

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2015
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS N&R CTR OF COLUMBUS CTY			STREET ADDRESS, CITY, STATE, ZIP CODE 1402 PINCKNEY STREET WHITEVILLE, NC 28472		
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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to obtain weekly weights for a resident (Resident #128) identified with weight loss as ordered by the physician for 1 of 2 resident reviewed for nutrition.</p> <p>Findings included:</p> <p>Resident #128 was admitted on 7/2/14 with a diagnosis of dysphagia. A significant change Minimum Data Set (MDS) dated 5/11/15 was completed removing Resident #128 from hospice. The MDS indicated Resident #128 did not having a terminal illness, had severe cognitive impairment and was not receiving anything by mouth (NPO). The Care Area Assessment stated Resident #128 had no weight loss and his current weight was 139 pounds. The staff was directed to continue his tube feedings as ordered, monitor his tolerance and monitor his weights.</p> <p>A review of Resident #128 August physician orders indicated he was to receive 1 can of Glucerna 1.5 bolus (all at once) feeding every six hours along with 200 milliliter of water with each feeding. A review of Resident #128 's Medical Administration Record (MAR) from 6/1/15 to present indicated he was receiving his bolus tube feedings at 12:00 PM, 6:00 PM, 12:00 AM and 6:00 AM as ordered.</p>	F 281	<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>Corrective Action for Resident Affected For resident # 128, on 8/17/15 the DON entered the weekly weight monitoring order into Point Click Care and on 8/19/15 a CNA obtained a weight and entered in Point Click Care. See exhibit #3.</p> <p>Corrective Action for Resident Potentially Affected On 9/10/15 the Quality of Life team (Administrator, DON, ADON, MDS Coordinator and Dietary Manager) reviewed all current residents with a significant weight loss or weight gain in the last three months. This was completed by running the weights exception report from PCC. Any residents noted with a significant weight loss or</p>	9/10/15	

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

TITLE

(X6) DATE

Electronically Signed

09/10/2015

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 281	<p>Continued From page 1</p> <p>A review of Resident #128's monthly weights revealed the following: June 17, 2015 weight of 134 pounds, July 13, 2015 weight of 133 pounds and August 11, 2015 weight of 128 pounds (3% weight loss in the last 30 days and 4.5 % weight loss in last 60 days).</p> <p>A review of the Registered Dietitian (RD) Nutritional Recommendation dated 7/7/15 noted weight loss and recommended weekly weights to determine if the tube feeding needed to be increased. The Director of Nursing (DON) and the Nurse Practitioner (NP) reviewed the recommendation on 7/8/15 and the NP indicated she agreed with the weekly weights. Review of Resident #128's July 2015 physician's orders revealed an order for weekly weights was initiated on 7/13/15 but the medical record did not have any evidence that weekly weights were obtained.</p> <p>Another RD Nutritional Recommendation dated 8/11/15 again recommended weekly weights as previously stated in July 2015. This recommendation was reviewed by the DON and NP on 8/13/15 and again the NP agreed with the recommendation. Review of Resident #128's August 2015 physician's orders revealed an order for weekly weights was initiated on 8/17/15 but the medical record did not have any evidence that weekly weights were obtained.</p> <p>During an interview on 8/18/15 at 2:40 PM, Nurse #1 stated Resident #128 was cooperative with his feedings and his condition was stable.</p> <p>During an interview on 8/18/15 at 3:50 PM, the dietary manager (DM) stated she was not aware Resident #128 was losing weight. She stated she</p>	F 281	<p>weight gain were reviewed to ensure they were having weekly weights obtained until their weight stabilized. See exhibit #2.</p> <p>Systemic Changes Weekly, in the Quality of Life meeting, significant weight losses and weight gains will be reviewed through the Weight and Vital dashboard. Any resident noted with a significant weight loss or weight gain will be initiated on weekly weights times four weeks or until stable. When the significant loss or gain is noted, during the meeting the ADON will initiate weekly weight monitoring in Point Click Care and will notify the restorative aides of the weekly weight requirement. The QA team will review dietary recommendations weekly to ensure weekly weight recommendations are in Point Click Care and initiated on weekly weights. Any in-house Nurse Manager or Dietary Manager 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 Nurse Managers and Dietary Managers and will be reviewed through the Quality Assurance Process to verify that the change has been sustained. See exhibit #3.</p> <p>Quality Assurance The ADON will monitor this issue using the "Survey Quality Assurance Tool #1" for weekly weights. The monitoring will include reviewing all residents on weekly</p>		

