

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

PRINTED: 05/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345457	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2017
NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052		
(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 278 SS=D	<p>483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum</p>	F 278	The statements included are not an admission and do not constitute	5/4/17	

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

TITLE

(X6) DATE

Electronically Signed

04/27/2017

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 278	<p>Continued From page 1</p> <p>Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident (Resident #28) identified as PASRR Level II.</p> <p>Findings included:</p> <p>Resident #28 was admitted to the facility on 03/13/2017 with diagnoses including anxiety disorder and depression.</p> <p>A review of Resident #28's admission Minimum Data Set (MDS) assessment dated 03/20/17 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care.</p> <p>A review of the PASRR Level II letter of determination notification dated 03/16 /17 indicated Resident #28 was determined as PASRR Level II.</p> <p>On 04/04/2017 at 5:28 PM an interview was conducted with the SW who stated she was responsible for coding Section A1500 PASRR Level II for Resident #28. The SW stated she was aware Resident #28 was determined as PASRR Level II and she made an error and missed coding PASRR Level II.</p> <p>On 04/04/17 at 8:06 AM an interview was conducted with the Director of Nursing (DON)</p>	F 278	<p>agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>F278 How corrective action will be accomplished for each resident found to have been affected by the deficient practice <input type="checkbox"/> On April 4, 2017 the MDS for resident <input type="checkbox"/>s # 28 March 20, 2017 Admission day MDS was modified to accurately code the correct Level II PASRR.</p> <p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice <input type="checkbox"/> Nurse consultant inquired with Discharge Planner as to patients with Level II PSARR <input type="checkbox"/>s, as of April 24, 2017 there are were no current residents <input type="checkbox"/> with a Level II PSARR <input type="checkbox"/>s in house. No action needed at this time.</p> <p>Measures to be put in place or systemic changes made to ensure practice will not re-occur - The Nurse Consultant reviewed with the MDSC and the DC Planner the requirements from the RAI Manual for coding ALL sections of the MDS</p>		

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F 278	Continued From page 2 who stated his expectation was that Resident #28's admission MDS assessment dated 03/20/17 would have been accurately coded to reflect Resident #28 was determined as PASRR Level II. The DON stated Resident #28 was determined as PASRR Level II on admission to the facility. On 04/05/2017 at 8:11 AM an interview was conducted with the Administrator who stated his expectation was that the admission MDS assessment dated 03/20/17 would have been accurately coded to reflect Resident #28 was determined as PASRR Level II	F 278	accurately, including any resident with a documented Level II PASRR must be coded accurately in Section A, A1500, pages A-14 through A-16 in the MDS 3.0 RAI Manual. The MDS Consultant or designee will audit 5 residents <input type="checkbox"/> with a comprehensive MDS with a Level II PSARR for accuracy in coding of section A of the MDS 1X weekly for 4 weeks, 2X monthly for 1 month, and monthly for 10 months. Discharge Planner will keep an active list of current residents requiring Level II PASRR. MDS Consultant or designee will be given a list of residents requiring a Level II PASRR as they are identified to verify in section A of the Comprehensive MDS that the Level II PASRR was correctly coded. Any coding issue identified on the audits will be corrected, upon identification and MDS resubmitted to reflect the change. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur - Results of Audits will be reviewed at the Monthly Quality Assurance Meeting for further analysis and resolution if needed X 12 months.		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		5/4/17	

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F 431	Continued From page 3 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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	F 431			

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F 431	<p>Continued From page 4</p> <p>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:</p> <p>Based on observation, record review, and staff interviews the facility failed to remove 3 Lantus insulin pens and 3 Novolog flex pens that were not dated when opened and 1 open and expired Advair Diskus available for use in 3 of 4 medications carts on north and south units, failed to discard 1 opened and undated vial of Influenza Vaccine and 1 opened and expired Forteo Injectable pen from 1 of 2 medication storage refrigerators on north unit and failed to discard 2 open and room temperature cartons of liquid supplement opened and available for use on top of 2 of 4 medication carts: #2 and #3 on north unit.</p> <p>Findings included: A review of the facility policy section 5.3 regarding Storage and Expiration of Medications, Biological, Syringes and Needles which was revised on 01/01/13 indicated that the facility should ensure that medications and biologicals have an expiration date on the label, have not been retained longer than recommended by the manufacturer or supplier guidelines and have not been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier.</p> <p>It also indicated that once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened</p>	F 431	<p>F431</p> <p>How corrective action will be accomplished for each resident found to have been affected by the deficient practice – The insulin devices were destroyed and new syringes were ordered.</p> <p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – Medication carts were audited by SDC and Unit Managers for any other medications that were not dated with Open Date on April 26, 2017 with no other instances found of medications not dated with an Open Date.</p> <p>Nurses re-in-serviced on storage and expiration of drugs and biologicals specifically emphasizing “Opened Date” of medications and necessity of dating containers when they are opened, by DON. In-services were completed on 4/30/17.</p> <p>Measures to be put in place or systemic changes made to ensure practice will not re-occur, Prior to shift to shift nurse change the oncoming nurse will visualize with the off going nurse the medication drawer and</p>		

