STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345495	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STEWART HEALTH CENTER	6920 MARCHING DUCK DRIVE CHARLOTTE, NC 28210

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan to address the risk of bleeding for a resident on a blood thinner for 1 of 5 residents reviewed for unnecessary medication use (Resident #38). The findings included: Resident #38 was admitted to the facility on 11/16/15 with diagnoses of atrial fibrillation, hypertension and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) dated 11/23/15 revealed Resident #38 was	F 279	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Steward Health Center of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Steward Health Center reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction	12/11/15

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

Electronically Signed | 01/04/2016

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F 279	Continued From page 1 cognitively intact. The MDS further revealed Resident #38 had received an anticoagulant, a blood thinner, 7 out of 7 days during the admission MDS lookback period. Review of the physician order's for Resident #38 revealed she received Coumadin, a blood thinner, 3 milligrams once a day. Review of Resident #38's care plan dated 11/29/15 revealed she did not have a care plan to address risk of bleeding related to use of a blood thinner. An interview conducted on 12/09/15 at 11:45 AM with the Director of Nursing revealed she had been completing the Care Plans since the MDS Nurse left in 2013. She stated Resident #38 should have been care planned for the potential for bleeding due to being on a blood thinner. The DON stated she had overlooked the care plan for bleeding risk for Resident #38.	F 279	serves as the allegation of compliance. This statement of deficiencies will be taken to the Stewart Health Center's Quality Assurance/Assessment Committee on 1/18/16. F279 1. Corrective action to be accomplished for each resident affected by the deficient practice: The alleged deficient practice was corrected for the resident affected (Resident #38) by MDS Coordinator immediately upon discovery and verified for accuracy and completion by Director of Nursing. 2. Corrective action to be accomplished for those residents having the potential to be affected by the same deficient practice: A complete audit of residents currently receiving anticoagulant therapy was completed by the Director of Nursing on 12/4/2015 to verify the appropriate care plan is in place. RN MDS Coordinator will continue to ensure that all residents on anticoagulant therapy have been appropriately care planned. 3. Measures put in place or systemic changes made to ensue that the deficient practice will not occur: RN MDS Coordinator will care plan all newly admitted residents with newly prescribed anticoagulants with appropriate	

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F 279	Continued From page 2	F 279	monitoring and interventions. Director of Nursing will audit monthly. 4. Monitoring Process: Director of Nursing will present the result of audits of all residents receiving anticoagulant therapy in monthly QAPI meeting. Audits will be presented once per month x 3 months and then quarterly.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		12/11/15

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F 431	Continued From page 3 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to remove expired medications from 3 of 3 medications rooms. The findings included: A review of the facilities policy dated April 2007 read in part "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." 1. An observation of the Main Medication Room on 12/08/15 at 11:45 AM revealed three tubes of insta-glucose that contained no resident name and an expiration date of 11/2015. Also during this observation a bottle of Ecotrin 81 mg (milligram) tablets that contained no resident name and an expiration date of 09/2015 was found. 2. An observation of the Riverburch Medication Room on 12/08/15 at 12:10 PM revealed an unopened bottle of Tussin DM (dextromethorphan or cough suppressant) that contained no resident name and an expiration date of 10/2015. 3. An observation of the Magnolia Medication	F 431	F431 1. Corrective action to be accomplished for each resident affected by the deficient practice : All expired medications were immediately disposed off in compliance with regulatory requirements by Director of Nursing. 2. Corrective action to be accomplished for those residents having the potential to be affected by the same deficient practice : An audit of all medication rooms was completed by Director of Nursing on 12/11/15. Our Pharmacy Consultant completed an additional audit on 12/17/15 to ensure all medications are stored in compliance with regulatory requirements. 3. Measures put in place or systemic changes made to ensure that the deficient practice will not occur : Audits of all medication storage areas to be completed by designated RN on a	

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F 431	Continued From page 4 Room on 12/08/15 at 12:30 PM revealed a bottle of Prostat that contained no resident name and an expiration date of 09/2015. An interview with Director of Nursing (DON) on 12/08/15 at 11:51 AM revealed that the third shift nurses were responsible for checking medication rooms and medications carts for expired medications. She further stated that the pharmacy staff was in the building on 11/10/15 and also checked the medication rooms and medication carts. She explained that she had been short staffed for several months and had not had the time to check behind them. She would expect that the third shift nurses would remove any expired medication that were found and destroy them per facility protocol or return them to the pharmacy.	F 431	nightly basis. A second audit to be completed by Director of Nursing or designee. These audits will occur weekly x 4 weeks, bi-weekly x 1 month, and monthly x 6 months. Our Pharmacy Consultant will conduct audits monthly x 6 months and bi-monthly x 6 months. 4. Monitoring Process : Audits from both the Director of Nursing and Pharmacy Consultant will be reported and reviewed during the Stewart Health Center's QAPI meeting.	