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	345255	A. BUILDING ______ B. WING ______	10/24/2013

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CAROLINA CARE CENTER	111 HARRILSON ST CHERRYVILLE, NC 28021

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records, and resident and staff interviews, the facility failed to assess a resident's preference for time to get up in the morning for 1 of 5 sampled residents (Resident #46) and frequency of showers per week for 3 of 5 sampled residents (Residents #8, #18, and #48) reviewed for choices. The findings included: 1. Resident #46 was admitted on 10/29/10 with diagnoses including dementia. A quarterly Minimum Data Set (MDS) dated 09/27/13 revealed Resident #46 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The quarterly MDS further revealed Resident #46 required extensive assistance with bed mobility and was totally dependent on staff for transfers. Review of a notice to staff taped to the nurse's station on the 100 hall revealed 3rd shift (11:00 PM TO 7:00 AM) nurse aides (NAs) were responsible for completely dressing and getting up a list of 7 residents identified by room number	F 242	Carolina Care Center continues to allow residents to make choices about aspects of their life that are significant to the resident including schedules of waking and bathing. Corrective action for the alleged deficient practice was accomplished for Resident #46 by correcting the time of arising on CNA schedule sheet to time of resident's preference. Corrective action for Residents # 8,#18 and #48 was accomplished by Director of Nursing adjusting bathing/shower schedule to accomodate the preference of these three residents.Corrective action for resident #8 showers completed on 10/23 and 10/25/2013. Corrective action for other residents having the potential to be affected by the alleged deficient practice was corrected by managers surveying the residents or their responsible party for time of arising and bathing frequency. The list of the resident's preferred time of arising and bathing schedule were revised in accordance with resident's/responsible	11/10/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 11/12/2013

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 242	Continued From page 1 on the 100 hall every morning. The notice also included instructions for NAs to get up 3-4 residents on the 200 hall. The notice was sign by the Director of Nursing (DON) and dated 09/18/13. Resident #46's room and bed number were included on the notice. An interview with the Admissions Coordinator on 10/23/13 at 2:30 PM revealed she did not assess for any residents' preferences during the admission process and thought this information was obtained by the Admission Nurse. During an interview on 10/23/13 at 2:35 PM the Admission Nurse stated she completed a head to toe assessment but did not ask any questions regarding residents' preferences while completing the nursing admission assessment. An interview with NA #3 on 10/24/13 at 8:55 AM revealed 3rd shift NAs would have some of the residents on her 1st shift (7:00 AM to 3:00 PM) assignment dressed and out of bed before they left in the morning. NA #3 further stated she thought the residents were assisted out of bed before 1st shift because they required assistance with eating. During an interview on 10/24/13 at 10:45 AM Resident #46's family member stated she did not recall Resident #46's preference for when to get up in the morning being assessed on admission or at any other time since her admission to the facility. An interview with NA #4 on 10/24/13 at 10:50 AM revealed 3rd shift NAs assisted residents out of bed according to the list on the nurse's station on the 100 hall and any others that asked to get up.	F 242	party's.11/03/2013 Measures put into place to ensure that the alleged deficient practice does not recur includes Carolina Care Center Preferences For Customary Routine and Activities Assessment is completed on admission by Activity Staff and reviewed quarterly with the care planning schedule to document resident's desired frequency of bathing and time of awakening.11/05/2013 Residents Responsible Party's bathing/awakening schedules are updated in accordance with resident's/Responsible Party's preferences. 11/09/2013 The Admission Director upon admission advises the residents/Responsible Party's of Resident's right to choice. The Social Worker advises the resident of the right to choice during the admission process. Resident's right to choice reinservice was done for all nursing staff 11/03/2013. Medication Nurse/Supervisor reviews Point of Care Compliance Report for her residents before shift ends to ensure documentation is complete. Licensed personnel will initial 24 hr resident report after reviewing report. CNA's were inserviced on Point of Care Documentation . 11/03/2013 The Activity Director/Assistant Activity Director reports updates of resident's choices to the weekly Tracking Committee. The Director of Nursing and Assistant Director of Nursing reports data from meeting to monthly Quality Assurance and Assessment Committee for recommendations as changes needed to assure resident preferences are	

