JUN 12 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, record review, resident and staff interviews the facility failed to provide oral (mouth) care for 1 of 3 sampled residents who required staff assistance with oral care. (Resident # 194). Finding included: Resident # 194 was admitted to the facility on 3/28/2011 and readmitted on 5/28/2011. Cumulative diagnoses included stroke, with right side deficits. The quarterly Minimum Data Set (MDS) completed on 3/27/2012 indicated Resident # 194 was cognitive intact. The MDS revealed that Resident #194 required extensive assistance from staff for her personal hygiene and that she had limitations on one side of her upper extremity. Resident # 194 had her natural teeth and some are missing. A review of the most recent care plan for Activities of Daily Living (ADL) dated 4/23/2012 revealed that Resident # 194 was unable to complete ADL task independently related to generalized weakness and a history of stroke. As an intervention, approaches indicated that staff	F 312	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the 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 will be completed by the dates indicated. F 312 – 1. How the corrective action will be accomplished for the resident(s) affected? Resident # 194 was assessed on 06/01/2012 by the Director of Nursing for receiving mouth care; resident stated that she had received oral care this morning. Certified Nursing Assistants were in-serviced by the Staff Development Coordinator regarding mouth care performed at least daily for resident #194 and any other resident requiring assistance. This in- service training was completed by 06/09/2012.	6/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas P. Tolglloun	Administrator	

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 312	Continued From page 1 should provide assistance as needed with oral care, personal hygiene and grooming needs. In an interview on 5/7/2012 at 2pm, Resident # 194 stated that she never gets oral care. In a follow-up interview on 5/8/2012 at 3:30pm with Resident # 194, she indicated that she had not received oral care this morning from her aide. In an interview on5/9/2012 at 1pm Resident # 194 was up in her brocha chair looking at TV, when asked about oral care, she indicated that she had not received oral care again today. Resident # 194 natural teeth were observed to be gunky, dirty and yellowish in color when she open her mouth. On 5/10/2012 at 9:52am, Nurse Aide #1 (NA #1) was observed performing morning care on Resident #194, which involved bathing, grooming and dressing. NA #1 offered Resident #194 petroleum ointment for her lips after styling her hair, but did not provide oral care inside of the resident ' s mouth. In an interview on 5/10/2012 at 11am with NA # 1, she was asked if she provided routine care to Resident #194 this morning. She responded that she provided care in the manner that she usually does, and to her knowledge, she did not overlook anything. When questioned if she recalled brushing Resident #194 ' s teeth, she admitted that she forgot to brush her teeth, attributing it to being nervous because she was observed while performing morning care. In an interview with the Director of Nurses on	F 312	2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice? Audits of residents requiring assistance with mouth care were completed on 06/09/2012 by the Unit Managers and Staff Development Coordinator. Any negative findings were immediately corrected. 3. Measures in place to ensure that practices will not occur - Certified Nursing Assistants were in-serviced regarding assistance with mouth care for dependent residents by the Unit Manager and Staff Development Coordinator to be completed by 06/09/2012. All new Certified Nursing Assistant hires will be trained during new hire orientation that mouth care for Dependent resident is to be provided during ADL care no less than daily by the Staff Development Coordinator. Weekly audits of 10% each unit will be performed to ensure residents who are dependent are receiving mouth care by the Unit Managers for four weeks, than monthly for two months.	6/9/12

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F 312	Continued From page 2 6/11/2012 at 8:51am she explained that she expected all nurse aides to provide oral care to residents needing extensive assistance. The mouth should be checked before completing oral hygiene.	F 312	4. How the facility plans to monitor and ensure that correction is achieved and sustained? Weekly audits of 10% each unit will be performed to ensure residents who are dependent are receiving mouth care by the Unit Managers for four weeks, than monthly for two months. Audits will be presented and reviewed at the weekly Risk Meeting and at the Quarterly Quality Assurance Meeting for three months. Any concerns found will be taken to the weekly Risk Meeting and to the Quarterly Quality Assurance Committee Meeting for complete problem resolution.	6/9/12
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to monitor the effectiveness of	F 329	F 329 - 1. How the corrective action will be accomplished for the resident(s) affected? Staff #.4 was immediately suspended pending investigation. All Nurses' were in-serviced by the Unit Managers and Staff Development Coordinator on proper documentation of behavior medications.	6/9/12