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F 431	<p>Continued From page 5</p> <p>medications and the facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.</p> <p>A review of the facility protocol titled Insulin Storage Recommendation with revision dated 03/31/2015 indicated that Lantus pens, Novolog vials, Novolog Flex Pens should be labeled with date opened and are to be discarded after 28 days; refrigerated or unrefrigerated, Influenza Vaccine multi-dose vials including Afluria are to be stored in the refrigerator but do not freeze; staff are expected to date the vial of Influenza Vaccination-specifically Afluria when opened and discard after 28 days, Forteo Injection pens should be discarded 28 days after opening and are to be protected from light.</p> <p>A review of the facility protocol titled Recommended Minimum Medication Storage Parameters (based on manufacturer guidance) Oral and/or Enteral Medications with revision dated 03/31/15 indicated that liquids in original bottles (not specifically mentioned elsewhere) are to refer to manufacturer's recommendation for storage.</p> <p>A review of the facility protocol titled Recommended Minimum Medication Storage Parameters (based on manufacturer guidance) Inhaled Medications with revision dated 03/31/15 indicated that Advair Diskus should be dated when removed from the foil pouch and discarded 1 month after removal from the foil pouch or after all blisters have been used, whichever comes first.</p> <p>A review of the facility policy 5.3 Storage and</p>	F 431	<p>ensure that all insulins are dated with date opened and audit tool completed and signed which is a systemic change to make nurses even more aware of the need to check for expired meds and ensuring "Date Opened" is completed when medications are put into service. . . The Unit Manager or designee will conduct audit of drugs and biologicals in each applicable medication carts on Tuesday weekly X 4 weeks, bi-monthly (Every other Tuesday) x1 and monthly (First Tuesday of the Month) x10. Pharmacy Consultant will do cart audits during 1 visit each month for a period of 4 months. Re-education and/or disciplinary action will be documented for all infractions found. Results will be reviewed in weekly quality assurance risk management meeting for further analysis with minutes provided for verification of process.</p> <p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur - Results of audits will be reported during Monthly QA to discuss F Tag 431 for further analysis and revision if needed x4 months.</p>		

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F 431	<p>Continued From page 6</p> <p>Expiration of Medications, Biologicals, Syringes and Needles revision 01/01/13, indicated that the facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. The manufacturer label on the back of the supplement carton indicated that the supplement was supposed to "be refrigerated prior to serving, shake well, open cap, pull foil tab, pour and serve, reseal and refrigerate after opening"</p> <p>1. Resident #32 was admitted to the facility on 03/14/17 and diagnoses included diabetes mellitus (DM).</p> <p>A physician's order dated 03/27/17 indicated that Resident #32 receive Lantus Solostar insulin pen - inject 15 units subcutaneously one time a day related to type II DM.</p> <p>On 04/05/17 at 2:13 PM Resident #32's Lantus pen was observed on the #2 north unit medication cart ready for use and was opened and undated. There was a yellow sticker located on the opened Lantus pen and included a place for date opened and the date was not indicated and the space was blank.</p> <p>On 04/05/17 at 2:13 PM an interview was conducted with Nurse #1. He stated that he had used the Lantus pen located on med cart #2 for Resident #32 for the morning dose. He stated he did not know when Lantus expired once out of the refrigerator and opened. He stated that the yellow sticker should have indicated the date opened and that he did not know when Resident #32's Lantus pen was opened. He stated that without an opened date he was unable to determine if</p>	F 431			

