PRINTED: 03/03/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			SURVEY PLETED
		345278	B. WING_		02	/19/2016
	ROVIDER OR SUPPLIER RN SURRY SNF	,		STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030	ACCOUNTS OF THE PROPERTY OF TH	**************************************
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279 SS=D	A facility must use the to develop, review an comprehensive plan of the facility must develop and for each resident objectives and timetal medical, nursing, and needs that are identificated assessment. The care plan must do to be furnished to attain highest practicable playschosocial well-beit §483.25; and any serbe required under §48 due to the resident's §483.10, including the under §483.10, including the under §483.10 including the under §483.10 including the under §483.10 facility failed to develon interventions, includin behaviors and non-phor a resident receiving for 1 of 6 residents, R. The findings included: Resident #12 was addressed the findings included: Resident #12 was addressed the facility for the findings included: Resident #12 was addressed for the findings included the findings includ	e results of the assessment d revise the resident's of care. Islop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ed in the comprehensive escribe the services that are in or maintain the resident's sysical, mental, and ng as required under vices that would otherwise 33.25 but are not provided exercise of rights under a right to refuse treatment is not met as evidenced ew and staff interviews the pactare plan with critical gonoitoring target armacological interventions, go psychotropic medications esident #12. Initted to the facility is included pneumonia, and chronic back pain. 12/16/2015, 7/17/2015 and gnoses of depression, with psychosis.	F 2	F 279 PLAN OF CORRECTION: For resident #12 care plan I revised to include non-phar interventions and to monit target behaviors, related to psychotropic medication (S ensure the deficient practice occur again: Staff has been monitor/record target behaviors, residents receiving psychotimedication. A daily monitoring tool, 24 has been implemented doc any new orders or changes monitored daily by Director Nursing. Director of Nursin implement changes to care affected residents. Daily monitoring tool will be reported Quality Assurance Committed Standing agenda item. [See documentation] Completion Date: 3/10/16	as been macological or /record the use of eroquel). To will not educated to iors of opic hr. report, umenting and will be or of g will olans of quarterly to ee as a	
LABORATORY D	IRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE	^	TITLE		(X6) DATE

Any deficiency statement ending with an exterisk (*) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; RRGI11

Facility ID: 953376

If continuation sheet Page 1 of 13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345278	B. WNG			02/	19/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030			
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F 279	of antianxiety medica antidepressants, and medication. A review of physician Seroquel 75 milligram was to be given by m Lexapro 20 mg, an art to be given daily. Atta was ordered to be gived day. A review of the Medical showed that these me ordered during Decerand to date in Februa No behavioral monitoresident 's medical renon-pharmacological documented for this management. The resident 's care payentoropic medicatoresident will remain for related complications disorder, discomfort, disturbance, constipal impairment. The in Administer psychotropic physician. Monitor effectiveness every sinon-pharmacological any target behaviors in Seroquel. The care pand updated 1/23/2017 The Director of Nursing 2/19/2016 at 11:46 and the nurse responsible	mum Data Set dated at she had received 7 days tion, 7 days of 7 days of 7 days of antipsychotic orders showed that is (mg) an antipsychotic, buth daily at bedtime. Intidepressant, was ordered and 1 mg, an antianxiety, en by mouth three times a ation Administration Record adications were given as inber 2015, January 2016 ry 2016. It was noted in the accord. No interventions were esident. In the colon use, including Seroquel, The goal stated, "The ee of psychotropic drug, including movement intropotension, gait tion or cognitive/behavioral terventions included, "Die medications as ordered for side effects and infit." It did not include any interventions. It did not list o monitor for the use of lan was initiated 5/14/2014 6.	F	279			