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F 281	<p>Continued From page 2</p> <p>ran a weight report each week but did not notice the 3% weight loss dated 8/11/15 on Resident #128 and she only got the RD Nutritional Recommendations after the DON reviewed them. The DM verified Resident #128 was not of the list for weekly weights for July 2015 or August 2015 until yesterday when she was directed by the DON to add him to the list.</p> <p>During a telephone interview on 8/18/15 at 4:20 PM, the RD stated she gave the DM and DON copies of all Nutritional Recommendations and she was trying to determine if Resident #128's tube feeding needed adjustment. She stated she repeated the recommendation she made in July 2015 for weekly weights when she saw Resident #128 again on 8/11/15 and there were no weekly weights available for her to determine if nutritional adjustment was indicated.</p> <p>During an interview on 8/19/15 at 10:25 AM the NP stated the DON or the Assistant Director of Nursing (ADON) monitored the residents identified with weight loss and she expected the nursing staff to act on the RD recommendation for weekly weights immediately, especially when the resident was fed solely by a tube feeding.</p> <p>During an interview on 8/19/15 at 11:20 AM the DON stated a weekly meeting was held every Thursday to review any resident identified either by the computer or by the RD with weight loss. The DON stated it was at this time the weekly weight list was updated and given to the ADON to give to the restorative aides to weigh each identified resident. The DON was unable to offer an explanation why Resident #128 was not on the July 2015 or August 2015 weekly weight list for the restorative aides to weigh.</p>	F 281	weights to ensure this requirement is being met. 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, MDS Coordinator, Health Information Manager, Dietary Manager and Social Worker. See exhibit #4.		

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F 281	Continued From page 3 During an interview on 8/19/15 at 11:30 AM, the restorative aide (RA) stated the ADON gave her a list every week of the residents who needed weekly weights and that Resident #128 was not on the list for July 2015 or August 2015. During an observation on 8/19/15 at 11:45 AM, Nurse #2 recalled working with Resident #128 for over a year and stated he was cooperative with his care and tube feedings. Nurse #2 administered the ordered tube feeding and water flushes without any identified concerns. Resident #128 also tolerated the feeding without any concerns. Nurse #2 stated she was not aware Resident #128 was on weekly weights and not aware he was having any weight loss. During an interview on 8/19/15 at 3:00 PM, the ADON stated the DM ran a report from the computer that identified residents with weight loss. The ADON stated the computer report along with the RD Nutritional Recommendations were reviewed weekly in their meeting each Thursday. It was at this time, residents who had not already been added to the weekly weight sheet were added. The ADON was unable to offer an explanation why Resident #128 was not weighed weekly as ordered by the physician since 07/13/15. During an interview on 8/19/15 at 3:20 PM the administrator stated it was her expectation that weekly weights but obtained timely for any resident identified with weight loss, but immediate attention to weight loss be addressed for any resident who was fed solely by a tube feeding.	F 281			
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		9/10/15	