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F 329	Continued From page 3 administered anxiolytic medications for 1 of 9 (resident # 245) resident records reviewed. Findings included: The facility's policy and procedures for medication administration and documentation dated 09/01/2011 revealed "6.0 General Dose preparation and Administration," read in part on page 2 of 3 in paragraph 6 - "After medication administration, Facility staff should take all measures required by facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information when medications are given, PRN medications, on appropriate forms." Resident #245 was admitted on 12/28/2011 to the facility after a hospital stay for worsening Alzheimer's disease and increased dementia. The record revealed the resident was diagnosed with Alzheimer's disease and dementia. The care plan dated 12/29/11 indicated the resident had a focus care area. Focus - Resident has Anxiety as evidenced by (AEB) being anxious. Goals - The resident will exhibit a decrease in anxious moods by next review. Interventions - Staff will encourage resident to use coping mechanisms, Staff will encourage the resident to tell staff when anxious, Staff will observe for signs and symptoms of anxiety, Staff will administer medications as ordered by physician and notify the physician when needed. Staff will observe the resident for signs and symptoms of triggering mechanisms of anxiety. The resident's quarterly Minimum Data Set (MDS) dated 03/22/2012 documented the resident to be: Cognitively	F 329	2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice? Audits of residents who are given PRN medications for behaviors were monitored with no negative findings identified. This was completed on 05/10/2012 by pharmacy. Any negative findings were immediately corrected. All Nurses' were in-serviced by the Unit Managers and Staff Development Coordinator on proper documentation of behavior medications. 3. Measures in place to ensure that practices will not occur - Licensed Nurse's were in-serviced on 05/10/2012 by the RN Unit Manager's and the Staff Development Coordinator on how and where to document Behavior and PRN Medications that are given as well as where and when to document the Behaviors. Any new Nurse hires will be trained during new hire orientation about proper documentation.	6/9/12

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F 329	Continued From page 4 Impaired and having no behaviors exhibited during the assessment time frame. The physician's orders revealed the physician added the anxiolytic medication -Xanax 0.25 milligram (mg) 1 per oral (PO) as needed (PRN) to the resident's medication list on 02/10/12 due to the resident's increased anxiety. A review of the resident's Medication Administration Record (MAR) revealed there were no initials or other documentation to indicate the resident had been administered the anxiolytic medication during the months of February, March, April, and May 2012. The resident's 2012 behaviors sheet (all months inclusive) located with the resident's MAR had no documentation to show the resident had any behaviors indicating the need to administer the medication. A review of the resident's Xanax Controlled Medication Utilization Record log revealed staff member #7 whose signature could not be identified, had signed out one Xanax for the resident on 02/13/2012. Staff member #4, who was identified, had signed out Xanax for the resident on 6 occasions, 03/05/2012, 04/03/12, 04/04/12, 04/10/12, 04/23/12, and 05/06/12. A complete review of the resident's paper and electronic charts revealed there was no documentation to show the medication, Xanax, was administered to the resident by either nurse during the months noted. The back side of the resident's February, March, April, and May's MARs was observed to be blank and did not document a reason for giving the "As Needed" (PRN) anxiolytic medication or documentation the resident was monitored to evaluate the medication's effectiveness after administration. The consultant pharmacist's monthly Medication	F 329	4. How the facility plans to monitor and ensure that correction is achieved and sustained? Weekly audits of 5 residents per unit will be performed to ensure Behavior and PRN Medications are documented appropriately per policy by the Unit Managers for four weeks, than monthly for two months. Audits will be presented and reviewed at the weekly Risk Meeting and at the Quarterly Quality Assurance Meeting for three months. Any concerns found will be taken to the weekly Risk Meeting and to the Quarterly Quality Assurance Committee Meeting for complete problem resolution.	6/9/12

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F 329	Continued From page 5	F 329		

Regimen Review (MRR) did not document information concerning the 7 doses of Xanax signed out on the anxiolytics log, the lack of medication administration documentation on the resident's MAR or the lack of documented information on the resident's behaviors sheet. The consultant pharmacist had no documentation on the MRR or any other document to show she reviewed the resident's need for continued use of the Xanax or making a recommendation the anxiolytic medication be discontinued.

