

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345397</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SHORELAND HLTH CARE &amp; RETIREME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472</b>
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F 253 SS=D	<p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to provide a sanitary environment by failing to clean tube feeding poles and the floor beneath the poles of feeding formula for 3 of 3 days of survey (Resident #112, Resident #8).</p> <p>The findings included:</p> <p>1. Resident #112 was admitted to the facility on 10/14/14 with a diagnosis including Dysphagia and was receiving Glucerna via a gastrostomy tube. During an observation on 1/5/15 at 12:15PM there were three dime sized, dried light brown matter on the floor under the tube feed pole. The tube feeding pole also was covered with multiple, dried light brown spots at the base of the pole. A family member was also present in the room.</p> <p>During an observation on 1/5/15 at 3:15PM the floor and the pole remained the same. During an interview with the family at this time it was stated that housekeeping had already cleaned the room.</p> <p>During an observation on 1/6/15 at 8:50AM the resident was in her geri chair with the tube feeding formula running. The pole was seen with multiple, dried light brown spots covering the base of the pole. There was three dime sized</p>	F 253	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 253</p> <p>Corrective Action for Resident Affected For resident # 112 and # 8 the tube feeding poles and floor beneath were cleaned and sanitized by the Housekeeping Department Supervisor on 1/8/15.</p> <p>Corrective Action for Resident Potentially Affected All current residents that utilize a feeding pole were audited on 1/8/15 for cleanliness of their feeding pole and floor beneath. This was completed by</p>	1/23/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>01/23/2015</b>
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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 253	<p>Continued From page 1 and dried light brown matter on the floor under the pole.</p> <p>Observations on 1/6/15 at 3:18PM showed the tube feeding pole in the same condition and only two dime sized, dried light brown matter was seen on the floor under the pole.</p> <p>Observations on 1/7/15 at 10:15AM showed the pole in the same condition and the floor was cleaned.</p> <p>During an interview with the Housekeeping Assistant on hall 200 on 1/7/15 at 10:16AM she stated the housekeeping was responsible for the floor, but nursing was responsible for the tube feeding poles.</p> <p>During an interview with the Housekeeping Supervisor on 01/07/2015 at 10:59AM he stated that nurses are supposed to clean the tube feeding poles and pumps. He further stated that the nurses are the ones that change the bags and it is easy to clean up when wet because if the formula dried it is harder to wipe off.</p> <p>During an interview with the Director of Nursing on 1/7/15 at 11:00AM she stated that cleaning the poles is not directly assigned to anyone and that who ever sees formula on the pole should be cleaning it.</p> <p>During a follow up interview with the Director of Nursing on 1/7/15 at 1:30PM she stated it was expected that formula would not be on the floor on dried on the poles.</p> <p>During an interview with the Administrator on 1/7/15 at 1:35PM he stated it was his expectation</p>	F 253	<p>Housekeeping Department Supervisor. No concerns were identified with this audit.</p> <p><b>Systemic Changes</b> Effective 1/15/15 the daily cleaning of the tube feeding poles was assigned to the housekeeping department. On 1/15/15 the Housekeeping Department employees FT, PT and PRN were in-serviced on policy number HSK-110 by the Housekeeping Department Supervisor. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all Housekeeping employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p><b>Quality Assurance</b> The Staff Development Coordinator will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Tube Feeding Poles. The monitoring will include assessing tube feeding poles and the floors beneath for cleanliness. This will be completed on a sample of 5 residents <input type="checkbox"/> a week x 2 weeks then monthly for 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing,</p>		

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F 253	Continued From page 2 for the floors and tube feeding poles to be clean at all times.  2. Resident # 8 was admitted to the facility on 5/19/2009 with diagnosis including Dysphagia and was receiving Glucerna 1.2 cal continuously via a gastrostomy tube.  On 1/5/14 at 11:00 AM the feeding tube pump was observed with 3 to 5 dime and nickel sized light tan drops.  On 1/6/14 at 9:17 AM the feeding tube pump was observed with 3 to 5 dime and nickel sized light tan drops.  On 1/6/14 at 3:23 PM the feeding tube pump was observed with 3 to 5 dime and nickel sized light tan drops.  On 1/7/14 at 10:20 AM the feeding tube pump was observed with 3 to 5 dime and nickel sized light tan drops.  During an interview on 1/7/14 at 10:57 AM the housekeeping manager stated that the nurses are suppose to clean the tube feeding poles and pumps. He stated that nurses are the ones that change the bags and it is easier to clean when wet and if left to dry it is harder to wipe up.	F 253	Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or	F 371		1/23/15	

