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F 431	Continued From page 15 ensure secure storage of resident medications has to potential for unauthorized access to the medications. Findings include: Review of the facility policy titled "Medication administration" occurred on 4/22/15. This policy, revised on 6/14/14, stated, ". . .The medication cart will be locked and stored in the Nurses station when not in use. . .The medication cart is to be locked when not in clear view of the person administering the medications. . . ." Observation on 04/21/15 at 8:03 a.m. of the third floor south end nursing unit showed an unattended, unlocked medication cart in the hallway. On 04/21/15 at 8:23 a.m., observation showed an unlocked medication cart in the hallway next to the dining room on the second floor south end nursing unit. The nurse (#15) stood at the other side of the dining room with her back to the medication cart as she spoke with, and took a resident's blood pressure.	F 431		
F 494 SS=B	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part;	F 494	**F494.** It is the practice of this facility that all individuals working in the facility have current certification if required for their position. 1. Individual "A" renewed her certification on 12/11/14 when it was identified that it was expired.	5/28/15

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F 494	Continued From page 16 or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on review of the state nurse aide registry files, facility record review, and staff interview, the facility failed to ensure a nurse aide (Individual A) working with residents in the facility remained certified. Individual A provided 176 hours of nursing related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: Individual A contacted the state nurse aide registry on 12/11/14 to renew her certification. The state nurse aide registry file review identified Individual A's certification expired 11/05/14. On 12/11/14, nurse aide registry personnel contacted the facility regarding the nurse aide's expired certification. A facility administrative nurse	F 494	2. All current certified nursing assistants have the potential to be affected by this practice. 3. Facility uses scheduling software When to Work for licensed nurses and certified nursing assistants. The software has a data field where certification expiration can be entered. An alert comes up 30 days prior to the expiration date and remains until a current date is entered. The Staffing Nurse/designee entered certification dates for all staff in January of 2015. 4. Quality audits will be completed by the Staffing Nurse/designee on 5 staff per week for 4 weeks then 10 staff monthly for three months to verify date in When to Work matches current certification date for the employee. Audits will be reviewed by the QAPI committee for continued compliance.	

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F 494	Continued From page 17	F 494		

(#21) indicated information would be provided regarding the dates and hours worked by Individual A since 11/05/14.

The administrative nurse (#21) provided information by fax transmission on 12/11/14 which identified Individual A had worked with residents in the facility without certification for a total of 176 hours between 11/05/14 and 12/11/14.

During an interview on 04/23/15 at 10:51 a.m., the staffing manager (#22) verified Individual A worked from 11/05/14 through 12/11/14 without certification.