STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	R-C 03/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET ST GRANITE FALLS, NC 28630

(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 On 03/12/14, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section, conducted a revisit in conjunction with a new compliant. While some of the deficiencies cited on the recertification survey of 01/12/14 were corrected, effective on 03/12/14, the facility remains out of compliance due to re-citations and new citations.	F 000		
{F 164} SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	{F 164}		4/7/14

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

Electronically Signed

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 164}	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to close the resident's door and pull the privacy curtain during administration of medications via Nasogastric (NG) Tube for 1 of 3 residents observed during medical treatment (Resident #183). The findings included: Resident #183 was admitted to the facility on 03/08/14 with diagnoses which included chronic airway obstruction, coronary artery disease, and coronary atherosclerosis. The Minimum Data Set (MDS) was unavailable related to the resident's recent admission. Further review of Resident #183's medical record revealed the resident was cognitively intact and was capable of making her needs known by writing on a white board. On 03/12/14 at 10:08 AM Resident #183 was observed sitting up in bed A, the first bed upon entrance to the room. At 10:10 AM Nurse #1 entered Resident #183's room to administer medications. During observation of medication administration via Resident #183's NG Tube the privacy curtain was not pulled between Bed A and the resident in Bed B and the door remained opened. At 10:13 AM observations were made of residents walking up and down the hallway and looking into Resident #183's room. Resident #183's body language was observed as trying to hide during the process of Nurse #1 administering the medications.	{F 164}	1.For resident #183 her privacy curtain was closed. 2. For any residents having the potential to be affected, all staff(nursing, dietary, housekeeping, maintenance, laundry, administrative and activities) were inserviced by DON/designee on providing privacy to residents on 3/13,3/14,3/17,3/18 & 3/25/2014. Nurse #1 was given a disciplinary warning and that included termination. Audits conducted by administrative nurses, charge nurses and consultant. 3. Licensed nursing staff will be conducting daily audits of 7 residents(10% of largest populated hall) x 1 week, weekly audits x 4 weeks, monthly audits x 3 months, then to QA. Issues noted with staff are to be addressed immediately with re-education and or disciplinary action. 4.Results of audits will be reported to DON and to monthly QA committee. Any trends or patterns will be discussed. New interventions or recommendations will be implemented as ordered.	

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{F 164}	Continued From page 2 On 03/12/14 at 10:16 AM an interview was conducted with Nurse #1. She stated she was trained to provide privacy when rendering care and/or administering medications to residents by any route other than PO (by mouth). She further stated before she administered the medications by the resident's NG Tube she should have closed the door and pulled the privacy curtain between the residents, she indicated "I forgot." On 03/12/14 at 3:28 PM an interview was conducted with the Assistant Director of Nursing (ADON). She reported the staff was trained to provide complete privacy when giving care and/or administering medications to residents. She stated this meant closing the doors, pulling the privacy curtains, and/or closing the window blinds. She further stated she expected the nurses to provide privacy to residents when medications were administered. On 03/12/14 at 3:58 PM an interview was conducted with the Director of Nursing (DON). She stated she expected residents to be provided privacy when medicines were administered and/or any resident care was being provided. She further stated the privacy curtains should have been pulled between the residents and the door should have been closed.	{F 164}		
{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:	{F 281}		4/7/14

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{F 281}	Continued From page 3 Based on observations, record review, and staff interview, the facility failed to administer 1 of 3 sampled residents with the correct dosage of Tylenol (a pain medication) (Resident #11). The findings included: Resident #11 was admitted to the facility on 01/09/13 with diagnoses which included generalized pain, hypertension, and dementia. The annual Minimum Data Set (MDS) dated 01/29/14 indicated Resident #11 was cognitively intact and was capable of making her needs known. A review of the physician orders dated 05/14/13 included an order to administer: "Acetaminophen (Tylenol) Ex-Str (extra strength) 500 mg (milligram) caplet 1 to 2 tablets every 6 hours as needed for pain." A review of the Medication Administration Record (MAR) for the month of March 2014 revealed by the nurse's initials that Resident #11 received Tylenol Ex-Str 500 mg (2 tablets) on 03/08/14 at 11:32 AM. On 03/10/14 at 4:41 PM observed Medication Aide (MA) #1 removed 2 tablets of Tylenol 325 mg tablets from the stocked medication bottle in the top left drawer of the medication cart and placed them into a cup to be administered to Resident #11. MA #1 reviewed the physician order and stated the Tylenol was the wrong dosage. MA #1 poured the tablets back into the bottle and looked through all of Resident #11's medications. MA #1 indicated Resident #11 did not have her own Tylenol 500 mg bottle.	{F 281}	1. For resident #11, Tylenol extra strength, 500 mg tablet was obtained from pharmacy immediately. Nurse #1 was given disciplinary action that resulted in termination. 2. For any residents having the potential to be affected, Licensed nurses and medication aides were inserviced by DON/designee on medication pass administration, such as the 5 rights of medication administration, having correct medications on hand, checking the label against EMAR for accuracy, back up pharmacy and new medication administration policy on 3/14/2014,3/17/2014, and 4/2/14. Any issues identified are forwarded to DON/pharmacy for correction. 3.Nursing staff passing medications were randomly audited by DON or designee during medication pass administration for accuracy and availability. Random daily audit of 2 nurses and/or med aides x 1 week, then random weekly audits x 4 weeks, then monthly x 3 months. Any issues identified will be forwarded to DON for disciplinary action. 4. Results of audits will be reported to monthly QA committee meeting by the DON. Any trends or patterns identified will be discussed. New interventions or recommendations will be implemented as ordered.	