An observation of the resident was conducted on 05/10/2012 at 2:10 PM. The resident was found to be totally blind but could speak and stated she did not know how long she had lived in the facility. The resident did know she had family that would visit. There was no behavior issues noted during the observation.

An interview with the facility's Director of Nursing (DON) was conducted on 05/10/2012 at 2:45 PM concerning her expectations for documentation of medications administered to the facility's residents. The DON explained her expectations to be - The nurses are required to sign out all controlled medications and document their removal on the resident's controlled medication logs. They are required to document on the MAR after any medication is administered to a resident and are required to document on the back of the MAR as to the reason a PRN medication is given and its effectiveness.

On 05/10/2012 at 3:15 pm an interview was conducted with staff nurse # 4 concerning the lack of administration documentation, the reason the medication was given, and follow up of the

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F 329	Continued From page 6 medication's effectiveness after signing out the 6 anxiolytic Xanax pills for the resident. The nurse responded, I recall talking to the other surveyor on Monday about resident # 245. I told her the resident had been taking Xanax. I looked in the controlled medication log book and told her the last time I gave the resident a Xanax was on 05/06/2012. The nurse explained the steps and documentation requirements when giving a medication at the facility to be: Take the medication out of the container, give it to the resident, sign out the medication on the NARC log. The nurse indicated she had signed out the Xanax noted on the Narc log (Rx C91374879) and it was her signature on the log. The nurse stated, "I gave it to her because she was showing signs of anxiety. I didn't know I was supposed to document the medication on the back of the MAR, I thought the back of the MAR was only for pain medication given." The nurse indicated she was not aware she was supposed to document on the back of a resident's MAR when she gave a PRN medication and monitor the resident for the effectiveness of the medication administered. The nurse stated, "I didn't initial the MAR for any of the Xanax I gave this resident, I must have forgotten to document administering the medication all 6 times." An interview with the facility's consultant pharmacist was conducted on 05/10/2012 at 5:35 PM. The consultant pharmacist explained her monthly medication regimen reviews to be: " I look at the resident's MARs, new orders, labs, weights, etc. I will look at the Behaviors sheets to see if there is a change in the resident's behaviors. If behaviors are stable and the resident has not received the medication for	F 329		6/9/12

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F 329	Continued From page 7 some time I will recommend a reduction or discontinuance of the medication." The consultant pharmacist explained she would review the resident's administered medication documented on the resident ' s declining count sheet (Controlled Medication Utilization Record) when removed, documentation on the MAR when given and documentation on the back of the MAR if the medication was a PRN and the reason the medication was given.	F 329		6/8/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on facility observations, record review,	F 425	F 425 – 1. How the corrective action will be accomplished for the resident(s) affected? Medications and House Stock were audited by the Unit Managers on 05/11/2012 and found to be within compliance. 2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice? Audits of Medications and House Stock were completed on 05/11/2012 and 06/09/2012 and found to be in compliance. 3. Measures in place to ensure that practices will not occur -	6/9/12