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F 282 SS=G	<p>Continued From page 4 PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to follow the care plan for use of a lift to transfer a resident resulting in a left leg fracture for 1 of 1 sampled resident. (Resident #89) The findings included: Resident #89 was admitted to the facility on 5/13/2015 with diagnoses which included Anemia, Malaise and fatigue, Schizophrenia, Anxiety, Difficulty in walking, Muscle weakness and history of fall. Resident #89 ' s care plan dated 10/14/2014 and reviewed 7/9/2015 indicated " the resident has an Activities of Daily Living (ADLs) self care performance deficit. " The care plan indicated the goal as " I will maintain current level of function in ADLs through the next 90 days. " The care plan interventions included " I require lift for transfers during toileting and anticipate my needs. "</p> <p>The quarterly Minimum Data Set (MDS) dated 7/9/2015 indicated Resident #89 was severely cognitively impaired. The MDS also indicated the resident required extensive assistance of two persons for bed mobility and extensive assistance of one person for transfer. The MDS also indicated the resident was totally dependent on staff for all Activities of Daily Living (ADLs).The resident was not coded for falls and was coded for walking did not occur.</p>	F 282	<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>Corrective Action for Resident Affected For resident #89, on 7/24/15 the resident was sent to the hospital for evaluation for injury post fall. On 9/9/15, the MDS Coordinator added to the residents care plan, I sometimes refuse to be transferred with a lift and tell staff I do not need it. In the event I refuse, do not transfer me without a lift, notify my nurse and she will educate me on safety of using a lift for transfers. See exhibit #8.</p> <p>Corrective Action for Resident Potentially Affected On 9/9/15 the MDS nurse audited all current residents who use a transfer</p>		

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F 282	<p>Continued From page 5</p> <p>The resident ' s Kardex (a care guide for direct staff identifying residents ' care needs at the facility) under transfer headline indicated the resident required lift for transfers.</p> <p>Review of the facility Accident Report dated 7/24/2015 revealed the resident " was transferred using the stand pivot technique and acquired a tibia fracture on 7/24/2015. The resident ' s care plan indicated to use a sit to stand lift " Under the investigation headline the report indicated " The resident asked the Nurse Aide(NA) to be placed back in the bed. The Nurse Aide(NA) transferred her using the stand pivot technique, instead of using the a lift . Upon the resident being transferred the resident heard a pop sound and later complained of pain to the left leg. The NA # 1 reported the incident to the nurse. The leg was assessed by the primary nurse and the Medical Doctor (MD) was contacted. The MD gave orders to obtain an x-ray and call with results. The x -ray was obtained that evening and results came back as a no displaced distal tibia fracture. The resident was sent out to Emergency Room(ER) for evaluation and was sent back to the facility with follow up appointment orders to see a surgeon. The resident has an appointment to see a surgeon of her choice on 7/29/2015. " The incident report concluded that " The employee failed to use the proper transfer technique. "</p> <p>Review of the orthopedic report dated 8/6/2015 indicated the impression of the resident ' s leg injury was " Tibia shaft fracture. " The report also revealed the resident was placed in a cast and ordered to be non-weight bearing. "</p> <p>During the interview with NA #1 on 8/18/2015 at 12:30 PM, she verified she did not use the lift to transfer the resident on 7/24/2015 because the resident had stated to her " you don ' t need the</p>	F 282	<p>device to determine if anyone may refuse the device. This was completed by talking with the nurse aides and nurses over various shifts regarding any resident who is care planned to use a lift. Any resident identified for refusals is care planned for refusal and the intervention ç I sometimes refuse to be transferred with a lift and tell staff I do not need it. In the event I refuse, do not transfer me without a lift, notify my nurse and she will educate me on safety of using a lift for transfers. ç See exhibit #9.</p> <p>Systemic Changes During the annual skills fair initiated on 8/24/15 and lead by the Staff Development Coordinator; RN çs, LPN çs, Med Tech çs, and CNA çs fulltime, part time and PRN were in-serviced on the importance of following the care plan, to use the designated lift for each resident and what to do when a resident refuses to use a lift. Any in-house nursing 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, Med Tech çs and CNA çs and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. See exhibit #10.</p> <p>Quality Assurance The Nurse Managers will monitor this issue using the "Survey Quality Assurance Tool #2 for monitoring transfer devices.</p>		