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{F 281}	Continued From page 4	{F 281}		

On 03/10/14 at 4:45 PM MA #1 was interviewed. She stated Tylenol 500 mg tablets were not stocked on the medication carts. She further stated only Tylenol 325 mg tablets were stocked. She indicated the resident's PRN medications were stored in a separate drawer and labeled with the resident's name when the medication dosages were different from the regularly stocked medications. MA #1 further indicated she was unaware of Resident #11 having her own Tylenol medication and she had not administered any Tylenol 500 mg to Resident #11.

On 03/10/14 at 4:58 PM the March 2014 MAR was reviewed. The MAR indicated, by Nurse #1's initials; she had administered Tylenol 500 mg (2 tablets) on 03/08/14 at 11:32 AM.

On 03/12/14 at 10:22 AM Nurse #1 was interviewed. She confirmed her initials on the MAR for March 2014. She stated she administered 2 tablets of Tylenol 325 mg to Resident #11 on 03/08/14 at 11:32 AM from the stocked Tylenol medication bottle. She revealed Resident #11 had not had any Tylenol 500 mg tablets in her medication drawer and she had always given Resident #11 the Tylenol from the stocked Tylenol medication bottle.

On 03/12/14 at 3:58 PM the Director of Nursing (DON) was interviewed. She confirmed the stock medication of Tylenol has a dosage of 325 mg's and Tylenol 500 mg's was not a stocked medication. She stated her expectation was for all nurses and medication aides to administer the correct dosage for all medications including PRN and/or stocked medications as ordered by the physician.

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F 322	Continued From page 5	F 322		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to check for proper placement of a feeding tube prior to administering medications and flush the feeding tube with at least 30 milliliters of water before medications were administered to 2 of 2 sampled residents observed during medication administration (Residents #183 and #63). The findings included: 1. Resident #183 was admitted to the facility on	F 322	1. Resident #183 and resident #63 had their orders changed to administer all medications crushed and administered in a NG/G-tube together with the clarified order written as to the reason why. Nurse #1 was given disciplinary action that included termination. Nurse #2 was given disciplinary warning and medication aide #3 was given disciplinary warning and both were re-educated. 2. For any residents having the potential	4/7/14

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F 322	Continued From page 6 03/08/14 with diagnoses which included chronic airway obstruction, coronary artery disease, and coronary atherosclerosis. The Minimum Data Set (MDS) was unavailable related to Resident #183's recent admission. Further review of Resident #183's medical record revealed the resident was cognitively intact. Review of the physician's orders dated 03/08/14 revealed "nurse to verify placement of NG Tube before administering feedings and medications." Review of the Medication Administration Record (MAR) dated 03/08/14 through 03/31/14 indicated; by the nurse's initials, Nurse #1 had checked NG Tube placement on 03/12/14 at 7:00 AM. On 03/12/14 at 10:10 AM during medication administration Nurse #1 was observed without a stethoscope to check for placement of an naso-gastric tube (NG) Tube for Resident #183. During observation Nurse #1 placed 10 milliliters (ml) of warm water into the same cup with the crushed medications. Nurse #1 poured the 10 ml's of water and medication combination into the NG Tube, after the NG Tube was cleared, Nurse #1 then flushed the NG Tube with 30 ml of warm water. On 03/12/14 at 10:16 AM an interview was conducted with Nurse #1. She stated she had checked the NG Tube placement of Resident #183 approximately 2 hours before she administered the medications. She further stated she should have checked the tube placement right before she gave the medications but she "just didn't ."	F 322	to be affected, staff were inserviced by DON/designee on medication administration via NG tube/G-tube and correct placement of NG/G-tube on 3/12,3/13,3/14, 3/28/14 as specified by the standards of practice to include: flushing tube prior to administration of medication with 30 cc of water, mix each individual medication in 30cc of water, give each medication individually, flush between each medication with 30 cc of water, and at the end of administering the medications, flush again with 30 cc of water. All residents with NG/G-tubes were assessed by medical provider and clarification order written to administer all meds crushed, mixed together and given at the same time with reason. 3. Random audits on 50% of total NG/G-tube residents were conducted daily x 1 week, then randomly weekly x 4, then randomly monthly x 3 months and then to QA. All audits were conducted by DON or designee. Any issues identified were forwarded to DON for disciplinary action. 4. Results of audits will be reported by DON to monthly QA committee meeting. Trends or patterns identified will be discussed. New interventions or recommendations will be implemented as ordered.	

