

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/26/2015
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301		
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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews the facility failed to treat 1 of 1 sampled resident with dignity and respect by leaving the resident wet during the lunch meal. (Resident # 72)</p> <p>The findings included:</p> <p>Resident # 72 was admitted to the facility on 4/23/2013 and readmitted on 3/10/2015 with diagnoses which included difficulty walking, muscles weakness, and lack of coordination, abnormal posture and hypertension.</p> <p>Review of the resident ' s urinary incontinence management evaluation dated 2/16/2015 revealed the resident scored 1 point which indicated the resident was not a candidate for scheduled toileting program.</p> <p>The quarterly Minimum Data Set (MDS) dated 5/21/2015 indicated Resident # 72 was alert and oriented with mild cognitive impairment. The MDS also indicated the resident was incontinent of bowel and bladder and required 1 person assist with the transfers .The MDS also indicated the resident required extensive assistance with 2 person assist with Activities of Daily Living(ADL).</p>	F 241	<p>The facility endeavors to always promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality. The facility has policies and procedures designed to maintain these goals. Dignity training is one of many components covered in ongoing training. It is the facility's intent to ensure all new employees are instructed regarding dignity policies and procedures. Resident and family satisfaction surveys, resident interviews and observations, resident council meetings, consultant reviews and various quality assurance measures are examples of the many components utilized.</p> <p>1. Corrective Action- CNA #1 was counseled by Director of Nursing (DoN) on 6/22/15 regarding not providing timely incontinence care for Resident #72 at noon on 06/22/15. CNA #1 was re-assigned to non-resident care duties until dignity re-training was provided by the DoN on 06/23/15.</p> <p>Starting 06/22/15, the DoN, Quality</p>	7/17/15	

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

TITLE

(X6) DATE

Electronically Signed

07/17/2015

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 241	<p>Continued From page 1</p> <p>The resident ' s urinary incontinence Care Area Assessment (CAA) dated 5/21/2015 documented " resident triggered due to inability to toilet and total incontinence of bladder and bowel. Resident is diagnosed with degenerative joint disease and coronary artery disease. She has been incontinent since admission to facility in 2013. Resident wears briefs for protection and containment. Incontinent care is managed by staff every 2 hour and as needed. "</p> <p>Resident # 72 care plan dated 6/3/2015 indicated the resident with a problem of " functional bladder incontinence due to confusion, dementia and impaired mobility. " the care plan indicated the goal as " the resident will remain free from skin breakdown due to incontinence and brief use through next review. " The care plan intervention included: The resident uses disposable briefs, clean perineal area with each incontinence episode, check every round as required for incontinence. "</p> <p>Review of the meal times revealed on 6/22/2015 at 12:00 Noon, lunch was served on the A hall where Resident # 72 resided.</p> <p>On 6/22/2015 at 12:41 PM, Resident # 72 was observed to be leaning on one side of the bed while sitting in bed. Resident had just finished eating as she still had food spillage on her table. The trays were also observed on the hallway. The resident was asked whether she was okay. The resident stated that she was not okay because she was feeling itchy in her buttocks and she was very uncomfortable sitting in bed while wet. The resident added she had notified Nurse Aide (NA)</p>	F 241	<p>Assurance (QA) Nurse, and Infection Control (IC) Nurse conducted interviews with all residents able to be interviewed regarding personal care interactions and their feelings regarding dignity.</p> <p>Starting on 06/22/15, Administrator, DoN, QA Nurse, IC Nurse, MDS Nurses, Staff Development Coordinator (SDC) and Social Worker (SW) increased observations of dining & in-room care experiences. Instructions to caregivers on how to enhance the care experience are being provided, if appropriate, during observations.</p> <p>2. Id of Others- Starting 06/22/15, the DoN, IC Nurse, and QA Nurse conducted interviews with all residents able to be interviewed regarding personal care regarding their feelings and dignity. No other residents identified.</p> <p>3. Measures- Starting on 06/22/15, the Administrator, DoN, QA Nurse, IC Nurse, MDS Nurses, SDC and SW increased observations of dining & in-room care experiences. Instructions to caregivers on how to enhance the care experience are being provided, if appropriate, during observations.</p> <p>The DoN, SDC, QA Nurse and IC Nurse verbally started on 06/22/15 staff re-training. Formal in-service re-training conducted on 06/23/15, 06/24/15, 06/25/15 and 06/28/15. Re-training covered the importance of being observant for needed incontinence care</p>		

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F 241	<p>Continued From page 2</p> <p># 1 who was her aide to change her before eating her lunch but she did not come back to change her. The resident also added she just ate her lunch while wet and NA # 1 came back and picked the tray but failed to come back to change her brief. The resident added she felt very sad, helpless and useless eating while wet and sitting in her bed wet for long period of time.</p> <p>On 6/22/2015 at 12:52 PM, NA # 1 was asked whether Resident # 72 had requested for her brief to be changed before eating her lunch and NA # 1 said that the resident was right that she had asked to be changed but she(NA # 1) was busy taking care of Resident # 72 ' s roommate. NA # 1 further stated even after Resident # 72 had finished eating her lunch she forgot to change the resident because she was still busy taking care of other residents in the hall. NA # 1 also reported that she should have asked for assistance from other staff to help her with changing the resident but she was afraid that she was going to get in trouble. When NA # 1 was asked why she did not change the resident before she (the resident) started eating she stated her priority was feeding the roommate. She added she forgot to change the resident because she did not think the resident was wet.</p> <p>During an interview with Nurse # 1 on 6/22/2015 at 2: 00 PM, she stated that Nurse ' s aides at the facility were expected to change the residents as soon as they request to be changed. The Nurse # 1 added if the Nurse ' s Aide (NA) was unable to change a resident briefs then they were expected to ask for assistance from other staff member.</p> <p>During an interview with the Unit Manager on 6/22/2015 at 3: 00 PM, she stated that Nurse ' s</p>	F 241	<p>during all forms of resident interactions (dining environment, caregiver interaction, the importance of knocking on doors before entering; privacy and being observant were other aspects emphasized during the re-training sessions).</p> <p>As part of the QA process, dignity was one of the topics for the July monthly in-service training schedule. That training was presented for all clinical care staff (RNs, LPNs & CNAs) by the DoN, SDC and QA Nurse from 07/13/15 - 07/17/15. Any clinical staff member who did not receive in-service training by 7/17/15 will not be allowed to work until re-training has been completed.</p> <p>Since Hospice contract in place, Hospice Director in-serviced their clinical care staff regarding dignity on 7/10/15 & 7/16/15.</p> <p>4. Monitor- A Quality Assurance (QA) study was implemented under the supervision of the Administrator to monitor resident care, staff interactions and dignity. The DoN, SDC, QA Nurse, IC Nurse or Weekend RN Supervisor will utilize the QA tool "Survey QA Tool to Ensure Dignity". The monitoring will include observing incontinence care and dining experiences. At least five (5) residents will be reviewed weekly for four weeks; then weekly for three months or until resolved by QOL/QA committee.</p> <p>Findings will be given to the weekly Quality of Life- QA committee and</p>		

