STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	**514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164**

(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 000	INITIAL COMMENTS No deficienies were cited as a result of the complaint investigation. See Event ID # PLKV11.	F 000		
F 761 SS=B	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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 secure and label unidentified loose pills in 5 of 5 medication carts (100 back hall cart, 100 hall rehabilitation cart, 400 hall cart, 500 short hall cart, and 500 long hall cart).	F 761	What processes led to the deficiency cited? Licensed nursing staff failed to properly secure and label unidentified (7) loose pills for each of 5 medication carts. While	7/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/19/2018

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 761	Continued From page 1 Findings included: 1. An observation of the 500 short hall medication cart on 06/29/18 at 10:15 AM revealed: a. 1 unidentified yellow capsule loose in the third drawer b. one half of an unidentified white tablet loose in the third drawer. An interview with the 500 short hall nurse at the time of the observation revealed she was unable to identify the medications and did not know why the pills became loose in the cart. The nurse was going to find a bag to place the loose pills in and send them back to the pharmacy. The nurse stated if she found loose pills in the cart they were placed in a bag and sent to the pharmacy. 2. An observation of the 100 back hall medication cart on 06/29/18 at 10:23 AM revealed: a. 1 loose green pill in the second drawer An interview with the 100 back hall nurse at the time of the observation revealed she thought the pill was an iron tablet. The nurse stated the pill could have been dropped accidentally during a medication pass. The nurse discarded the loose pill in the sharps container at that time. The nurse stated if she found loose pills in the medication cart she discarded them in the sharps container. 3. An observation of the 100 hall rehabilitation	F 761	medication carts are cleaned each shift and checked each night for expired/unlabeled medications, these (7) loose pills were overlooked between each of these carts. What procedure(s) will be implemented to correct the deficiency cited? The (7) loose pills found during the survey were immediately discarded by the licensed nurses assigned to each medication cart following facility procedure. One of the facility pharmacy consultants also checked medication carts during a routine monthly review on 7/9/18 and found no unidentified loose pills. The Medication Administration General Guidelines policy was revised with specific guidelines for cleanliness and orderliness of each medication cart as follows: "Every licensed nurse is ultimately responsible for his/her medication cart during the course of his/her shift, including the overall cleanliness and orderliness of the cart which is expected to be maintained at all times. "Medication carts are to be kept clean and in order. Carts must be kept clean, free from spills, stocked appropriately, and free from any loose pills/medications, expired medications, discontinued medications, and discharged resident medications. "Third shift nurses will be assigned to check medication carts on his/her unit(s) nightly for overall cleanliness and orderliness including removing all loose	

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medication cart on 06/29/18 at 10:25 AM revealed:

a. 1 purple unidentified loose pill in the second drawer

An interview with the 100 hall rehabilitation nurse at the time of the observation revealed she was unable to identify the medication and did not know why the pill became loose in the cart. The nurse discarded the pill in the sharps container at that time. The nurse stated if she found loose pills in the medication cart she discarded them in the sharps container. The nurse also stated third shift checked the medication carts nightly for loose pills or expired medications.

4. An observation of the 500 long hall medication cart on 06/29/18 at 10:58 AM revealed:

a. 1 orange pill loose in the third drawer

b. 1 white pill loose in the third drawer

An interview with the 500 long hall nurse at the time of the observation revealed she thought the orange pill was an aspirin and was unsure what the white pill was. The nurse did not know why the medications were loose in the cart and discarded the pills in the sharps container at that time. The nurse stated if she found loose pills in the medication cart she discarded them in the sharps container.

5. An observation of the 400 hall medication cart on 06/29/18 at 11:17 AM revealed:

a. 1 pink unidentified loose pill in the third drawer.

F 761

pills , unlabeled medications, expired medications, discontinued medications, and discharged resident medications from the cart drawers. These nurses will sign that this task has been done on their assignment sheets indicating completion.

"Each Nursing Supervisor/Nurse in Charge will check medication carts weekly for overall cleanliness including removing all loose pills , unlabeled medications, expired medications, discontinued medications, and discharged resident medications from the cart drawers on his/her corresponding shifts. Disciplinary action will be taken as necessary for areas of concern. This will be noted on the Interdisciplinary Rounds sheet by each noting which cart/shift was checked indicating completion.

"SDC/Case Management Coordinator will check each medication cart monthly for overall cleanliness including removing all loose pills, unlabeled medications, expired medications, discontinued medications, and discharged resident medications from the cart drawers. Disciplinary action will be taken as necessary for areas of concern. This will be noted on the Interdisciplinary Rounds sheet (same one used by Nursing Supervisors) noting any concerns and indicating completion.

All licensed nurses were in-serviced on this policy revision between 7/2/18 and 7/23/18.

What monitoring procedures will be implemented to ensure the plan of

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F 761	Continued From page 3	F 761		

An interview with the 400 hall nurse at the time of the observation revealed she was unable to identify the medication and did not know why the pill became loose in the cart. The nurse discarded the pill in the sharps container at that time. The nurse stated if she found loose pills in the medication cart she discarded them in the sharps container. The nurse also stated pharmacy checked the medication carts monthly for loose pills or expired medications.

An interview with the Assistant Director of Nursing (ADON) on 06/29/18 at 10:18 AM revealed the third shift supervisor checked medication carts nightly for loose medication. The Staff Development Coordinator (SDC) and the Risk Assessment Nurse also audited the medication carts periodically for loose pills or expired medication.

An interview with the Director of Nursing (DON) on 06/29/18 at 10:46 AM revealed her expectation of nurses was to discard loose pills in the sharps container. The DON also stated pharmacy checked medication carts monthly for loose pills or expired medications.

A subsequent interview with the DON on 06/29/18 at 5:30 PM revealed it was her expectation that medication carts be clean and in order.

correction is effective and the deficiency cited remains corrected and/or in compliance with the regulatory requirements?
Daily auditing of each medication carts will be conducted by the licensed nurse assigned to each medication cart these audits will begin on 7/2/18 and will be conducted on every shift X 2 weeks, followed by weekly X 4 weeks, and finally monthly X 3 months. Nursing Supervisors on each shift will monitor to ensure completion of these audits by each licensed nurse.

The 1st shift Nursing Supervisor or the ADON will conduct an audit of each medication cart beginning on 7/9/18 weekly X 6 weeks to verify that 3rd shift licensed nurses are following the revised policy. Disciplinary actions will be taken as necessary.

The Staff Development Coordinator will conduct an audit of each medication cart monthly X 4 months beginning in August to verify that 3rd shift licensed nurses are following the revised policy. Disciplinary actions will be taken as necessary.
Results of all audits will be reviewed by Director of Nursing who will immediately address any concerns. The Director of Nursing will review results of all audits and any corrective actions necessary with the Quality Assurance & Performance Improvement Committee monthly X 5 months beginning in July and then quarterly X 3 for any further problem resolution that may be needed.

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F 761	Continued From page 4	F 761	Who is responsible for implementing the acceptable plan of correction? The Director of Nursing is responsible for ensuring that the plan of correction is implemented as written.	