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F 282	Continued From page 6 lift you can transfer me without it." NA #1 further reported she pivoted the resident and after lying the resident in bed the resident started yelling in pain stating she (Resident # 89) had a pop in her leg. NA # 1 also reported she was unaware of where the kardex was located, and was not aware of the use of the kardex which indicated the resident was to be transferred using a lift. NA #1 also reported she always used the lift to transfer Resident # 89 from her chair to bed and the resident had not resisted the use of the lift prior to this incident. On 8/19/2015 at 8:30 AM, observation of the resident in bed revealed no obvious pain noted. The resident was observed with a royal blue hard cast from toes to knee on her left leg. During the interview with the facility Administrator on 8/19/2015 at 10:50 am, she stated she had investigated the circumstances of Resident #89's left leg fracture on 7/24/2015 and determined that NA #1 had not followed the care plan intervention to use a lift for toilet transfers. The Administrator stated she had interviewed NA #1 on 7/24/2014 and obtained her statement concerning Resident #89 ' s fracture. She stated that NA #1 reported she did not know where the Kardex was located and the use it served. The Administrator stated the employee was suspended from work on 7/24/2015. She was educated, that at any time, if she felt that the resident was not safe in current transferring device that she should contact her nurse, so the nurse could contact the appropriate staff member to correct the problem. The Administrator added that NA # 1 was aware the resident needed a lift, as she had used the lift prior to this incident to toilet the resident.	F 282	The monitoring will include reviewing five transfers for correct lift, correct technique and to review the corresponding care plan for interventions if refusal is noted with the resident. 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, MDS Coordinator, Health Information Manager, Dietary Manager and Social Worker. See exhibit #11.		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		9/10/15	

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F 323	<p>Continued From page 7</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to use a lift to transfer a resident resulting in a leg fracture for 1 of 1 sampled resident who was care planned for use of a lift. (Resident #89) The findings included: Resident #89 was admitted to the facility on 5/13/2015 with diagnoses which included Anemia, Malaise and fatigue, Schizophrenia, Anxiety, Difficulty in walking, Muscle weakness and history of fall. Resident #89 ' s care plan dated 10/14/2014 and reviewed 7/9/2015 indicated " the resident has an Activities of Daily Living (ADLs) self care performance deficit. " The care plan indicated the goal as " I will maintain current level of function in ADLs through the next 90 days. " The care plan interventions included " I require lift for transfers during toileting and anticipate my needs. " The quarterly Minimum Data Set (MDS) dated 7/9/2015 indicated Resident #89 was severely cognitively impaired. The MDS also indicated the resident required extensive assistance of two persons for bed mobility and extensive assistance of one person for transfer. The MDS also indicated the resident was totally dependent on staff for all Activities of Daily Living (ADLs).The</p>	F 323	<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>Corrective Action for Resident Affected For resident #89, on 7/24/15 the resident was sent to the hospital for evaluation for injury post fall. On 9/9/15, the MDS Coordinator added to the residents care plan, " I sometimes refuse to be transferred with a lift and tell staff I do not need it. In the event I refuse, do not transfer me without a lift, notify my nurse and she will educate me on safety of using a lift for transfers. " See exhibit #8.</p> <p>Corrective Action for Resident Potentially Affected</p>		

