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
	345319	A. BUILDING _____ B. WING _____	C 12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	416 ELDERBERRY LANE MARSHALL, NC 28753

(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 000	INITIAL COMMENTS No deficiencies cited as a result of complaint investigation. Event ID 769C11	F 000	Elderberry Health Care submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on	
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: Based on record review and staff interviews the facility failed to administer 2 doses of a respiratory medication to 1 of 1 resident reviewed for providing care and services to maintain well being. (Resident # 34). The findings included: Resident #34 was admitted to the facility on 10/28/13 with multiple diagnoses including chronic obstructive pulmonary disease (COPD) exacerbation and history of pulmonary embolism. A review of Resident #34's five day Minimum Data Set (MDS) dated 11/03/13 indicated Resident #34 was severely cognitively impaired for daily decision making skills and required extensive assistance for all activities of daily living (ADL) care. A review of the physician's progress note dated	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Cutshall — TITLE: Administrator — (X6) DATE: 1-13-14

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.

DHSR Received Black Mountain JAN 15 2014 by: PAM

Original Signature Date: 1-9-14

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F 309	Continued From page 1 11/19/13 specified the resident appeared ill and his vital signs were stable. The resident was without fever and had an oxygen saturation above 90 percent on five liters of oxygen via nasal cannula (NC). The Resident was using his accessory muscles to breath and his lungs had diffuse rales and wheezing. Resident #34 was diagnosed with pneumonia. A review of the physician's order dated 11/19/13 at 12:20 PM included a new order written for Albuterol 0.083% per hand held nebulizer every three hours while awake for one (1) week, then as needed. The order also included oral antibiotics. A review of Resident #34's Medication Administration Record (MAR) for 11/19/13 revealed medication not documented as given for 2:00 PM or the 5:00 PM dose of the Albuterol 0.083%. On the MAR the box for the nurse's initials at the 2:00 PM dose had an "X" and the box for the nurse's initials at the 5:00 PM dose was empty. An interview with the Physician on 12/12/13 at 3:05 PM indicated taking the Albuterol 0.083% inhalation medications could have helped Resident #34 with breathing. The Physician did not indicate the medication would have changed Resident #34's overall medical condition. An interview with Nurse #3 on 12/12/13 at 5:28 PM revealed she was the nurse responsible for Resident #34 on the day of 11/19/13. Nurse #3 was not able to give any explanation for Resident #34 not having documented Albuterol 0.083% as given at the 2:00 PM and the 5:00 PM medication administration times. Nurse #3 also explained	F 309	that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be granted an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process. It is the facility's practice and intent to ensure that necessary care and services are provided and received to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility and pharmacy have policies and procedures designed to maintain these goals. Comprehensive assessments, audits, care plan team meetings, MD visits, MAR reviews, various consultant reviews, and quality assurance monitoring are examples of the many components utilized.	

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F 309	Continued From page 2 she did not know if the resident received the medication. An interview with the DON on 12/12/13 at 5:46 PM stated she did not have any explanation for Resident #34 not having documented Albuterol 0.083% as given at the 2:00 PM and the 5:00 PM medication administration times. The DON further stated it was her expectation the Albuteral 0.083% was administered as ordered in a timely manner. The DON further explained when a new medication was ordered for a resident and the facility did not have the medication the facility could get the medication from the pharmacy or the pharmacy could deliver the medication to the facility.	F 309	Resident #34 was a closed record review. No additional corrective action can be implemented for resident #34. In this case, resident#34's care team members were involved in ensuring necessary care and services were being provided. The referenced 11/19/13 new medication order was given by the resident's physician as a routine order. The facility and pharmacy logs reflect the order was transmitted to the pharmacy shortly following receipt of the order. The MAR reflects the medications were obtained and initiated prior to the normal pharmacy delivery time. The 2pm slot showing an "X" was not intended to reflect a missed dose but rather indicate the initial dose wasn't scheduled for that particular time slot. The MAR labeling inadvertently caused confusion of the physician's intent for the initial dose. The intitial dose of antibiotics began at 5pm and the Albuterol at 8pm.	
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	F 431		

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F 431	Continued From page 3 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 observations and staff interview the facility failed to remove expired medications from 2 of 3 medication carts and 1 medication room refrigerator. The findings included: A review of the manufacturer's instructions for Novolog insulin indicated vials should be refrigerated until opened and must be discarded 28 days after opening. A review of the manufacturer's instructions for Latanoprost eye drops indicated unused solution should be discarded 6 weeks after opening. A review of the manufacturer's instructions for Flulaval(influenza virus vaccine) indicated vials must be discarded 28 days after opening. A review of the facility's Medication Storage guidelines indicated insulins should be discarded 28 days after opening and Latanaprost eye drops should be discarded 6 weeks after opening. The guidelines also indicated that vaccines were good for 6 months after opening and listed several	F 431	Because all residents with new medication orders are potentially affected by the cited deficiency , beginning on 12/12/13, the Director of Nursing and ADON reviewed the MARS to physician orders for those residents who had new orders within the month of November and December to ensure that orders were followed. No other residents were affected. To enhance currently compliant operations, the pharmacy consultant conducted a review of the emergency drug kit for commonly prescribed medications and reviewed the pharmacy policy manual. The pharmacy added Albuterol to the facility emergency kit to provide quicker availability for Albetrol.	01/10/14 01/09/14

