STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING ST WINDSOR, NC 27983

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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 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:	F 431	The medication Forteo was placed in the refrigerator in the medication room. Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: All medication carts were audited to ensure proper storage of medications. Licensed Staff were in-serviced on Storage of Medications. The Director of Nursing or designee will conduct audits of medication carts 2 times a week X 2 weeks and then weekly times 4 weeks and monthly times 2 months to ensure proper storage of medications. Negative findings will be addressed when noted. The Director of Nursing or Designee will review data for patterns/trends and report during the Quality Assessment and Assurance committee meeting monthly times 3 months. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop/implement additional interventions as needed to ensure continued compliance.	8/8/12 8/8/12 8/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Penny Brown | TITLE: Administrator | (X6) DATE: 8-23-12

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 431	Continued From page 1 Based on observation, policy review, and staff interviews, the facility failed to securely store medication in 1 of 3 medication carts during medication pass, and failed to properly store medication requiring refrigeration as specified by the manufacturer. Findings include: 1. The facility policy titled Medication Cart Use, Security, revised June 2008, read in part: "during routine administration of medications...no medications are kept on top of the cart." Observation on 8/8/12 at 8:30AM revealed one Forteo (medication for osteoporosis) injection prefilled syringe stored on top of the 300 hall medication cart. Observation of medication pass on 8/8/12 at 8:35AM revealed nurse #1 prepared nine medications for resident #85. The nurse entered the resident's room and administered the medications. At 8:38AM, the nurse prepared an insulin injection for resident #85, entered the resident's room, and administered the injection. The Forteo injection remained on top of the medication cart during the medication administration. At 8:42AM, the nurse prepared a medication for resident #94, entered the resident's room, and administered the medication. The Forteo injection remained on top of the medication cart during the medication administration. At 8:55AM, the nurse prepared three medications for resident #41, entered the resident's room, and administered the medications. The Forteo injection remained on top of the medication cart during the medication administration. At 9:05AM, the nurse prepared six medications for resident #3, entered the resident's room, and administered the medications. At 9:10AM, resident #3 requested a	F 431	DISCLAIMER CLAUSE Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.	

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F 431	Continued From page 2	F 431		

medication for itching. The nurse prepared the medication, entered the resident's room, and administered the medication. The Forteo injection remained on top of the medication cart during the medication administration. At 9:13AM, the nurse prepared seven medications for resident #140, entered the resident's room, and administered the medications. The Forteo injection remained on top of the medication cart during the medication administration.

In an interview on 8/8/12 at 9:18AM, nurse #1 acknowledged the Forteo injection had been left on top of the medication cart throughout the medication pass. Nurse #1 stated "I shouldn't have left it on top of the cart. I gave the injection earlier and forgot to put it back in the cart."

In an interview on 8/8/12 at 5:16PM, the Director of Nursing stated her expectation was for the staff to store medications properly and not to leave any medication on the top of the medication cart.

2. The facility policy titled Medication Cart Use, revised June 2008, read in part: "when the medication pass is completed, return the medication cart to the medication room or appropriate medication cart storage area. Return refrigerated items to the refrigerator."

The manufacturer's product information for Forteo (medication for osteoporosis) injection read in part: "Storage and Handling - the Forteo delivery device should be stored under refrigeration at 2 to 8 degrees Celsius (36-46 degrees Farenheit) at all times...during the use period, time out of the refrigerator should be minimized."

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F 431	Continued From page 3 An observation of the 300 hall medication cart on 8/8/12 at 3:25PM revealed one Forteo injection prefilled syringe stored in the top drawer of the cart. The syringe was labeled "store in refrigerator." In an interview on 8/8/12 at 3:30PM, the second shift nurse (nurse #2) stated the pharmacy checked the carts monthly for proper drug storage. The nurse on duty was also responsible for checking the cart. Nurse #2 stated Forteo injection was supposed to be stored in the refrigerator, not in the cart. The nurse removed the injection from the medication cart. In an interview on 8/8/12 at 5:16PM, the Director of Nursing stated her expectation was for the staff to store medications properly. She expected medication requiring refrigeration to be returned to the refrigerator immediately after use. In an interview on 8/9/12 at 9:34AM, the first shift nurse (nurse #1) stated she was aware that Forteo injection should be refrigerated. Nurse #1 stated she normally returned the Forteo injection to the refrigerator immediately after it was given. After she gave the injection the morning of 8/8/12, there had been several interruptions, and she didn't return it to the refrigerator. Nurse #1 stated she placed the injection in the medication cart and forgot to return it to the refrigerator after the completion of medication pass. In a telephone interview on 8/13/12 at 11:20AM, a drug information specialist with the manufacturer stated Forteo should be stored at 36-46 degrees Farenheit when not in use. She stated the device should be returned to the refrigerator immediately after each use.	F 431		

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