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F 371	<p>Continued From page 3 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to prevent water from seeping up into 1 of 1 walk in coolers. The facility also failed to effectively clean and degrease the range hood walls and filters and failed to clean a sticky residue from 2 of 2 drink nozzles.</p> <p>The findings included:</p> <p>1. During the initial kitchen tour on 1/5/14 at 10:40 AM the walk in cooler was observed. The cooler floor was observed with dark colored water that puddled below the shelving unit to the right of the door. Stepping into the cooler towards the freezer door dark colored water was observed on the floor between the seams.</p> <p>On 1/6/14 at 3:05 PM the cooler floor was observed with dark colored water that puddled below the shelving unit to the right of the door. Stepping into the cooler towards the freezer door dark colored water was observed on the floor between the seams.</p> <p>On 1/7/14 at 10:33 AM the cooler floor was observed with dark colored water that puddled below the shelving unit to the right of the door.</p>	F 371	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 371</p> <p>Corrective Action for Resident Affected</p> <p>Juice nozzles were cleaned by dietary manager on 1/7/14 and continue to be cleaned and monitored daily.</p> <p>Cleaning schedule posted by dietary manger on 1/7/14 and continues to be monitored daily/weekly for completion.</p> <p>Hood range walls and side cleaned by dietary staff on 1/7/14 and continue to be cleaned and monitored daily.</p>		

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F 371	<p>Continued From page 4</p> <p>Stepping into the cooler towards the freezer door dark colored water was observed on the floor between the seams.</p> <p>During an interview on 1/7/14 at 10:34 AM the Administrator stated that when the facility was built the cement foundation was not built to the correct depth for the freezer. He indicated the facility had put in a new stainless steel floor and dug a new drain system to move the water away from the building which had not solved the problem. He stated that after any huge rain they get water in the cooler.</p> <p>Review of the work order invoice dated 11/19/14 documented work had been done on the cooler floor and drainage for the cooler.</p> <p>2. Review of the undated monthly cleaning schedule documented that on each Saturday to "clean vents" There were no signatures to indicate the cleaning schedule had been followed.</p> <p>During the initial kitchen tour on 1/5/14 at 10:45 AM the range hood and filters were observed. The filters were observed with a light film of golden grease on the 7 filters. The side and back walls of the hood were observed had a light film of grease and dust particles.</p> <p>On 1/6/14 at 10:12 AM the filters were observed with a light film of golden grease on the 7 filters. The side and back walls of the hood were observed had a light film of grease and dust particles.</p> <p>On 1/6/14 at 3:11 PM the filters were observed with a light film of golden grease on the 7 filters. The side and back walls of the hood were</p>	F 371	<p>Hood range filter professional cleaned on 1/20/15. Professional cleaning of hood range filters to be completed every 4 months; dietary staff to clean filters weekly.</p> <p>Walk-in cooler evaluated by contractor on 1/8/15. Repairs made by contractor on 1/20/15 to prevent puddled water on floor. Walk-in cooler floor cleaned and monitored daily by dietary staff.</p> <p>Corrective Action for Resident Potentially Affected</p> <p>Juice nozzles were cleaned by dietary manager on 1/7/14 and continue to be cleaned and monitored daily.</p> <p>Cleaning schedule posted by dietary manger on 1/7/14 and continues to be monitored daily/weekly for completion.</p> <p>Hood range walls and side cleaned by dietary staff on 1/7/14 and continue to be cleaned and monitored daily.</p> <p>Hood range filter professional cleaned on 1/20/15. Professional cleaning of hood range filters to be completed every 4 months; dietary staff to clean filters weekly.</p> <p>Walk-in cooler evaluated by contractor on 1/8/15. Repairs made by contractor on 1/20/15 to prevent puddled water on floor. Walk-in cooler floor cleaned and monitored daily by dietary staff.</p>		