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

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F 241	Continued From page 3 aides at the facility were responsible for answering call lights and making sure the resident were dry not wet before meal times. She added that Resident # 72 brief should have been changed before she ate her meal. The Unit Manager also added NA # 1 had been in serviced about responding to the residents ' incontinent needs before meal times. During an interview with the Director of Nursing on 6/23/2015 at 12:30 PM, she stated that her expectation was for the Nurse ' s Aides at the facility to check residents and change the residents ' briefs before eating their meals. The DON also stated that when a resident request to be changed then the expectation was for the Nurse ' s aides to stop what they were doing and change the resident.	F 241	corrective action initiated as appropriate. Results of the audits will then be submitted for review at the monthly QA Meeting.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		7/17/15	

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F 279	<p>Continued From page 4</p> <p>due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a care plan to address significant weight loss for 1 of 7 sampled residents (Resident #62) reviewed for nutrition. Findings included:</p> <p>Resident #62 was admitted to the facility on 02/27/15 and readmitted on 04/28/15. The resident's documented diagnoses included hypertension, cerebrovascular accident, chronic anemia, and osteoporosis.</p> <p>The resident's monthly Weight Report documented his February 2015 weight was 154 pounds, and his March 2015 weight was 150 pounds.</p> <p>A 04/28/15 hospital Discharge Summary documented Resident #62 was hospitalized from 04/02/15 until 04/28/15.</p> <p>The resident's monthly Weight Report documented his May 2015 weight was 127 pounds.</p> <p>The resident's monthly Weight Report documented his June 2015 weight was 119 pounds.</p> <p>Resident #62 lost 35 pounds or experienced a 22.7% weight loss in approximately three months (between 02/27/15 when he weighed 154 pounds</p>	F 279	<p>It is this facility's philosophy and normal practice to use the results of the assessment to develop, review and revise the resident's comprehensive care plan. The facility has in place developed written policies and procedures. The Interdisciplinary Care Plan Team are trained during their orientation period the processes for developing a comprehensive plan of care. The Nurse Consultant, other support advisors provide routine refresher training and in-services. Physician reviews, consultant reviews, quality assurance monitoring and staff training are examples of the various components utilized. Interdisciplinary Care Plans are developed for each resident, and are designed to address potential problems, and offer approaches designed to meet specific goals.</p> <p>1. Corrective Action- Resident #62's weight interventions were re-assessed by the Dietary Manager (DM) and Registered Dietician (RD) on 06/25/15.</p> <p>Resident #62's individualized plan of care was amended on 6/26/15 by the MDS Coordinator to include weight loss, incorporating the already in place goals and interventions.</p>		

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F 279	<p>Continued From page 5 and the first week in June 2015 when he weighed 119 pounds).</p> <p>A 06/12/15 Interdisciplinary Progress Note documented Resident #62's weight dropped to 115 pounds.</p> <p>Review of Resident #62's care plan reviewed weight loss was never identified as a problem.</p> <p>At 2:09 PM on 06/26/15 the Minimum Data Set (MDS) Coordinator stated she was responsible for developing care plans to address weight loss. After reviewing Resident #62's care plan, she reported it did not identify weight loss as a problem. She explained she must not have been notified that the resident experienced significant weight loss. According to the MDS Coordinator, this notification would have come from the weight committee which met weekly or from the nutrition section of the MDS assessments which identified significant weight loss at 30 or 180 days. Upon review of Resident #62's weights, she commented the resident's care plan should have addressed weight loss. She stated care plans were supposed to address newly emerging problems, such as Resident #62's weight loss, between quarterly MDS assessments.</p>	F 279	<p>2. Id of Others- All residents with weight loss was reviewed by the MDS Coordinator from 06/26/15 through 7/03/15. Starting on 07/05/15, the Director of Nursing (DoN) re-audited care plans for those residents with a potential for weight loss or actual weight loss to ensure, where appropriate, weight loss goals and interventions were addressed on the residents' plan of care.</p> <p>3. Measures- The weight committee monitoring process was reviewed and revised by the DoN and Nurse Consultant.</p> <p>An in-service was conducted on 06/26/15 by the DoN for the Interdisciplinary Team (IDT) regarding monitoring process and care plans to address weight loss concerns and any interventions utilized.</p> <p>Weight committee will continue to meet weekly and audit charts to ensure that weight loss care plans are in place as indicated.</p> <p>4. Monitor- Nurse Consultant will monitor weight process revisions during the July and August visits.</p> <p>A Quality Assurance (QA) study was implemented under the supervision of the DoN to monitor weight loss care plans. The DoN and Weight Committee will utilize the QA tool "Survey QA Tool for Comprehensive Care Plans". The monitoring will include reviewing charts of residents with weight loss to ensure weight loss care plans are in place. This</p>		