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Further interview with Nurse #1 stated she dissolved the medicines in warm water, administered them via the NG Tube, and flushed the NG Tube with warm water until the tube was cleared. She demonstrated filling the plastic medicine cup to the first line with water; which indicated 10 ml, then filled another plastic medicine cup to the top line; which indicated 30 ml. She stated she did not want the resident to feel full so she used "very little" water. She indicated she had not seen a physician's order as to how much water should be used therefore she just "guesses."

On 03/12/14 at 3:28 PM an interview was conducted with the ADON. She stated she expected the nurses to verify placement of an NG Tube right before administering medications. She further stated checking the NG Tube placement 2 hours before would be unacceptable practice. She indicated she expected the nurses to flush an NG Tube with 30 ml of warm water before administering medications and flush the NG Tube with 30 ml of warm water after the medications have been administered.

On 03/12/14 at 3:58 PM an interview was conducted with the DON. She stated she expected the nurses to check NG Tube placement right before administering medications but an acceptable time would be no more than 15 minutes before administering the medications. She further stated she expected the nurses to flush NG Tubes with 30 ml of warm water before and after administering medications.

2. Resident #63 was most recently admitted to the facility on 11/23/13. Her diagnoses included dysphagia, anorexia and Alzheimer's disease.

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The most recent quarterly Minimum data Set (MDS), dated 03/01/14, coded her with long and short term memory impairments and severely impaired decision making skills, requiring extensive assistance for all activities of daily living skills and being fed via tube.

Review of the monthly recap of physician orders and Medication Administration Record (MAR) for March 2014 revealed the nurse was to verify placement of the gastrostomy tube (g-tube) before meds and to administer Ditropan (a urinary antispasmodic agent) 5 mg by tube 4 times per day.

On 03/10/14 at 12:15 PM, Medication Aide (MA) #3 was observed to administer Ditropan via g-tube. MA #3 washed her hands and turned off the continuous tube feeding formula. With a bolus syringe, she emptied a cup of water containing crushed Ditropan in the bolus syringe and allowed the mixture of medication in water to enter via gravity. She flushed the tube with more water after the medication was administered. At this time, MA #3 was asked about flushing the g-tube with water prior to the mixture of medication and water. MA #3 stated the nurse had been in and flushed about an hour ago.

Follow up interview with MA #3 on 03/12/14 at 2:17 PM via telephone revealed the nurse was responsible for checking placement of the tube not the MA. She further stated that the computerized MAR will flag to show that the placement of the tube feeding had been checked. Review of the MAR revealed this was set up to flag once a shift, i.e. 7:00 AM and 7:00 PM (as staff work 12 hour shifts). Per this interview, MA

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F 322	Continued From page 9 #3 recalled the nurse was Nurse #2. Nurse #2 was interviewed on 03/12/14 at 2:37 PM via telephone. She stated that she checked g-tube placements before administering medications. She further stated that when there are medication aides administering medications, she covers two halls. During these times she generally checks all g-tube placements at 7:30 AM, 11:30 AM and 3:30 PM as she cannot be available immediately before all medication administrations. Interview with the Assistant Director of Nursing on 03/12/14 at 3:27 PM revealed nurses are expected to check g-tube placement "right before" a medication aide administers the medication. She further stated the facility standard was flush with 30-50 cc of water before and after medication administration. Interview on 03/12/14 at 3:56 PM with the Director of Nursing revealed the longest time between checking g-tube placement and administering medications should be 15 - 30 minutes.	F 322		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility medication error rate was	F 332	1. Resident #183's medication was reviewed by medical provider and order	4/7/14

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greater than 5% as evidenced by 2 medication errors out of 26 opportunities; one error was a result of giving the medication in the morning instead of in the evening as it was ordered and the other error resulted from crushing all medications and administering them at one time via a Nasogastric Tube, resulting in a medication error rate of 7.69% for 1 of 6 residents observed during medication administration (Resident #183).

The findings included:

Resident #183 was admitted to the facility on 03/08/14 with diagnoses which included chronic airway obstruction, coronary artery disease, and coronary atherosclerosis. The Minimum Data Set (MDS) was unavailable related to Resident #183's recent admission. Further review of Resident #183's medical record revealed the resident was cognitively intact and was capable of making her needs known by writing on a white board.

On 03/12/14 at 9:51 AM Nurse #1 was observed crushing the following medications:
a) Pravachol 80 mg (milligrams) one tablet
b) Venlafaxine HCL 37.5 mg one tablet
c) Plavix 75 mg one tablet
d) Lisinopril 20 mg one tablet
e) Norvasc 10 mg one tablet
f) Aspirin 81 mg one tablet
g) Coreg 6.25 mg one tablet
h) Calcium 500 mg + D one tablet
i) Oxycodone 10 mg one tablet
j) Colace 100 mg one capsule

The Colace 100 mg capsule was pulled apart and the granules were poured onto the other medications which were all crushed for

received to crush and administer crushable medications via NG tube together due to inability to tolerate feedings and fluid overload on 3/27/14. Nurse#1 was issued a disciplinary warning to include termination on 3/12/14.