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F 371	<p>Continued From page 5</p> <p>observed had a light film of grease and dust particles.</p> <p>On 1/7/14 at 10:24 AM the filters were observed with a light film of golden grease on the 7 filters. The side and back walls of the hood were observed had a light film of grease and dust particles.</p> <p>During an interview on 1/7/14 at 10:26 AM the Certified Dietary Manager (CDM) stated that the hood and filters used to be cleaned every week, but now was cleaned every 2 weeks.</p> <p>During an interview on 1/7/14 at 10: 27 AM the cook stated that they usually took the filters down every Saturday and cleaned them. She could not remember the last time the filters had been cleaned.</p> <p>Review of the undated monthly cleaning schedule documented on each Saturday to " clean vents " and on 2 Saturdays to "clean the juice machine." There were no signatures to indicate the cleaning schedule had been followed.</p> <p>3. Review of the undated monthly cleaning schedule documented on 2 Saturdays of each month to "clean the juice machine." There were no signatures to indicate the cleaning schedule had been followed.</p> <p>During the initial kitchen tour on 1/5/14 the drink nozzles were observed. The thickened liquid nozzle handle was sticky and the outside nozzle had a coating of sticky residue. The second nozzle handle had a coating of sticky residue.</p> <p>On 1/6/14 at 3:09 PM the thickened liquid nozzle</p>	F 371	<p><b>Systemic Changes</b> An in-service will be completed on 1/22/2015 by the clinical nutrition specialist (registered dietitian). Those who attended were dietary staff employees -FT and PT. Any in-house dietary staff member who did not receive in-service training will not be allowed to work until training has been completed. Staff was in-serviced on the following topics: Food Service Sanitation: Cleaning &amp; Sanitizing. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.</p> <p><b>Quality Assurance</b> The dietary manager will monitor the issue using the Quality Assurance Dietary Monitor Tool for monitoring Cleaning and Sanitation. This will be completed 5 times a week for 2 weeks and then monthly x 3 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life/Quality Assurance Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Support Nurses, Social Workers, Dietary Manager and Business Office Manager.</p>		

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F 371	Continued From page 6 handle was sticky and the outside nozzle had a coating of sticky residue. The second nozzle handle had a coating of sticky residue.  On 1/7/14 at 10:28 AM the thickened liquid nozzle handle was sticky and the outside nozzle had a coating of sticky residue. The second nozzle handle had a coating of sticky residue.  During an interview with the CDM on 1/7/14 at 10:28 AM she stated that she had a cleaning schedule posted but did not know where it was. She stated she would put the nozzles in hot water to clean immediately.	F 371			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to act upon a pharmacy recommendation for 2 of 5 residents reviewed for unnecessary medications by failing to respond to a gradual dose reduction request, a dosing time change request and a risk versus benefit request. (Resident #23, Resident #54)	F 428	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of	1/23/15	

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F 428	<p>Continued From page 7</p> <p>The findings included:</p> <p>Ex. 1:</p> <p>Resident #23 was admitted on 4/6/13 with diagnoses including Dementia, Anxiety and Depressive disorder.</p> <p>Resident #23 had a physician's order written on 7/2/13 for Ativan 1 milligrams (mg) every 8 hours, every day for Anxiety and on 12/18/13 an order was written for Celexa 30 milligrams every morning for Depression (an increase from the 20 milligrams Resident #23 was receiving).</p> <p>Review of the Pharmacy Consultant recommendation dated 3/31/14 showed a request for a gradual dose reduction (GDR) to Ativan 1 milligrams at 6AM and 10PM and a 2PM dose of 0.5milligrams. There was no response from the physician.</p> <p>Review of the Pharmacy Consultant notes dated 4/30/14, 6/30/14 and 8/28/14 documented there had been no response from the physician regarding the GDR.</p> <p>Review of the Pharmacy Consultant recommendation on 8/28/14 again requested a GDR for the Ativan to 1 milligrams at 6AM and 10PM and a 2PM dose of 0.5milligrams. The request was agreed to by the primary care physician the same day.</p> <p>Further review of the Pharmacy Consultant recommendations dated 12/31/13, 3/31/14 and 6/30/14 showed requests informing the primary care physician the maximum recommended daily</p>	F 428	<p>correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 428</p> <p>Corrective Action for Resident Affected For resident # 23, Dr. Farias was contacted for a gradual dose reduction of the following medication Celexa on 01/07/15 by the Director of Nursing and stated for the facility to contact Lifesource for the Gradual Dose Reduction (GDR). The Pharmacy Request for GDR was addressed by Linda Capiello NP on 01/20/15.</p> <p>For resident # 54, Dr. Fleming was contacted for a gradual dose reduction of the following medication Haldol on 01/07/15 by the Director of Nursing. The physician responded by providing a risk /benefits statement and declined a GDR for this resident.</p> <p>Corrective Action for Resident Potentially Affected All current residents have the potential to be affected by the alleged deficient practice. On 01/19/15 a chart audit was completed for all current residents for pharmacy recommendations that have not been carried out. This was completed by the consultant pharmacist by reviewing each residents chart pharmacy notes and recommendations and comparing them to</p>		