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F 323	<p>Continued From page 8</p> <p>resident was not coded for falls and was coded for walking did not occur.</p> <p>The resident ' s Kardex (a care guide for direct staff identifying residents ' care needs at the facility) under transfer headline indicated the resident required lift for transfers.</p> <p>Review of the facility Accident Report dated 7/24/2015 revealed the resident " was transferred using the stand pivot technique and acquired a tibia fracture on 7/24/2015.The resident ' s care plan indicated to use a sit to stand lift " Under the investigation headline the report indicated " The resident asked the Nurse Aide(NA) to be placed back in the bed. The Nurse Aide(NA) transferred her using the stand pivot technique, instead of using a lift . Upon the resident being transferred the resident heard a pop sound and later complained of pain to the left leg. The NA # 1 reported the incident to the nurse. The leg was assessed by the primary nurse and the Medical Doctor (MD) was contacted. The MD gave orders to obtain an x-ray and call with results. The x -ray was obtained that evening and results came back as a no displaced distal tibia fracture. The resident was sent out to Emergency Room(ER) for evaluation and was sent back to the facility with follow up appointment orders to see a surgeon. The resident has an appointment to see a surgeon of her choice on 7/29/2015. " The incident report concluded that " The employee failed to use the proper transfer technique. "</p> <p>Review of the orthopedic report dated 8/6/2015 indicated the impression of the resident ' s leg injury was " Tibia shaft fracture. " The report also revealed the resident was placed in a cast and ordered to be "non-weight bearing. "</p> <p>During the interview with NA #1 on 8/18/2015 at 12:30 PM, she verified she did not use the lift to</p>	F 323	<p>On 9/9/15 the MDS nurse audited all current residents who use a transfer device to determine if anyone may refuse the device. This was completed by talking with the nurse aides and nurses over various shifts regarding any resident who is care planned to use a lift. Any resident identified for refusals is care planned for refusal and the intervention çI sometimes refuse to be transferred with a lift and tell staff I do not need it. In the event I refuse, do not transfer me without a lift, notify my nurse and she will educate me on safety of using a lift for transfers.ç See exhibit #9.</p> <p>Systemic Changes During the annual skills fair initiated on 8/24/15 and lead by the Staff Development Coordinator; RNçs, LPNçs, Med Techçs, and CNAçs fulltime, part time and PRN were in-serviced on the importance of following the care plan, to use the designated lift for each resident and what to do when a resident refuses to use a lift. Any in-house nursing 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, Med Techçs and CNAçs and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. See exhibit #10.</p> <p>Quality Assurance The Nurse Managers will monitor this</p>		

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F 323	<p>Continued From page 9</p> <p>transfer the resident on 7/24/2015 because the resident had stated to her " you don ' t need the lift you can transfer me without it." NA #1 further reported she pivoted the resident and after lying the resident in bed the resident started yelling in pain stating she (Resident # 89) had a pop in her leg. NA # 1 also reported she was unaware of where the kardex was located, and was not aware of the use of the kardex which indicated the resident was to be transferred using a lift. NA #1 also reported she always used the lift to transfer Resident # 89 from her chair to bed and the resident had not resisted the use of the lift prior to this incident.</p> <p>During the interview with Nurse # 1 on 8/18/2015 at 1:00 PM, She reported that on 7/24/2015 she was called to resident #89 ' s room by NA #1 who stated she transferred the resident without the use of the lift and the resident heard a pop accompanied with pain in her left leg. Nurse #1 also reported she assessed the resident and she found the resident ' s left leg was swollen. She (Nurse # 1) then notified the Physician who ordered an x- ray. Nurse # 1 further added after the x-ray results came back as positive for a fracture on the resident ' s left leg, the Physician ordered the resident to be sent out to the emergency room(ER).</p> <p>On 8/19/2015 at 8:30 AM, observation of the resident in bed revealed no obvious pain noted. The resident was observed with a royal blue hard cast from toes to knee on her left leg.</p> <p>During the interview with the facility Administrator on 8/19/2015 at 10:50 am, she stated she had investigated the circumstances of Resident #89's left leg fracture on 7/24/2015 and determined that NA #1 had not followed the care plan intervention to use a lift for toilet transfers. The Administrator stated she had interviewed NA #1 on 7/24/2014</p>	F 323	<p>issue using the "Survey Quality Assurance Tool #2 for monitoring transfer devices. The monitoring will include reviewing five transfers for correct lift, correct technique and to review the corresponding care plan for interventions if refusal is noted with the resident. 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, MDS Coordinator, Health Information Manager, Dietary Manager and Social Worker. See exhibit #11.</p>		

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OMB NO. 0938-0391

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F 323	Continued From page 10 and obtained her statement concerning Resident #89 ' s fracture. She stated that NA #1 reported she did not know where the Kardex was located and the use it served. The Administrator stated the employee was suspended from work on 7/24/2015. She was educated, that at any time, if she felt that the resident was not safe in current transferring device that she should contact her nurse, so the nurse could contact the appropriate staff member to correct the problem. The Administrator added that NA # 1 was aware the resident needed a lift, as she had used the lift prior to this incident to toilet the resident.	F 323			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		9/10/15	

