SEP 2 7 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING ______ B. WING ______	C 09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR RD SMITHFIELD, NC 27577

(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 interviews, the facility failed to ensure medication was administered as ordered by the physician for 1 of 6 sampled residents (Resident #1). The findings included: Resident #1 was admitted into the facility on 8/22/13 and was discharged on 8/26/13 to the hospital for evaluation of rectal bleeding. Admission diagnoses into the facility included Malignant Melanoma (refers to cancer of the skin).The minimum data set had not been completed in its entirety due to Resident #1 was a new admission. The admission level of care screening tool (FL2) indicated Resident #1's mental status was constant to person and intermittent to place and time. A review of the nurse's admission note dated 8/22/13 indicated Resident #1 was admitted at 11:25 pm from the hospital. A review of the physical exam completed by the physician on 8/26/12 revealed stage four skin cancer was indicated. A review of the physician's orders dated 8/20/13 through 8/31/13 indicated the following orders: Dexamethasone 4 mg (milligrams) by mouth daily. Dexamethasone is a steroid that has the ability to alter the immune system responses.	F 281	Resident #1 is no longer in the facility. A 100% audit of all medication carts was completed on September 6, 2013 the Administrative nursing staff to ensure that all residents had a supply of all ordered medications. Any medications not found were ordered and received. All nurses and medication aides were inserviced on administration of medication as ordered by the physician and on ensuring proper medication supplies to include ordering procedures by the Staff Facilitator completed on 9/26/13. Administrative nurse(s) will use an audit tool to check the medication cart within 24 hours of residents' admission/re-admission or re-entry to ensure that all medications are available. Upon the identification of any potential concern, the pharmacy/back up pharmacy will be notified to obtain medications as indicated by the Administrative nurse(s).	10/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Fitzgerald
TITLE: Administrator
(X6) DATE: 9/26/13

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 281	Continued From page 1 One of the uses of Dexamethasone is to treat certain cancers. A review of the medication administration record (MAR) revealed the following medication was not signed as administered: Dexamethasone 4 milligrams (mg) on 8/23/13 at 8:00 am, 8/24/13 at 8:00 am In an interview on 9/4/13 at 2:20 pm, MA (medication aide) #1 acknowledged that on 8/23/13 she did not administer Dexamethasone 4 mg tablet at 8:00 am because the medication was not available on the medication cart. She stated that she made the nursing supervisor on duty aware that the medication was not available. MA #1 concluded the nursing supervisor responded that she would check into it. In an interview on 9/4/13 at 2:35 pm, Nurse #1 indicated that she was the charge nurse of MA #1 on 8/23/13. She acknowledged that she was aware that Dexamethasone was not available on the medication cart. Nurse #1 stated she was under the impression that the family was supposed to bring the medication to the facility. She concluded she did not notify the facility administration staff. In an interview on 9/4/13 at 3:00 pm, the resource nurse stated that when a resident was admitted into the facility the charge nurse of the resident was responsible for ensuring admission medication orders were verified by the physician and faxed to the pharmacy to ensure medications were filled and received. The resource nurse added that sometimes she assisted the nurses with transcription of medication orders but that she did not assist with Resident #1.	F 281	The results of these audits will be forwarded to the Executive QI committee by the QI Nurse monthly x 3 then quarterly for the identification of any trends, follow up action as deemed necessary and to determine the need for and/or frequency of continued monitoring.	

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F 281	Continued From page 2 In an interview on 9/4/13 at 3:10 pm, the nursing supervisor acknowledged that the MA #1 normally informed her if any meds were circled or not administered. The supervisor acknowledged that she was aware that Dexamethasone was not available on the medication cart. She added that she could not recall what day she faxed the physician's order over to the pharmacy. The nursing supervisor indicated she could not recall if she notified the administration staff at the time she became aware the medication was not available. In an interview on 9/4/13 at 4:50 pm MA #3 acknowledged that on 8/24/13 he did not administer Dexamethasone at 8:00 am because the medication was not available on the medication cart. MA #3 stated on 8/24/13 between 9:30 pm - 10:00 pm the family brought the medication from home and he administered the medication per demand of the family. He added that he forgot to document on the MAR an explanation of the specific time the medication was administered. In an interview on 9/5/13 at 11:22 am, the director of nursing (DON) accompanied by the administrator stated she expected Dexamethasone to have been administered as ordered by the physician. The DON concluded that she expected to have been notified by the nursing staff upon discovery that the medication was not available on the medication cart.	F 281		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333		