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F 242	Continued From page 2 NA #4 did not know how residents were selected for the list posted on the nurse's station. An interview was conducted with the Director of Nursing (DON) on 10/24/13 at 11:40 AM. The DON stated there were 15 residents on the 100 hall who required the use of a total lift for transfers out of bed and in an effort to divide up the workload the 3rd shift NAs get up some of the residents before they leave. The DON further stated Resident #46 would not be able to communicate her preference for getting out of bed in the morning and ate her breakfast in the dining room at 8:00 AM. The interview further revealed residents and/or family members were not interviewed regarding preferences to determine which residents would be assisted out of bed by the 3rd shift NAs. 2. Resident #48 was admitted on 01/02/13 with diagnoses including Parkinson's disease. A quarterly Minimum Data Set (MDS) dated 08/03/13 revealed Resident #48 has short and long-term memory problems and moderately impaired cognitive skills for daily decision making. The quarterly MDS further revealed Resident #48 was was totally dependent on staff for bathing and showers. Review of shower schedule posted at the nurse's station revealed Resident #48 was scheduled for showers on Tuesday and Thursday. An interview with Resident #48's family member on 10/24/13 at 12:14 PM revealed Resident #48 received two showers a week at the facility but had showered at least three times a week prior to her admission to the facility. The family member stated she could not recall facilty staff assessing	F 242	honored. Quality Assurance and Assessment Committee reviews Tracking Reports for a period of one year.	

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F 242	Continued From page 3 Resident #48's preference regarding frequency of showers and would like for Resident #48 to have three showers a week. An interview was conducted on 10/23/13 at 2:02 PM with Nursing Assistant (NA) #1. NA #1 confirmed she worked on the shower team and stated residents were scheduled for showers twice a week by room number. NA #1 further stated she notified the Director of Nursing (DON) when a resident or family member requested more frequent showers so the DON could adjust the shower schedule. An interview was conducted on 10/23/13 at 2:20 PM with the Activity Director. The Activity Director stated she assessed whether a resident preferred a tub bath or a shower when they were admitted to the facility but did not assess preference regarding the frequency of showers or baths. An interview was conducted on 10/23/13 at 2:32 PM with the MDS Nurse. The MDS Nurse stated she assessed how much assistance residents required with bathing/showers but did not assess preferences for frequency of bathing/showers. An interview was conducted on 10/24/13 at 2:38 PM with the Director of Nursing (DON). The DON stated residents usually received two showers a week and if a resident or family member requested more frequent showers they would accommodate this request. The interview further revealed residents' were not assessed regarding preference for frequency of showers. 3. Resident #8 was admitted to the facility with diagnoses which included diabetes and depression. Resident #8's most recent Quarterly	F 242		

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F 242	Continued From page 4 Minimum Data Set (MDS) dated 09/07/13 assessed her as having moderate cognitive impairment. Further review of the MDS indicated Resident #8 required extensive assistance with personal hygiene and bathing. Review of the facility's shower schedule the Resident #8 was to receive baths on Wednesdays and Fridays. Review of the Point of Care ADL (activities of daily living) Report revealed Resident #8's was not receiving her showers twice per week. Documentation on this report revealed Resident #8 went 12 days (10/04/13 through 10/15/13) without having a shower. An interview was conducted on 10/22/13 at 9:09 AM with Resident #8. Resident #8 indicated she usually received a shower once per week but would prefer to have a shower more frequently. An interview was conducted on 10/23/13 at 2:02 PM with Nursing Assistant (NA) #1. NA #1 confirmed she worked on the shower team and stated residents were scheduled for showers twice a week by room number. NA #1 further stated she notified the Director of Nursing (DON) when a resident or family member requested more frequent showers so the DON could adjust the shower schedule. An interview was conducted on 10/23/13 at 2:20 PM with the Activity Director. The Activity Director stated she assessed whether a resident preferred a tub bath or a shower when they were admitted to the facility but did not assess preference regarding the frequency of showers or baths.	F 242		

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An interview was conducted on 10/23/13 at 2:32 PM with the MDS Nurse. The MDS Nurse stated she assessed how much assistance residents required with bathing/showers but did not assess preferences for frequency of bathing/showers.

An interview was conducted on 10/24/13 at 2:38 PM with the Director of Nursing (DON). The DON stated residents usually received two showers a week and if a resident or family member requested more frequent showers they would accommodate this request. Also, if a resident might need more than two showers a week for hygiene reasons they can provide more.