2. For any resident having the potential to be affected, inservices were conducted by DON/designee on 3/12,3/13,3/14 and 3/28/14 on correct administration of medications via NG/G-tube, new NG/G-tube policy, new medication pass policy and their administration, to include the 5 rights of medication administration, and timely delivery of medications. All residents with NG/G-tube were assessed by medical provider and orders written for clarification to crush and mix medication together and administer at the same time.

3. Random daily audits of 2 nurses and/or med aides were conducted x 1 week by DON or designee, random weekly audits x 4 weeks, random monthly audits x 3 months, then to QA. Any issues identified were forwarded to DON for disciplinary action.

4. Results of audits are reported by DON at monthly QA committee meeting. Any trends or patterns identified will be discussed. New interventions or recommendations will be implemented as ordered.

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administration to Resident #183 via an NG Tube.

On 03/12/14 at 10:10 AM Nurse #1 was observed administering the crushed medications to Resident #183 by NG Tube.

A review of Resident #183's medical record revealed physician orders dated 03/08/14 for Colace (docusate sodium) 100 mg one capsule per NG Tube q hs (each night at bedtime).

A review of Resident #183's Medication Administration Record (MAR) dated 03/08/14 through 03/31/14 revealed the order had been correctly transcribed for administration of Colace 100 mg by NG Tube each night at bedtime (8:00 PM) according to the physician's order.

An interview was conducted with Nurse #1 on 03/12/14 at 10:16 AM. She stated until today, she had not provided care to Resident #183. She indicated she mistakenly administered the Colace 100 mg by NG Tube to the resident at 10:10 AM instead of 8:00 PM as ordered. Nurse #1 further indicated the physician's order for the Colace 100 mg by NG Tube should have been given at 8:00 PM. She admitted she reviewed the medications to be administered by the NG Tube but did not look at the times the medications should have been given. Further interview with Nurse #1 revealed she was unaware that medications were to be given one at a time instead of all together in an NG Tube.

An interview was conducted with the ADON on 03/12/14 at 3:28 PM. She stated she was unaware that medications were to be administered one at a time instead of all together in an NG Tube. She further stated she expected

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F 332	Continued From page 12 the nurses to review the physician's orders, the MAR, and administer the medications as ordered. An interview was conducted with the DON on 03/12/14 at 2:58 PM. She stated she expected nurses to administer medications at the correct times and according to the physician's orders. She further stated she expected nurses to administer medications one at a time and not together in an NG Tube.	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident	F 425	1. Resident #90's requip was received by	4/7/14

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F 425	Continued From page 13 interview and staff interviews, the facility failed to provide pharmacy services to 1 of 3 sampled residents. Resident #90 did not receive 5 doses of Requip (a Parkinson's medication) when the medication had been obtained and available in the pharmacy which was located in the facility. The findings included: Resident #90 was admitted to the facility on 10/13/12. His diagnoses included Parkinson's Disease. The most recent Minimum Data Set, a quarterly dated 01/21/13, coded him as being cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status. Resident #90's March 2014 physician orders included the medication of Requip 3 milligrams (mg) 4 times per day. A telephone order was written 03/08/14 (no time) to hold the Requip 3 mg until pharmacy could reorder. Review of the Medication Administration Record (MAR) for March 2014 revealed Requip 3 mg was scheduled to be given at 6:00 AM, 11:00 AM, 4:00 PM, and at 9:00 PM. Per the MAR, Requip was not administered on 03/08/14 at 9:00 PM, on 03/09/14 at 6:00 AM, 11:00 AM, 4:00 PM and 9:00 PM. This indicated 5 doses were missed. The reason documented on the MAR for this medication not being administered was that pharmacy had not dispensed the medication. Resident #90 was interviewed on 03/10/14 at 3:35 PM. Resident #90 stated that he ordered his own medications, including Requip, through mail order and gave it to the facility to administer to him. He ordered a 90 day supply and he stated	F 425	facility pharmacy. Nurse #1 received disciplinary action that included termination. 2. For any residents that have the potential to be affected, Licensed Nursing staff and medication aides were inserviced on 3/13 & 3/14 by DON/designee on medication pass and availability of medications, borrowing medications, obtaining medications from the pharmacy when medication runs low or is out of stock, utilizing back up pharmacy when primary pharmacy is unavailable and informing staff of the upcoming medication cart audits. Inservice included Pharmacy and back-up pharmacy phone numbers and were posted at nursing station for reference. 3.Random audits were conducted by DON/ Designee on minimum of 7 residents daily x 1 week, minimum 7 residents random weekly x 4 weeks, minimum 7 residents random monthly x 3 months, then to QA committee. 4. Results of audits will be reported by DON at monthly QA committee meeting. Any trends or patterns will be discussed. New interventions or recommendations will be implemented as ordered.	

