STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255221	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HALL HEALTH CARE CENTER	101 MILLS STREET BROOKHAVEN, MS 39601

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F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of Mississippi State Department of Health, from 4/8/19 through 4/11/19. The facility was found not to be in substantial compliance with requirements of participation for Medicare and Medicaid and cited deficiencies at F641, F656, F688, and F761. The census at the time of survey was 60, and the facility is licensed for 81 beds.	F 000		
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, interview and policy review, the facility failed to assure an accurate Minimum Data Set (MDS) assessment for medications received and Preadmission Screening and Resident Review (PASARR) conditions, for one (1) of five (5) residents, Resident (R) #41. This has the potential to affect the 17 residents the facility identified with major mental disorder and 29 residents identified to receive antidepressant medication. Findings include: Review of the facility "Certifying Accuracy of the Resident Assessment-med-pass revised 12/2009" policy, documented, "All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that	F 641	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. This Plan of Correction constitutes the facilities credible allegation of compliance. F 641 * Resident #41's Admission Assessment was corrected on 4/10/19 by the Minimum Data Set (MDS) Nurse and Social Worker to reflect antidepressants received and	5/10/19

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

Electronically Signed | 04/30/2019

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 641	Continued From page 1 portion of the assessment." The admission MDS with an Assessment Reference Date (end date of the look back period) of 03/11/19, under PASARR Conditions was not checked to indicate R #41 had a serious mental illness, and "Medications" were coded "zero", indicating no antidepressant medication was received during the last 7 days. The facility failed to follow their policy and assure an accurate MDS assessment was completed to assist with the care plan process. Review of the electronic medical record "Face Sheet" identified R #41 was admitted to the facility on 03/04/19, with diagnoses of major depressive disorder recurrent, and bipolar disorder. Review of the electronic March 2019 "Medication Administration Record" identified R #41 received Trazodone (antidepressant) 50 milligram (mg) by mouth at bedtime every day from 03/04/19, and Duloxetine (antidepressant) HCL DR 60 mg by mouth every day from 03/05/19. Interview with the MDS Coordinator on 04/09/19 at 4:15 PM, identified the medication section on the 03/11/19 MDS should have been coded to identify an antidepressant medication was received seven (7) days during the last seven (7) days. The MDS Coordinator said it was coded incorrectly, in error, and she would correct the MDS. She said the PASARR section of the MDS is completed by the Social Worker. On 04/09/19 at 4:15 PM, the Social Worker was asked about coding "0" for the PASARR	F 641	diagnosis of a Serious Mental Illness on 4/19/19. A letter from ASCEND was received by the facility on 3/14/19,indicating a Level II was needed due to Resident # 41's diagnosis of a major illness. On 5/1/19, Resident #41 was determined to be appropriate for Nursing Home Placement. Resident #41 suffered no adverse effects from this deficient practice. * All Residents with serious mental illness and who are taking anti-depressants have the potential to be affected by this deficient practice. * A 100% Audit of Section "N" of the Minimum Data Set (MDS)on the last Comprehensive Assessment completed on each Resident was completed by the MDS Nurse on Resident's receiving antidepressants on 4/26/19, to ensure coding is correct on the MDS. There are thirty three Residents receiving antidepressants and MDS's were coded correctly with no additional errors noted. A 100% Audit was completed by Social Worker on 4/26/19, with focus on Resident's with serious mental illnesses/receiving antidepressants. There were no additional Residents identified in the audit and MDS's were coded correctly. An in-service was held on 5/7/19, by the Director of Nursing (DON), with the Interdisciplinary Care Plan Team, consisting of MDS Nurse, Social Worker, Activity Director, Dietary Manager, Care Plan Nurse and the Assistant Director of Nursing, to review the MDS coding	

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F 641	Continued From page 2 Conditions on the MDS. The social worker said she didn't think R #41's diagnoses were considered a serious mental illness, so she did not check the serious mental illness box.	F 641	procedures, as indicated in the Resident Assessment Instrument Manual. The MDS Coordinator will monitor the coding on the MDS to ensure compliance, beginning 4/29/19, as scheduled, per the Minimum Data Set Calendar, weekly times eight weeks. Areas of concern will be addressed, by the MDS Nurse and/or the Social Worker, respectfully, as identified. * The Director of Nursing is responsible for ensuring the accuracy of the MDS Assessment and will monitor compliance, beginning 5/1/19, per MDS Calendar Schedule, one time weekly times eight weeks and then one time monthly on an ongoing basis. Any adverse findings will be forwarded by the Director of Nursing to the facility Quality Assurance and Performance Improvement(QAPI)/Quality Assurance (QA) Committee at monthly meetings for corrective actions, as indicated.	
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 -	F 656		5/10/19