4. Resident #18 was admitted to the facility with diagnoses which included congestive heart failure and arthritis. Resident #18's most recent Minimum Data Set (MDS) dated 08/23/13 revealed she had moderate cognitive impairment and needed extensive assistance with bathing.

Review of the facility's shower schedule the Resident #8 was scheduled to receive showers on Wednesdays and Fridays.

An interview was conducted on 10/21/13 at 2:32 PM with Resident #18. She stated she would like to have more than two showers per week. She stated she took one every day or every other day at home.

An interview was conducted on 10/23/13 at 2:02 PM with Nursing Assistant (NA) #1. NA #1 confirmed she worked on the shower team and stated residents were scheduled for showers twice a week by room number. NA #1 further stated she notified the Director of Nursing (DON) when a resident or family member requested

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F 242	Continued From page 6 more frequent showers so the DON could adjust the shower schedule. An interview was conducted on 10/23/13 at 2:20 PM with the Activity Director. The Activity Director stated she assessed whether a resident preferred a tub bath or a shower when they were admitted to the facility but did not assess preference regarding the frequency of showers or baths. An interview was conducted on 10/23/13 at 2:32 PM with the MDS Nurse. The MDS Nurse stated she assessed how much assistance residents required with bathing/showers but did not assess preferences for frequency of bathing/showers. An interview was conducted on 10/24/13 at 2:38 PM with the Director of Nursing (DON). The DON stated residents usually received two showers a week and if a resident or family member requested more frequent showers they would accommodate this request. Also, if a resident might need more than two showers a week for hygiene reasons they can provide more.	F 242		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		11/10/13

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F 309	Continued From page 7 Based on record review and staff interviews the facility failed to follow a Physician ordered bowel protocol for a resident with no bowel movement for three consecutive days for 1 of 5 sampled residents reviewed for constipation (Resident #46). The findings included: Resident #46 was admitted on 10/29/10 with diagnoses including dementia and constipation. A quarterly Minimum Data Set (MDS) dated 09/27/13 revealed Resident #46 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The quarterly MDS further revealed Resident #46 frequently incontinent of bladder and bowel and required extensive assistance with toilet use. A care plan for constipation dated 10/04/13 indicated Resident #46 was at risk for related to the daily use of psychotropic and pain medications. The goal was for Resident #46 to have at least one bowel movement (BM) every three days. Interventions included: Administer routine medications per Physician's orders, Assess resident (bowel sounds, distention, fever, pain) and notify the Physician of abnormal findings immediately, Encourage fluids, and Follow bowel protocol for as needed laxative administration. Review of the "Bowel and Bladder Report" for Resident #46 from 09/01/13 through 10/23/12 revealed no BMs documented from 09/06/13 through 09/10/13 (5 days) and from 10/02/13 through 10/05/13 (4 days). Review of Resident #46's Medication	F 309	Carolina Care Center ensures each resident receives necessary care and services to maintain their highest practical physical, mental, and psychosocial well-being. Corrective action for resident #46 was accomplished by resident receiving stool softeners as ordered on a daily basis. The Bowel Protocol of the facility has been reviewed with nurses and Bowel Management Report was reviewed for the past seven days. Bowel management orders and protocol were followed. Corrective actions for other residents having potential to be affected by the alleged deficient practice were accomplished by bowel management lists being checked for all residents. Residents in need of laxatives were initiated in accordance with protocol on 10/25/2013. No other residents were affected by the alleged deficient practice. Measures put into place to ensure the alleged deficient practice does not recur include: Bowel/Constipation Protocol and Procedures for the facility updated on 11/09/2013. Bowel Management Protocol update includes alerts from message page are compared with Resident Bowel Management Report for the past seven days on a daily basis. Any resident requiring bowel protocol will be evaluated at this time for need of a laxative or other intervention. Laxative is placed on EMAR to be given on the third day (one dose only). Nurses in-serviced to review BM report	