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F 428	<p>Continued From page 8</p> <p>dose of Celexa was 20 milligrams every day in the elderly due to increased risk of QT prolongation and to evaluate reducing Resident #23's Celexa back to 20 mg every morning to be within the dosing guidelines. The recommendation of 6/30/14 showed the Celexa had now been increased to 40mg every day and recommended reducing the Celexa or providing documentation of risks versus benefits of continued use of Celexa at the current dose. There was no response to the Pharmacy Consultant's 3 recommendations from the physician.</p> <p>During an interview with the Pharmacy consultant on 1/7/15 at 11:30AM she stated that oftentimes it is months before she hears back regarding a GDR. She stated the facility is responsible for faxing her requests to the physician and then placing the response in the medical chart. She stated that she never had any replies from the three request for GDR and risks versus benefits from the physician regarding the Celexa and in 12/2014 basically stopped asking since the resident had no observed negative outcome. She further stated the resident most likely had justification for the increase in dosage but she did not hear from the physician. She stated she had addressed her concerns with the Medical Director but there had not been a change.</p> <p>During an interview with the Director of Nursing on 1/7/15 at 12:45PM she stated that she had spoken with the primary care physician and the physician did not respond to the GDR request because the resident is seen by psychiatric services.</p> <p>During an interview with the primary care</p>	F 428	<p>the most recent physician's orders for any outstanding request. On 01/20/15 16 Pharmacy MD Recommendations were given to the Director of Nursing for follow-up with the attending physicians. As of 01/23/15, 14 out of 16 recommendations have been addressed by the attending physicians. The remaining 2 recommendations will be addressed by the attending physician or Lifesource by 02/04/15.</p> <p>Systemic Changes Effective 01/15/15 the following procedure was incorporated for following up monthly pharmacy recommendations for staff and monthly pharmacy recommendations for MD. When the Monthly Pharmacy Report is delivered to the Director of Nursing (DON), the DON will assign a copy of the Monthly Pharmacy Physician Recommendations to the Unit Manager. The Recommendation will be faxed to the MD by the Unit Manager with a cover sheet explaining that a response is needed from the MD within five business days of receiving the fax. If the fax has not been received by the sixth business day, the Unit Manager will re fax the recommendation to the MD, call the MD's office and make them aware a response is needed and will also notify the DON. If the second fax has not been received within an additional five business days the Unit Manager will notify the Administrator and DON and contact will be made to the MD by the DON. All efforts to obtain a response from the MD will be documented on the recommendation form</p>		

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F 428	<p>Continued From page 9</p> <p>physician on 1/7/15 at 1:00PM she stated that the resident is seen by psychiatric services and they address the resident's psych medication needs and these request should be addressed by psych services.</p> <p>During a follow up interview with the Director of Nursing on 1/7/15 at 1:20PM she stated that she would expect pharmacy recommendations to be answered timely.</p> <p>During an interview with the Administrator on 1/7/15 at 1:35PM he stated that he would expect pharmacy recommendations to be answered timely by the physician.</p> <p>Ex. 2:</p> <p>Resident #23 was admitted on 4/6/13 with diagnoses including Dementia, Anxiety and Depressive disorder.</p> <p>Resident #23 had a physician ' s order written on 7/2/13 for Ativan 1 milligrams (mg) every 8 hours, every day for Anxiety.</p> <p>Review of the Medication Administration Records documented hand-written entries changing the dosing time from midnight, 8AM and 4PM to 6AM, 12PM and 6PM.</p> <p>Review of the Pharmacy Consultant notes dated 3/31/14, 4/30/14, 5/30/14, 6/30/14, 7/29/14 and 8/28/14 documented multiple memos sent to the Director of Nursing regarding the dosing time being changed in the Medication Administration Record to every 6 hours and given three time a</p>	F 428	<p>and filed in the resident's chart. If a response has not been received within ten business days, the DON and Administrator will notify the facility Medical Director for further guidance. The procedure for responding to the monthly pharmacy staff recommendations will be as follows: When the DON receives staff recommendations the report will be addressed as indicated and a response written in the column titled Staff Response. The report will be addressed by the DON within twenty one days of receipt or sooner if indicated and filed in the Monthly Pharmacy Recommendations Notebook. The Nurse Management Team (DON, Staff Development Coordinator and Unit Manager) received education on this new procedure by the Administrator on 01/15/15.</p> <p>Quality Assurance The QA Nurse Consultant will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Pharmacy Consults. The monitoring will include verifying that the monthly pharmacy review report recommendations were carried out as outlined above. This will be completed on a sample of 10 resident's a month for 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS</p>		