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F 656	Continued From page 3 (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 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, interview, record review, and policy review, the facility failed to ensure a care plan intervention, for limited range of motion (ROM) was implemented, for one (1) of 21 residents, Resident (R) #34. This had the potential to affect the 15 residents identified by the facility with limitation in range of motion.	F 656	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal	

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F 656	Continued From page 4 Findings include: Review of the facility policy, titled "Comprehensive Assessments and the Care Delivery Process," revised December 2016, revealed "Comprehensive assessments, care planning and the delivery of care process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring the results and adjusting interventions. Assessment of the individual requires gathering relevant information from multiple sources which would include evaluations from other disciplines. Information would be analyzed then decision making would lead to a person-centered plan of care. Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals." Review of the facility policy titled "Specialized Rehabilitative Services," revised December 2009, "The facility will provide Rehabilitative Services to residents as indicated by the Minimum Data Set (MDS). In addition to Rehabilitative Nursing Care, the facility provides specialized rehabilitative services from Physical Therapy, Speech Pathology/Audiology, and Occupational/Activity Therapy. Therapeutic Services are provided only upon the written order of the resident's Attending Physician." Review of R #34's "Plan of Care", with an onset date 02/25/19, revealed, "Resident at risk for contracture development related to impaired mobility, left sided paralysis, and as having a high-risk assessment diagnosis of Cerebral Vascular Accident (CVA)." The goal was for the resident to have no development of contractures	F 656	and State Law. This Plan of Correction constitutes the facilities credible allegation of compliance. F 656 * Resident #34 suffered no adverse effects from this deficient practice. Resident #34 was screened on 4/11/19, by the Speech Language Pathologist(SLP) and the Occupational Therapist (OT), He was evaluated and treatment initiated with Speech Therapy (ST) and Occupational Therapy (OT) on 4/29/19. Speech Therapy treatment necessary for improvement of memory and problem solving skills with Care Plan being updated on 5/9/19 by the Care Plan nurse. Occupational Therapy treatment is for Self-Care and putting on and taking off shoes,c plus, He will need a resting hand orthotic to the left hand and monitor skin condition for effective skin breakdown and contractures with Care Plan being updated on 5/9/19 by the Care Plan Nurse. * All Residents with limited Range of Motion have the potential to be affected by this deficient practice. There are Fifteen Residents with limited range of motion, to include Resident #34 and there were no other Residents identified as being affected by this deficient practice. * A 100% audit of Resident Physician Orders for Therapy Evaluations and Treatments was completed on 4/12/19, by the Regional Therapy Manager. It	

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F 656	Continued From page 5 through the next review period, 06/12/19. Approaches listed for prevention of contracture development included, "Consult PT/OT [physical therapy/occupational therapy] for evaluation and treat as indicated, and Certified Nursing Assistants were to encourage active range of motion." The failure of the facility to implement care plan interventions did not assure R #34 received therapy services to meet established goals documented in the plan of care and maintain or improve range of motion. Review of the medical record "Face Sheet" documented R #34 was admitted to the facility on 02/25/19, with diagnoses of Cerebral Infarction (stroke), Anemia, Pain, Nausea, Vomiting, Depression, and Schizophrenia. Review of the admission "Minimum Data Set" (MDS) assessment, with "Assessment Reference Date" (end date of look back period) of 03/04/19, revealed a "Brief Interview for Mental Status" (BIMS) score 11 of a possible 15, indicating mild cognitive impairment, required extensive assistance with activity of daily living, functional limitation in range of motion with upper and lower extremity impairment to one (1)side, and did not use a cane, walker, wheelchair or limb prosthesis for mobility. Interview on 04/08/19 at 10:57 AM, with R #34, revealed the resident was admitted to the facility from the hospital, but previously lived in another long term care facility. The resident said he had a stroke in October 2018, and was not currently receiving any therapy services or restorative exercise. He said the left side of his body was	F 656	included ensuring that Resident Care Plans had been addressed appropriately, Screens/Evaluations were completed per facility policy & procedure and to ensure all Residents appropriate for Therapy Screens/Evaluations or Nursing Range of Motion was implemented, as indicated. Therapy Staff In-service completed on 4/12/19, by the Regional Therapy Manager, to include the policy and procedures for screening Residents, per Physician Order and that care plans are to be updated to reflect appropriate interventions. The Regional Therapy Manager will monitor Care Plans of new Residents, beginning on 4/12/19, to ensure compliance with care plan interventions through weekly audits of new admissions, quarterly screens due by the Minimum Data Set calendar schedule. Resident's identified, at risk, for decrease in Range of Motion/Mobility against therapy screen logs times twelve weeks and then on an ongoing basis. * The Director of Nursing and/or Assistant Director of Nursing are responsible for ensuring compliance to a Resident's Plan of Care. They will monitor Resident's Therapy screening orders and implementation through follow-up after new admissions in the 24/48/72 Hour Chart Checks, beginning on 5/1/19 and, at least, Quarterly and per the Minimum Data Set Schedule and, as needed, in a change in a Resident's condition where a therapy screen and/or eval is ordered by the Physician. They will, in addition to,	