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(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING_ 345278 B. WING 02/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F280 F 279 Continued From page 2 F 279 she agreed that they were not included on the PLAN OF CORRECTION: care plan. She explained that the resident gets For resident #16 care plan has been tearful at times and wants her family. She revised to include medication changes indicated that the nurses will give her tasks to do, like folding linen to distract her. She explained and examples of anxiety and aggression that nurses who know this resident will do these (hitting and kicking staff). To insure interventions automatically, without being the deficient practice will not occur included on the care plan. again; care plans of readmitted 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 residents will be revised within 72hrs. PARTICIPATE PLANNING CARE-REVISE CP SS=D of admission to the facility. A daily monitoring tool, 24 hr. report, has been The resident has the right, unless adjudged implemented documenting any new incompetent or otherwise found to be order or changes. This is completed by incapacitated under the laws of the State, to staff nurses, and will be monitored daily participate in planning care and treatment or by Director of Nursing, who will changes in care and treatment. implement changes to care plan of affected residents. Staff education A comprehensive care plan must be developed provided on using the 24 Hr. form. within 7 days after the completion of the comprehensive assessment; prepared by an Daily monitoring of compliance will be interdisciplinary team, that includes the attending reported quarterly to Quality Assurance physician, a registered nurse with responsibility Committee as a standing agenda item. for the resident, and other appropriate staff in [See supporting documentation] disciplines as determined by the resident's needs, and, to the extent practicable, the participation of Completion Date: 3/10/16 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced Based on record review and staff interview the facility failed to update a care plan with the current psychotropic medications and dosages

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345278	B. WING			02	19/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 830 ROCKFORD STREET MOUNT AIRY, NC 27030	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 280	for one of six resident medications. Resident medications. Resident medications. Resident The findings included: Resident #16 was re-8/29/15 with diagnosis dementia, Alzheimer abnormality accompant Data Set (MDS) dated indicated Resident #1 memory impairment a with daily decision maincluded use of an antereatment. Re-admission orders is (antipsychotic) 0.5 min The Ativan (antianxiet) Review of the care plaincluded a problem for 2:00 PM, Risperdal 0.1 as needed at bedtime and dementia disease for use of the Risperdal Interview on 02/18/20. Director of Nursing revupdated care plans for explained she missed and dosages when Reand on subsequent calinterview revealed Resaggression at times ar	s receiving psychotropic at #16. admitted to the facility on sincluding advanced by type and behavioral any dementia. The Minimum at 12/16/15, a quarterly, had short and long term and moderate impairment sking abilities. This MDS tipsychotic medication in his included Risperdal illigrams (mg) once a day, y) was discontinued. an with an update of 9/23/15 an wit	F:	280				
F 329	care plan due to nurse 483.25(I) DRUG REGI	es knew his behaviors.	F3	329				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/03/2016 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345278	B. WING_		02	/19/2016
	ROVIDER OR SUPPLIER RN SURRY SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	BE	(X5) COMPLETION DATE
F 329 SS=D	UNNECESSARY DRI Each resident's drug in unnecessary drugs. drug when used in ext duplicate therapy); or without adequate more indications for its use; adverse consequence should be reduced or combinations of the resident, the facility may who have not used argiven these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral intervention contraindicated, in an drugs. This REQUIREMENT by: Based on record revisitating regime was free they failed to identify and failed to attempt as	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate or in the presence of es which indicate the dose discontinued; or any easons above. ensive assessment of a must ensure that residents attipsychotic drugs are not eas antipsychotic drug to treat a specific condition examented in the clinical who use antipsychotic dose reductions, and has, unless clinically effort to discontinue these is not met as evidenced is not met as evidenced ew and staff interviews, the example of the treat and the second of the example of the an antipsychotic, for 1 of 6	F3	F329 PLAN OF CORRECTION: A dose reduction recommendate Seroquel was requested to the for Resident #12. Drug regine each resident have been review pharmacist. A monthly monithas been developed for month by pharmacist. Dose reduction recommendations will be made provider, and tracked on this formulation of same will be in the resident medical record. Of Nursing will monitor month spreadsheet from pharmacist. Monitoring of compliance will reported quarterly to Quality Acommittee as an ongoing agen [See supporting documentations.] Completion Date: 3/10/16	physician ens of yed by the oring tool y review e to orm. e placed Director ly the be ssurance da item.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345278	B, WING_			02/19/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030	ā	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE CC		