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F 425	Continued From page 8 and staff interviews the facility failed to remove expired medications from 2 of 3 medication storage areas (medication storage rooms). Findings include: 1. On 5/8/2012 at 3:30 pm an observation was made in the medication room for rooms 44-74 of seven bottles of Calcium Oyster Cal 250 mg with an expiration date of 4/2012, five bottles of Aspirin 325 mg with an expiration date of 3/2012, two bottles of Buffered Aspirin 325 mg with an expiration date of 2/2012, and one Arginaid with an expiration date of 4/2012. When asked who checked the stock medications expiration dates, Nurse #1 stated on 5/8/12 at 3:35 pm that the Unit Manager usually checked them. She also indicated that the nurse using the cart at times checked the expiration dates. The Unit Manager on 5/8/12 at 3:36 pm stated that it was the responsibility of all licensed staff to be sure expired medications were removed. 2. On 05/11/2012 at 8:05 AM an observation was conducted of the facility's Teal unit's medication storage room with the Teal unit's nurse manager, staff member # 6. In the refrigerator located in the medication room an expired insulin medication was observed: Novolin R U-100 Lot # AZF0544 Manufacturer's expiration date 03/2014. The vial's protective cap had been removed and several needle marks were observed in the rubber top. The vial was labeled by the pharmacy on the Rx label as "House Stock." The vial was documented as being opened on 03/21/12.	F 425	Licensed Nurse's, Unit Managers and Central Supply Clerk were in-serviced regarding compliance of expiration dates of House Stock Medications on 06/09/2012 by the Staff Development Coordinator. Weekly audits will be performed to ensure House Stock Medications are in date compliance and have not expired by the Unit Managers for four weeks, than monthly for two months. 4. How the facility plans to monitor and ensure that correction is achieved and sustained? Weekly audits will be performed to ensure Medications and House Stock Medications are in date compliance and have not expired by the Unit Managers for four weeks, than monthly for two months. Audits will be presented and reviewed at the weekly Risk Meeting and at the Quarterly Quality Assurance Meeting for three months. Any concerns found will be taken to the weekly Risk Meeting and to the Quarterly Quality Assurance Committee Meeting for complete problem resolution.	6/9/12

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F 425	Continued From page 9 An interview with the Teal unit's manager was conducted on 05/11/2012 at 8:15 AM. The unit manager indicated the insulin was expired based on the documented date it was opened. The facility's policy and procedures for Insulin storage dated 03/27/2012 and entitled Medication Storage Recommendations, page 3 of 8 in paragraph "Insulin Vials" read in part, "Based on American Diabetes Association guidelines, all unopened insulins are recommended to be stored in the refrigerator. All vials should be dated when opened and discarded 28 days after opening except for Novolin R which can be used up to 42 days after opening." A calculation of the days since the insulin bottle was opened was found to be - 51 days (March 10 days), (April 30 days), (May 11 days). The insulin found in the facility's medication refrigerator was 9 days past the discard date.	F 425		6/9/12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of 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	F 431	F 431 -- 1. How the corrective action will be accomplished for the resident(s) affected? Medications and House Stock were audited by the Unit Managers on 05/11/2012 and found to be within compliance. Treatment Carts were immediately audited and all others were found to be locked.	6/9/12

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F 431	Continued From page 10 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 facility observations, record review, and staff interviews the facility failed to date an opened Tuberculin test vial 1 of 3 medication rooms, and to assure that the wound treatment cart was locked in 1 of 4 treatment carts. Findings include: 1. At 3:44 pm on 5/8/2012 one bottle of Tubersol (Purified Protein Derivative [PPD] tuberculin test) was observed open and undated in the medication room refrigerator for rooms 44-74. Nurse #2 indicated on 5/8/2012 at 3:46 pm that the person opening the Tubersol should have put the opening date on it. The manufacturer's recommendation was if a vial of Tubersol had	F 431	2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice? Audits of Medication's and House Stock were completed on 05/11/2012 and 06/09/2012 and found to be in compliance. Treatment Carts were immediately audited and all others were found to be locked. Licensed Nurse's were in-serviced on 06/09/2012 by the Unit Managers and Staff Development Coordinator to not leave Treatment Cart unlocked and to secure keys at all times. 3. Measures in place to ensure that practices will not occur - Licensed Nurse's, Unit Managers and Central Supply Clerk were in-serviced regarding compliance of expiration dates of Medications and House Stock Medications on 06/09/2012 by the Staff Development Coordinator. Weekly audits will be performed to ensure Medications and House Stock Medications are in date compliance and have not expired by the Unit Managers for four weeks, than monthly for two months. Treatment Carts will be audited weekly for four weeks, than monthly for two months to ensure that they are locked when not in use and that the keys are secured by the Licensed Nurse.	6/9/13