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F 656	Continued From page 6 affected by the stroke and he could not use his left hand or leg. The resident said he received therapy at the other facility. R #34 said he just thought his money for therapy had run out because staff at the previous facility told him Medicaid only paid for 10 days of therapy, so he thought he might be close to or over his limit. Review of the medical record revealed staff failed to locate documentation that a physical or occupational therapy evaluation was completed since admission to the facility on 02/25/19. Interview on 04/11/19 at 10:30 AM, with the Director of Therapy (DT), revealed the initial therapy assessment was not completed because nursing staff reported R #34 was very ill with nausea and vomiting early in his admission. The DT said the therapy staff want the resident to feel well enough to participate in therapy, so he could make progress toward goals. Resident #34's illness could have been the initial reason a therapy screen was not completed, but since the resident was in the facility more than five (5) weeks, a therapy screen should have been completed. Interview on 04/11/19 at 11:37 AM, with MDS Coordinator and the Care Plan Nurse, revealed R #34's comprehensive care plan meeting was held on 03/13/19, but the resident or family member did not attend. The MDS Coordinator said she was not aware R #34 had a prosthesis for his right leg. As far as she knew, he did not tell anyone about the prosthesis. The MDS Coordinator said with left-sided weakness and the right side prosthesis, R #34 could be evaluated for therapy. The care plan nurse said R34's care plan listed a consultation for PT/OT and	F 656	what is routine stated above, they will monitor compliance one time weekly times eight weeks, then continue, weekly, on an ongoing basis. Any adverse findings will be forwarded, by the Director of Nursing, to the Quality Assurance and Performance Improvement/Quality Assurance Committee at monthly meetings, for corrective action, as indicated.	

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F 656	Continued From page 7 treatment as indicated as one intervention for prevention of contractures and confirmed the care plan intervention for the prevention and development of contractures had not been implemented. During an interview on 04/11/19 at 2:33 PM, the Director of Nursing (DON) said therapy screens should occur as soon as possible after admission. The DON stated screens completed by members of the Interdisciplinary Team (IDT) assist the care plan coordinators with the development of the resident's comprehensive care plan. She state that the information collected during screens and interviews with residents help the IDT understand a new resident's goals for care. The DON stated that knowledge of the resident's goals and wishes, regarding therapy and rehabilitation, would be helpful information for all staff who participate in the resident's care plan meetings. The DON further stated the purpose of the care plan was to assist all disciplines, including therapy team members in knowing which interventions were or were not effective in reaching the resident's goals for care. The DON stated if the resident did not desire to have any type of therapy, then that information should be discovered through the therapy screening process.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		5/10/19

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F 688	Continued From page 8 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure one (1) of 21 residents reviewed, Resident (R) #34, received a therapy evaluation and treatment for limitation in range of motion (ROM). This had the potential to affect the 15 residents identified by the facility with limitation in range of motion. Findings include: Review of the facility policy, titled "Health, Medical Condition and Treatment Options, Informing Residents" revised December 2016, revealed, "Each resident admitted to the facility will be informed of his/her total health status and medical condition, including diagnosis, treatment recommendations, and prognosis in advance of treatment and on an ongoing basis, unless otherwise instructed by the resident's legal representative." Further review of the policy revealed such information will include providing the resident with information about his/her functional status and rehabilitation and restorative potential.	F 688	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. This Plan of Correction constitutes the facilities credible allegation of compliance. F 688 * Resident #34 suffered no adverse effects from this deficient practice. Resident #34 was evaluated on 4/11/19, by Speech Language Pathologist and Occupational Therapist. He refused therapy services, at that time. He agreed on 4/29/19 to be evaluated and began Occupational Therapy and Speech Therapy. * All Residents with limited range of	

