STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and physician interviews the facility failed to administer two medications on time, as ordered by physician, for 1 of 4 sampled resident (Resident # 24). Findings included: Resident #24 was admitted on 4/24/17. Review of the admission Minimum Data Set assessment dated 5/1/17, revealed resident ' s intact cognition. Her diagnoses included gastro-esophageal reflux disease (digestive disease) and sinus infection. 1.a. Record review of Resident 24 ' s physician ' s orders for July 2017 revealed: Omeprazole (medication for gastro-esophageal reflux disease to use before meals) Capsule Delayed Release, 20 mg (milligram), to give one capsule by mouth one time a day at 7:30 AM. Review of Resident 24 ' s Medication Administration Record (MAR) for July 2017 revealed the administration of Omeprazole on 7/9/17 (Sunday) at 10:50 AM, on 7/12/17 (Wednesday) at 9:12 AM, on 7/15/17 (Saturday) at 10:04 AM and on 7/16/17 (Sunday) at 10:36 AM.	F 281	The statements included are not an admission and do not constitute 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. F281 How the corrective action will be accomplished for the resident(s) affected. Resident # 24 medication times changed to facilitate timely medication pass. F281 How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Medication pass times changed for each unit based on room number to facilitate timely medication pass. All Licensed nurses will be educated on timely medication pass for 1 hour before	8/16/17

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

Electronically Signed | 08/09/2017

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F 281	Continued From page 1 Record review of the nurses ' notes for July 2017 revealed no documented late medications administration or reasons for Omeprazole on 7/9/17, 7/12/17, 7/15/17 or 7/16/17. Record review of the mealtime schedule for July 2017 revealed the breakfast time at 8:00 AM. 1.b. Record review of Resident 24 ' s physician ' s orders for July 2017 revealed: Fluticasone Propionate Suspension (nasal spray for sinus infection), 50 Mcg (microgram), two sprays in both nostrils daily at 9:00 AM. Review of Resident 24 ' s MAR for July 2017 revealed the administration of Fluticasone on 7/9/17 at 10:53 AM. On 7/16/17 at 2:35 PM, during an interview, Resident #24 indicated that she had received her medications late, particularly on weekends. The resident continued she received medication for her stomach disease after meal, instead of before the meal. On 7/19/17 at 10:00 AM, during an interview, the Director of Nursing indicated that she expected the nurses to administer medications at the correct time and according to physician ' s order. When the medication was administered late, the staff was to notify the physician and follow the new order. On 7/19/17 at 1:25 PM, during an interview, the Physician indicated he expected the nurse to call him when medication was administered late and follow his new decision/order.	F 281	and 1 hour after scheduled medication times. F281 Measures in place to ensure practices will not reoccur. Director of Nursing, House Supervisors, RN Unit Managers or ADON will review Medication Administration Audit report for late administration of medications daily Monday through Friday X 4 weeks, Weekly X 4 weeks, and monthly X 1 for problem resolution if needed. Results of audits will be reviewed weekly at the Quality Assurance Weekly Risk meeting for further problem resolution. All new hire licensed nurses will be educated in general orientation on timely medication pass for 1 hour before and 1 hour after scheduled medication times. F281 How the facility plans to monitor and ensure correction is achieved and sustained. Results of audits will be reviewed at Quarterly Quality Assurance meeting X 1 for further problem resolution.	

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F 281	Continued From page 2 On 7/19/17 at 1:45 PM, during an interview, Nurse #8, indicated Resident 24 ' s medications were administered late on 7/9/17, 7/12/17, 7/15/17 and 7/16/17. She did not complete nurse ' s notes about late medication administration and had not notified the physician.	F 281		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to provide nail care and scheduled shower for 1 of 3 sampled residents (Resident #189). Findings included: Resident #189 was admitted on 12/07/16 with diagnoses, in part, left humerus head fracture (shoulder), leukemia and diabetes mellitus. Review of the care plan updated 2/17/17, revealed the resident had a self-care performance deficit in ADL (activity of daily living) and required physical assistance for bathing and showers. The minimum data set dated 03/03/17, revealed Resident #189's cognition was moderately impaired and totally dependent on one person for bathing and showering. There was no refusal of care.	F 312	F312 How the corrective action will be accomplished for those residents affected: Resident # 24 was provided nail care and scheduled shower. F312 How the corrective action will be accomplished for those residents with the potential to be affected by the same practice: The DON and ADON educated all Nurses and Certified Nursing Assistants on nail care twice a week on bath and shower days and as needed, and following shower/or Bath schedule. Residents in-house were examined by DON / Unit Manager/House Supervisor to ensure no other residents needed attention to their nails and shower schedules updated for all residents. F312 Measure in place to ensure practices will not occur: DON and ADON to educate all new hire Licensed nurses and Certified Nursing Assistants on performing nail care twice a week on bath and shower days and as needed. Unit	8/16/17