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	345420	A. BUILDING _____ B. WING _____	C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 431	Continued From page 11 been entered and was in use for 30 days it should be discarded because oxidation and degradation may have reduced the potency. 2. A review of the facility's policy and procedure for medication storage was conducted on 05/10/2012 at 5:00 PM. The policy entitled 6.0 General Dose Preparation and Medication Administration indicated on page 3 in paragraph 7 - "Facility should ensure that medication carts are always locked when out of sight or unattended." On 05/08/2012 at 5:40 PM an observation was made of one of the facility's resident halls and nursing station named "MAUVE II." To the right of the nurse's station the unit's wound care treatment cart was observed. The treatment cart was observed to have the key lock button in the out position indicating all of the drawers were unlocked. The key to the treatment cart was observed to be just underneath the lid of the treatment book lying on top of the cart. Several drawers in the cart were observed to contain prescription medications for residents and their physician ordered treatments. During the initial observation it was also observed that the nursing staff on the unit were administering medications and providing care and/or serving the dinner meal away from the treatment cart and the nurse's station. Family members were observed walking past the cart and residents were in wheelchairs in close proximity to the cart. A second observation was made on 05/08/2012 at 6:30 PM. The unit's treatment cart was still observed to be unlocked as the key lock button was observed in the out position indicating	F 431	4. How the facility plans to monitor and ensure that correction is achieved and sustained? Weekly audits will be performed to ensure Medications and House Stock Medications are in date compliance and have not expired by the Unit Managers for four weeks, than monthly for two months. Treatment Carts will be audited weekly for four weeks, than monthly for two months to ensure that they are locked when not in use and that the keys are secured by the Licensed Nurse. Audits will be presented and reviewed at the weekly Risk Meeting and at the Quarterly Quality Assurance Meeting for three months. Any concerns found will be taken to the weekly Risk Meeting and to the Quarterly Quality Assurance Committee Meeting for complete problem resolution.	6/9/12

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F 431	Continued From page 12 all of the drawers were unlocked. The key to the cart was observed to still be under the lid of the treatment book on top of the cart. No staff was observed at the nurse's station or near the treatment cart for over 10 minutes. The nurses were conducting medication pass and nursing assistants were giving after dinner care and treatment. A third observation was made on 05/06/2012 at 6:55 PM. The treatment cart's key lock button was observed in the out position indicating the cart was still unlocked. Several residents and family members continued to be observed passing the unlocked treatment cart. No staff members were using the treatment cart or in close proximity of the nurse's station. On 05/06/2012 at 7:00 PM an interview was conducted with staff member # 3, a nurse on the hall. The interview was concerning the unlocked wound care treatment cart and unsecured key. During observation of the wound care cart by staff member #3 she indicated the treatment cart was not locked and the key was under the lid of the treatment book. The nurse indicated the cart was not supposed to be left unlocked and the key was not supposed to have been left in the treatment book. The nurse stated, "It should have been locked up." The nurse locked the treatment cart and took the key and secured it in unit's medication room. Upon return the nurse stated, "I don't know who left the key in the treatment book or who was the last person to use the cart leaving it unlocked." On 05/10/2012 at 9:50 AM an interview was conducted with the facility's Director of Nursing	F 431		6/9/12

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F 431	Continued From page 13 (DON) concerning her expectation for securing the wound care cart. The DON stated the cart should be locked when not attended and the key should have been secured.	F 431		6/9/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based record reviews and staff interviews the facility failed to record administration of an anxiolytic medication that was prescribed as needed on the Medication Administration Records and failed to document its effectiveness. Findings included: The facility's policy and procedures for medication administration and documentation dated 09/01/2011 revealed "6.0 General Dose preparation and Administration," read in part on page 2 of 3 in paragraph 6 - "After medication administration, Facility staff should take all	F 514	F 514 – 1. How the corrective action will be accomplished for the resident(s) affected? Staff # 4 was immediately suspended pending investigation. All Nurses' were in-serviced by the Unit Managers and Staff Development Coordinator on proper documentation of behavior medications. 2. How the corrective action will be accomplished for the resident(s) affected? Audits of residents who are given PRN medications for behaviors were monitored with no negative findings identified. This was completed on 05/10/2012 by pharmacy. Any negative findings were immediately corrected. Licensed Nurses' were in-serviced by the Unit Managers and Staff Development Coordinator on proper documentation of behavior medications on 05/10/2012..	6/9/12