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F 688	Continued From page 9 Review of the facility policy titled "Specialized Rehabilitative Services," revised December 2009, revealed, "The facility will provide Rehabilitative Services to residents as indicated by the Minimum Data Set (MDS). In addition to Rehabilitative Nursing Care, the facility provides specialized rehabilitative services from Physical Therapy, Speech Pathology/Audiology, and Occupational/Activity Therapy. Therapeutic Services are provided only upon the written order of the resident's Attending Physician." Review of the facility policy, titled "Scheduling Therapy Services," revised July 2013, revealed the therapist shall interview the resident and consult with the Attending Physician as to the type of treatment to be administered. Therapy is scheduled in coordination with Nursing Service and is documented in the resident's medical records." Interview on 04/08/19 at 10:57 AM, with R #34, revealed the resident was admitted to the facility from the hospital, but previously lived in another long term care facility. The resident said he had a stroke in October 2018, and was not currently receiving any therapy services or restorative exercise. He said the left side of his body was affected by the stroke and he could not use his left hand or leg. The resident said he received therapy at the other facility. R #34 said he just thought his money for therapy had run out because staff at the previous facility told him Medicaid only paid for ten days of therapy, so he thought he might be close to or over his limit. Review of the medical record failed to find documentation that a therapy evaluation or screen was completed since R #34's admission	F 688	motion have the potential to be affected by this deficient practice. Fifteen Residents, to include Resident #34, were identified as having limited range of motion and there were no additional concerns noted in audit. All Residents were either getting therapy or Restorative Nursing. * A 100% audit was completed on Residents with hospital returns, new admissions, with weight loss, with falls, per Quarterly and Annual Assessment Calendar and per referrals, per facility policy & procedure on 4/12/19 by the Regional Therapy Manager to identify residents with limited range of motion for evaluation and treatment, as needed/indicated. Therapy Staff In-service completed, 4/12/19, by the Regional Therapy Manager, to include the Policy and Procedures for Screening & Evaluating Residents. The Regional Therapy Manager will monitor compliance, beginning 4/12/19, to the Screening & Evaluating Policy and Procedures through weekly audits of new admissions, resident's with weight loss, Falls, quarterly, Annual and referral screens due by the Minimum Data Set calendar schedule. Resident's identified, at risk, for decrease in ROM/Mobility against therapy screen logs times twelve weeks and then on an ongoing basis. * The Director of Nursing and/or Assistant Director Of Nursing are responsible for ensuring compliance of Resident's	

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F 688	Continued From page 10 to the facility on 02/25/19. The failure of the facility to conduct a therapy evaluation when limitation of range of motion was identified did not assure R #34 received therapy services to meet established goals documented in the plan of care and maintain highest level of function. Review of the medical record "Face Sheet" documented R #43 was admitted to the facility on 02/25/19, with diagnoses of Cerebral Infarction (stroke), Anemia, Pain, Nausea, Vomiting, Depression, and Schizophrenia. Review of the admission "Minimum Data Set" (MDS) assessment, with an "Assessment Reference Date" (end date of look back period) of 03/04/19, revealed a "Brief Interview for Mental Status" (BIMS) score 11 of a possible 15, indicating mild cognitive impairment. The resident required extensive assistance with activity of daily living, functional limitation in range of motion with upper and lower extremity impairment to one (1) side, and did not use a cane, walker, wheelchair or limb prosthesis for mobility. Review of R #34's "Plan of Care" onset date 02/25/19, revealed, "Resident at risk for contracture development related to impaired mobility, left sided paralysis, and as having a high-risk assessment diagnosis of Cerebral Vascular Accident (CVA)." The goal was for the resident to have no development of contractures through the next review period, 06/12/19. Approaches listed for prevention of contracture development included, "Consult PT/OT [physical therapy/occupational therapy] for evaluation and treat as indicated, and Certified Nursing	F 688	Therapy Screenings and Evaluations through follow-up after new admissions in the 24/48/72 hour chart checks, after a Resident's significant weight loss, Falls, Hospital Returns, and at least Quarterly, then Annually and upon referrals and per the Minimum Data Set Schedule and as needed in a change in a Resident's condition where a therapy screen and/or evaluation is ordered by the Physician. Beginning 5/1/19, the Director of Nursing and Assistant Director of Nursing will monitor for compliance once a week times eight weeks, then on an ongoing basis. Any adverse findings will be forwarded, by the Director of Nursing, to the Quality Assurance and Performance Improvement/Quality Assurance Committee at monthly meetings for corrective action, as indicated.	