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F 431	Continued From page 4 vaccines but the influenza vaccine was not included in the list. 1. Inspection on 12/11/13 at 3:15 PM of the refrigerator in the medication storage room revealed a 5 milliliter (ml) vial of Flulaval influenza vaccine with a date opened label of 10/22/13. The vial had approximately 1 ml of vaccine remaining in the vial. An interview on 12/11/13 at 5:23 PM with the Assistant Director of Nursing revealed she was responsible for the facilty's infection control program and also administration of the influenza vaccines. She stated she was not aware the package insert indicated the medication expired 28 days after opening and was going by the Medication Storage guidelines for vaccines. An interview on 12/11/13 at 5:31 PM with the Pharmacy Manager revealed the guideline provided by the manufacturer of the flu vaccine should be followed and that any unused vaccine should be discarded 28 days after the vial had been entered. An interview on 12/12/13 at 4:40 PM with the Director of Nursing (DON) about the facility's policy for labeling of insulin and eye drops revealed the nurses should put the date they open eye drops or insulin on the bottle. She stated unopened insulin should be refrigerated until opened. When asked what her expectations were for storage of insulin, eye drops and flu vaccine the DON stated she expected medications to be removed from the medication cart or medication room when they reached their expiration date. 2. Inspection on 12/11/13 at 3:34 PM of the 200 Hall medication cart revealed a bottle of	F 431	Starting on 12/13/13, under the direction of the Director of Nursing and with the assistance of the pharmacy consultant, all nurses began receiving in-service training regarding the pharmacy manual section covering recommended delivery standards for new medication orders. The training emphasized medication receipt and professionally accepted initial dose timeframes for new medication orders. Effective 12/16/13, a a quality assurance program was implemented under the supervision of the Director of Nursing to monitor receipt of new medication orders and their initial administration. The Director of Nursing, pharmacy consultant or designated quality assurance representative will perform randowm checks of resident MARS on those residents who have had a new medication order at least weekly for the first month and then at least monthly	01/09/14

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F 431	Continued From page 5 unopened Novolog insulin for Resident # 91 with a pharmacy dispensed date of 10/09/13. An interview on 12/11/13 at 3:46 PM with Nurse # 1 revealed the insulin should have been stored in the refrigerator until it was opened. Nurse # 1 stated it was on the cart and available for use and she would have used it if the resident had needed sliding scale insulin coverage. An interview on 12/12/13 at 4:40 PM with the Director of Nursing (DON) about the facility's policy for labeling of insulin and eye drops revealed the nurses should put the date they open eye drops or insulin on the bottle. She stated unopened insulin should be refrigerated until opened. When asked what her expectations were for storage of insulin, eye drops and flu vaccine the DON stated she expected medications to be removed from the medication cart or medication room when they reached their expiration date. 3. Inspection on 12/11/13 at 4:04 PM of the 100 Hall medication cart revealed a bag labeled for Resident # 6 that contained a partially used bottle of Latanoprost eye drops that did not have a label indicating when it was opened or when it was dispensed from the Pharmacy. An interview on 12/11/13 at 4:18 PM with Nurse # 2 revealed the facility policy for labeling of eye drops specified they should be labeled when they were opened. Nurse # 2 confirmed the eye drops should be discarded 6 weeks after opening and she did not know when the bottle was opened. An interview on 12/12/13 at 4:40 PM with the Director of Nursing (DON) about the facility's policy for labeling of insulin and eye drops revealed the nurses should put the date they	F 431	for next two months and on-going. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The facility utilizes a clinical pharmacy to provide the system and services of licensed pharmacists that are in the accordance with the State and Federal guidelines related to drugs and biological, their records , labeling and storage. There are multiple checks and balances to monitor the various drug and biological systems. The referenced vials were discarded on 12/11/13 per facility policy. All medication carts and mediacation storage areas were rechecked on 12/12/13 by the Director of Nursing and ADON for any other vials, liquids, medications, etc. that had exceeded the manufacturer best use by after opening date.. No other containers were found.	

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F 431	Continued From page 6 open eye drops or insulin on the bottle. She stated unopened insulin should be refrigerated until opened. When asked what her expectations were for storage of insulin, eye drops and flu vaccine the DON stated she expected medications to be removed from the medication cart or medication room when they reached their expiration date.	F 431	Licensed nurses will check medication carts daily for dates and recommended use by dates. Licensed nurses received a refresher training under the direction of the Director or Nursing from 12/11/12 through 01/10/13 on being observant of dates, the recommended use by, items requiring refrigeration and what to do if an item is found outside the guidelines. Pharmacy provided an updated medication storage guideline sheet that includes guidelines for the influenza vaccine. The Director Nursing or designated quality assurance representative will audit medication carts and storage areas weekly for one month and on-going to ensure compliance. The pharmacy consultant will continue to audit medication carts and storage areas monthly as an additional check. The Director of Nursing or designated quality assurance representative will provide a report to the facility Quality Assurance Committee monthly and on-going.	01/09/14 01/13/14