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that he should have had enough of the Requip to last through 03/19/14; however, he had not received his Requip for the last 3 days. He further stated that today he received 2 Requip pills, a 1 mg tablet and a 2 mg tablet instead of the 1 pill (3 mg tablet) that he had ordered and received via mail order.

On 03/11/14 at 4:29 PM, a pharmacy technician (who worked in the onsite pharmacy) stated that when she received a sticker indicating a medication needed to be refilled, she filled the order and left it for the pharmacist to review, approve and then dispense to the medication cart. She further stated that if needed and the facility called the pharmacist during the weekend, the pharmacist would come in on the weekend to refill the medication order.

On 03/11/14 at 4:33 PM, Nurse #4 stated that when a medication runs out, there was a back up pharmacy that could be used around the clock to obtain the medication. He further stated the back up pharmacy could send a partial order to cover the resident's needs until the facility's pharmacy could refill the medication. He stated he was the nurse in charge this particular weekend (03/08/14 - 03/09/14) and he did not know why the medication was not obtained. If the back up pharmacy did not have the necessary medication or if there was no staff to send to the back up pharmacy, then staff had the option to call the physician to hold the medication until it was available.

On 03/11/14 at 5:11 PM, the Pharmacist #1 who ran the onsite pharmacy was interviewed. He stated that he was responsible for all in house dispensing of medications. He stated that he

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filled the medication boxes and placed a sticker on the box to be used for reordering. The box was observed with 2 compartments. The pharmacist stated that the larger compartment on the left side of the box was filled with most of the medication. The smaller right side of the box had approximately a 5 day supply of medication. He stated that when the left side of the box was empty, staff then switched to the right side of the box for medications. When staff switched to the right side that was a reminder for staff to remove the refill sticker and send it to the pharmacy for refill. He further stated that if a medication totally ran out of the box, especially on the weekends, staff called him or used the local back up pharmacy. The pharmacist stated that Resident #90 ordered his own medications from mail order and was very good at making sure his medications did not run out and were always available for refill by the pharmacist. The pharmacist stated that the pharmacy stored the medications received from Resident #90 but the nursing staff still had to alert the pharmacy when the medication box ran low and needed to be refilled. The pharmacist stated nursing staff should have been well aware the Requip was getting low before it ran out. The pharmacist stated Resident #90's Requip was actually available and in the pharmacy when he did not receive it on 03/08/14 and 03/09/14. The pharmacist stated he did not receive notification that Resident #90's Requip needed to be refilled until Monday 03/10/14. Once alerted, he refilled it with the available pills located in the pharmacy from when Resident #90 had last ordered this medication. The pharmacist stated with the current system of him being available by phone and a back up pharmacy available, Resident #90's Requip should not have been missed.

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On 03/11/14 at 5:33 PM, Nurse #6 was interviewed via phone. Nurse #6 stated that the process was to pull the sticker and place it in the pharmacy book when the medication was running low or to call the back up pharmacy if the medication was totally out. Nurse #6 initialed administering the Requip on the MAR on 03/08/14 at 6:00 AM. She could not recall the number of Requip tablets left or whether she noticed a refill was needed.

Several attempts to contact Nurse #7 via telephone were unsuccessful. Nurse #7 initialed the MAR as not administering the dose of Requip missed at 9:00 PM on 03/08/14 and on 03/09/14. He had noted on the MAR the medication was held related to the pharmacy had not filled the order.

Follow up interview with Resident #90 on 03/11/14 at 5:51 PM revealed he was told there were no more Requip in the medication cart to give him. He could not recall who told him this information. He stated that he experienced more tremors in his legs during the time he missed the Requip.

Nurse #1 was interviewed on 03/12/14 at 9:14 AM. Nurse #1 initialed the missed doses of Requip on 03/09/14 at 6:00 AM, 11:00 AM and 4:00 PM. Nurse #1 stated that when there were 5 to 6 days of medications left for a resident in the medication cart, she placed a reorder sticker or hand wrote the needed medication on the pharmacy sheet. Pharmacy sheets were turned in daily and sometimes several times per day. She stated if the medication was not a necessary one such as a narcotic, she would note that it was

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F 425	Continued From page 17 held. She further stated that she did not know there was a back up pharmacy to utilize. Nurse #1 confirmed she did not administer the Requip to Resident #90 as noted on the MAR. She further stated that she had informed Nurse #4 that the medication was not available. On 03/12/14 at 9:38 AM the Director of Nursing stated that staff was expected to place a refill order to the pharmacy as soon as the medication started running low. The policy stated 3 days before the medication runs out. She further stated that staff should know to go to the in-house pharmacy or to the back up pharmacy. She was unaware of the Requip running out until yesterday. On 03/12/14 at 3:18 PM, the Assistant director of Nursing stated Resident #90 ordered his own medication through mail order to save money. When the medications arrived, the front office took them to the in house pharmacy to be repackaged and labeled. She stated the back up pharmacy could have been used or that the pharmacist could have been called. She also stated that Resident #90 may have refused offers 9 (if made) to use the back up pharmacy because of the expense. On 03/12/14 at 3:53 PM, Resident #90 stated the staff may have said something about a back up pharmacy but he knew he had ordered and received the Requip. He further stated he should have had approximately 40 more pills and all staff had to do was find them.	F 425		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	{F 431}		4/7/14

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{F 431}	Continued From page 18 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: Based on observations, staff interviews, and record review the facility failed to label the dosage strength of a medication;	{F 431}	1. Resident #153's label corrected to show correct dosage of glucosamine chondroitin.	