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F 279	Continued From page 6	F 279	will be done weekly for three months or until resolved by QOL/QA committee. Findings will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be submitted for review at the monthly QA Meeting.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews the facility failed to provide incontinence care for 1 of 1 sampled resident who requested to be changed before meal time but was left wet during lunch time. (Resident # 72) The findings included: Resident # 72 was admitted to the facility on 4/23/2013 and readmitted on 3/10/2015 with	F 315	The facility endeavors to always promote incontinent care for residents to assure appropriate treatment and services in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality. The facility has policies and procedures designed to maintain these goals. Incontinence training is one of many components covered in ongoing training. It is the facility's intent to ensure	7/17/15	

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F 315	<p>Continued From page 7</p> <p>diagnoses which included difficulty walking, muscles weakness, and lack of coordination, abnormal posture and hypertension.</p> <p>Review of the resident ' s urinary incontinence management evaluation dated 2/16/2015 revealed the resident scored 1 point which indicated the resident was not a candidate for scheduled toileting program.</p> <p>The quarterly Minimum Data Set (MDS) dated 5/21/2015 indicated Resident # 72 was alert and oriented with mild cognitive impairment. The MDS also indicated the resident was incontinent of bowel and bladder and required 1 person assist with the transfers .The MDS also indicated the resident required extensive assistance with 2 person assist with Activities of Daily Living(ADL).</p> <p>The resident ' s urinary incontinence Care Area Assessment (CAA) dated 5/21/2015 documented " resident triggered due to inability to toilet and total incontinence of bladder and bowel. Resident is diagnosed with degenerative joint disease and coronary artery disease. She has been incontinent since admission to facility in 2013.Resident wears briefs for protection and containment. Incontinent care is managed by staff every 2 hour and as needed. "</p> <p>Resident # 72 care plan dated 6/3/2015 indicated the resident with a problem of " functional bladder incontinence due to confusion, dementia and impaired mobility. " the care plan indicated the goal as " the resident will remain free from skin breakdown due to incontinence and brief use through next review. " The care plan intervention included: The resident uses disposable briefs,</p>	F 315	<p>all new clinical employees are instructed regarding incontinence policies and procedures. Resident and family satisfaction surveys, resident interviews and observations, skills checks, consultant reviews and various quality assurance measures are examples of the many components utilized.</p> <p>1. Corrective Action- CNA #1 was counseled by Director of Nursing (DoN) on 6/22/15 regarding not providing timely incontinence care for Resident #72 at noon on 06/22/15. CNA #1 was re-assigned to non-resident care duties until dignity re-training was conducted by Director of Nursing (DoN) on 06/23/15.</p> <p>Starting on 06/22/15, the Administrator, DoN, Quality Assurance (QA) Nurse, Infection Control (IC) Nurse, MDS Nurses, Staff Development Coordinator (SDC) and Social Worker (SW) increased observations of dining & in-room care experiences concentrating on personal care and incontinence care. Instructions to caregivers on how to enhance the care experience are being provided, if appropriate, during observations.</p> <p>2. Id of Others- Starting on 06/22/15, the Administrator, DoN, QA Nurse, IC Nurse, MDS Nurses, SDC and SW increased observations of dining & in-room care experiences.</p> <p>Starting 06/22/15 the DoN, SDC, QA Nurse and IC Nurse conducted observations of other incontinent</p>		

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F 315	<p>Continued From page 8</p> <p>clean perineal area with each incontinence episode, check every round as required for incontinence. "</p> <p>Review of the meal times revealed on 6/22/2015 at 12:00 Noon, lunch was served on the A hall where Resident # 72 resided.</p> <p>On 6/22/2015 at 12:41 PM, Resident # 72 was observed to be leaning on one side of the bed while sitting in bed. Resident had just finished eating as she still had food spillage on her table. The trays were also observed on the hallway. The resident was asked whether she was okay. The resident stated that she was not okay because she was feeling itchy in her buttocks and she was very uncomfortable sitting in bed while wet. The resident added she had notified Nurse Aide (NA) # 1 who was her aide to change her before eating her lunch but she did not come back to change her. The resident also added she just ate her lunch while wet and NA # 1 came back and picked the tray but failed to come back to change her brief. The resident added she felt very sad, helpless and useless eating while wet and sitting in her bed wet for long period of time.</p> <p>On 6/22/2015 at 12:52 PM, NA # 1 was asked whether Resident # 72 had requested for her brief to be changed before eating her lunch and NA # 1 said that the resident was right that she had asked to be changed but she(NA # 1) was busy taking care of Resident # 72 ' s roommate. NA # 1 further stated even after Resident # 72 had finished eating her lunch she forgot to change the resident because she was still busy taking care of other residents in the hall. NA # 1 also reported that she should have asked for assistance from</p>	F 315	<p>residents focusing on personal care and incontinence care.</p> <p>From 06/23/15 to 07/09/15 DoN, QA Nurse, and IC Nurse re-assessed all resident bladder assessments, care guides and care plans.</p> <p>3. Measures- Starting on 06/22/15 the Administrator, DoN, QA Nurse, IC Nurse, MDS Nurses, SDC and SW increased observations of dining & in-room care experiences. Instructions to caregivers on how to enhance the care experience are being provided, if appropriate, during observations.</p> <p>The DoN, SDC, QA Nurse and IC Nurse verbally started on 06/22/15 staff re-training. Formal in-service re-training conducted on 06/23/15 06/24/15, 06/25/15 and 06/28/15. Re-training covered the importance of being observant for needed incontinence care during all forms of resident interactions and being observant were some of the aspects emphasized during the re-training sessions.</p> <p>As part of the QA process, incontinence care was added to the July monthly in-service training schedule. That training was presented for all clinical care staff (RNs, LPNs & CNAs) by the DoN, SDC and QA Nurse from 07/13/15 - 07/17/15. Any clinical staff member who did not receive in-service training by 7/17/15 will not be allowed to work until re-training has been completed.</p>		