F 329	weakness, dementia A review of physiciar showed that Seroque antipsychotic, was to bedtime. A dose redi 10/31/2014, with the daily to 50 mg daily. 75 mg daily on 11/9/2 remained at 75 mg si Progress notes dated 1/6/2016 included the depression and deme The resident's care psychotropic medicat an antipsychotic, Lex Ativan an antianxiety stated, "The resident psychotropic drug rel movement disorder, of disturbance, constipating impairment." The in Administer psychotroby physician. Monito effectiveness every sonn-pharmacological any target behaviors Seroquel. The care pand updated 1/23/20 Resident #12's Mini 2/3/2016 indicated the fantianxiety medication, and 7 da medication. The resi assessment indicated understood. A review of the Medic showed that Seroque.	s included pneumonia, and chronic back pain. orders dated 11/9/2014, 175 milligrams (mg), an be given by mouth at action was attempted dosage of Seroquel 100 mg. The dose was increased to 1014. The dose has note this order. 17/17/2015, 12/16/2015, and a diagnoses of anxiety, antia with psychosis. Including Seroquel, apro, an antidepressant, and medication. The goal at will remain free of ated complications, including discomfort, hypotension, gait atterventions included, "pic medications as ordered or for side effects and hift. "It did not include any interventions. It did not list to monitor for the use of colar was initiated 5/14/2014 at she had received 7 days tion, 7 days of antipsychotic ys of antidepressant.	F3	229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345278	B. WING			02	/19/2016
NAME OF PROVIDER OR SUPPLIER NORTHERN SURRY SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030		DE		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTIO	ON SHOULD B IE APPROPRI		(X5) COMPLETION DATE
5/14/2015 with no recreduction of Seroquel The pharmacist was i 11:00 am. He explair with the physician by expected the physician reduction. He stated recommending the do The Director of Nursir 2/19/2016 at 11:46 an the nurse responsible asked about non-phar she agreed that they care plan. She also e would often become of searching for her fami children were young, nurses would give her linen to distract her. So who knew her would k interventions automat included on the care p The physician was un provided a written stat received at 12:00 pm. " (Resident #12) was (every day) and was re episode of delirium the to 75 mg (daily) 11/20 Seroquel 75 mg (daily)	ebruary 2016. ring was noted in the secord. No interventions were esident. ere conducted monthly from commendations for dose. Interviewed on 2/19/2016 at sed that he communicated fax when needed and he in to order the dose that he just missed see reduction. In gwas interviewed in She identified herself as for the care plan. When reacological interventions, were not included on the explained that the resident delusional, crying and dely, believing that her She explained that the tasks to do, like folding she indicated that nurses know to do these ically, without being blan. In available for interview, but the sement dated 2/19/2016, that stated: Itaking Seroquel 100 mg enduced to 50 mg 10/2014.		428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345278	B. WING			02/	19/2016
	ROVIDER OR SUPPLIER RN SURRY SNF			8	STREET ADDRESS, CITY, STATE, ZIP CODE 130 ROCKFORD STREET MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 428 SS=D	IRREGULAR, ACT Of The drug regimen of reviewed at least one pharmacist. The pharmacist must the attending physician nursing, and these resulting pharmacist must consulting pharmacist gradual dose reductions benefit rationale for the antipsychotic medical residents reviewed for (Resident #12). The findings included Resident #12 was add 4/21/2013. Diagnose weakness, dementiant Resident #12 is Minit 2/3/2016 indicated the of antianxiety medical medication, and 7 day medication.	each resident must be the a month by a licensed report any irregularities to an, and the director of ports must be acted upon. is not met as evidenced lew and staff interview the t failed to recommend a an and/or a risk versus the continued use of the tion, Seroquel, for 1 of 6 r unnecessary medications : mitted to the facility s included pneumonia, and chronic back pain. mum Data Set dated at she had received 7 days tion, 7 days of antipsychotic	F	428		hysician ns of d by the ring tool review to m. placed Director y the surance a item.	
