

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/01/2015
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		
(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 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations, manufacturer ' s specifications, staff and resident interviews, the facility failed to maintain a medication error rate of 5% or less as evidenced by 2 (two) errors out of 27 (twenty seven) opportunities resulting in a medication error rate of 7.4%. The findings included:</p> <p>a. Review of the medical record revealed Resident #52 was admitted to the facility on 10/31/13 and had diagnoses that included Gastro-esophageal Reflux Disease (GERD). GERD is when acid from the stomach escapes into the tube which connects the throat to the stomach (esophagus) causing pain, inflammation and heartburn. The Quarterly Minimum Data Set Assessment dated 1/17/15 revealed the resident was cognitively intact with no short or long term memory problems.</p> <p>Review of the physician ' s order summary report for active orders as of 3/26/15 for Resident #52 revealed an order that read: " Omeprazole Capsule Delayed Release 20 MG (milligrams). Give 20mg by mouth in the morning for GERD. Take one capsule 30-60 minutes before eating. " Omeprazole is a medication used to treat GERD and works by reducing the amount of acid the stomach produces.</p>	F 332	<p>This plan of correction is prepared and submitted as required by law. By submitting this plan of correction Genesis Healthcare Alleghany Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F332:</p> <p>1) Resident #52 was assessed by the Assistant Director of Nursing on 4/1/15 with no adverse outcomes for not receiving his Omeprazole DR and Multivitamins w/ Minerals as ordered.</p> <p>2) All other residents receiving Omeprazole DR or Multivitamin w/ Minerals were assessed and no residents were found to have any negative outcomes.</p> <p>3)An Omnicare Pharmacy Registered</p>	4/20/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/17/2015

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 332	<p>Continued From page 1</p> <p>Review of the manufacturer ' s package insert for Omeprazole DR (Delayed Released) capsules under dosage and administration read: " Should be taken before eating. " Omeprazole is a proton pump inhibitor. The pump is stimulated in the presence of food to aid in digestion. For this reason, omeprazole should be taken on an empty stomach 30-60 minutes before a meal to allow the drug to reach peak levels.</p> <p>The Medication Administration Record (MAR) for April 2015 for Resident #52 revealed an entry that read: " Omeprazole Capsule Delayed Release 20mg. Give 20mg by mouth in the morning for GERD. Take one capsule 30-60 minutes before eating. " The medication entry revealed the medication was scheduled to be given at 7:00AM.</p> <p>On 4/1/15 at 8:26AM, Nurse #1 was observed to prepare and administer medications to Resident #52. The Nurse administered a 20mg capsule of Omeprazole DR to the resident. The Nurse stated in an interview after giving the resident his medications that the resident had already eaten breakfast. The Nurse stated the medication should have been prior to eating but it was difficult to get residents their medications at 7:00AM during shift change.</p> <p>The RN (Registered Nurse) Supervisor stated in an interview on 4/1/15 at 8:58AM that the time Omeprazole was given depended on the physician ' s order and when the resident preferred to take the medications.</p> <p>On 4/1/15 at 9:19AM, Resident #52 stated in an interview that he usually got up around 6:45AM and that breakfast was usually served around 7:30AM. The Resident stated that he did not</p>	F 332	<p>Nurse provided 1:1 education to the nurse making the medication errors. The Nurse Practice Educator re-educated licensed nursing staff from 4/15/15 through 4/20/15 on the administration of medication as ordered. The Nurse Practice Educator will do random medication pass observations with the licensed nurses 1 x weekly x 4 weeks then 2 x monthly x 1 month then 1 x monthly x 1 month.</p> <p>4)The Nurse Practice Educator will take the results of the random medication pass observations to the Quality Assurance Committee monthly. Any issues identified will be addressed by the Quality Assurance Committee.</p>		