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F 431	<p>Continued From page 7</p> <p>Resident #32's Lantus pen had expired prior to him administering the insulin on 04/05/17. He stated that medication should be removed from the cart and discarded when it is expired. He immediately removed the undated Lantus pen from the #2 north unit medication cart.</p> <p>On 04/05/17 at 3:33 PM an interview was conducted with the Director of Nursing (DON) who stated that his expectation was the nursing staff would have dated the Lantus pen for Resident #32 when it was opened as per facility policy. The DON stated that his expectation was that the nursing staff per facility protocol would have checked that Resident #32's Lantus pen was dated when opened prior to administering the Lantus pen to Resident #32 the morning of 04/05/17. The DON stated his expectation was that nursing staff would have identified that Resident #32's Lantus pen was not dated when opened and nursing staff would have discarded the insulin prior to administration of the insulin because without an opened date there was no way to determine when the Lantus pen had expired. The DON placed a copy of the facility protocol titled Insulin Storage Recommendation with revision dated 03/31/2015 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility.</p> <p>On 04/05/17 at 4:08 PM a review of the Medication Administration Record (MAR) revealed Resident #32 received Lantus 15 units on 04/05/17 at 8:27 AM per physician's orders as indicated by Nurse #1's documentation on the MAR.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his</p>	F 431			

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F 431	<p>Continued From page 8</p> <p>expectation was that the nursing staff would have placed an opened date on insulin as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to expiration dates of opened medications on the medication carts and the refrigerators within the facility. This education had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated that his expectation is that prior to administering insulin to Resident #32 on 04/05/17, staff should have checked that the insulin had been labeled appropriately with an opened date as per facility protocol.</p> <p>2. Resident #80 was admitted to the facility on 12/22/16 and diagnoses included diabetes mellitus (DM).</p> <p>A physician's order dated 12/22/16 indicated that Resident #80 was to receive Insulin Glargine (Lantus) Pen-Injector 100 units/1 milliliter(ml)-inject 10 units subcutaneously one time a day related to DM with diabetic neuropathy.</p> <p>On 04/05/17 at 2:13 PM Resident #80's Lantus pen was observed on the #2 north unit medication cart ready for use and was opened and undated. There was a yellow sticker located on the opened Lantus pen and included a place for date opened and the date was not indicated and the space was blank.</p> <p>On 04/05/17 at 2:13 PM an interview was conducted with Nurse #1 who stated he did not</p>	F 431			

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F 431	<p>Continued From page 9</p> <p>know when Lantus expired once out of the refrigerator and opened. He stated that he administered medication to resident #80 this morning using the Lantus pen on cart #2. He stated that the yellow sticker should have indicated the date opened. He stated that he did not know when Resident #80's Lantus pen was opened. He stated that without an opened date he was unable to determine if Resident #80's Lantus pen had expired prior to administering the insulin on 04/05/17. He stated that expired medication should be discarded and not used. He immediately removed the Lantus pen from the #2 north unit medication cart.</p> <p>On 04/05/17 at 3:33 PM an interview was conducted with the DON who stated that his expectation was the nursing staff would have dated the Lantus pen for Resident #80 when it was opened as per facility policy. The DON stated that his expectation was that the nursing staff per facility protocol would have checked that Resident #80's Lantus pen was dated when opened prior to administering the Lantus pen to Resident #80. The DON stated his expectation was that nursing staff would have identified that Resident #80's Lantus pen was not dated when opened and nursing staff would have discarded the insulin prior to administration of the insulin because without an opened date there was no way to determine when the Lantus pen had expired. The DON placed a copy of the facility protocol titled Insulin Storage Recommendation with revision dated 03/31/2015 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility.</p> <p>On 04/05/17 at 4:08 PM, a review of the MAR revealed Resident #80 received Lantus 10 units</p>	F 431			

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F 431	<p>Continued From page 10</p> <p>on 04/05/17 at 10:24 AM per physician's orders as indicated by Nurse #1's documentation on the MAR.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his expectation was that the nursing staff would have placed an opened date on insulin as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to expiration dates of opened medications on the medication carts and the refrigerators within the facility. This education had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated prior to administering insulin to Resident #80, nursing staff should have checked that the insulin had an opened date as per facility protocol.</p> <p>3. Resident #177 was admitted to the facility on 07/27/16 and diagnoses included diabetes mellitus (DM).</p> <p>A physician's order dated 08/11/16 indicated that Resident #177 was to receive Lantus solostar 100 units/1 ml Insulin Pen - inject 15 units subcutaneously at bedtime related to DM Type II.</p> <p>On 04/05/17 at 2:13 PM Resident #117's Lantus pen was observed on the #3 north unit medication cart ready for use and was opened and dated but it was smeared and illegible. There was a yellow sticker located on the opened Lantus pen and included a place for date opened and the date was not indicated and the space was blank.</p>	F 431			