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F 315	<p>Continued From page 9</p> <p>other staff to help her with changing the resident but she was afraid that she was going to get in trouble. When NA # 1 was asked why she did not change the resident before she (the resident) started eating she stated her priority was feeding the roommate. She added she forgot to change the resident because she did not think the resident was wet.</p> <p>During an interview with Nurse # 1 on 6/22/2015 at 2: 00 PM, she stated that Nurse ' s aides at the facility were expected to change the residents as soon as they request to be changed. The Nurse # 1 added if the Nurse ' s Aide (NA) was unable to change a resident briefs then they were expected to ask for assistance from other staff member.</p> <p>During an interview with the Unit Manager on 6/22/2015 at 3: 00 PM, she stated that Nurse ' s aides at the facility were responsible for answering call lights and making sure the resident were dry not wet before meal times. She added that Resident # 72 brief should have been changed before she ate her meal. The Unit Manager also added NA # 1 had been in serviced about responding to the residents ' incontinent needs before meal times.</p> <p>During an interview with the Director of Nursing on 6/23/2015 at 12:30 PM, she stated that her expectation was for the Nurse ' s Aides at the facility to check residents and change the residents ' briefs before eating their meals. The DON also stated that when a resident request to be changed then the expectation was for the Nurse ' s aides to stop what they were doing and change the resident.</p>	F 315	<p>Since Hospice contract in place, Hospice Director(s) in-serviced their clinical care staff regarding incontinence care observations on 7/10/15 & 7/16/15.</p> <p>4. Monitor- A Quality Assurance (QA) study was implemented under the supervision of the Administrator to monitor resident care, staff interactions and dignity. The DoN, SDC, QA Nurse, IC Nurse or Weekend RN Supervisor will utilize the QA tool "Survey QA Tool to Ensure Incontinent Residents Are Being Changed Timely and When Requested". The monitoring will include observing incontinence care. At least five (5) residents will be reviewed weekly for four weeks; then weekly for three months or until resolved by QOL/QA committee.</p> <p>Findings will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.</p> <p>Results of the audits will then be submitted for review at the monthly QA Meeting.</p>		
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		7/17/15	

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F 325 SS=D	<p>Continued From page 10 UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review the facility failed to provide physician-ordered large portions as an intervention for weight loss to 1 of 7 sampled residents (Resident #62) reviewed for nutrition. Findings included:</p> <p>Resident #62 was admitted to the facility on 02/27/15 and readmitted on 04/28/15. The resident's documented diagnoses included hypertension, cerebrovascular accident, chronic anemia, and osteoporosis.</p> <p>The resident's monthly Weight Report documented his February 2015 weight was 154 pounds, and his March 2015 weight was 150 pounds.</p> <p>Resident #62's 03/06/15 admission Minimum Data Set (MDS) documented his cognition was severely impaired, he was independent with eating, and his weight was stable.</p>	F 325	<p>The facility continually strives to ensure a resident's nutritional status is maintained unless unavoidable through various sources and programs both internal and external including but not limited to chart audits, weight records, dietary tracking, dietician audits, physician reviews, QA studies, and other system processes.</p> <p>1. Corrective Action- Resident #62's weight interventions were re-assessed by the Dietary Manager (DM) and Registered Dietician (RD) on 06/25/15.</p> <p>Re-training was conducted on 06/25/15 and 07/07/15 for staff by the DM on tray card accuracy and the importance of following the diets/portions.</p> <p>Resident #62's individualized plan of care was amended on 6/26/15 by the MDS Coordinator to include weight loss,</p>		

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F 325	<p>Continued From page 11</p> <p>A 04/28/15 hospital Discharge Summary documented Resident #62 was hospitalized from 04/02/15 until 04/28/15.</p> <p>A 04/28/15 re-admit comprehensive Nutritional Assessment documented Resident #62 was readmitted to the facility on a regular, mechanical soft diet with 120 cubic centimeters (cc) of liquid nutritional supplement twice daily (BID).</p> <p>The resident's monthly Weight Report documented his May 2015 weight was 127 pounds.</p> <p>A 05/22/15 physician's order and Diet Requisition Form documented Resident #62 was to start receiving large portions at lunch and supper.</p> <p>A 05/22/14 Interdisciplinary Progress Note documented a weekly weight meeting was held, and Resident #62 had double portions added to his lunch and supper meals to help prevent further weight loss.</p> <p>A 05/24/15 quarterly MDS documented Resident #62's short and long term memory were impaired, his decision making skills were moderately impaired, he required set-up assistance only with meals, and his weight was stable with no significant weight loss or gain in the last thirty or one hundred and eighty days.</p> <p>Review of Resident #62's care plan reviewed weight loss was never identified as a problem.</p> <p>The resident's monthly Weight Report documented his June 2015 weight was 119 pounds.</p>	F 325	<p>incorporating the already in place goals and interventions. Resident #62 is now being fed by staff. Resident #62 is on weekly weights and will have a re-evaluation on 07/17/15 to see if weekly weights need to continue.</p> <p>2. Id of Others- DM and RD audited all charts and updated, if appropriate, the Meal Tracker System.</p> <p>A weight assessment was conducted by MDS and the Director of Nursing (DoN) from 06/26/15 through 7/03/15 to ensure there were no other residents with significant weight change not receiving interventions as planned/directed.</p> <p>On 06/26/15, DoN audited care plans for those residents with a potential for weight loss or actual weight loss to ensure, where appropriate, weight loss goals and interventions were addressed on residents' plan of care. The review revealed no other residents.</p> <p>3. Measures- Re-training was conducted on 06/25/15 and 07/07/15 for all dietary staff by the DM on tray card accuracy and the importance of following the diets/portions. Clinical staff was retrained regarding checking tray slips for accuracy on 06/23/15, 06/24/15, 06/25/15 and 06/28/15.</p> <p>DM or their designee will conduct tray line audits for tray accuracy. Audits will continue for at least 6 months or until QA team determines that staff is following tray</p>		