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{F 431}	Continued From page 19 Glucosamine-Chondroitin for 1 of 6 residents observed during medication administration (Resident #153). The findings included: Resident #153 was admitted to the facility on 01/03/14 with diagnoses which included Alzheimer's disease, rheumatoid arthritis, malaise, and fatigue. The most recent Minimum Data Set (MDS) dated 01/16/14 coded Resident #153 as being cognitively intact and capable of making her needs known. On 03/12/14 at 8:35 AM during medication administration the Med Aide (MA) Technician was observed to remove one tablet of Glucosamine-Chondroitin to be administered to Resident #153. Further observation revealed the label on the bottle was identified with Resident #153's name, the name of the medication; Glucosamine-Chondroitin, how the medication was to be administered; once daily, and the medication route was by mouth (PO), on the label the dosage strength could not be identified. On 03/12/14 at 8:37 AM a review of the Medication Administration Record (MAR) dated for the month of March 2014, MA #1 revealed the medication, Glucosamine-Chondroitin's dosage strength could not be identified. Further review of the MAR revealed the Glucosamine-Chondroitin had been administered to Resident #153 on 03/01/14 through 03/11/14 at 8:00 AM. A review of Resident #153's medical record revealed physician orders dated 01/03/14 for "Glucosamine-Chondroitin Tab, take one tablet by mouth every morning (Osteo Bi-flex)."	{F 431}	2. For any residents that have the potential to be affected an inservice was held by the DON/designee for licensed nursing staff, medication aides and pharmacy staff on 3/13 and 3/14 for correct labeling on cubes to match the medical provider order. Writing order clarifications inservice was held for licensed nursing staff 3/28. 3.DON/designee audited a minimum of 7 resident's Medication cart cubes randomly daily x 1 week, then minimum of 7 resident's cubes randomly weekly x 4 weeks, minimum of 7 resident's cubes randomly monthly x 3 months and then to QA. 4. Results of audits will be reported by DON to monthly QA committee meeting. Trends or patterns identified will be discussed. New interventions or recommendations will be implemented as ordered.	

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On 03/12/14 at 8:40 AM an interview was conducted with MA #1. She stated until today she had not been assigned to work the hallway. She further stated the bottle of medication should have the dosage strength labeled for verification of the five rights prior to administering any medication to a resident. She revealed the five rights as follows:
1) Right Resident
2) Right Medication
3) Right Dosage/Strength
4) Right Route
5) Right Time

On 03/12/14 at 9:00 AM an interview was conducted with the ADON. She verified her initials on the MAR for the month of March, 2014. She indicated she had administered Glucosamine-Chondroitin to Resident #153 on 03/03/14, 03/04/14, and 03/11/14. She stated she should not have administered the medication without the dosage strength labeled on the bottle. She further stated the bottle should be labeled with the dosage strength.

On 03/12/14 at 9:10 AM an interview was conducted with Pharmacist #2. She confirmed the Glucosamine-Chondroitin bottle was to be labeled with the dosage strength prior to dispensing the medication for administration to Resident #153.

On 03/12/14 at 9:23 AM an interview was conducted with the DON. She stated she expected the dosage strength to be labeled on all medications.

On 03/12/14 at 9:42 AM a telephone interview was conducted with the Director of Facility

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{F 431}	Continued From page 21 Pharmacy Services. He stated the facility pharmacy was having problems with their computer system and he was aware bottles and/or containers were not being labeled accurately. He further stated the Glucosamine-Chondroitin medication should have had the dosage strength information on the label.	{F 431}		
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	{F 441}		4/7/14

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{F 441}	Continued From page 22 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to sanitize a blood glucose meter (glucometer) with a healthcare facility grade approved disinfectant to kill blood borne pathogens for 4 of 4 medication carts. The findings included: A review of the manufactures label on the Clorox container indicated the wipes were effective on "germs including viruses that cause colds, flu, and common bacteria such as Staphylococcus aureus (Staph), Salmonella enterica, and E. coli." Further review of the label revealed the Clorox Disinfecting wipes were made with a bleach-free formula. On 03/10/14 at 4:29 PM Medication Aide (MA) #1 was observed cleaning a glucometer with a Clorox disinfectant wipe. On 03/10/14 at 4:35 PM an interview was conducted with MA #1. She stated she had an in-service in January 2014 and was instructed to use the Clorox wipes to clean the blood glucose meters (glucometers). She further stated she was unaware the Clorox wipes were not effective against blood borne pathogens such as Hepatitis	{F 441}	1. No specific resident identified 2. For any residents with the potential to be affected, licensed nursing staff and medication aides were inserviced by DON/designee on 3/17/14 & 3/28/14 on proper glucometer cleaning. All residents with ordered blood glucose testing were issued their own personal glucometer prior to DFS exit on 3/12/2014. New glucometer policy written and implemented on 3/17/14 per NC SPICE statewide program for infection control recommendations. Wipes approved for killing Blood-Borne pathogens were purchased for cleaning per policy. 3. Random audits on glucometer policy for cleaning and issuing individual glucometers of 2 nurses/med aides were conducted by DON/designee daily x 1 week, 2 nurses/med aides random weekly audits x 4 weeks, 2 nurses/med aides random monthly audits x 3 months and then to QA. Any issues will be reported to DON for disciplinary action. 4. Results of audits will be reported by	