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F 431	<p>Continued From page 11</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 observations, record review, and staff interviews, the facility failed to discard expired eye drop medications for 4 of 4 sampled residents (Resident #9, Resident #18, Resident #24, and Resident #62) from 3 of 6 medication carts (100 Hall cart, 400 Hall cart, 500 Hall cart) inspected for proper medication labeling and storage.</p> <p>The findings included: 1. Record review for Resident #9 revealed a current Physician ' s Order for Xalatan to " instill one drop into both eyes at bedtime for a diagnosis of Glaucoma. " Review of Resident #9 ' s Medication Administration Record (MAR) revealed the Xalatan eye drops (a medication used in the treatment of high eye pressure in people with glaucoma or ocular hypertension) were administered as ordered to the resident each night at bedtime since the vial was opened on 5/29/2015 until the present time. An observation on 8/19/2015 at 11:00 AM of the 100 Hall medication cart revealed an expired vial of Xalatan eye drops was labeled for Resident #9. The eye drops vial was opened and almost empty. The vial ' s label revealed the pharmacy</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 corrected by the date or dates indicated.</p> <p>Corrective Action for Resident Affected On 8/19/15 the DON verified all expired vials of Xalatan eye drops had been removed from each medication cart. See exhibit #5.</p> <p>Corrective Action for Residents Potentially Affected On 8/19/15 the DON audited all medication carts for any expired Xalatan eye drops. See exhibit #5.</p>		

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F 431	<p>Continued From page 12</p> <p>dispensed the medication on 5/26/2015 and the vial was opened on 5/29/2015. There was no expiration date on the vial label. According to the manufacturer ' s guidelines, Xalatan eye drops should be kept refrigerated until opened and discarded, six weeks after opening. Manufacturer instructions specified the vial did not have to be refrigerated after being opened. Based on the date on the vial ' s label, the Xalatan eye drops would have expired and should have been discarded on 7/10/2015, six weeks after being opened.</p> <p>An interview was conducted on 8/19/2015 at 11:15 AM with Nurse #6 who was assigned to the 100 Hall medication cart. During the interview Nurse #6 stated she was responsible for removing expired medications from the medication cart during her shift. She stated that it was her understanding that eye drops, including Xalatan, did not have an expiration date. She further stated that she was aware that the eye drops were to be dated when opened. Nurse #6 stated: " we are supposed to check the pharmacy list posted in the medication room to determine which medications have an expiration date. I did not check the pharmacy list for the Xalatan eye drops. " She brought a copy of the pharmacy " Medication Expiration Times " list from out of the medication room and saw that Xalatan eye drops were on the list and identified as expiring six weeks after opening. Nurse #6 agreed that the Xalatan eye drops for Resident #9 should have been discarded and reordered. She promptly removed the vial of Xalatan eye drops for Resident #9 from the medication cart and stated she would discard them and order new drops from the pharmacy immediately. An interview conducted by telephone with Nurse #7 who had signed Resident #9 ' s Medication</p>	F 431	<p>Systemic Changes</p> <p>During the annual skills fair initiated on 8/24/15 and lead by the Staff Development Coordinator; RN¿s, LPN¿s fulltime, part-time and PRN were in-serviced on the McNeill¿s Long Term Care Pharmacy Recommended Storage for Selected Items. This education included expiration times for Xalatan eye drops and other selected items used in the facility with expiration dates. 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 through the Quality Assurance Process to verify that the change has been sustained. See exhibit #6.</p> <p>Quality Assurance</p> <p>The Director Of Nursing will monitor this issue using the "Survey Quality Assurance Tool #3 for monitoring expired Xalatan eye drops. The monitoring will include reviewing all medication carts for expired medications utilizing the McNeill¿s Long Term Care Pharmacy Recommended Storage for Selected Items. 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</p>		