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F 312	Continued From page 3 The shower schedule further reflected the NA on the 3:00 PM to 11:00 PM shift was responsible for providing his shower on Tuesday and Friday. 0n 07/17/17 at 10:46 AM, during an interview, Resident #189 indicated he needed his nails trimmed. An observation at this time revealed his finger nails were longer than Resident #189 preferred and jagged and had dark matter under all of them he was wearing a dark blue t-shirt with an embossed sports image. A review of a nurse aide (NA) task completion sheet dated 07/18/17 for bathing revealed "not applicable" documented by NA #6 as the response for the task completion. On 07/19/2017 at 9:56 AM, an observation revealed Resident #189 had long and jagged nails with black matter under all of the nails and wearing the same dark blue t-shirt with an embossed sports image from 07/17/17 it was soiled. On 07/19/2017 at 9:56 AM, during an interview, Resident #189 indicated the staff still had not trimmed his nails, and he said he doesn't take showers he takes sponge baths, he had on the same shirt since Monday. On 07/19/17 at 10:00 AM, Nurse #8 indicated Resident #189's scheduled bath day was Monday and Thursday. She indicated when a resident refused care it was documented in the nursing note.	F 312	Manager will verify task has been completed for nail care and shower care on 10% of each unit weekly for period of 4 weeks, Biweekly X 2, and monthly X 1. Results of Audits will be reviewed at weekly Quality Assurance Risk meeting for further problem resolution. 312 How the facility plans to monitor and ensure correction is achieved and sustained: All nail and shower audits will be reviewed at Quarterly Quality Assurance meeting X 1.	

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F 312	Continued From page 4	F 312		

On 07/19/17 at 10:06 AM as NA #5 observed the resident's nails she said that they needed to be trimmed and cleaned. When asked how often do finger nails get cleaned and trimmed? Her response was the finger nails were to be trimmed when they were observed. She reported Resident #189 does not resist care.

On 07/19/17 at 10:30 AM, during an interview Nurse #9 indicated the correct shower days for Resident #189 were Tuesday and Friday on the second shift during 3:00 PM-11:00 PM.

On 07/19/17 at 11:12 AM, during an interview Nurse #8 said she had documented the late entry of the refusal of the bath on 07/17/17 in error after she had misread the shower schedule.

On 07/19/2017 at 3:06 PM, during an interview NA #6 indicated she was assigned Resident #189 from 8:00pm until 11:00PM. The resident was assigned to have a shower on 07/18/17 from 3:00 PM until 11:00 PM and that NA #5 was assigned to give it. She indicated she charted "not applicable" because NA #5 had not provided the shower and had not documented.

On 07/19/2017 at 3:14 PM, during an interview Nurse #9 reported the NA who stayed over into the next shift was expected to provide the care and to chart on the care tracker. She indicated the assignment sheet for 07/18/17 was shredded.

On 07/19/2017 at 4:25 PM, during an interview, the Director of Nursing indicated her expectation was for all residents to be offered a shower and to document if they refused or care was not provided.

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F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		8/16/17

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.

(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

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F 431	Continued From page 6 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 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 failed to remove two boxes of Ensure Clear expired medications from 1 of 2 medication carts on Mauve hall, one vial of expired Lantus insulin, expired Lantus insulin pen from 1 of 2 medication cart on Teal hall, one bottle of expired R-Dukes Magic Mouth Wash and expired plastic bag of 5% Dextrose from the refrigerator in the medication storage room on Mauve hall. Findings Included: 1. a. On 7/17/17 at 10:35 AM, during the observation of the medication cart on Mauve one hall with Nurse #5, there were two boxes of Ensure Clear, 280 ml (milliliter), which were expired on 1/7/17. On 7/17/17 at 10:40 AM, during an interview, Nurse #5 indicated that the nurses, who worked on the medication carts, were responsible to check for expired medications. The nurse confirmed that she had not checked the expiration date on two boxes of Ensure Clear in	F 431	F 431 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Expired items were found on 2 medication carts and 1 storage room. All items were removed and destroyed. F 431 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ Drugs and biologicals in each applicable storage area and medication carts will be audited and any expired items or improperly stored items will be removed and disposed of per facility policy. Nurses will be in-serviced on storage and expiration of drugs and biologicals by DON and/or ADON. F 431 Measures to be put in place or systemic changes made to ensure	