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F 428	<p>Continued From page 10 day at 6AM, 12P and 6PM when the order read every 8 hours.</p> <p>Review of the Physician ' s orders dated 8/28/14 showed the Ativan had been changed to reflect a gradual dose reduction and to be given at 6A, 2PM and 10PM.</p> <p>During an interview with the Director of Nursing on 1/7/15 at 10:20AM she stated the pharmacist gives the facility recommendations for the Physician and recommendations for areas nursing needs to address. I thought the issue with the times being changed by the nurses was resolved. I believe the nurses were so accustomed to giving the Ativan at 6A, 12P, 6P and 12A that when they saw it written differently in the Medication Administration Record they changed it back to the hours they were familiar with. She stated she had no other explanation for why this happened and the medication should have been given every eight hours.</p> <p>During an interview with the Pharmacy Consultant on 1/7/14 at 11:30AM she stated that she gives memos to the facility each month with recommendations for changes nursing needs to correct. The Ativan being given every six hours was addressed and each month she would address it again. It was finally corrected in August 2014 when the physician did a gradual dose reduction on the Ativan.</p> <p>During an interview with the Administrator on 1/7/15 at 1:35PM he stated he would expect medications to be given as ordered.</p>	F 428	Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.		

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F 428	<p>Continued From page 11</p> <p>2. Resident #54 was originally admitted to the facility on 12/13/07 with diagnoses including, Anxiety, Depressive Disorder, Dementia with unspecified behavioral disturbance and Unspecified Psychosis.</p> <p>A physician's order was written on 3/3/14 for Resident #54 for Haloperidol (Haldol)1mg twice daily for Unspecified Psychosis.</p> <p>Review of the Consultant Pharmacist's note dated 8/28/14, read in part, "Haldol 1mg. bid (twice daily) since decreased 11/10/13. Will ask MD (medical doctor) to evaluate gradual dose reduction or provide risk versus benefit documentation."</p> <p>Review of the Consultant Pharmacist Recommendations dated 8/28/14, read, "Haldol 1mg BID since 11/10/13 dose reduction. He still has some hollering out documented per chart records. Per CMS guidelines for antipsychotic use, please evaluate for dose reduction of his Haldol or provide benefits vs. risk documentation for the chart to support continued use without dose reduction."</p> <p>Review of the Consultant Pharmacist's note on 9/29/14, read in part, "No response noted to Haldol memo. Follow-up Haldol memo. Patient with some documented yelling out and shaking bed rails so dose reduction probably not appropriate in the patient. Last gradual dose reduction 11/13."</p> <p>Review of the Consultant Pharmacist's note on 10/31/14, read in part, "9/14, MD (Medical Doctor) agreed to pharmacy consult, but there was no change made to Haldol and no benefits</p>	F 428			

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F 428	<p>Continued From page 12 versus risks documented in his chart."</p> <p>Review of the Consultant Pharmacist note dated 11/25/14, read in part, "No change made to Haldol order yet. Will not resend now because pt. (patient) continues to have yelling out doc. (documented) behaviors not completely controlled with current dose. Will continue to monitor."</p> <p>During an interview on 1/7/15 at 11:34 AM, the facility Consultant Pharmacist revealed that Resident #54's behavior was not controlled by the medication he was receiving. She revealed that physicians usually responded to the recommendations in a good period of time, but there had been an issue with some of the physicians getting back with her. The Consultant Pharmacist revealed that the pharmacy recommendations were given to the Director of Nursing and the information was forwarded to the physician. She stated that she had not gotten a response from the physician regarding the benefits versus risk documentation for Resident #54's Haldol.</p> <p>During an interview on 1/7/15 at 1:29 PM, the Director of Nursing stated that she was sending a letter to all the physicians informing them that they had to put a reason in response to the pharmacist's recommendation instead of agreeing and signing the recommendation. She revealed that the unit manager usually received the pharmacist's recommendations and forwarded the recommendations to the physicians. She stated that usually the physicians were good at returning the information. She revealed that some of the physicians responded to the information the same day and they had to</p>	F 428			