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(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 431	Continued From page 11 On 04/05/17 at 2:13 PM an interview was conducted with Nurse #2 who stated she did not know when Lantus expired once out of the refrigerator and opened. She stated that the yellow sticker should have indicated the date opened. She stated that she could not read the smeared handwritten date on the Lantus pen for Resident #177. She stated that she did not know when Resident #177's Lantus pen was opened. She stated that without an opened date she was unable to determine if Resident #177's Lantus pen had expired. She stated that the next dose was scheduled in the evening and that any expired medication should not be given to residents and should be discarded. She immediately removed the Lantus pen from the #3 north unit medication cart. On 04/05/17 at 3:33 PM an interview was conducted with the DON who stated that his expectation was the nursing staff would have dated the Lantus pen for Resident #177 when it was opened as per facility policy. The DON stated his expectation was that nursing staff would have identified that Resident #177's Lantus pen was not dated when opened and nursing staff would have discarded the insulin because without a legible opened date there was no way to determine when the Lantus pen had expired. The DON placed a copy of the facility protocol titled Insulin Storage Recommendation with revision dated 03/31/2015 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility. On 04/05/17 at 4:08 PM, a review of the MAR revealed Resident #177 was to receive the next dose of Lantus 15 units on 04/05/17 at bedtime	F 431			

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F 431	<p>Continued From page 12</p> <p>per physician's orders. The last dose was received on 04/04/17 at 10:41 PM with the same Lantus pen on cart #3 identified for Resident #177 per documentation on the MAR.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his expectation was that the nursing staff would have placed an opened date on insulin as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to expiration dates of opened medications on the medication carts and the refrigerators within the facility. This education had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated prior to administering any insulin to Resident #177, nursing staff should have checked if the insulin had an opened date as per facility protocol.</p> <p>4. Resident #54 was admitted to the facility on 01/17/17 and diagnoses included diabetes mellitus (DM).</p> <p>A physician's order dated 04/03/17 indicated that Resident #54 was to receive Novolog FlexPen insulin 100 units/1 ml subcutaneously as per sliding scale before meals and at bedtime.</p> <p>On 04/05/17 at 2:13 PM Resident #54's Novolog FlexPen was observed on the #3 north unit medication cart ready for use and was opened and undated. There was a yellow sticker located on the opened Novolog FlexPen and included a place for date opened and the date was not indicated and the space was blank.</p>	F 431			

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F 431	<p>Continued From page 13</p> <p>On 04/05/17 at 2:13 PM an interview was conducted with Nurse #2 who stated she did not know when Novolog FlexPen expired once out of the refrigerator and opened. She stated that the yellow sticker should have indicated the date opened. She stated that she did not know when Resident #54's Novolog FlexPen was opened. She stated that without an opened date she was unable to determine if Resident #54's Novolog FlexPen had expired. She stated that expired medication should not be given to residents and should be discarded. She immediately removed the open and undated Novolog FlexPen from the #3 north unit medication cart.</p> <p>On 04/05/17 at 3:33 PM an interview was conducted with the DON who stated that his expectation was the nursing staff would have dated the Novolog FlexPen for Resident #54 when it was removed from the refrigerator and opened as per facility policy. The DON stated his expectation was that nursing staff would identify Resident #54's Novolog FlexPen was not dated when opened and nursing staff would have discarded the insulin because without an opened date there was no way to determine when the Novolog FlexPen had expired. The DON placed a copy of the facility protocol titled Insulin Storage Recommendation with revision dated 03/31/2015 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility.</p> <p>On 04/05/17 at 4:08 PM, a review of the MAR revealed Resident #54 was to receive Novolog insulin per sliding scale on 04/05/17 at next meal per physician's orders. The last dose was received on 04/02/17 at 11:20 AM per sliding</p>	F 431			