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F 431	Continued From page 7 her medication administration cart at the beginning of her shift. b. On 7/18/17 at 8:10 AM, during the observation of the medication cart on Teal middle hall with Nurse #13, there were one vial of insulin Lantus, 100 units, opened on 5/15/16, expired on 6/12/16 and insulin pen for Lantus insulin Glargine injection, opened on 6/16/17, expired on 7/14/17. On 7/18/17 at 8:10 AM, during an interview, Nurse #13 indicated that the nurses from second shift, who worked on the medication carts, were responsible to check and remove all the expired medications. The nurse confirmed that she checked only medications she was ready to use. 2. On 7/17/17 at 10:45 AM - during the observation of the refrigerator in the medication storage room on Mauve one hall with Nurse #9, there were expired medications found: one bottle of R-Dukes Magic Mouth Wash, 280 ml, which was expired on 7/11/17 and one plastic bag of 5% Dextrose, 1000 ml, which was expired on 7/16/17. On 7/17/17 at 10:50 AM, during an interview, Nurse #9, unit manager, indicated that she was responsible to control that all the expired medications were removed from the medication storage room. She expected that all the nurses should check the expiration date of medications in the storage room. The unit manager did not check the expiration date of the medications in the storage room today. On 7/19/17 at 10:00 AM, during an interview, the Director of Nursing indicated that the night shift nurses were responsible to check all the	F 431	practice will not re-occur Director of Nursing, RN Unit manager, House Supervisor or Assistant Director of Nursing will conduct audit of drugs and biologicals on each medication cart weekly X 4 weeks, Bi Weekly X 2 weeks and monthly X 1. Results of audits will be reviewed at Weekly Quality Assurance Risk meeting for further problem resolution if needed. All new hire licensed nurses will be educated in general orientation on storage and expiration of drugs and biologicals. F 431 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Results of all audits will be reviewed at Quarterly Quality Assurance meeting X 1 for further problem resolution if needed.	

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F 431	Continued From page 8 medications. Her expectation was that no expired items be left in the medication carts or in medication storage rooms.	F 431		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 514		8/16/17

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F 514	Continued From page 9 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and physician interviews the facility failed to maintain complete and accurate documentation of delayed medication administration for 1 of 4 sampled residents (Resident # 24). Findings included: Resident #24 was admitted on 4/24/17. Review of the admission Minimum Data Set assessment dated 5/1/17, revealed resident ' s intact cognition. Her diagnoses included gastro-esophageal reflux disease (digestive disease) and sinus infection. 1.a. Record review of Resident 24 ' s physician ' s orders for July 2017 revealed: Omeprazole (medication for gastro-esophageal reflux disease to use before meals) Capsule Delayed Release, 20 mg (milligram), to give one capsule by mouth one time a day at 7:30 AM. Review of Resident 24 ' s Medication Administration Record (MAR) for July 2017 revealed the administration of Omeprazole on 7/9/17 (Sunday) at 10:50 AM, on 7/12/17 (Wednesday) at 9:12 AM, on 7/15/17 (Saturday) at 10:04 AM and on 7/16/17 (Sunday) at 10:36 AM. Record review of the nurses ' notes for July 2017 revealed no documented late medications administration or reasons for Omeprazole on 7/9/17, 7/12/17, 7/15/17 or 7/16/17. Record review of the mealtime schedule for July	F 514	F514 How the corrective action will be accomplished for the resident(s) affected. Resident # 24 medication times changed to facilitate timely medication pass. F514 How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Medication pass times changed for each unit based on room number to facilitate timely medication pass. All Licensed nurses will be educated on timely medication pass for 1 hour before and 1 hour after scheduled medication times. F514 Measures in place to ensure practices will not reoccur. Director of Nursing, House Supervisors, RN Unit Managers or ADON will review Medication Administration Audit report for late administration of medications daily Monday through Friday X 4 weeks, Weekly X 4 weeks, and monthly X 1 for problem resolution if needed. Results of audits will be reviewed weekly at the Quality Assurance Weekly Risk meeting for further problem resolution. All new hire licensed nurses will be educated in general orientation on timely medication pass for 1 hour before and 1 hour after scheduled medication times. F514 How the facility plans to monitor and ensure correction is achieved and sustained. Results of audits will be reviewed at	

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F 514	Continued From page 10 2017 revealed the breakfast time at 8:00 AM. 1.b. Record review of Resident 24 ' s physician ' s orders for July 2017 revealed: Fluticasone Propionate Suspension (nasal spray for sinus infection), 50 Mcg (microgram), two sprays in both nostrils daily at 9:00 AM. Review of Resident 24 ' s MAR for July 2017 revealed the administration of Fluticasone on 7/9/17 at 10:53 AM. On 7/16/17 at 2:35 PM, during an interview, Resident #24 indicated that she had received her medications late, particularly on weekends. The resident continued she received medication for her stomach disease after meal, instead of before the meal. On 7/19/17 at 10:00 AM, during an interview, the Director of Nursing indicated that she expected the nurses to administer medications at the correct time and according to physician ' s order. When the medication was administered late, the staff was to notify the physician, document it and follow the new order. On 7/19/17 at 1:25 PM, during an interview, the Physician indicated he expected the nurse to call him when medication was administered late and follow his new decision/order. On 7/19/17 at 1:45 PM, during an interview, Nurse #8, indicated Resident 24 ' s medications were administered late on 7/9/17, 7/12/17, 7/15/17 and 7/16/17. She did not complete nurse ' s notes about late medication administration and had not notified the physician.	F 514	Quarterly Quality Assurance meeting X 1 for further problem resolution.	