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F 428	Continued From page 13 continue faxing the pharmacist recommendations to some of them. The DON stated that she would be responsible for doing the whole pharmacy process.  During an interview on 1/7/15 at 1:39 PM the Administrator revealed that his expectation was that most of the time the physician would have taken the pharmacist's opinion that nothing needed to be done at that time. He further acknowledged that the physician should have gotten back with the pharmacist.  On 1/7/15 at 2:06 PM an attempt was made to contact Resident #54's physician regarding the failure to respond to the pharmacist's recommendations. The physician was not available for interview.  During another interview on 1/7/15 at 2:32 PM the Director of Nursing stated that she did not know why the physician did not respond to the pharmacist's recommendations. She revealed the physician signed the pharmacist's recommendation but the physician did not note the reason/risk/benefits for the prescribed medication.	F 428			
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.	F 431		1/23/15	

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F 431	<p>Continued From page 14</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and pharmacist interview the facility failed to store refrigerated medications between 36 to 46 degrees Fahrenheit for 1 of 1 medication refrigerator.</p> <p>The findings included:</p> <p>The facility policy titled " Medication Storage in the Facility " undated read in part: " Medications requiring "refrigeration" or "temperatures between</p>	F 431	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be</p>		

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F 431	<p>Continued From page 15 36 degrees F (Fahrenheit) and 46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring."</p> <p>Observation on 1/7/15 at 10:43 AM of the sign on the medication refrigerator door titled "Refrigerator Temp Monitor " dated January 2015 revealed on January 5, 2015 and January 6, 2015 the refrigerator temperature was documented at 34 degrees.</p> <p>During an observation on 1/7/15 at 10:43 AM the medication refrigerator for the facility revealed the temperature was 28 degrees F confirmed by Nurse #1. There were 5 unopened vials of Humulin R insulin, 4 boxes, each containing one vial of Flu Vaccine, 2 bottles of Tubersol and 3 boxes of Calcitonin Salmon nasal solution observed in the medication refrigerator. The package insert for Humulin R Insulin under storage read: " Unopened Humulin R should be stored in a refrigerator 36-46 degrees F. " The Flu Vaccine label on the box read: " Do not freeze. The Tubersol label on the box read, " Do no freeze. Store at 35 to 46 degrees F. " Also the Calcitonin Salmon Nasal solution on the box read, " Freezing is to be avoided. "</p> <p>During an interview on 1/7/15 at 10:43 AM Nurse #1 stated she did not know what the temperature should be in the medication refrigerator.</p> <p>01/07/2015 10:42 AM Nurse #2 during an interview stated she did not know what the temperature in the medication refrigerator should be.</p> <p>01/07/2015 11:03 AM Nurse #3 stated she was not sure what the medication refrigerator</p>	F 431	<p>corrected by the date or dates indicated.</p> <p>F 431</p> <p>Corrective Action for Resident Affected On 1__/_7_/15_ the Maintenance Director assessed the Medication Room refrigerator and calibrated it to be within the range of 36-46 degrees Fahrenheit.</p> <p>Corrective Action for Resident Potentially Affected On 1__/_7_/15_ the Staff Development Coordinator revised the refrigerator temperature log to reflect the acceptable temperature range of 36-46 degrees Fahrenheit and instructions on what to do if the temperatures are above or below the desired range.</p> <p>Systemic Changes On 1__/_15_/15_ all RN□s, LPN□s FT, PT and PRN were in-serviced on the new refrigerator temperature log and what to do when temperatures were outside the desired range. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all Nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>Quality Assurance The Staff Development Coordinator will monitor this issue using the "Survey</p>		



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F 431	<p>Continued From page 16 temperature should be.</p> <p>On 01/07/2015 11:08 AM the Director of Nursing (DON) stated temperatures are checked by the 3rd shift Nurse and when the temperature went below 35 degrees F she should have notified maintenance.</p> <p>During an interview on 01/07/2015 11:36 AM the Consulting Pharmacist stated the medication refrigerator temperature should be between 36-46 degrees F. The Pharmacist stated that when she came to the facility she did not check the refrigerator temperatures.</p>	F 431	<p>Quality Assurance Tool for Monitoring Refrigerator Temps. The monitoring will include reviewing the refrigerator temp log for acceptable temperature ranges and the actual refrigerator temp at the time of the audit. This will be completed weekly x 2 weeks then monthly times 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.</p>		