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F 431	<p>Continued From page 14</p> <p>scale orders from the Novolog FlexPen in use on cart #3.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his expectation was that the nursing staff would have placed an opened date on insulin as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to expiration dates of opened medications on the medication carts and the refrigerators within the facility. This education had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated prior to administering any insulin to Resident #54, nursing staff should check that the insulin had an opened date as per facility protocol.</p> <p>5. Resident #43 was admitted to the facility on 03/03/17 and diagnoses included diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD) and respiratory failure.</p> <p>5.a. A physician's order dated 01/09/17 indicated that Resident #43 was to receive Novolog FlexPen insulin 100 units/1 ml subcutaneously as per sliding scale before meals and at bedtime and was discontinued on 01/29/17. A physician order dated 03/03/17 indicated that Resident #43 was to receive Novolog 100 units/ml (vial) subcutaneously as per sliding scale before meals and at bedtime.</p> <p>On 04/06/17 at 8:45 AM Resident #43's Novolog FlexPen was observed on cart #1 on south unit ready for use and was opened and undated even</p>	F 431			

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F 431	<p>Continued From page 15</p> <p>though there was a physician order to discontinue the Novolog FlexPen on 01/29/17. There was a yellow sticker located on the opened Novolog FlexPen and included a place for date opened and the date was not indicated and the space was blank.</p> <p>On 04/06/17 at 8:45 AM an interview was conducted with Nurse #3 who stated she had not administered Novolog FlexPen insulin to Resident #43 on this day. She stated that she had not looked for the opened date on Residents #43's Novolog FlexPen and was unsure when it would expire. She stated that the nurse who had opened the Novolog FlexPen should have indicated an opened date. She stated that the yellow sticker located on the opened Novolog FlexPen should have an opened date on it. She stated without an opened date she was unable to determine if Resident#43's insulin had expired. She stated that expired medication should not be given to residents and should be discarded appropriately immediately. She removed the undated Novolog FlexPen from the #1 south unit medication cart.</p> <p>On 04/06/16 at 9:00 AM, a review of the MAR revealed that Resident #43 was to receive Novolog 100 units/1 ml subcutaneously per sliding scale before meals and at bedtime.</p> <p>On 04/06/17 at 9:15 AM an interview was conducted with Nurse #3 who stated that she had found an opened and dated vial of Novolog in the refrigerator on south unit medication storage room that was utilized by nurses for Resident #43 to administer Novolog Sliding Scale per physician's order. She stated that the Novolog Pen should be removed from the cart and</p>	F 431			

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F 431	<p>Continued From page 16 discarded.</p> <p>5.b. A physician's order dated 03/03/17 indicated that Resident #43 was to receive Advair Diskus Aerosol powder breath activated 250-50 microgram(mcg)/dose 1 puff two times a day.</p> <p>On 04/06/16 at 8:45 AM Resident #43's Advair Diskus was observed on cart #1 on south unit ready for use, opened and dated 03/04/17 which was expired 3 days per protocol. The observation on 04/06/17 at 9:15 AM indicated that there were 10 doses left in the Advair Diskus and that Nurse #3 had administered a dose to resident.</p> <p>On 04/06/17 at 8:45 AM an interview was conducted with Nurse #3 who stated she had administered Advair Diskus 1 puff per physician's order to Resident #43 at 8:00 AM. She stated that she was not aware of the expiration date of the Advair Diskus once it was out of the foil package. Nurse #3 stated that she did see a date written on the box for Advair Diskus of 03/04/17. She stated that when looking at the facility policy she could see that the Advair Diskus expired 30 days after being removed from the foil packet. She stated that she needed to discard Resident #43's Advair Diskus from cart #1 on south unit and have it replaced immediately per pharmacy guidelines.</p> <p>On 04/06/17 at 9:00 AM, a review of the MAR revealed Resident #43 had received Advair Diskus 1 puff two times a day at 8:00 AM and 4:00 PM on 04/04/17, 04/05/17 and had received 1 puff at 8:00 AM on 04/06/17.</p> <p>On 04/06/17 at 10:33 AM an interview was conducted with the DON who stated that his expectation was the nursing staff would have</p>	F 431			

