STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to administer medications as ordered for 1 of 12 sampled residents reviewed for unnecessary drugs. A probiotic used to help maintain digestion (Floranex) and a corticosteroid used for asthma (Flovent) was not administered for three days after Resident #51's readmission. In addition, the Floranex was not available for administration for two other days. The findings are: 1a. Record review revealed Resident #51 was readmitted to the facility on 11/06/12 after a hospitalization for pneumonia and pleural effusion. Review of Physician Orders dated 11/06/12 revealed an order for Floranex chewable tablet one tablet to be given twice a day. Review of Resident #51's Medication Administration Record (MAR) for November 2012 revealed the Floranex was not administered November 7, 8 and 9. Documentation on the back of the MAR revealed the medication was not available. The nurse (Nurse #1) who readmitted Resident #51 on 11/06/12 was interviewed on 11/29/12 at	F 281	Graham Nursing & Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Nursing and Rehabilitation Center's response to the statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further Graham Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement through informal dispute resolution, formal appeal procedure and or any other administrative legal proceedings.	

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

Administrator 12/20/12

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.

Received
DEC 27 2012
By: SKH

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F 281	Continued From page 1 2:00 PM. Nurse #1 stated she thought it was around 8:00 PM when the resident arrived at the facility and the facility's protocol for late readmissions was to fax the orders to the pharmacy. If the pharmacy was closed and the medication could not wait, then they were expected to get the medication from the back up pharmacy. Nurse #1 stated she did not remember the specifics of the attempts to obtain Resident #51's medications on 11/06/12. The Director of Nursing (DON) was interviewed on 11/29/12 at 2:30 PM and stated she was not sure what happened regarding the three days of missing medication for Resident #51. A follow up interview with the DON at 2:50 PM revealed the pharmacy had received the fax from the facility on 11/06/12 for the new medications but apparently when the pharmacy called the facility to clarify what new medications had been ordered, they had been told an antibiotic was the only new order. The DON stated her expectations were for staff to recognize all orders for any new medications on admission and to let the pharmacy or the back up pharmacy know the accurate orders. Further review of Resident #51's MAR for November 2012 on 11/29/12 at 2:00 PM revealed the Floranex tablet was scheduled at 6:00 AM and 6:00 PM. Documentation on the MAR revealed the last dose of Floranex had been administered on 11/27/12 at 6:00 PM. The medication had not been administered November 28th or the 29th. Documentation on the back of the MAR revealed the medication was not available.	F 281	F 281 The Staff Facilitator completed an audit on 11/29/12 of Resident #51 medications against the MAR to ensure that all medications are available and given per MD order. 100% Audit was completed by the Staff Facilitator and Staff Nurses on 12/03/12 for all residents medications against the MAR to ensure that all medications are available per MD order. All identified areas of concerns were immediately corrected by the Staff Facilitator. An in service was conducted on 11/29/12 by the Staff Facilitator with all nurses and medication aides ensuring that all medications and MARs matched during medication administration. All licensed nurses were in serviced regarding the process of faxing the completed MARs to pharmacy and obtaining medications	

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F 281	Continued From page 2 The Director of Nursing (DON) was interviewed on 11/29/12 at 2:30 PM and stated her expectation was for staff to reorder any medication before it ran out and was not sure why Resident #51's Floranex was not available. A follow up interview with the DON at 2:50 PM revealed the medication had been reordered on 11/24/12 but did not know why the medication had not arrived. A follow up interview with the DON on 11/29/12 at 3:25 PM revealed Resident #51 had no adverse effects from missing this medication. During an interview on 11/29/12 at 3:00 PM, Nurse #1 stated she did not remember if the last dose administered on 11/27/12 at 6:00 PM was the last available dose or not. During an interview with Medication Aide (MA) #1 on 11/29/12 at 3:15 PM the MA stated when she started to give the 6:00 AM dose of Floranex on 11/28/12 there was empty box in the drawer and the red sticker had been pulled which meant it had been reordered. The MA #1 stated she had asked Nurse #1 about the empty box and was informed the medication had been reordered but did not know when. b. Record review revealed Resident #51 was readmitted to the facility on 11/06/12 after a hospitalization for pneumonia and pleural effusion. Review of Physician Orders dated 11/06/12 revealed an order for Flovent 110 micrograms, one inhalation to be given twice a day.	F 281	of any new admission and/or re-admission into the facility by Staff Facilitator on 12/03/12. All newly hired nurses and Medication Aides will be in serviced by the Staff Facilitator regarding ensuring that all medications and MARs matched during medication administration. All licensed nurses will be in serviced regarding the process of faxing the completed MARs to pharmacy on any new admission and/or readmission into the facility by Staff Facilitator on 12/03/12. A MAR/TAR audit tool was implemented on 11/29/12 to ensure that all admission and readmission medications to include Resdent #51 as applicable, are reviewed by the staff nurse and faxed to pharmacy	

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F 281	Continued From page 3 Review of Resident #51's Medication Administration Record (MAR) for November 2012 revealed the Flovent was not administered November 7, 8 and 9. Documentation on the back of the MAR revealed the medication was not available. The nurse (Nurse #1) who readmitted Resident #51 on 11/06/12 was interviewed on 11/29/12 at 2:00 PM. Nurse #1 stated she thought it was around 8:00 PM when the resident arrived at the facility and the facility's protocol for late readmissions was to fax the orders to the pharmacy. If the pharmacy was closed and the medication could not wait, then they were expected to get the medication from the back up pharmacy. Nurse #1 stated she did not remember the specifics of the attempts to obtain Resident #51's medications on 11/06/12. The Director of Nursing (DON) was interviewed on 11/29/12 at 2:30 PM and stated she was not sure what happened regarding the three days of missing medication for Resident #51. A follow up interview with the DON at 2:50 PM revealed the pharmacy had received the fax from the facility on 11/06/12 for the new medications but apparently when the pharmacy called the facility to clarify what new medications had been ordered, they had been told an antibiotic was the only new order. The DON stated her expectations were for staff to recognize all orders for any new medications on admission and to let the pharmacy or the back up pharmacy know the accurate orders. A follow up interview with the DON on 11/29/12 at 3:25 PM revealed Resident #51 had no adverse	F 281	daily and obtained as needed. Upon receipt of medications, the nurse will verify that medications have been obtained by signing and dating the audit tool. This tool will be monitored by the DON/Staff Facilitator 5 times per week x 4 weeks, 3 times per week x 4 weeks, 2 times per week x 4 weeks, weekly x 4 weeks then monthly x 2 months. All identified areas of concern will be immediately corrected by the DON, Staff Facilitator or Staff Nurse. The results of these audits will be forwarded to the Executive QI Committee by the DON on a monthly x 3 then quarterly for review follow -up action for potential or identified concerns as deemed appropriate and to determine the need and/or frequency of continued monitoring.	12/03/12

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F 281	Continued From page 4 effects from missing this medication. The DON further stated a PRN (as needed) breathing treatment was available but the resident had not needed or requested it during this three day time period of missing the medication.	F 281		