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{F 441}	Continued From page 23 and/or HIV. On 03/10/14 at 4:47 PM an interview was conducted with Nurse #3. She stated the facility did not have glucometers that were assigned to each resident. She confirmed the staff had an in-service in January 2014 and was instructed to use the Clorox wipes to clean the glucometers. She stated she was unaware the Clorox wipe was not effective in killing blood borne pathogens such as Hepatitis and/or HIV. She further stated she had asked about using the Clorox disinfecting wipes because these were not what she had used in other facilities. She confirmed the container of Clorox wipes sitting on the medication cart was the wipes she used to clean the glucometers. On 03/11/14 at 10:18 AM an interview was conducted with Nurse #2. She indicated the staff had an in-service in January 2014 and was instructed to use the Clorox wipes to disinfect the glucometers. She stated she was unaware the Clorox wipes were not effective against blood borne pathogens. She further stated the Clorox disinfectant wipes were kept on all medication carts and at the nurse's station. She confirmed the Clorox wipes sitting on top of the medication cart was the wipes she was using to clean the glucometers. On 03/11/14 at 10:28 AM an interview was conducted with Nurse #5. She confirmed the staff had an in-service regarding the cleaning of the glucometers in January 2014. She stated the facility did not have glucometers assigned to each resident. She further stated she was instructed to use the Clorox disinfectant wipes and they stayed on top of the medication carts. She indicated she	{F 441}	DON to monthly QA committee meeting. Any trends or patterns will be discussed. New interventions or recommendations will be implemented as ordered.	

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	345246	A. BUILDING _____ B. WING _____	R-C 03/12/2014

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{F 441}	Continued From page 24	{F 441}		

was unaware the Clorox wipes being used were not effective against Hepatitis and/or HIV.

On 03/11/14 at 4:42 PM an interview was conducted with the ADON. She indicated that all staff had an in-service on cleaning glucometers in January 2014 using the Clorox disinfecting wipes. She further indicated she was unaware the Clorox wipes were not effective against blood borne pathogens which included Hepatitis and/or HIV. She stated the Clorox wipes were purchased at a local store. She further stated the Clorox wipes sit on top of the 4 medication carts in the facility.

On 03/11/14 at 5:14 PM an interview was conducted with the DON. She stated the nurses were instructed during an in-service in January 2014 to clean the glucometers before and after each use with Clorox wipes. The DON further stated she expected the nurses to sanitize and disinfect the glucometers as they were instructed during the in-service. She indicated she was not aware the Clorox wipes were not effective against blood borne pathogens such as Hepatitis and/or HIV. She further indicated the facility had used a disinfectant wipe called "Sani-Wipe" in the past but did not know the reason for changing to the Clorox wipes.

On 03/11/14 at 6:00 PM a telephone interview was conducted with the Clorox Disinfecting Wipe Representative. He indicated the over the counter Clorox wipes were not a healthcare facility grade approved disinfectant and were not effective in killing blood borne pathogens.

On 03/12/14 at 11:42 AM a telephone interview was conducted with the Statewide Program for

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{F 441}	Continued From page 25 Infection Control and Epidemiology (SPICE) consultant. He stated the over the counter Clorox disinfectant wipes were not healthcare facility approved, should not be used to clean glucometers, and would not be effective against blood borne pathogens. On 03/12/14 at 1:34 PM an interview was conducted with the Administrator. She stated the nurses were instructed to sanitize and disinfect the glucometers with the Clorox wipes according to the in-service in January 2014. The Administrator confirmed she had purchased the Clorox wipes from a local store. She further stated she was unaware the glucometers had to be cleaned with a healthcare facility approved disinfectant wipe. She indicated she was not aware the Clorox wipes were not effective against blood borne pathogens.	{F 441}		
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	{F 520}		4/7/14