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F 325	<p>Continued From page 12</p> <p>A 06/10/15 physician's order changed Resident #62's liquid nutritional supplement to 2-calorie 120 cc three times daily (TID).</p> <p>A 06/12/15 Interdisciplinary Progress Note documented Resident #62's weight dropped to 115 pounds.</p> <p>At 5:52 PM on 06/24/15 nursing assistant (NA) #2 was feeding supper to Resident #62 in his room. She stated the resident would eat everything if the staff took the time to feed him. The resident's tray slip documented he was to receive "large portions". However, Resident #62 had the same amount of chicken and dumplings and Capri vegetable blend as other residents on the same hall who received regular portions. The NA commented the staff checked meal slips against the trays to make sure residents received supplements, likes and dislikes were honored, and residents received the correct food consistency and portion sizes.</p> <p>At 5:45 PM on 06/25/15 the dietary manager (DM) stated Resident #62 did not receive large portions of ground meatloaf or vegetables although his tray slip specified "large portions". He reported at the kitchen trayline the caller was supposed to call out information on the tray slips such as diet prescription, dislikes, and supplements. According to the DM, the cook then honored the information which was called out as she prepared the plates, and repeated the information back to the caller as the plate was passed back across the production line. He commented he was not always sure there was visual inspection of the plates before being placed on trays and into meal carts.</p>	F 325	<p>card procedures (Month 1- at least 6 days, 2 meals; Month 2- at least 5 days, 2 meals; Month 3- at least 4 days, 2 meals; Month 4- at least 3 days, 2 meals (random as needed); Month 5- at least 3 days, 2 meals (random as needed) and Month 6- 2 days, 2 meals (random as needed)).</p> <p>An in-service was conducted on 06/26/15 by the DoN for the Interdisciplinary Team (IDT) regarding monitoring process and care plans to address weight concerns and any interventions utilized.</p> <p>The weight monitoring process was reviewed and revised by the DoN and Nurse Consultant. All weight data collected for the MDS will continue to be reviewed by the IDT and Weight Committee. The data for weight change will be compared with the weight report which includes daily weights, weekly weights, and monthly weights. All residents that trigger for weight change, > 5% in 30 days or >10% in 6 months will be identified and interventions monitored. The facility care plan team will continue to create a plan of care that addresses actual weight change or weight change potential. Weight committee will continue to meet weekly and audit charts to ensure that weight loss care plans are in place as indicated.</p> <p>4. Monitor- Nurse Consultant will monitor weight process revisions during July and August visits.</p> <p>With weight reviews occurring on a</p>		

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F 325	Continued From page 13 At 10:55 AM on 06/26/15 the DM stated when tray slips specified "large portions" the residents were to receive larger portions of all foods. He explained some residents only received large portions of protein foods, but this would be noted on the meal tickets. He reported residents received large portions to prevent weight loss, promote wound healing, and to improve low albumin and pre-albumin levels. However, he commented he thought the large portions provided to Resident #62 were to address weight loss. At 11:50 AM on 06/26/15 NA #3 stated NAs were supposed to match the tray slips against the plates when they set up resident meal trays. She reported the staff was looking to make sure residents received supplements, likes and dislikes were honored, and residents received the correct diet consistencies and portion sizes as documented on the tray slips. At 2:18 PM on 06/26/15 NA #4 stated monthly weights were obtained starting the first of each month, and it took about three of four days to obtain weights for all residents in the building. She reported Resident #62 lost a considerable amount of weight since being hospitalized in April 2015.	F 325	weekly and quarterly basis, the management nursing staff will be able to review the effectiveness of all interventions in place to prevent unavoidable weight change and that the MDS data is being entered correctly. Findings will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of both clinical and dietary audits will then be submitted for review at the monthly QA Meeting.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		7/17/15	

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F 371	<p>Continued From page 14 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain egg salad made with mayonnaise at 41 degrees Fahrenheit or below during the operation of the kitchen trayline. Findings included:</p> <p>At 5:55 PM on 06/22/15 egg salad sandwiches were observed in a thick foil pan on a cart. There were no interventions in place to keep the sandwiches cold.</p> <p>At 5:57 PM on 06/22/15 a digital thermometer was used to check the temperature of the egg salad filling in the sandwiches. The egg salad registered 64.7 degrees Fahrenheit. At this time the dietary manager (DM) reported the egg salad was assembled around 3:00 PM on 06/22/15, and the sandwiches were stored in the walk-in refrigerator until the trayline began operation. He stated there were only three more carts left to go out to residents who ate in their rooms on different halls.</p> <p>Review of the facility's trayline temperature log revealed no temperature was documented on the egg salad as the 06/22/15 supper trayline began operation. In fact, there were no temperatures recorded on cold salads in the log during the month of June 2015 what so ever.</p> <p>At 9:05 AM on 06/24/15 the DM stated the facility</p>	F 371	<p>It has been the policy and normal practice of this facility to store, prepare, distribute and serve food under sanitary conditions as reflected through the County Sanitation Inspections and outside contractor audits. The facility has policies and procedures designed to maintain these goals. Ongoing outside contractor audits Health Department inspections, NC DHSR inspections, dietician planning, consultant reviews, quality assurance monitoring and staff training are examples of the components utilized.</p> <ol style="list-style-type: none"> 1. Corrective Action- The egg salad sandwiches were prepared as an alternate substitution option. No one had been served the substitution. As a precautionary measure, the sandwiches were discarded immediately upon discovery of the out of range recommended temperature. 2. Id of Others- An inspection of all food temperatures was conducted by the Dietary Manager (DM) on 06/22/15 to ensure that no other items had out of range recommended temperatures. 3. Measures- To prevent this from occurring again procedural changes were 		