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F 431	<p>Continued From page 17</p> <p>removed and discarded the discontinued Novolog Flex Pen and expired Advair Diskus for Resident #43 per facility policy. The DON stated that his expectation was that the nursing staff per facility protocol would have known when an Advair Diskus expired once out of the foil packet. The DON placed a copy of the facility protocol titled Insulin Storage Recommendation with revision dated 03/31/2015 and one of the facility protocol titled Recommended Minimum Medication Storage Parameters (based on manufacturer guidance) Inhaled Medications with revision dated 03/31/15 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his expectation was that the nursing staff would have discarded expired Advair Diskus as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to expiration dates of opened medications on the medication carts and the refrigerators within the facility. This education had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated prior to administering Advair Diskus to Resident #43, nursing staff should check the expiration date as per facility protocol.</p> <p>6. Resident #65 was admitted to the facility on 02/11/15 and diagnoses included arthritis.</p> <p>A physician order dated 06/08/15 indicated that Resident #65 was to receive Forteo solution 600</p>	F 431			

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

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F 431	<p>Continued From page 18</p> <p>mcg/2.4 ml inject 600 mcg subcutaneously one time a day related to osteoporosis and the order was discontinued on 05/12/16.</p> <p>On 04/05/17 at 2:13 PM an observation of the medication refrigerator in medication storage on north unit revealed an expired Forteo injection for Resident #65 inside of the original medication box inside of a labeled ziptop bag.</p> <p>On 04/05/17 at 2:13 PM an interview was conducted with Nurse #1 and Nurse #2 who stated that Resident #65 was currently residing at facility. Nurse #1 stated that he was not sure why the Forteo injection was still in the refrigerator. Nurse #2 stated that Resident #65 no longer received that medication. Nurse #1 and Nurse #2 could not state who was responsible to remove expired medications from the medication refrigerators or why the medication was not removed from the refrigerator when it was discontinued. Nurse #1 and Nurse #2 stated that the Forteo injection for Resident #65 was in the refrigerator ready for use. Nurse #1 agreed that the Forteo injection should be removed from the refrigerator and needed to be discarded per policy.</p> <p>On 04/05/17 at 3:33 PM an interview was conducted with the DON who verified that the Forteo injection for Resident #65 had expired 03/2017 and was in the medication refrigerator ready for resident use. The DON stated it was his expectation that nursing staff would check for and remove any expired medication from the unit refrigerator per facility policy. The DON placed a copy of the facility protocol titled Recommended Minimum Medication Storage Parameters (based on manufacturer guidance) Injectable</p>	F 431			

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F 431	<p>Continued From page 19</p> <p>Medications with revision dated 03/31/15 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his expectation was that the nursing staff would have discarded expired Forteo injection as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to expiration dates of opened medications on the medication carts and the refrigerators within the facility. This education had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated that nursing staff should check for and remove any expired medication from the refrigerators in medication storage areas as per facility protocol.</p> <p>7. Resident #24 was admitted to the facility on 03/08/17 and diagnoses included DM. Resident #24 had an unplanned discharge from the facility of 03/22/17.</p> <p>A physician order dated 03/08/17 indicated that Resident #24 was to receive Novolog solution 100 units/1 ml as per sliding scale subcutaneously three times a day for DM.</p> <p>On 04/05/17 at 2:13 PM an observation of the medication cart #3 on north unit revealed an opened and undated vial of Novolog for discharged Resident #24.</p> <p>On 04/05/17 at 2:13 PM an interview was</p>	F 431			

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F 431	<p>Continued From page 20</p> <p>conducted with Nurse #2 who stated that Resident #24 was recently discharged from the facility. Nurse #2 stated that she was not sure why the Novolog vial was still in medication cart. She could not state who was responsible to remove expired medications from the medication carts when residents were discharged. She stated that the Novolog vial for Resident #24 was in the medication cart and ready for use. She stated that the Novolog vial should be removed from medication cart #3 immediately and should be discarded per policy.</p> <p>On 04/05/17 at 3:33 PM an interview was conducted with the DON who verified that the Novolog vial for Resident #24 who was discharged from the facility, was in medication cart #3 and ready for resident use. The DON stated it was his expectation that nursing staff would check for and remove any medication that belonged to discharged residents from the medication carts and discard them immediately per facility policy. The DON placed a copy of the facility protocol titled Insulin Storage Recommendation with revision dated 03/31/2015 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his expectation was that the nursing staff should have discarded the Novolog vial belonging to former Resident #24 from the medication cart as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to expiration dates of opened medications on the medication carts and the refrigerators within the facility. This education</p>	F 431			