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F 431	<p>Continued From page 13</p> <p>Administration Record (MAR) indicating she had administered the Xalatan eye drops to the resident after the six weeks expiration date. The interview revealed Nurse #7 was not aware that the eye drops expired six weeks after opening. Nurse #7 stated she should have checked the pharmacy " Medication Expiration Times " list posted in the medication room to see if the eye drops had an expiration date. She further stated " I would not have administered the drops if I had realized they were expired. I just did not realize eye drops had a short expiration date. "</p> <p>2. Record review for Resident #18 revealed a current Physician ' s Order for Xalatan to " instill one drop into both eyes at bedtime for a diagnosis of Glaucoma. " Review of Resident #18 ' s MAR revealed the Xalatan eye drops were administered as ordered to the resident each night at bedtime since the vial was opened on 5/29/2015 until the present time.</p> <p>An observation on 8/19/2015 at 11:00 AM of the 100 Hall medication cart revealed an expired vial of Xalatan eye drops was labeled for Resident #18. The eye drops vial was opened and almost empty. The vial ' s label revealed the pharmacy dispensed the medication on 4/17/2015 and the vial was opened on 6/14/2015. There was no expiration date on the vial label. According to the manufacturer ' s guidelines, Xalatan eye drops should be kept refrigerated until opened and discarded six weeks after opening. Based on the date on the vial ' s label, the Xalatan eye drops would have expired and should have been discarded on 7/26/2015, six weeks after being opened.</p> <p>An interview was conducted on 8/19/2015 at 11:15 AM with Nurse #6 who was assigned to the 100 Hall medication cart. During the interview Nurse #6 stated she was responsible for</p>	F 431	<p>the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, MDS Coordinator, Health Information Manager, Dietary Manager and Social Worker. See exhibit #7.</p>		

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F 431	Continued From page 14 removing expired medications from the medication cart during her shift. She stated that it was her understanding that eye drops, including Xalatan, did not have an expiration date. She further stated that she was aware that the eye drops were to be dated when opened. Nurse #6 stated: " we are supposed to check the pharmacy list posted in the medication room to determine which medications have an expiration date. I did not check the pharmacy list for the Xalatan eye drops. " She brought a copy of the pharmacy " Medication Expiration Times " list from out of the medication room and saw that Xalatan eye drops were on the list and identified as expiring six weeks after opening. Nurse #6 agreed that the Xalatan eye drops for resident #18 should have been discarded and reordered. She promptly removed the vial of eye drops from the cart and stated she would discard them and order new drops from the pharmacy immediately. An interview conducted by telephone with Nurse #7 who had signed Resident #18 ' s MAR indicating she had administered the Xalatan eye drops to the resident after the six weeks expiration date. The interview revealed she was not aware that the eye drops expired six weeks after opening. Nurse #7 stated she should have checked the pharmacy " Medication Expiration Times " list posted in the medication room to see if the eye drops had an expiration date. She further stated " I would not have administered the drops if I had realized they were expired. I just did not realize eye drops had a short expiration date. " 3. Record review for resident #62 revealed a current Physician ' s Order for Xalatan to " instill one drop into both eyes at bedtime for a diagnosis of Glaucoma. " Review of Resident #62 ' s MAR revealed the Xalatan eye drops were	F 431			

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F 431	<p>Continued From page 15</p> <p>administered as ordered to the resident each night at bedtime since the vial was opened on 6/17/2015 until the present time.</p> <p>An observation on 8/19/2015 at 11:30 AM of the 400 Hall medication cart revealed an expired vial of Xalatan eye drops was labeled for Resident #62. The eye drops vial was opened. The vial ' s label revealed the pharmacy dispensed the medication on 5/27/2015 and the vial was opened on 6/17/2015. There was no expiration date on the vial label. According to the manufacturers guidelines, the Xalatan eye drops expired and should have been discarded on 7/29/2015, six weeks after being opened.</p> <p>An interview was conducted on 8/19/2015 at 11:25 AM with Nurse #8 who was assigned to the 400 Hall medication cart. During the interview Nurse #8 stated it was part of her duties to check the medication cart for expired medications during her shift. She stated she did not know that the Xalatan eye drops expired six weeks after being opened. She further stated that she would have removed the eye drops from the medication cart if she had known they were expired. Nurse #8 was familiar with the pharmacy list of " Medication Expiration Times " which was posted in the medication room off of the 400, 500, and 600 Halls. She stated she did not know to look for eye drop expiration dates on that list. Nurse #8 promptly removed the Xalatan eye drops from the medication cart and stated she would order new drops for Resident #62 at once.</p> <p>An interview conducted on 8/19/2015 at 12:05 PM by telephone with Nurse #9 who had signed Resident #62 ' s MAR indicating she had administered the Xalatan eye drops to the resident after the six weeks expiration date. The interview revealed she was not aware that the eye drops expired six weeks after opening. Nurse #9</p>	F 431			