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F 371	<p>Continued From page 15</p> <p>made its own egg salad. He reported it contained eggs, mayonnaise, relish, and black pepper. He remarked the facility kept egg salad made up almost all the time because the residents enjoyed sandwiches with and between meals. Once the trayline began operation, he commented it took about an hour to run all the meal carts out of the kitchen.</p> <p>At 10:55 AM on 06/26/15 the DM stated the PM assistant cook usually made up enough egg salad to last for a couple of days. He stated most of the time the egg salad sandwiches she assembled were not used until the next day.</p> <p>At 11:03 AM on 06/26/15 the AM cook stated cold salads made with mayonnaise were usually prepared around 10:30 AM, and used at the upcoming lunch and supper meals. She reported any leftover salad was usually disposed of at the end of the day, and fresh was prepared the next morning.</p>	F 371	<p>implemented on 06/23/15. Dietary staff will prepare any cold foods/sandwiches the day prior with a log for temperatures and proper labeling/dating.</p> <p>Verbal re-training with dietary staff started on 06/22/15. Formal in-service training was conducted on 06/23/13 by the DM regarding proper prep/storage, chilling process, tray service, cold and hot food temperature monitoring and temperature recording logs all cold/hot food items.</p> <p>4. Monitor- Temperature testing on food tray line items and trays delivered to residents prior to serving will be completed by the cook and recorded on the appropriate logs.</p> <p>The DM or designee will conduct inspections of storage, preparation and service of meals for appropriate temperature ranges.</p> <p>Audits will continue for at least 6 months or until QA team determines that staff is following temperature guidelines: (Month 1- at least 6 days, 2 meals; Month 2- at least 5 days, 2 meals; Month 3- at least 4 days, 2 meals; Month 4- at least 3 days, 2 meals (random as needed); Month 5- at least 3 days, 2 meals (random as needed) and Month 6- 2 days, 2 meals (random as needed)).</p> <p>Results of the inspections will be reported and reviewed in the monthly facility QA meetings for the next 3 months.</p>		

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

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F 371	Continued From page 16	F 371			
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) 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.</p> <p>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.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, Pharmacist, Pharmacist Nurse Consultant, and staff interviews the contracted pharmacy failed to monitor the medication refrigerator temperature logs that were posted on the doors of the refrigerators for temperatures that were out of range for medications stored in 2 of 3 refrigerators. Findings included: Review of the (name of pharmacy) Pharmacy</p>	F 425	<p>Results of audits will be submitted for review at the monthly QA Meeting.</p> <p>The facility utilizes a clinical pharmacy to provide the system and services of licensed pharmacists that are in accordance with state and federal guidelines related to drugs and biologicals, their records, labeling and storage. The pharmacy provides consultation on all aspects of the provision of pharmacy services in the</p>	7/17/15	

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F 425	Continued From page 17 Services Policy dated 01/01/12 revealed under K, "Medications requiring refrigeration or temperatures between 2 degrees C (36 F) and 8 degrees C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring." Under O, the policy revealed, "Medication storage conditions are monitored on a (monthly) basis by (the consultant pharmacist) and corrective action taken if problems are identified." Review of the Unit C Medication Refrigerator Temperature Log dated May 2015 revealed recorded temperatures for 05/16/15 through 05/18/15 and 05/21/15 through 05/24/15. No other temperatures were recorded. The log showed the temperature should be between 36 and 46 degrees. There was no Unit C Medication Refrigerator Temperature Log dated June 2015. Review of the Unit D Medication Refrigerator Temperature Log dated May 2015 revealed 4 days where refrigerator temperatures were not recorded. The log did not specify what temperature the refrigerator should be kept at. The Unit D June 2015 Medication Refrigerator Temperature Log revealed the temperature should be 36-46 degrees. The temperature for 06/01/15 was not recorded. There were five recorded temperatures less than 36 degrees with no corrections to the temperature noted. Review of the 05/20/15 Medication Room Compliance Report completed by the Pharmacy Nurse Consultant for Unit A revealed proper temperature was maintained (36-46 degrees). No Medication Room Compliance Reports were completed for Units C and D. An observation on 06/25/15 at 5:00 PM revealed the Unit C medication refrigerator temperature was 52 degrees. This temperature was verified by Nurse #2.	F 425	facility. There are multiple internal and external checks and balances established to monitor the various drug and biological systems. 1. Corrective Action- Any liquid vaccines and medications that could have been potentially affected by the out of range temperatures in the affected refrigerators were removed immediately by Quality Assurance (QA) Nurse and Director of Nursing (DoN). Vaccines and medications were returned to the pharmacy that evening. Pharmacy replaced liquid vaccines and medication that were removed with their next delivery. All medication refrigerators were checked by maintenance to ensure proper operation. Units were adjusted and rechecked thirty (30) minutes later, all medication refrigerators were within recommended temperature range. Unit nurses re-checked all refrigerator temperatures every hour for the next 24-hours to ensure temperatures were not fluctuating. Findings reported to the DoN. With temperatures remaining within range, daily checks resumed per policy. 2. Id of Others- The remaining unit refrigerator was checked and the temperature was within range. Logs reflected temperatures within recommended range. 3. Measures- A revised temperature log		