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F 514	Continued From page 14 measures required by facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information when medications are given, PRN medications, on appropriate forms." Resident #245 was admitted on 12/28/2011 to the facility after a hospital stay for worsening Alzheimer's disease and increased dementia. The resident's medical record revealed the resident was diagnosed with Alzheimer's disease and dementia. The care plan dated 12/29/11 indicated the resident had a focus care area. Focus - Resident has Anxiety as evidenced by (AEB) being anxious. Goals - The resident will exhibit a decrease in anxious moods by next review. Interventions - Staff will encourage resident to use coping mechanisms, Staff will encourage the resident to tell staff when anxious, Staff will observe for signs and symptoms of anxiety, Staff will administer medications as ordered by physician and notify the physician when needed. Staff will observe the resident for signs and symptoms of triggering mechanisms of anxiety. The resident's quarterly Minimum Data Set (MDS) dated 03/22/2012 documented the resident to be: Cognitively impaired and having no behaviors exhibited during the assessment time frame. The physician's orders revealed the physician added the medication -Xanax 0.25mg 1 by mouth (PO) as needed (PRN) to the resident's medication list on 02/10/12 due to the resident's increased anxiety. A review of the resident's Medication Administration Record (MAR) revealed there were no initials or other	F 514	3. Measures in place to ensure that practices will not occur - Licensed Nurse's were in-serviced on 05/10/2012 by the RN Unit Manager's and the Staff Development Coordinator on how and where to document Behavior and PRN Medications that are given as well as where and when to document the Behaviors. Any new Nurse hires will be trained during new hire orientation about proper documentation. 4. How the facility plans to monitor and ensure that correction is achieved and sustained? Weekly audits of 5 residents per unit will be performed to ensure Behavior and PRN Medications are documented appropriately per policy by the Unit Managers for four weeks, than monthly for two months. Audits will be presented and reviewed at the weekly Risk Meeting and at the Quarterly Quality Assurance Meeting for three months. Any concerns found will be taken to the weekly Risk Meeting and to the Quarterly Quality Assurance Committee Meeting for complete problem resolution.	6/9/12

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F 514	Continued From page 15 documentation to indicate the resident had been administered the medication during the months of February, March, April, and May 2012. The resident's 2012 behaviors sheet (all months inclusive) located with the resident's MAR had no documentation to show the resident had any behaviors indicating the need to administer the medication. A review of the resident's Xanax log revealed staff member #7, whose signature could not be identified, had signed out one Xanax for the resident on 02/13/2012. Staff member #4, who was identified, had signed out Xanax for the resident on six occasions, 03/05/2012, 04/03/12, 04/04/12, 04/10/12, 04/23/12, and 05/06/12. A complete review of the resident's paper and electronic charts revealed there was no documentation to show the medication, Xanax, was administered to the resident by either nurse during the months noted. The back side of the resident's February, March, April, and May's MARs was observed to be blank and did not document a reason for giving the "As Needed" (PRN) medication or documentation the resident was monitored to evaluate the medication's effectiveness after administration. The consultant pharmacist's monthly Medication Regimen Review (MRR) did not document information concerning the 7 doses of Xanax signed out on the Controlled Medication Utilization Record, the lack of medication administration documentation on the resident's MAR, or the lack of documented information on the resident's behaviors sheet. The consultant pharmacist had no documentation on the MRR or any other document to show she reviewed the resident's need for continued use of the Xanax or making a recommendation the medication be discontinued.	F 514		6/9/12

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F 514	Continued From page 16 An interview with the facility's Director of Nursing (DON) was conducted on 05/10/2012 at 2:45 PM concerning her expectations for documentation of medications administered to the facility's residents. The DON explained her expectations to be - The nurses are required to sign out all controlled medications and document their removal on the resident's controlled medication logs. They are required to document on the MAR after any medication is administered to a resident and are required to document on the back of the MAR as to the reason a PRN medication is given and its effectiveness. On 05/10/2012 at 3:15 pm an interview was conducted with staff nurse # 4 concerning the lack of administration documentation, the reason the medication was given, and follow up of the medication's effectiveness after signing out the 6 Xanax pills for the resident. The nurse responded, I recall talking to the other surveyor on Monday about resident # 245. I told her the resident had been taking Xanax. I looked in the controlled medication log book and told her the last time I gave the resident a Xanax was on 05/06/2012. The nurse explained the steps & documentation requirements when giving a medication to be to take the medication out of the container, give it to the resident, sign out the medication on the resident's controlled medication log. The nurse indicated she had signed out the Xanax noted on the controlled medication log (Rx C91374879) and it was her signature on the log. The nurse stated, "I gave it to her because she was showing signs of anxiety. I didn't know I was supposed to document the medication on the back of the MAR, I thought the	F 514		6/9/12