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F 431	<p>Continued From page 21</p> <p>had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated that nursing staff should check for and remove any expired medication from the refrigerators as well as medication of discharged residents in medication storage areas as per facility protocol.</p> <p>8. On 04/05/17 at 2:13 PM, 1 vial of opened and undated Influenza Vaccine was observed in 1 of 2 medication refrigerators in a clear plastic zip top bag inside the north unit medication storage area.</p> <p>On 04/05/17 at 2:13 PM an interview was conducted with Nurse #1 and Nurse #2 who stated that they were not sure why the Influenza Vaccine was open and undated and still in the refrigerator. They both stated that the nurse who opened the Influenza Vaccine vial was responsible to date when the vial was opened. They stated that the Influenza Vaccine was in the refrigerator ready for resident use. They both stated and agreed that the Influenza Vaccine should be removed from the refrigerator and discarded since the vial was not dated when opened per facility policy.</p> <p>On 04/05/17 at 3:33 PM an interview was conducted with the DON who verified that the Influenza Vaccine vial was opened and undated and was in the medication refrigerator on north unit ready for resident use. The DON stated it was his expectation that nursing staff would check for and remove any open and undated or expired medication from the unit refrigerator and discard per facility policy. The DON placed a copy of the facility protocol titled Recommended</p>	F 431			

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F 431	<p>Continued From page 22</p> <p>Minimum Medication Storage Parameters (based on manufacturer guidance) Injectable Medications with revision dated 03/31/15 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his expectation was that the nursing staff would have discarded opened and undated Influenza Vaccine vial as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to open and undated as well as expiration dates of medications on the medication carts and in the refrigerators within the facility. This education had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated that nursing staff should check for and remove any opened, unlabeled and expired medication from the refrigerators in medication storage areas as per facility protocol.</p> <p>9. On 04/05/17 at 2:13 PM on 2 of 2 medication carts #2 and #3 were observed on north unit, each had 1 carton (32 fluid oz.) of liquid supplement labeled Med Plus 2.0 vanilla opened and sitting at room temperature on top of each cart.</p> <p>On 04/05/17 at 2:13 PM an interview was conducted with Nurse #1 and Nurse #2 who stated that both liquid supplement cartons of Med Plus 2.0 had been on their carts (cart #2 and #3) since early in their shift and had been administered to residents. They stated that they</p>	F 431			

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F 431	<p>Continued From page 23</p> <p>did not know how long the supplement was allowed be out of the refrigerator. They stated that they had not read the manufacturer's instructions for storage of the supplement. They both verified and stated that the manufacturer label on the back of the supplement carton indicated that the supplement was supposed to "be refrigerated prior to serving, shake well, open cap, pull foil tab, pour and serve, reseal and refrigerate after opening". They verified and stated that the 2 cartons of supplement were still on top of cart #2 and #3 and were ready for resident consumption and confirmed that the boxes were not chilled or refrigerated and should be discarded. They both agreed that the unused portions of the supplement in the cartons should be discarded per facility policy.</p> <p>On 04/05/17 at 3:33 PM an interview was conducted with the DON who verified that the 2 cartons of Med Plus 2.0 was opened, room temperature and on top of cart #2 and #3 on north unit ready for resident consumption. The DON stated it was his expectation that nursing staff would refrigerate or chill the Med Plus 2.0 per manufacturer label and discard unused portions immediately per facility policy. The DON placed a copy of the facility protocol titled Recommended Minimum Medication Storage Parameters (based on manufacturer guidance) Oral and/or Enteral Medications with revision dated 03/31/15 in the staff reference/narcotic count books kept in the bottom drawer of each medication cart in the facility.</p> <p>On 04/06/17 at 10:43 AM an interview was conducted with the Administrator who stated his expectation was that the nursing staff would have refrigerated or chilled the cartons of Med Plus 2.0</p>	F 431			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345457	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2017
NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052		
(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 431	Continued From page 24 as per facility protocol. The Administrator stated that the DON had initiated re-education to the nursing staff in regards to refrigerating medications, liquids and injections per facility policy. This education had taken place with the nursing staff working second shift on 04/05/17 and with the nursing staff working third shift the morning of 04/06/17 and would continue until all nursing staff had been re-educated. The Administrator stated that nursing staff should check for and remove any opened, unlabeled and expired medications, liquids and injections from the medication carts and refrigerators in medication storage within the facility as per facility protocol.	F 431			