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F 425	<p>Continued From page 18</p> <p>In an interview on 06/25/15 at 5:03 PM Nurse #2 verified the temperature log on the front of the refrigerator was for May. She stated she did not know where the June temperature log was. Nurse #2 indicated a refrigerator temperature of 52 degrees was too high.</p> <p>An observation on 06/25/15 at 5:22 PM revealed the Unit D medication refrigerator temperature was 25 degrees. This temperature was verified by Nurse #3.</p> <p>In an interview on 06/25/15 at 5:25 PM Nurse #3 stated she needed to call maintenance and also keep the refrigerator door closed. She stated if the refrigerator temperatures were out of range the medications should not be used.</p> <p>In an interview on 06/25/15 at 6:20 PM the Director of Nursing stated no temperature log was done for the Unit C refrigerator in June. She indicated it was a problem that the refrigerator temperatures were out of range.</p> <p>In an interview on 06/25/15 at 6:38 PM the Pharmacy Manager indicated the Pharmacist Nurse Consultant should check the medication refrigerator logs monthly. He stated medication refrigerators should be kept between 36 degrees and 46 degrees. The Pharmacy Manager stated a refrigerator temperature of 32 degrees or less was below freezing and the medications in the refrigerator should not be used. He indicated that if it was unknown what the medication refrigerator temperatures were (dates not recorded) there was no way to tell if the temperatures were below freezing therefore the medications should not be used. The Pharmacy Manager stated any tuberculins, insulins, epogen, Procrit, and vaccines (pneumonia, Hepatitis B) should be either discarded or returned to the pharmacy. He indicated 25 degrees was too cold and 52 degrees was too warm for the storage of</p>	F 425	<p>was implemented to record corrective action(s) if temperatures fluctuate outside of recommended range. Facility Quality Assurance (QA) Nurse and Infection Control (IC) Nurse will be responsible to audit each medication refrigerator at least weekly to ensure compliance. The third shift nurse on each unit or designee remains responsible for recording and auditing the temperature logs to ensure appropriate ranges.</p> <p>DoN conducted training from 06/25/15 through 06/28/15 with nurses and medication aides on policies and procedures regarding checking and recording temperatures and steps to take if temperature is out of range.</p> <p>The pharmacy audit process was amended to ensure pharmacy RN consultant inspected all medication refrigerators and logs each month; reporting out of range findings to DoN, designee and/or maintenance.</p> <p>An in-service was conducted with all pharmacy nurses and other appropriate pharmacy staff by Pharmacy's Clinical Services Director on 07/15/15.</p> <p>4. Monitor- QA Nurse, IC Nurse or their designee will randomly audit medication refrigerators and logs weekly for temperatures within range, complete log recordings and corrective action, if appropriate, for the next three months to ensure effectiveness of the plan.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/26/2015
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301		
(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 425	Continued From page 19 medications. In an interview on 06/26/15 at 3:05 PM the Pharmacy Nurse Consultant indicated she did not monitor each medication room refrigerator monthly. She stated she rotated the halls each month unless the facility had a particular concern about a unit. She indicated if the temperature logs were available she checked them. When questioned further, The Pharmacy Nurse Consultant confirmed the temperature logs had never been unavailable. She stated she did not report the refrigerator temperature discrepancies as she did not realize there was a problem since she did not monitor all the units' medication refrigerators. She indicated medications should be maintained between 36 and 46 degrees. The Pharmacy Nurse Consultant stated medications that were kept outside the parameters should not be used, especially if they had been stored below 32 degrees as ice crystals may have formed in the medications.	F 425	DoN will provide a report to the facility Quality Assurance Committee (QA) monthly for the next three (3) months to monitor effectiveness of the plan and/or until satisfied that the desired outcomes are achieved.		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		7/17/15	

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F 431	<p>Continued From page 20 applicable.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to store medications at recommended temperatures for 2 of 3 medication refrigerators. Findings included: Review of the Unit C Medication Refrigerator Temperature Log dated May 2015 revealed recorded temperatures for 05/16/15 through 05/18/15 and 05/21/15 through 05/24/15. No other temperatures were recorded. The log showed the temperature should be between 36 and 46 degrees. There was no Unit C Medication Refrigerator Temperature Log dated June 2015. Review of the Unit D Medication Refrigerator Temperature Log dated May 2015 revealed 4 days where refrigerator temperatures were not recorded. The log did not specify what</p>	F 431	<p>It is the policy and normal practice of this facility to store medications at recommended temperatures in accordance with currently accepted professional principles. There are multiple internal and external checks and balances established to monitor the various drug and biological systems.</p> <p>1. Corrective Action- Any liquid vaccines and medications that could have been potentially affected by the out of range temperatures in the affected refrigerators were removed immediately by Quality Assurance (QA) Nurse and Director of Nursing (DoN).</p>		