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F 514	Continued From page 17 back of the MAR was only for pain medication given." The nurse indicated she was not aware she was supposed to document on the back of a resident's MAR when she gave a PRN medication and monitor the resident for the effectiveness of the medication administered. The nurse stated, "I didn't initial the MAR for any of the Xanax I gave this resident, I must have forgotten to document administering the medication all 6 times." An interview with the facility's consultant pharmacist was conducted on 05/10/2012 at 5:35 PM. The consultant pharmacist stated she had been told by the DON there was an issue with the nursing documentation of the anxiolytic medication administered to #245 and wanted to explain what she looked at during her monthly reviews. The consultant pharmacist explained her monthly medication regimen reviews to be: "I look at the resident's MARs, new orders, labs, weights, etc. I will look at the Behaviors sheets to see if there is a change in the resident's behaviors. If behaviors are stable and the resident has not received the medication for some time I will recommend a reduction or discontinuance of the medication. The consultant pharmacist explained she would review the resident's administered medication documented on the resident's declining count sheet (Controlled Medication Utilization Record) when removed, documentation on the MAR when given and documentation on the back of the MAR if the medication was a PRN and the reason the medication was given.	F 514		6/9/12

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	345420	A. BUILDING 01 - MAIN BUILDING-01 B. WING	05/30/2012

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 the door to room 92 failed to latch when closed. 42 CFr 483.70 (a)	K 018	K 018 The latch to door in room 92 was repaired to close properly on June 8, 2012. Staff members will be re-educated concerning the necessity to provide work orders for needed repairs in a timely manner prior to June 30, 2012. Maintenance staff monitors status of doors on a monthly basis as a part of monthly inspections.	June 30,
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029	K 029 All door wedges removed from the food storage area on the day of inspection. Food service staff will be educated about the fire hazards of using door props prior to June 30, 2012. The food service director will do weekly inspections checking for door props. Door closures are being installed on all linen room and shower room doors. The closures are scheduled to be completed by July 13, 2012. The addition of closures will correct the concern about the soiled linen storage within the shower room area. These doors, along with the others in the facility, will be checked as a part of the monthly maintenance program.	July 13, 201

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

LNHA 6-14-

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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	345420	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/30/2012

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K 029	Continued From page 1 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 the door to the dry storage room in the kitchen was wedged open. B. Based on observation on 05/30/2012 the Teal Bathing room was being used for storing soiled linen and the door did not have a closer on it. C. Based on observation on 05/30/2012 the soiled linen room for the laundry has two doors that failed to close and latch.	K 029	The door to the soiled linen room was corrected to close and latch properly on June 13, 2012. These doors, along with the others in the facility, will be checked as a part of the monthly maintenance program.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation and staff interview on 05/30/2012 the staff did not know about the master door release switch at the nurses station. 42 CFR 483.70 (a) B. Based on observation on 05/30/2012 the fire door at the beauty shop was sticking when the doors closed. C. Based on observation on 05/30/2012 there were attic access doors that bolt type latches that could lock someone in the attic. One is in the	K 038	K038 Master door release switches have been added to each of the nurse's stations on June 8, 2012. The staff will be in-serviced prior to June, 30, 2012 concerning the proper use of the master switch in case of an emergency. This in-service will be repeated annually. The fire door near the beauty salon was repaired on June 12, 2012 and now closes properly. This door, along with others in the facility, will be checked monthly as a part of the maintenance program. The attic door access locks have been assessed and a locksmith will complete the work prior to July 13, 2012. The corrected locks will meet the required life safety code. These doors, along with others in the facility, will be checked monthly as a part of the maintenance program. The lock on the door in the dining room has been corrected to meet the state standard between 34 and 48 inches on June 8, 2012. This door, along with others in the facility, will be checked monthly as a part of the maintenance program.	July 13, 20