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F 332	<p>Continued From page 2</p> <p>receive medications prior to breakfast but was given his morning medications after breakfast.</p> <p>The Director of Nursing (DON) stated in an interview on 4/1/15 at 10:26AM that she would talk with the resident to see what his choice was regarding the time he would like to take his morning medications.</p> <p>b. Review of the physician ' s order summary report for active orders as of 3/26/15 for Resident #52 revealed an order that read: Daily Multiple Vitamins/Min Tablet (Multiple Vitamins-Minerals). Give 1 unit by mouth in the morning. "</p> <p>The Medication Administration Record (MAR) for April 2015 for Resident #52 revealed an entry that read: " Daily Multiple Vitamins/Min Tablet (Multiple Vitamins-Minerals). Give 1 unit by mouth in the morning. "</p> <p>On 4/1/15 at 8:26AM, Nurse #1 was observed to prepare and administer medications to Resident #52. The Nurse removed a bottle from the medication cart that read Multiple Vitamin. There was no information on the bottle that the vitamin contained minerals. The Nurse dispensed one tablet into a medication cup with other medications and administered the vitamin tablet to the resident.</p> <p>Nurse #1 stated in an interview on 4/1/15 at 9:08AM that the multiple vitamin was a stock medicine and the residents all got the same thing. The Nurse was observed to remove the bottle from the medication cart and stated the vitamin did not contain minerals. The Nurse was observed to look through a drawer of the medication cart and stated she thought there was</p>	F 332			

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F 332	Continued From page 3 a bottle of multiple vitamins with minerals on the cart but she could not find it. The Nurse stated she did not read the entire order and did not realize that a multiple vitamin with minerals was to be given to the resident.	F 332			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		4/20/15	

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F 356	<p>Continued From page 4</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to post current nurse staffing information from 3/27/15 till 3/31/15. Findings included:</p> <p>On 3/30/15 at 9:00 AM, an initial facility tour was conducted the nurse staffing information sheet was observed at the first nursing station. It was dated 3/26/15 and did not include a how many residents were present in the facility (resident census).</p> <p>Another observation on 3/30/15 at 10:20 AM the nurse staffing information sheet was updated to reflect the accurate date with staffing hours but the resident census was blank.</p> <p>On an observation 3/31/15 at 8:15 AM, the nurse staffing information sheet was posted with the correct date and staffing hours but the resident census was still blank.</p> <p>Another observation on 3/31/15 at 2:30 PM, the nurse staffing information sheet was posted with the correct date and staffing hours but the resident census was blank.</p> <p>In an interview on 3/31/15 at 3:50 PM, the director of nursing (DON) stated it was her responsibility to post the nurse staffing information daily. She confirmed posting the information last on 3/25/15</p>	F 356	<p>F356:</p> <p>1) Required information was added to the posted nurse staffing sheet on 3/31/2015.</p> <p>2) Director of Nursing assured correct information posted on nurse staffing sheet on 4/1/2015.</p> <p>3) On 4/1/15, Administrator provided re-education to Director of Nursing and RN Supervisor on assuring correct information posted for the nurse staffing sheet. The Administrator will monitor nurse staff posting 3 x weekly x 4 weeks then 2 x weekly x 4 weeks then 1 x weekly x 4 weeks.</p> <p>4) The Administrator will report results of monitoring nurse staffing sheet to the Quality Assurance Committee Monthly. Any issues identified will be addressed by the Quality Assurance Committee.</p>		

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F 356	<p>Continued From page 5</p> <p>for 3/26/15 because she was off on 3/26/15 and 3/27/15. The DON stated the RN supervisor was directed to post the nurse staffing information in her absence. She stated she was not aware that the information had to include the resident census.</p> <p>In an interview on 3/31/15 at 4:00 PM, the administrator confirmed the DON was responsible for posting the nurse staffing information daily. The administrator verified that she was aware that the resident census was a requirement for the nurse staffing information to be displayed daily. She also stated it was the RN supervisor's responsibility to sheet last week when the DON was absent.</p> <p>On 3/31/15 at 4:10 PM, the DON corrected nurse staffing information to reflect the resident census of 81.</p> <p>In an interview on 3/31/15 at 5:05 PM, the RN supervisor confirmed he was responsible for posting the nurse staffing information on 3/27/15-3/29/15. He stated it was an oversight on his part.</p> <p>In another interview on 4/1/15 at 12:10 PM, the administrator verified the manager on duty updated the nurse staffing information on the weekends but this past weekend, it was documented on the actual working schedule at the first nursing station on a clip board and not visible to the public.</p>	F 356			