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F 333	Continued From page 3 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administered medication as ordered by the physician for 1 of 6 sampled residents (Resident #1). The findings included: Resident #1 was admitted into the facility on 8/22/13 and was discharged on 8/26/13 to the hospital for evaluation of rectal bleeding. Admission diagnoses into the facility included Seizure Disorder .The minimum data set had not been completed in its entirety due to Resident #1 was a new admission. The admission level of care screening tool (FL2) indicated Resident #1's mental status was constant to person and intermittent to place and time. A review of the nurse's admission note dated 8/22/13 indicated Resident #1 was admitted at 11:25 pm from the hospital. A review of the physical exam completed by the physician on 8/26/12 revealed that Resident #1 seizure disorder was to be treated with Phenobarbital. A review of the physician's orders dated 8/20/13 through 8/31/13 indicated the following order: Phenobarbital 97.2 mg by mouth twice daily. A review of the medication administration record (MAR) revealed the following medication was not signed as administered: Phenobarbital 97.2 mg on 8/23/13 at 8:00 am, 8:00 pm, 8/24/13 at 8:00 am, 8:00 pm.	F 333	Resident #1 is no longer in the facility. A 100% audit of all residents' medication administration records was completed on 8/31/13 by licensed nurses with no issues with administration of medications as ordered by the physician identified. A 100% audit of all medication carts was completed on September 6, 2013 by Administrative nurses to ensure that all residents had a supply of all ordered medications. Any medications not found were ordered and received All nurses and medication aides were inserviced on administration of medication as ordered by the physician and on ensuring proper medication supplies to include ordering procedures by the DON and ADON completed on 9/26/13.	10/1/13

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F 333	Continued From page 4 In an interview on 9/4/13 at 2:20 pm, MA (medication aide) #1 acknowledged that on 8/23/13 she did not administer Phenobarbital 97.2 mg at 8:00 am because the medication was not available on the medication cart. She stated that she made the nursing supervisor on duty aware that the medication was not available. MA #1 concluded the nursing supervisor responded that she would check into it. In an interview on 9/4/13 at 2:35 pm, Nurse #1 indicated that she was the charge nurse of MA #1 on 8/23/13. She acknowledged that she was aware that Phenobarbital was not available on the medication cart. Nurse #1 stated she was under the impression that the family was supposed to bring the medication to the facility. She concluded she did not notify the facility administration staff. In an interview on 9/4/13 at 3:00 pm, the resource nurse stated that when a resident was admitted into the facility the charge nurse of the resident was responsible for ensuring admission medication orders were verified by the physician and faxed to the pharmacy to ensure medication were filled and received. The resource nurse added that sometimes she assisted the nurses with transcription of medication orders but that she did not assist with Resident #1. In an interview on 9/4/13 at 3:10 pm, the nursing supervisor acknowledged that MA #1 normally informed her if any meds were circled or not administered. The supervisor acknowledged that she was aware that Phenobarbital was not available on the medication cart. She added that she could not recall what day she faxed the physician's order over to the pharmacy. The	F 333	Administrative nurse(s) will use a QI audit tool to monitor the administration of medications as ordered by the physician 3-5 times per week X 4 weeks, weekly x 4 weeks, monthly x3, then quarterly. Upon identification of any potential concerns, the Administrative nurse(s) will follow up with the involved staff as appropriate. Administrative nurse(s) will use an audit tool to check the medication cart within 24 hours of residents' admission/re-admission or re-entry to include Resident #1 to ensure that all medications are available. Upon the identification of any potential concern, the pharmacy/back up pharmacy will be notified to obtain medications as indicated by the Administrative nurse(s).	

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F 333	Continued From page 5 nursing supervisor indicated she could not recall if she notified the administration staff at the time she became aware the medications were not available. In an interview on 9/4/13 at 3:34 pm MA #2 acknowledged that on 8/23/13 at 8:00 pm she did not administer Phenobarbital 97.2 mg due to the medication was not available on the medication cart. In an interview on 9/4/13 at 4:50 pm MA #3 acknowledged that on 8/24/13 he did not administer Phenobarbital 97.2 mg at 8:00 am or 8:00 pm because the medication was not available on the medication cart. MA #3 stated on 8/24/13 between 9:30 pm - 10:00 pm the family brought the medication from home and he administered the medication per demand of the family. He added that he forgot to document on the MAR an explanation of the specific time the medication was administered. In an interview on 9/5/13 at 11:22 am, the director of nursing (DON) accompanied by the administrator stated she expected Phenobarbital to have been administered as ordered by the physician. The DON concluded that she expected to have been notified by the nursing staff upon discovery that the medication was not available on the medication cart.	F 333	The results of these audits will be forwarded to the Executive QI committee by the QI Nurse monthly x 3 then quarterly for the identification of any trends, follow up action as deemed necessary and to determine the need for and/or frequency of continued monitoring.	