

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

PRINTED: 06/28/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2017
NAME OF PROVIDER OR SUPPLIER HIGHLAND FARMS			STREET ADDRESS, CITY, STATE, ZIP CODE 200 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431 SS=D	<p>483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>(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.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(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.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in</p>	F 431		7/7/17	

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

TITLE

(X6) DATE

Electronically Signed

06/26/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 431	<p>Continued From page 1</p> <p>locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interview the facility failed to remove a container of artificial tears ointment with an out of date manufacturer's expiration date from Laurel Hall medication cart and failed to remove an expired pharmacy-dispensed package of oxycodone from Azalea Front Hall medication cart which involved 2 of 3 medication carts.</p> <p>The findings included:</p> <p>Observation on 06/07/17 at 3:17 PM of Laurel Hall medication cart revealed an unopened container of artificial tears ointment with a manufacturer expiration date of April 2017 and a pharmacy dispensed date of 05/26/17 labeled for Resident # 61.</p> <p>Observation on 06/08/17 at 9:26 AM of Azalea Front Hall medication cart revealed a partially used, pharmacy-dispensed bubble pack of oxycodone 5 milligrams (mg) tablets which contained 57 tablets labeled for Resident # 57. The pharmacy-stamped expiration date was</p>	F 431	<p>Givens Highland Farms Retirement Community wishes to have this plan of correction stand as its allegation of compliance. Our date of alleged compliance is July 7, 2017 . Preparation and execution of this plan of correction does not constitute admission to nor agreement with either the existence of or scope and severity of any cited deficiencies or conclusion set forth in the statement of deficiencies. This plan is prepared and executed to ensure continuing compliance with regulatory requirements.</p> <p>Corrective actions taken for residents found to have been affected by alleged deficient practice:</p> <p>Resident # 61: The expired artificial tears ointment was removed from the medication cart and disposed of as directed. All other medications for Resident 61 were checked for expiration dates on 6/7/2017 by the Assistant</p>		

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F 431	<p>Continued From page 2</p> <p>06/01/17 and the pharmacy dispensed date was 06/01/16.</p> <p>Review of the narcotic administration record for the bubble pack of oxycodone 5 mg indicated Resident #57 last received one tablet of oxycodone 5 mg on 06/02/17 at 7:33 PM.</p> <p>An interview on 06/08/17 at 9:45 AM with Nurse # 1 revealed each nurse administering medication was responsible for checking expiration dates of medications when they were administering them. Nurse # 1 stated the pharmacy consultant also checked the medication carts for expired medications.</p> <p>An interview on 06/08/17 at 10:10 AM with Nursing Supervisor #1 revealed each nurse was responsible for checking the medication cart for expired medication prior to administering the medication.</p> <p>An interview on 06/08/17 at 11:10 AM with Nurse # 2 revealed every nurse was responsible for checking the medication cart every shift for expired medication.</p> <p>An interview on 06/08/17 at 2:00 PM with the Pharmacy Consultant revealed the expired artificial tears eye ointment labeled for Resident # 61 was a pharmacy error because it was expired when it was sent from the pharmacy to the facility and should never have left the pharmacy. He stated that he and the pharmacy nurse consultant both did checks of the medication carts for expired medication. He stated the nurse consultant last visited in April 2017 and he last visited in May 2017.</p>	F 431	<p>Director of Nursing.</p> <p>Resident # 57: The expired Oxycodone was removed from the medication cart and returned to pharmacy for destruction. All other medications for Resident # 61 were checked for expiration dates on 6/8/2017 by the Assistant Director of Nursing.</p> <p>Corrective actions taken for other residents having the potential to be affected by the alleged deficient:</p> <p>All resident medications and stock medications were audited for expiration dates by the Director of Nursing Completed on 6/8/17.</p> <p>Measures taken and systems changed to prevent repeat of alleged deficit practice:</p> <p>All licensed nurses and medication aides were reeducated regarding the facility protocol for expired meds by the Assistant Director of Nursing to be completed by 7/6/17</p> <p>The night shift RN Supervisor will audit the med rooms and each med cart every night for expired medication and remove medication that are scheduled to expire within 72 hours. Medications will be returned to the pharmacy per return to pharmacy policy this will be ongoing .</p> <p>Nightly audit documentation will be documented and reviewed by the DON or her Designee to assure compliance.</p>		

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F 431	<p>Continued From page 3</p> <p>An interview on 06/08/17 at 2:08 PM with the Director of Nursing (DON) revealed the nurse working the 11:00 PM to 7:00 AM shift on Sunday night was expected to check all the medication carts for expired medications as a double check system in case the other nurses had missed an expired medication. The DON stated Nurse # 3, the nurse who administered the expired oxycodone 5 mg tablet on June 2, 2017 to Resident # 57, should have seen that it was expired and not given it.</p> <p>In an interview on 06/08/17 at 3:11 PM with Nurse # 3, she confirmed that she administered one tablet of oxycodone 5 mg on 06/02/17 at 7:33 PM to Resident # 57 when Resident # 57 complained of left leg pain. Nurse # 3 stated she realized the medication had expired by one day but she didn't think there was any available in the emergency drug kit. Nurse # 3 stated she had been trained to check for expiration dates prior to administering medication.</p> <p>An interview on 06/08/17 at 3:13 PM with the DON revealed her expectation would be for the nurse to go to the supervisor to contact the pharmacy for a replacement instead of administering an expired medication. The DON stated the facility received a regular pharmacy delivery at 8:00 PM so a replacement could have been obtained from the pharmacy. The DON stated she would also expect the nurse to have called Resident # 57's physician for a substitute if necessary.</p> <p>An interview on 06/08/17 at 3:20 PM with the DON revealed the emergency drug kit contained 5 doses of oxycodone 5 mg and there were 5 doses available in the kit on 06/02/17 at 7:33 PM</p>	F 431	<p>In addition the nurse responsible for medication administration on each shift will audit his or her cart and document the audit on the specified form.</p> <p>In addition the Medication Carts and Medication Rooms will be visually checked 2 x weekly by the DON or her designee x 4 weeks, then 1 X weekly x 4 weeks. Random audits will then be ongoing to assure continued compliance.</p> <p>Pharmacy Representative will do quarterly audits that will include auditing for expired Medication.</p> <p>How facility plans to monitor its performance to make sure solutions are sustained:</p> <p>The Plan of Correction for Expired Medications will be reviewed monthly in Quality Assurance Performance Improvement Committee Meeting by the DON. Interventions will be modified or added based on outcome of monitoring for expired meds.</p>		

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F 431	Continued From page 4 when Nurse # 3 administered the expired tablet of oxycodone 5 mg to Resident # 57.. An interview on 06/09/17 at 11:09 AM with the Administrator revealed the 11:00 PM - 7:00 AM nurse was responsible for checking the medication carts for expired medication and should remove expired medications from the medication carts and get them replaced. The Administrator stated each nurse was expected to check expiration dates before administering medication. The Administrator stated Nurse # 3 should not have administered the expired oxycodone 5 mg tablet to Resident # 57 and the expired medication should not have been on the medication cart.	F 431			