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	255221	A. BUILDING _____ B. WING _____	04/11/2019

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F 688	Continued From page 11 Assistants were to encourage active range of motion." Interview on 04/11/19 at 10:30 AM with the Director of Therapy (DT)revealed the initial therapy assessment was not completed because nursing staff reported R #34 was very ill with nausea and vomiting early in his admission. She said the therapy staff want the resident to feel well enough to participate in therapy, so progress can be made toward goals. He stated a therapy screen is conducted upon admission and the only instances when a screen would not be conducted is if a resident was in the facility only for Respite care, receiving Hospice services, or was out of the facility, such as back in the hospital. She said she talked to the nursing staff about R #34, but she did not have anything in writing, such as a completed initial screening form. The purpose of the initial therapy screen was to gather baseline data, make recommendations and communicate the recommendations to the physician. R #34's illness could have been the reason a therapy screen was not completed, but since the resident was in the facility more than five (5) weeks, a therapy screen should have been completed. Interview on 04/11/19 at 2:33 PM, with the Director of Nursing (DON), revealed therapy screens should occur as soon as possible after admission of a resident to the facility. The DON stated that nursing staff send a referral to the therapy department and therapy staff then screen the resident. Based on the results of the screening, the therapists make recommendations if the resident could benefit from therapy services. The DON stated if the resident did not desire to have any type of therapy, then that information should be discovered through the therapy	F 688		

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F 688	Continued From page 12 screening process.	F 688		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and 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, interview, and policy review, it was determined the facility failed to ensure biologicals, medications, and other medical care supplies stored in two (2) of two (2) medication rooms were not expired. This had the potential to affect the census of 114 residents in the facility, who specifically have lab drawn,	F 761	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because	5/10/19

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F 761	Continued From page 13 Intravenous (IV) therapy, or use catheters. Findings include: Review of the facility's undated policy, titled "Storage of Medications," revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Additional review of the policy revealed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. The Administrator provided a written statement dated 04/11/19, that explained the facility did not have a policy and procedure related to the checking and removing of expired supplies. The facility's failure to remove expired medications, medical supplies, and biologicals allowed for the potential decrease in the effectiveness, sterility and safety of the items. 1. Observation, on 04/11/19 at 8:20 AM, of the Medication Room for the North, East, and South hallways, revealed two (2), 5-milliliter (ml) filled syringes labeled Heparin Lock Flush, USP 500 units in 0.9% Sodium Chloride, which were stored in a red plastic caddy. Both filled syringes had an expiration date of 03/2019. There were six (6) additional 5-ml filled syringes labeled Heparin Lock Flush, USP 500 units in 0.9 % Sodium Chloride, that were labeled with an expiration date of 12/2018. Continued observation revealed eight (8) green top specimen tubes, labeled BD vacutainer PST Gel and Lithium Heparin Medium, stored in a plastic bag in another cabinet in the medication room. Each of the tubes were labeled with the expiration date of 01/31/19. In addition, there was one (1) unopened plastic bottle of Arthritis and Sports Penetrating Heat Rub, with no	F 761	it is required by the provision of Federal and State Law. This Plan of Correction constitutes the facilities credible allegation of compliance. F 761 * Residents suffered no adverse effects from this deficient practice. The biologicals, medications and medical care supplies identified in the medication rooms as being expired were disposed of on 4/11/19 by the Treatment Nurse. * All Residents have the potential to be affected by this deficient practice. No Residents were affected by this deficient practice. * An In-service was held with nursing staff on 5/7/19, by the Administrator and Director of Nursing (DON), which included review of the policy and procedures in "Inventory Control" and "Storage of Medications", with emphasis on discarding of expired medications, biologicals and medical supplies. A 100% audit completed on 4/11/19, by the Treatment Nurse, in both medication rooms to identify additional expired meds/biologicals/supplies to be discarded. There were no additional expired meds/biologicals/supplies identified. The Treatment Nurse will monitor compliance through audits of both Medication Rooms five times weekly times eight weeks, beginning 4/29/19, and then one time weekly, ongoing.	