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{F 520}	Continued From page 26 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide evidence of a working plan of correction for an ongoing problem with medication administration; the provision of privacy during care; the complete labeling of drugs; and the disinfection of blood glucose meters. Residents #11, #183, #153 and 4 of 4 medication carts. The findings included: 1. Cross refer to F164. Based on observations, staff interviews, and record review the facility failed to close the resident's door and pull the privacy curtain during administration of medications via Nasogastric (NG) Tube for 1 of 3 residents observed during medical treatment (Resident #183). Per the plan of correction, staff were to be inserviced on privacy issues. There was no documentation to support that Nurse #1 had attended the inservice related to privacy. Nurse #1 stated on 03/12/14 that she could not recall attending any inservices. A review of the Quality assurance monitoring	{F 520}	1. See POC for F164,F281,F431 and F441 2. For any residents with the potential to be affected, direct care staff have been re-inserviced on 3/13,3/14,3/17,3/18,3/25 and 3/28/2014 for the above issues. New QA committee members added are new DON and Nurse Consultant. QA meetings will be conducted monthly beginning on March 6th, 2014. 3. Review of all current tags 5 x weekly by DON/designee. Any problems identified or ongoing QA issues are addressed 5 x weekly with department heads and/or DON/designee with disciplinary action. All tags are reviewed in the daily am meeting with any issues being immediately addressed and incorporated into monthly QA. 4. Results of all daily meeting minutes will be reported by DON to monthly QA meeting. Any trends or patterns identified will be discussed. New interventions or recommendations will be implemented as	

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{F 520}	Continued From page 27 revealed monitoring was completed on 4 staff (1 per hall) during medication pass to assure privacy was maintained. Nurse #1 had been observed on 03/06/14 and this audit revealed several issues including not knocking on doors. There was no evidence of follow up per this form. The Quality Assurance meeting notes dated 03/06/14 provided by the facility revealed "hall rounds are going well, any issues identified are immediately addressed and corrected." Interview on 03/12/14 at 5:06 PM with the nurse consultant revealed staff were inserviced regarding privacy and daily audits were being completed. She was sure Nurse #1 had attended an inservice even though her signature was not located on the sign in sheets. She reported that all tags previously cited were discussed at morning meetings and interventions for correction were put into place. She further stated that Nurse #1 was going to be terminated. Nurse #1 was terminated before the end of the survey. 2. Cross refer to F281. Based on observations, record review, and staff interview, the facility failed to administer 1 of 3 sampled residents with the correct dosage of Tylenol (a pain medication). (Resident #11). Per the plan of correction, staff were to be inserviced on medication administration. There was no evidence that Nurse #1 had attended the inservice related to medication administration. She had been had passed the yearly competency evaluation on 03/03/14 which included medication room review, medication cart-set up, and med pass. Nurse #1 stated on 03/12/14 that she could not recall attending any inservices.	{F 520}	ordered.	

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In addition, Nurse #1 was observed during medication pass on 03/06/14, once while working C hall and once while working D hall. Documentation on the D hall revealed no problems related to the administration of incorrect dosages.

A Quality assurance meeting took place on 03/06/14. Documentation of this meeting, dated 03/06/14, provided by the facility revealed "Continue to work on medication pass audits with nurses with improvement shown. New medication pass policy approved by (name of Medical Director) with implementation to be started as soon as possible."

Interview on 03/12/14 at 4:05 PM with the Director of Nursing revealed that the quality assurance rounds had indicated that she was aware of some medication issues. She stated she planned to provide disciplinary action and retraining but had not done so yet.

Nurse #1 was terminated on 03/12/14.

3. Cross refer to F431. Based on observations, staff interviews, and record review the facility failed to label the dosage strength of a medication; Glucosamine-Chondroitin for 1 of 6 residents observed during medication administration (Resident #153).

Review of the quality assurance monitoring tools revealed that the pharmacist audited the medication carts in January and noted a 2 percent error involving labeling. There was no evidence of additional monitoring by the pharmacist.

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Interview with the nurse consultant on 03/21/14 at 5:06 PM revealed that staff had been instructed to check the medication carts every day for expired medications. She further stated the audits did not include checking the labels for completeness or accuracy just for expiration dates.

4. Cross refer to F441. Based on observations and staff interviews the facility failed to sanitize a blood glucose meter (glucometer) with a healthcare facility grade approved disinfectant to kill blood borne pathogens for 4 of 4 medication carts.

Review of the quality assurance planned monitoring tools, revealed that monitoring was being completed and the documentation showed staff were disinfecting the glucose appropriately. There was no mention of the type of wipes being used.

On 03/12/14 at 1:34 PM an interview was conducted with the Administrator. She stated the nurses were instructed to sanitize and disinfect the glucometers with the Clorox wipes according to the in-service in January 2014. The Administrator confirmed she had purchased the Clorox wipes from a local store. She further stated she was unaware the glucometers had to be cleaned with a healthcare facility approved disinfectant wipe. She indicated she was not aware the Clorox wipes were not effective against blood borne pathogens.

Interview with the Assistant Director of Nursing on 03/12/14 at 3:42 PM revealed she was unaware that the kitchen disinfectant wipes were not

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{F 520}	Continued From page 30 effective on the blood borne pathogens. She further stated she was unsure who determined to provide the kitchen disinfectant wipes. Interview with the Nurse Consultant on 03/12/14 at 5:06 PM revealed she was not aware the staff were not using the approved disinfectant wipes on glucose meters.	{F 520}		