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K 038	Continued From page 2 maintance office. D. Based on observation on 05/30/2012 the lock on the Dining Room door was too high. Locks must be between 34 And 48 inches from the floor.	K 038		June 13, 2
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 the corridor light fixture was blocking the view of the exit sign over the front door. 42 CFR 483.70 (a)	K 047	K 047 The sign indicating "Exit" is now positioned so as not to be blocked by the light fixture. This was completed on June 13, 2012. New light fixtures in the future will not be installed if they block an exit sign.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K 056 Storage in the closet near the admissions office was corrected immediately to not have items stored too close to the sprinkler head. Storage closets have been marked to indicate the maximum height that items may be stored. Storage areas will be checked as part of the monthly maintenance program to prevent this from re-occurring in the future.	June 1, 2

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K 056	Continued From page 3 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 there was storage in the closet near Admissions that was to close to the sprinkler head. 42 CFR 483.70 (a)	K 056		July 13, 2
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/22012 the valves on the sprinkler accelerator were not electrically supervised. B. Based on observation on 05/30/2012 the facility did not have documentation of the sprinkler systems five (5) five year obstruction test and the time of water flow for the trip test. 42 CFR 483.70 (a)	K 062	K 062 The valves on the sprinkler accelerator are scheduled for electronically supervision repairs prior to July 13, 2012. Documentation concerning the five year obstruction test and water flow trip test are now on file on site. These files were received on June 12, 2012. These documents will be kept up to date by the maintenance staff.	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 the	K 067	K 067 The sampling tube for the duct detector has been cleaned and is scheduled to be replaced by July 13, 2012. The sampling tube will be checked monthly as a part of the maintenance monthly preventative program.	July 13, 2

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EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

TEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/30/2012

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMANCE HEALTH CARE CENTER	1967 HILTON STREET BURLINGTON, NC 27217

(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
K 067	Continued From page 4 sampleing tube for the duct detector in the air handler needing cleaning. 42 CFr 483.70 (a)	K 067		June 1, 2012
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 there was storage in the egress corridor at the side exit near the front entrance. 42 CFR 483.70 (a)	K 072	K 072 The exit at the corridor near the front entrance was made free from obstruction on the day of the inspection. Office changes now dictate that the HR director will assist in monitoring that this exit remains free of any item that prevents access to the egress. Monitoring will take place on a regular basis.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 there was storage in front of the electrical panels at Nurses Station on the Mauve Hall. 42 CFR 483.70 (a) B. Based on observation on 05/30/2012 the med. refrigerator on the Mauve Hall was not on the emergency circuit. C. Based on observation on 05/30/2012 room 44 was being remodeled and the covers were missing on all switches and receptacles.	K 147		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/30/201

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

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K 147	Continued From page 5 D. Based on observation on 05/30/2012 the receptacles in the toilets of rooms 8 & 10 were not GFCI protected. 42 CFR 483.70 (a)	K 147	K 147 The electrical panels at the nurse's station were made unobstructed on the day of the inspection. Taped warning areas have been placed as a reminder to staff. The staff will be in-serviced about the need for these panels to remain free of obstruction prior to June 30, 2012. These areas will be monitored as a part of the monthly maintenance preventative program. The med refrigerator was connected to a power source that is a part of the emergency circuit on the day of the inspection. The location of the refrigerator and circuit are now such that this change will be permanent. The nursing staff will be in-serviced prior to June 30, 2012 on the necessity of the refrigerator to remain on the emergency power source. Room 44 remodeling was completed on June 6, 2012. The outlet covers are now in place. The maintenance staff will receive in-service education on the need to either prevent access to remodeling areas or to replace the outlets during times of remodeling if the area has to be left unattended. In-services will be complete prior to June 30, 2012. The receptacles in rooms 8 and 10 are GFCI protected. This was completed on June 12, 2012 The maintenance staff will check such outlets monthly within the facility as a part of the monthly preventative maintenance programs.	June 30,

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345420	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/30/201

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

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