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F 309	Continued From page 8 Administration Records (MARs) for September and October of 2013 revealed she received Colace 100 mg (milligrams) and Senna S two tablets by mouth daily for constipation. In addition, the MARs for September and October of 2013 included orders for the following laxatives to be given as needed: Milk of Magnesia 30cc's (cubic centimeters) by mouth at bedtime if no BM in 48 hours and If no BM within 24 hours of Milk of Magnesia give Dulcolax suppository. Further review of the MARs revealed received Milk of Magnesia 30cc's on 09/10/13 and a Dulcolax suppository on 09/11/13. Review of nurses' notes revealed no documentation regarding assessment and/or interventions for constipation for either episode of no bowel movement for three days. An interview with Nurse #5 on 10/23/13 at 3:40 PM revealed a no BM in three days report was printed at the end of the day shift daily. Nurse #5 stated the list was reviewed at the beginning of shift for residents who may need to receive as needed laxatives per the bowel protocol. The interview further revealed Nurse #5 waited until later in the 3:00 PM to 11:00 PM shift and checked to see if the resident(s) had a BM on their own before administering a laxative. The Director of Nursing (DON) was interviewed on 10/24/13 at 12:15 PM. The DON stated the unit secretary printed the list of residents with no bowel movements for three consecutive days daily and gave the list to the 3:00 PM to 11:00 PM shift nurse for review. In addition, the DON stated she printed a copy of the report for herself Monday through Friday and reviewed it to be sure residents' received laxatives per the bowel	F 309	daily for residents in need of laxatives on 11/03/2013. The Director of Nursing, Assistant Director of Nursing(in absence of DON, Weekend Supervisor, and Treatment Nurse(in absence of Weekend Supervisor) reviews the resident bowel report daily to assure laxatives administered in accordance with protocol and place laxative on the EMAR initiated on 10/25/2013. Implementation of bowel protocol and laxatives to be given is documented on EMAR. Director of Nursing reviews weekdays and Weekend Supervisor reviews weekends the BM report for laxatives needed and protocol implementation on an ongoing basis. The Director of Nursing/Assistant Director of Nursing monitors and reports the bowel management review each week to the Tracking Committee meeting which reports to monthly Quality Assurance and Assessment Committee. The Quality Assurance and Assessment Committee will review audits for one year to ensure effectiveness of audit and compliance process.	

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F 309	Continued From page 9 protocol. The interview revealed the DON expected nurses to follow the established bowel protocol for all residents and was not sure why the bowel protocol was not initiated for Resident #46 for either episode of constipation.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide interventions or monitoring for significant weight loss for one (1) of three (3) residents reviewed for weight loss. (Resident #137) The findings are: Resident #137 was admitted on 05/13/13 with diagnoses including pressure ulcer, aftercare for orthopedic surgery, diabetes, and peripheral vascular disease. A 60-day Minimum Data Set (MDS) dated 07/08/13 indicated Resident #137 was cognitively intact and required set up help with eating. The MDS also noted Resident #137	F 325	Carolina Care Center continues to provide interventions to maintain nutrional status such as body weight. Resident #137 was discharged home after rehabilitation on 8/16/2013. The resident had talked with the Dietary Manager and MDS Nurse prior to care plan and indicated he did not desire supplements for weight gain due to his diabetic condition. The resident's weight was stable between 181 and 184 pounds between 06/11/2013 and 08/05/2013. Resident's weight was 184 on 08/05/2013 which was above average body mass index range. No other residents reviewed	11/10/13

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F 325 Continued From page 10

had weight loss of 5% or more in the last month. The Care Area Assessment (CAA) summary for nutritional status dated 05/20/13 stated Resident #137's food intake was good. The CAA noted Resident #137 was started on a high protein dietary supplement on 05/21/13 for wound healing. No weight loss was noted on CAA. Resident #137 was discharged home on 08/16/13.

A care plan dated 05/24/13 identified Resident #137 as at risk for hyper/hypoglycemia. Interventions included encouraging adherence to no concentrated sweets diet, monitoring for signs of hyper/hypoglycemia, and monitoring blood sugars as ordered. The care plan did not note Resident #137 was at risk for weight changes.

Review of the medical record revealed the following recorded weights:
-05/14/13 - 209 pounds
-06/11/13 - 181 pounds
-07/17/13 - 182 pounds
-08/05/13 - 184 pounds

Review of the medical record revealed no progress notes by Dietary Manager (DM) or Registered Dietician (RD) during Resident #137's stay at the facility.