	reduced to 50 mg dail was increased to 75 r remained at 75 mg sli physician orders date	el 100 mg (milligrams) daily y. On 11/9/2014 the dose ng daily. The dose has nce this order. Review of d 11/9/2014, showed that ordered to be given by		•			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345278	B, WING		02/	19/2016
-	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 330 ROCKFORD STREET MOUNT AIRY, NC 27030	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 428	diagnoses of anxiety, with psychosis. A review of the Medic showed that Seroque given as ordered duri 2016 and to date in F No behavioral monito resident 's medical renon-pharmacological documented for this repharmacy reviews we 5/14/2015 with no recreduction of Seroquel The pharmacist was i 11:00 am. He explair with the physician by expected the physician by expected the physician decommending the documented a written stareceived at 12:00 pm "(Resident #12) was (every day) and was repisode of delirium the 75 mg (daily) 11/20 Seroquel 75 mg (daily) 483.60(b), (d), (e) DR LABEL/STORE DRUG	ogress notes dated 5 and 1/6/2016 included the depression and dementia ation Administration Record I, Lexapro and Ativan were ing December 2015, January ebruary 2016. Ining was noted in the acord. No interventions were esident. In econducted monthly from commendations for dose Interviewed on 2/19/2016 at aced that he communicated fax when needed and he in to order the dose that he just missed lise reduction. Inavailable for interview, but tement dated 2/19/2016, that stated: Itaking Seroquel 100 mg reduced to 50 mg 10/2014. Induced patient had an en Seroquel was changed Induced patient is currently on Induced patient is currently on Induced in the services of Induced who establishes a system	F 428			
	accurate recordination	i, and determines that drug				

A. BUILDING A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER NORTHERN SURRY SNF STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 9 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. A. BUILDING B. WING O2/19/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030 C(X5) PREFIX (EACH CORRECTION SHOULD BE COMPLETION SHOULD SHOU	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER NORTHERN SURRY SNF STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 9 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION SHOULD BE COMPLETIO			7, 00100			
NORTHERN SURRY SNF 830 ROCKFORD STREET MOUNT AIRY, NC 27030 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 9 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 830 ROCKFORD STREET MOUNT AIRY, NC 27030 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (E		345278	B. WING		02/19/2016	
NORTHERN SURRY SNF (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 9 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. MOUNT AIRY, NC 27030 PROVIDER'S PLAN OF CORRECTION (S5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 431 F 431 F 431 F 431 F 431	NAME OF PROVIDER OR SUPPLIER	UPPLIER				
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 9 records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	NORTHERN SURRY SNF	NF				:
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 9 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. F 431 F 431 F 431				MOUNT AIRY, NC 27030		
records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	PREFIX (EACH DEFICIEN	CH DEFICIENCY MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE COMPLÉTIC	NC
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility falled to remove an expired medication from one of two medication carts and falled to date a multi dose insulin vial when opened in one of one medication rooms. The findings included: Observations on 02/18/2016 at 8:30 AM revealed	records are in order controlled drugs is reconciled. Drugs and biological labeled in accordant professional principital appropriate accessinstructions, and the applicable. In accordance with facility must store allocked compartment controls, and permit have access to the lateral drugs listed controlled drugs listed Comprehensive Drucontrol Act of 1976 abuse, except when package drug distributed quantity stored is mit be readily detected. This REQUIREMENT by: Based on observatifacility failed to remote from one of two mediate a multi dose inso of one medication roof the findings include.	e in order and that an account of all drugs is maintained and periodically biologicals used in the facility must be accordance with currently accepted all principles, and include the e accessory and cautionary s, and the expiration date when the proper temperature and permit only authorized personnel to set to the keys. If the provide separately locked, the expirate date in Schedule II of the expirate date in Schedule II of the expirate drugs subject to expit when the facility uses single unit rug distribution systems in which the pred is minimal and a missing dose can detected. UREMENT is not met as evidenced observations and staff interviews the expirate date to remove an expired medication of two medication carts and failed to ti dose insulin vial when opened in one dication rooms. Is included:	F	F431 PLAN OF CORRECTION: Immediately the nurse discarded vial of Insulin. A new vial was of Tessalon Pearls was also immed discarded and a new supply order Staff education was provided to staff regarding expiration date of medication, including surveillant removal of expired items. To exproper dating on multi-dose vial day expiration date will be writt vial when opened, before adminictly and osage. A 28 day calculation calendar has been placed on each medication cart, and in medication room. To ensure the deficient proper will not occur again; an expired medication tracking form will be MAR of each resident. Director Nursing will monitor monthly off medications have been cheed Monitoring of compliance will be reported quarterly to Quality Ascommittee as a standing agenda [See supporting documentation]	ordered. liately ered. nursing f all loce and nsure ls, a 28 en on listering on h on factice e on the of and sign ked. loce surance item.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			830 F	EET ADDRESS, CITY, STATE, ZIP CODE ROCKFORD STREET JNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 431	February. Observations in the management revealed one multi-double that had been opened administration. The vopened for use. The the pharmacy had set February. Interview with nurse # indicated the nurse shopened. Interview with the Direct of the pharmacy had set for use. Interview with nurse # indicated the nurse shopened.	e of 12/2015. The een given to the resident in hedication room refrigerator se vial of Novolog insulin and used for ial was not dated when medication label indicated at the medication in at 21 on 02/18/2016 at 8:56 AM hould date the vial when	F	431			
F 520 SS=D	medications were prol 483.75(o)(1) QAA COMMITTEE-MEMBE QUARTERLY/PLANS A facility must maintai assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessment	n a quality assessment and consisting of the director of ysician designated by the other members of the	F	520			
	issues with respect to and assurance activitie develops and impleme	ents appropriate plans of fied quality deficiencies.					

	O TON MILDIOANL &		(V2) MULT	IDLEC	ONSTRUCTION	(Y3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′			(V2	COMPLETED
		345278	B. WING				02/19/2016
	ROVIDER OR SUPPLIER			830	EET ADDRESS, CITY, STATE, ZIP CODE ROCKFORD STREET UNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 520	disclosure of the reco- except insofar as suc- compliance of such or requirements of this si Good faith attempts be and correct quality de a basis for sanctions. This REQUIREMENT by: Based on record revi- facility's Quality Asse- Committee failed to reprocedures and moni- the committee put interected deficiency that on a recertification sur- recited 2/19/16, on the survey. The deficiency consultant pharmacy irregularities of medic continued failure of the surveys of record sho inability to sustain an Assessment and Asse The findings included This tag is crossed re F428: Monthly medica monthly by a pharma- to the physician and of During the recertificat facility was cited at F4 an irregularity of labor	rds of such committee h disclosure is related to the committee with the rection. by the committee to identify diciencies will not be used as is not met as evidenced fews and staff interviews the assment and Assurance naintain implemented for these interventions that or place. This was for one t was originally cited 4/23/15 forevy and subsequently e current recertification by was in the area of review and report of lation regime at F428. The lee facility during two federal law a pattern of the facility's effective Quality for urance Program. Ifferenced to: lation review to be conducted cist and report irregularities director of nursing. It is subsequently lation survey of 4/23/15 the late to failure to report look for monitoring of a lation recited for failure to late age reduction of an	F	520	F520 The Quarterly Assessment Assurance Committee met Monitoring of psychotropic was discussed. To ensure the practice will not occur again has been added to the mont Assurance measurement more report form. This is reviewed quarterly Assurance meeting standing agenda item. More medication review to be complarmacist and report irregulate physician and director of Monitoring of compliance reported quarterly to Qualit Committee. Completion Date: 3/10/16	on 2-25- medica e deficie n; this to hly Qual onitors a d at eac g as a thly hducted hlarities f nursin vill be	tions ent opic lity and ch by a to gg.

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A, BUILDING		(X3) DATE SURVEY COMPLETED	
		345278	B. WING		02	2/19/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	pharmacist was part of and Assurance Commot included use of part to most residents did medications. The pharmedication reviews a the physicians were redirectly. Interview with the cor 2/19/16 at 10:40 AM of and a second common commo	ector of Nursing on AM revealed the consultant of the Quality Assessment nittee. The committee had sychotropic medications due not receive these armacist did monthly nd any recommendations to made by the pharmacist nsultant pharmacist on revealed he had missed a on recommendation for	F 520			