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F 431	<p>Continued From page 16</p> <p>stated she should have checked the pharmacy " Medication Expiration Times " list posted in the medication room to see if the eye drops had an expiration date. She further stated " I was not aware that the Xalatan eye drops expired six weeks after being opened. I know that I am not supposed to administer expired medications to residents. "</p> <p>4. Record review for Resident #24 revealed a current Physician ' s Order for Xalatan to " instill one drop into both eyes at bedtime for a diagnosis of Glaucoma. " Review of Resident #24 ' s MAR revealed the Xalatan eye drops were administered as ordered to the resident each night at bedtime since the vial was opened on 7/9/2015 until the present time.</p> <p>An observation on 8/19/2015 at 11:45 AM of the 500 Hall medication cart revealed an expired vial of Xalatan eye drops was labeled for Resident #24. The eye drops vial was opened. The vial ' s label revealed the pharmacy dispensed the medication on 7/9/2015 and the vial was opened on 7/9/2015. There was no expiration date on the vial label. According to the manufacturers guidelines, the Xalatan eye drops expired and should have been discarded on 8/13/2015, six weeks after being opened.</p> <p>An interview was conducted with Nurse #10 who was assigned to the 500 Hall medication cart on 8/19/2015 at 11:25 AM. During the interview Nurse #10 stated it was part of her duties to check the medication cart for expired medications during her shift. She stated she had not noticed the Xalatan eye drops for Resident #24 were expired. She verified she understood the facility policy to discard expired medications promptly. She further stated she was aware of the pharmacy list of " Medication Expiration Times " which was posted in the medication room off of</p>	F 431			

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F 431	<p>Continued From page 17</p> <p>the 400, 500, and 600 Halls. She stated she had not checked the list for the expiration of the Xalatan eye drops. Nurse #10 confirmed that she should have checked for the expiration date of the eye drops and disposed of them rather than administering them to Resident #24. She removed the expired eye drops from the medication cart and stated she would order new eye drops for Resident #24 at once. No staff who initialed administering the expired Xalatan eye drops to Resident #24 could be reached for interview.</p> <p>During an interview with the Staff Development Coordinator (SDC) on 8/19/2015 at 12:35 PM it was revealed that she held an in-service on the disposal of expired medications on 8/08/2015. The SDC stated during the in-service staff were instructed to label all short lived medications when opened. She further stated staff were instructed to check the list of Medication Expiration Times supplied by the pharmacy which provided the expiration dates of short lived medications. She stated staff were advised that the pharmacy list was posted in each medication storage room. She provided a copy of the pharmacy list and verified that Xalatan eye drops were documented as expiring six weeks after opening per manufacturer ' s instructions. The SDC stated staff are expected to mark all short lived medications with the opened date, however, they are not required to mark the medications with the expiration date. She further stated: " perhaps our system is not working. "</p> <p>During an interview on 8/19/2015 at 1:05 PM with the Director of Nursing (DON) it was revealed that her expectation was for staff to label medications with the open date, remove expired medications from the medication carts and to use the pharmacy list posted in the medication rooms to</p>	F 431			

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F 431	Continued From page 18 identify the expiration dates of opened medications. The DON stated due to the number of expired Xalatan eye drops found still in the medication carts, she did not feel the current policy was working. She stated the policy would be changed to include labeling short lived medications with their expiration date. During an interview on 8/19/2015 at 1:35 PM with the facility administrator it was revealed that she expected staff to label medications when opened, identify, discard, and reorder any expired medications. She stated under no circumstances should staff administer expired medication to a resident.	F 431			