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F 431	<p>Continued From page 21</p> <p>temperature the refrigerator should be kept at. The Unit D June 2015 Medication Refrigerator Temperature Log revealed the temperature should be 36-46 degrees. The temperature for 06/01/15 was not recorded. There were five recorded temperatures less than 36 degrees with no corrections to the temperature noted. Observations of the Unit C and Unit D refrigerators showed the following medications were stored there: Tuberculin Purified Protein Derivative (PPD), various insulins, Procrit, Hepatitis B Vaccines, and pneumococcal vaccines.</p> <p>Review of the Tuberculin Purified Protein Derivative (PPD) manufacturer instructions revealed under Storage: "Store at 2 degrees to 8 degrees C (Celsius) 35 to 46 degrees F (Fahrenheit). Do not freeze (bold letters). Discard product if exposed to freezing."</p> <p>Review of the United States Food and Drug Administration literature revealed, "According to the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36 F to 46 F. Avoid freezing the insulin. Do not use insulin that has been frozen."</p> <p>Review of the Prescribing Information for Procrit showed it should not be used if frozen. Procrit in multi-dose vials should be stored at 36°F to 46°F (2°C to 8°C).</p> <p>Review of the Vaccine Storage Temperatures showed the Hepatitis B and pneumococcal vaccines should be, "stored at 35-46 degrees. Irreversible loss of potency occurs with exposure to freezing temperatures."</p> <p>An observation on 06/25/15 at 5:00 PM revealed the Unit C medication refrigerator temperature was 52 degrees. This temperature was verified by Nurse #2.</p>	F 431	<p>Vaccines and medications were returned to the pharmacy that evening. Pharmacy replaced liquid vaccines and medication that were removed with their next delivery.</p> <p>All medication refrigerators were checked by maintenance to ensure proper operation. Units were adjusted and rechecked thirty (30) minutes later, all medication refrigerators were within recommended temperature range.</p> <p>Unit nurses re-checked all refrigerator temperatures every hour for the next 24-hours to ensure temperatures were not fluctuating. Findings reported to the DoN. With temperatures remaining within range, daily checks resumed per policy.</p> <p>2. Id of Others- The remaining unit refrigerator was checked and the temperature was within range. Logs reflected temperatures within recommended range.</p> <p>3. Measures- A revised temperature log was implemented to record corrective action(s) if temperatures fluctuate outside of recommended range. Facility Quality Assurance (QA) Nurse and Infection Control (IC) Nurse will be responsible to audit each medication refrigerator at least weekly to ensure compliance. The third shift nurse on each unit or designee remains responsible for recording and auditing the temperature logs to ensure appropriate ranges.</p> <p>DoN conducted training from 06/25/15</p>		

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F 431	<p>Continued From page 22</p> <p>In an interview on 06/25/15 at 5:03 PM Nurse #2 verified the temperature log on the front of the refrigerator was for May. She stated she did not know where the June temperature log was. Nurse #2 indicated a refrigerator temperature of 52 degrees was too high.</p> <p>An observation on 06/25/15 at 5:22 PM revealed the Unit D medication refrigerator temperature was 25 degrees. This temperature was verified by Nurse #3.</p> <p>In an interview on 06/25/15 at 5:25 PM Nurse #3 stated she needed to call maintenance and also keep the refrigerator door closed. She stated if the refrigerator temperatures were out of range the medications should not be used.</p> <p>In an interview on 06/25/15 at 6:20 PM the Director of Nursing (DON) stated no temperature log was done for the Unit C refrigerator in June. She indicated it was a problem that the refrigerator temperatures were out of range.</p> <p>In an interview on 06/25/15 at 6:38 PM the Pharmacy Manager indicated medication refrigerators should be kept between 36 degrees and 46 degrees. The Pharmacy Manager stated a refrigerator temperature of 32 degrees or less was below freezing and the medications in the refrigerator should not be used. He indicated that if it was unknown what the medication refrigerator temperatures were (dates not recorded) there was no way to tell if the temperatures were below freezing therefore the medications should not be used. The Pharmacy Manager stated any PPD, insulins, Procrit, and vaccines (pneumococcal, Hepatitis B) should be either discarded or returned to the pharmacy. He indicated 25 degrees was too cold and 52 degrees was too warm for the storage of medications.</p> <p>In an interview on 06/25/15 at 11:35 PM Nurse #4 stated it was the responsibility of the 7-3 shift</p>	F 431	<p>through 06/28/15 with nurses and medication aides on policies and procedures regarding checking and recording temperatures and steps to take if temperature is out of range.</p> <p>The pharmacy audit process was amended to ensure pharmacy RN consultant inspected all medication refrigerators and logs each month; reporting out of range findings to DoN, designee and/or maintenance.</p> <p>An in-service was conducted with all pharmacy nurses and other appropriate pharmacy staff by Pharmacy's Clinical Services Director on 07/15/15.</p> <p>4. Monitor- QA Nurse, IC Nurse or their designee will randomly audit medication refrigerators and logs weekly for temperatures within range, complete log recordings and corrective action, if appropriate, for the next three months to ensure effectiveness of the plan.</p> <p>DoN will provide a report to the facility Quality Assurance Committee (QA) monthly for the next three (3) months to monitor effectiveness of the plan and/or until satisfied that the desired outcomes are achieved.</p>		

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F 431	<p>Continued From page 23</p> <p>nurse to record the medication refrigerator temperatures. He indicated the temperatures should be kept between 40 and 45 degrees. He indicated if he found the medication refrigerator temperature to be out of range he would check the gauge to make sure it was working. If it was not working he would notify the DON so the medications could be moved. Nurse #4 stated the medications would freeze if the refrigerator temperatures registered 25 degrees and should not be used.</p> <p>In an interview on 06/25/15 at 11:43 PM Nurse #5 indicated the 11-7 nurses recorded the medication refrigerator temperatures on the logs. She stated the temperatures should be between 36 and 40 degrees. Nurse #5 stated if temperatures were out of range she would adjust the temperature and write the correction on the log.</p> <p>In an interview on 06/26/15 at 8:30 AM Nurse #6 stated it was the facility policy for the day shift nurses to record the medication refrigerator temperatures.</p> <p>In an interview on 06/26/15 at 10:00 AM the Hall Supervising Nurse stated medication refrigerator temperatures were recorded daily. She indicated if the night shift nurse did not record the temperature the day shift nurse should. She stated the nurse on each shift was responsible for checking the refrigerators. The Supervising Nurse stated medication storage refrigerators should be kept at 36-46 degrees.</p> <p>In an interview on 06/26/15 at 11:13 AM the DON stated it was the responsibility of the 11-7 shift nurse to record the medication refrigerator temperatures. She stated the Unit C May 2015 temperature log was actually for June and the nurse did not correct the date prior to recording the temperatures for June. When asked for the</p>	F 431			

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F 431	Continued From page 24 correct May 2015 temperature log, she indicated she was unable to produce it. She indicated it was her expectation that the nurses record the medication refrigerator temperatures every day. If the temperatures were not within 36-46 degrees she expected them to make corrections and note them on the log.	F 431			