An interview with the Dietary Manager (DM) on 10/23/13 at 11:10 AM revealed her practice was to provide the Registered Dietician (RD), MDS nurse, and Physician with a list of all residents with significant weight changes each week. The DM stated the RD then reviewed the residents and documented in the resident's medical record any changes made, typically including additional weight monitoring, additional supplements, and

F 325

during the survey were affected by the alleged deficient practice. No current residents in the facility were affected by the alleged deficient practice.
For residents having the potential to be affected by the alleged deficient practice, all current residents were reviewed for a signicant weight loss on 10/25/2013 by the Dietary Manager and Registered Dietician to ensure that the resident had supplements or weight loss was addressed by the physician or Registered Dietician and interventions included on resident's care plan. Licensed personnel and Dietary Manager were inserviced on message alert and follow up procedure for significant weight loss on 11/03/2013.
Message alert set up in Matrix for 4% loss in one month, 7% loss in 3 months, 9% loss in 6 months on 10/28/2013.
Meaures put into place to ensure alleged deficient practice does not recur:
Weights of residents are obtained upon admission and readmission. Weekly weights are obtained for two weeks after intial admission.
Dietary Manager reviews weights for signicant weight loss of 4% or more and reports to Registered Dietician and MDS Nurse for care plan interventions.
Physician is notified of signicant weight loss. Audits are conducted on all residents weekly and an ongoing basis 10/25/2013.
Unplanned weight loss event and progess note is completed for residents with signicant weight loss.
Dietary Manager reports weekly to the Tracking Committee signicant weight loss and interventions implemented by the

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(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 325	Continued From page 11 additional supervision during meals. The DM stated if the RD opts to not make changes other than increased weight monitoring, the RD still documented in the medical record that the significant weight loss had been noted and reviewed. The DM pulled her significant weight change report for 05/24/13 to 05/30/13 and stated Resident #137 was not identified on the report and should have been. When asked why Resident #137 was not included in report, the DM said it looked like the situation had fallen through the cracks. Interview with the MDS nurse on 10/24/13 at 09:22 AM revealed facility system was that once significant weight loss noted, MDS is notified by DM and the situation was discussed during morning meeting. After that, any of a dozen treatments may be initiated including a new care plan meeting, a significant change in status, an additional nutritional supplement, a speech referral, a physician referral, a new care plan, and weights were consistently monitored more frequently after a significant change (weekly or daily). The MDS nurse noted Resident #137's significant weight loss and stated the RD would initially address the need for change in treatment. The MDS nurse did not know why the RD did not address Resident #137's significant weight loss in this case. Interview with the Registered Dietician (RD) on 10/24/13 at 11:27 AM revealed Resident #137 had significant weight loss in the first month he was in facility. The RD stated she reviews every case of significant weight loss that was included on the weekly significant weight change sheet provided by the DM. The RD said Resident #137 had not been included on the weekly weight	F 325	care plan committee, Registered Dietician or Physician. The monthly Tracking Report is submitted to the Quality Assurance and Assessment Committee by Director of Nursing/Assistant Director of Nursing. The Quality Assurance and Assessment Committee reviews signicant weight loss report to ensure effectiveness and interventions for one year.	

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	345255	A. BUILDING ___ B. WING ___	10/24/2013

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F 325	Continued From page 12 change sheet. The RD also stated she believed all residents were weighed weekly upon admission and being monitored weekly by the DM, who would notify her if there continued to be weight changes. Interview with the Director of Nursing (DON) on 10/24/13 at 11:46 AM revealed her expectation that the DM is given daily, weekly, and monthly weights as they are recorded. The DM then reviewed to see if anyone had lost significant weight and if so, notified the physician, RD, and MDS Nurse. The DON stated the RD reviewed all significant weight loss and changes were made through the care planning process.	F 325		
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	F 431		11/10/13