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F 761	Continued From page 14 patient identifier, but with an expiration date of 11/2018. In the same cabinet there was one (1) Ventolin HFA inhaler, with no patient identifier, but with an expiration date of 09/2016. Interview on 04/11/19 at 8:22 AM, with the Assistant Director of Nursing (ADON), revealed the red plastic caddy supplies were used at a resident's bedside if there were orders to draw a blood specimen or for other types of Intravenous (IV) care. The ADON said the vacutainer tubes were for drawing blood samples for testing. She said she thought the green top tubes were used for drawing a sample for testing the resident's Thyroid Stimulating Hormone (TSH) level. Continued interview, on 04/11/19 at 8:30 AM, with the ADON, revealed blood work drawn at the facility would be processed at the local hospital, and blood work supplies such as vacutainers were supplied by the hospital. She said facility nursing staff would need to notify the local hospital when the facility needed those supplies replenished. She stated if a resident had an order for IV medication, the syringes with flushing solution would be delivered from the pharmacy and would be labeled specifically for the resident needing the care. The ADON said expired supplies or preparations for resident care should not be stored in the medication rooms, because a nurse could potentially pull and use an expired item for resident care, without first viewing the expiration date. 2. Observation, on 04/11/19 at 8:45 AM, of the Medication Room for the West hall, revealed a Steri-Gear/Fig Leaf Brand Leg Bag for attachment to an indwelling catheter was stored in the medication room. The leg bag had an expiration date of 12/2018. In a drawer in the	F 761	* The DON is responsible for ensuring Medication Room compliance of disposal of expired medications/biologicals/supplies through the monitoring of both Medication Rooms three times weekly times four weeks, beginning 5/1/19, and then at random, on a weekly basis, ongoing. Any adverse findings will be forwarded by the Director of Nursing to the Quality Assurance and Performance Improvement/Quality Assurance Committee Meetings, monthly, for correction action, as indicated.	

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F 761	Continued From page 15 medication room, there were two (2) vials of Assure Dose High and Normal Level Control Solutions used for a Prime Blood Glucose Monitoring Systems (Glucometer used to test blood sugar). Both vials of control solution were labeled with the expiration date of 12/31/18. Interview, on 04/11/19 at 8:55 AM, with the Admissions Nurse present during the West hall Medication room observation, revealed she did not think the glucometer and control solutions stored in the drawer had been used, but she said they should not be in the medication room, and available for use. She said the nursing staff would not want to use expired control solutions to test a glucometer because the product could be faulty and result in an inaccurate reading when testing a glucometer's accuracy for measuring a resident's blood sugar. The Admissions Nurse stated she would not want to use any expired supplies for resident care, and that would include an item such as the expired urine collection bag (leg bag). She said the medication room should not contain any expired medications or supplies as they may no longer be effective for resident care. She said she was not sure who was responsible for stocking the medication rooms, or for disposing of expired products. Interview, on 04/11/19 at 10:50 AM with the Director of Nursing (DON), revealed nurses were supposed to discard expired supplies when found. She said before obtaining a medication or items needed to perform resident care, the nurse should always check the item's expiration date to prevent use of outdated products. She further explained there had not been a certain staff person assigned to routinely inspect the medication rooms and remove expired	F 761		

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F 761	Continued From page 16 biologicals, medications, or other resident care supplies. However, she said there had been discussion about making that one of the assigned duties of the facility's Treatment Nurse. The DON stated every administrative nurse, which included the ADON, Minimum Data Set (MDS) Coordinator, the Care Plan nurse, and the Lead Charge Nurse were to make daily rounds in assigned areas of the facility, and the rounding responsibility included monitoring the medication rooms. She said if the nurses found expired medications, biologicals or supplies, they should remove them from the medication room(s). The DON said administrative nurses were not required to complete a check list or document the findings of their rounds, but they would verbally report any findings of concern. The DON said she was concerned that expired items were found in the medication rooms because if a nurse picked up an expired item such as a vacutainer tube, a syringe for flushing an IV line, or any other expired supply, the nurse should take time to go through all similar items, check the expiration dates, and remove any or all that were expired.	F 761		

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	255221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2019**

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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

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 4/12/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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