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F 431	Continued From page 13 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 observations and staff interviews, the facility failed to lock the narcotics storage compartments on 2 of 4 medication carts located on the resident halls during medication administration. The findings included: Observation of the medication cart identified as the 212 cart on 10/23/13 at 8:45 AM revealed the red lock for the narcotics storage compartment on the left of the medication cart to be in the unlocked position. Observation of the medication cart identified as the 212 cart on 10/23/13 at 9:05 AM revealed the red lock for the narcotics storage compartment on the left of the medication cart to be in the unlocked position. Interview with Nurse Aide #2 on 10/23/13 at 9:06 AM revealed the nurse assigned to medication cart 212 was not currently in the building but had	F 431	Carolina Care Center stores drugs and biologicals in locked compartments for storage of controlled drugs in accordance with State and Federal laws. Nurse#2 and Nurse#4 were reeducated during the survey to ensure narcotics drawers were locked as well as medication carts being locked. No medications were missing during narcotic counts at shift change on either of these carts. Corrective actions put into place for other residents with potential to be affected by this alleged deficient practice included an audit of all medication carts on 10/24/13 with instruction to each nurse regarding double locking of narcotics. Measures put into place to ensure the alleged deficient practice does not recur included: All licensed nurses re-inserviced regarding the need for double locking of narcotics.	

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

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F 431	Continued From page 14 gone to check on a resident in the apartments. Interview with Nurse #2 on 10/23/13 at 9:17 AM revealed she was assigned to medication cart 212 and was in the process of morning medication administration. On further interview Nurse #2 confirmed the red lock on the left side of the medication cart when activated locked the narcotic compartment and currently it was in the unlocked position. Nurse #2 further revealed she usually locked both locks when leaving the medication carts immediate area but she had been called over to the apartments. At 9:20 AM in continued interview Nurse #2 opened the narcotic drawer and revealed 39 containers of narcotics. Nurse #2 stated it was not her usual practice to leave the narcotic lock unlocked but to have both locks on the medication cart activated. Interview on 10/23/13 at 10:10 AM with the facility Consultant Pharmacist revealed the regulations dictated that narcotics be stored under a double lock system. On further interview the Consultant Pharmacist revealed the left lock does lock the narcotic drawer and that information was relayed to nursing staff during regular pharmacy in-services. The Consultant Pharmacist confirmed the best practice was for nursing staff to keep the narcotic drawer locked unless in use in addition to the lock that locks the entire cart. Interview on 10/24/13 at 10:00 AM with the Director of Nurses (DON) revealed her expectations were that the narcotics drawer was double locked whenever the nurse was out of sight of the medication cart. 2. Observation of the medication cart identified as	F 431	Director of Nursing,Staff Development Nurse or MDS Nurse conducts four weeks of daily audits of medication carts each shift to ensure medication carts/narcotics are locked. The Weekend Supervisor or Treatment Nurse conducts medication cart audits initiated 10/28/13. Monthly audits are conducted on all carts by Staff Development Nurse or MDS Nurse and the Weekend Supervisor or treatment nurse beginning 10/28/13. Monthly audit will continue on an ongoing basis. Quality Assurance Nurse reviews audits weekly to ensure licensed personnel use double locking and counseling nurses for non-compliance. The Director of Nursing/Assistant Director of Nursing monitors and reports security issues to the Administrator and to the Tracking Committee weekly which reports to the monthly Quality Assurance and Assessment Committee for one year to ensure effectiveness of audit and compliance process.	

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F 431	Continued From page 15 the 200 back hall cart on 10/23/13 at 9:13 AM revealed the lock for the narcotics storage compartment on the left side of the medication cart to be in the unlocked position. Continued observation revealed Nurse #4, assigned to that cart, to go down the hall into an office out of view of her medication cart. Nurse #4 was observed on 10/23/13 at 9:20 AM preparing a medication for resident administration. Continued observation revealed when the medication was ready to be dispensed Nurse #4 locked the one lock for the cart but not the narcotic lock and went into a resident's room to dispense the medication. Nurse #4 was observed to be in the resident's room for 6 minutes out of view of medication cart 200. On 10/23/13 at 9:26 AM cart 200 was checked for expired drugs with Nurse #4 in attendance. The top drawer of the 200 cart was observed to contain 52 cartons of narcotics. On 10/23/13 at 9:30 AM Nurse #4 confirmed that 52 cartons of narcotics were currently stored in the narcotic drawer on the 200 cart. On further interview Nurse #4 also confirmed the narcotics lock was not locked on her medication cart. Nurse #4 stated that while she was giving medications on the hall she only locked the main lock and left the narcotic lock inactivated. Nurse #4 revealed she probably should have locked both locks when leaving the medication cart. Interview on 10/23/13 at 10:10 AM with the facility Consultant Pharmacist revealed the regulations dictated that narcotics be stored under a double lock system. On further interview the Consultant Pharmacist revealed the left lock does lock the	F 431		

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