STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345161	A. BUILDING ______ B. WING ______	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERNETHY LAURELS	**102 LEONARD AVENUE NEWTON, NC 28658**

(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 deficiencies were cited as result of the complaint allegation. Event ID# 16C811. 3/5/18 Survey team deleted F 804 and F 865 before the scheduled IDR. Amended 2567 will be sent to the facility.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		2/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2018

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, resident, and staff interviews the facility failed to provide care in a manner to maintain the resident's dignity by not answering a call light timely for a resident that required assistance with toileting for 1 of 1 residents reviewed for incontinent care (Resident #45). This led to the resident soiling herself after waiting excessively for assistance to the bathroom. The finding included: Resident #45 admitted to the facility on 11/07/17 with diagnoses that included unsteadiness on feet, polyneuropathy, osteoporosis, chronic embolism, and others. Review of the most recent comprehensive minimum data set (MDS) dated 11/14/17 revealed Resident #45 was cognitively intact and required extensive assistance of 2 staff members with toileting. The MDS also revealed Resident #45 was frequently incontinent of bladder and no rejection of care or behaviors was identified during the assessment reference period.	F 550	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Abernethy Laurels of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance.	

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F 550

Continued From page 2

An observation was made on 01/25/18 at 11:00 AM. Resident #45's family member approached Nurse #3 at the medication cart and stated "her call light has been on for 45 minutes and she needs to use the bathroom." Nurse #3 stated she would get someone to assist Resident #45. The family member then stated "she has waited so long that she has already went in her pants." Nurse #3 then entered Resident #45's room and stated to the family member and the resident that the Nursing Assistants (NAs) were in another room assisting with care and they would be with her as soon as possible.

An interview was conducted with Nurse #3 on 01/25/18 at 11:03 AM. Nurse #3 stated she was not aware of how long Resident #45's call light had been on but stated she had gone and found the NAs on the unit and they were providing care to another resident and they would get to Resident #45 as soon as possible. She added they were really busy with several resident's needing assistance at one time.

An interview was conducted with Resident #45 and her family member on 01/25/18 at 11:07 AM. The family member stated Resident #45 had turned her call light on and then picked up the phone and called the family member at 10:30 AM. The family member further stated during the conversation on the phone Resident #45 stated she had turned the call light and was still waiting for the staff to assist her to the bathroom. The family member stated she hung up with Resident #45 and drove over to the facility and upon entering the unit Resident #45's call light was still turned on. The family member stated she had turned the call light off and then immediately turned it right back on and had waited an

F 550

Prefix Tag: F550
It is the intent of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

1) The plan of correcting the specific deficiency:

A Root Cause Analysis (RCA) was utilized to evaluate our processes to determine a root cause for the deficiency cited. The RCA verified that this resident is adjusting to a new environment and recently admitted to long term care. Resident #45 frequently urinates every hour to hour and half, does have a pull-up on for dignity due to resident's history of incontinence. Nursing staff report that resident is toileted every hour to hour and half. On 1/25/18 resident was toileted by nursing staff upon rising in the morning and after breakfast. Approximately an hour after being toileted , resident #45 pressed call light to be toileted again. NA responded to call light however was unable to assist resident to toilet due to resident #45 required two person assist with transfers. NA went to look for partner who was unavailable due to providing care to another resident. NA did not get assistance from nurse due to surveyor spending extensive amount of time completing med pass and completing narcotic count. NA did not go to another household to get assistance to help toilet

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F 550 Continued From page 3

additional 15 minutes and the staff still had not answered the call light and that was when the family member approached Nurse #3 at the medication cart. Resident #45 stated that she had waited so long that she had already wet herself and stated "it really hurts my pride when I go in my britches." The family member stated Resident #45 had to wait a long time on a frequent basis and she had shared her concerns with the facility social worker. Resident #45 confirmed she had turned her call light on at 10:30 AM and then called her family on the telephone and when the family arrived 30 minutes later the call light was still on and she was still waiting to be assisted to the toilet.

An observation was made on 01/25/18 at 11:15 AM. NA #1 and NA #2 entered Resident #45's room. NA #1 stated "I am so sorry, we answer the call lights in the order in which they come on and there was 5 people in front of you." Resident #45 stated to NA #1 "I have waited so long and already wet myself, I am not sure if I will go or not." NA #1 and NA #2 assist Resident #45 to the bathroom, stood her up and removed the pull up she was wearing. When NA #1 threw the pull up in the trash can it made a loud "thud" due to the excessive weight of the soiled pull up. Resident #45's skin was intact with no breakdown noted, she sat on the commode and was able to urinate again before standing up and a new pull was applied.

An interview was conducted with NA #1 on 01/25/18 at 2:44 PM. NA #1 confirmed she routinely cared for Resident #45 but stated she was still fairly new to the unit and indicated she was still learning all of Resident #45's needs. NA #1 stated Resident #45 required extensive

F 550

resident #45, therefore resident #45 had an incontinent episode.

2) The procedure for implementing the plan of correction for the specific deficiency:

On 1/25/18, resident #45 was provided incontinent care by CNAs, NA #1 and her partner and then toileted. Resident voided successfully.

On 2/12/18, Social Worker counseled resident #45 on expectations and adjusting to new environment. Resident #45 reports that she is satisfied with care and expressed no concerns. Resident confirms she has incontinent episodes stating, "I just can't help it because of my age." Resident feels that her needs are met and staff respond to her needs in a timely manner.

On 2/12/18, a voiding diary was initiated to determine resident's urinary pattern. The CNAs assigned to resident will report using the voiding diary and document if resident has urinary incontinent episodes, or if voided in toilet, and amount of fluid intake.

On 2/19/18 Physician's Elder Care Nurse Practitioner reviewed voiding diary to further evaluate incontinence and determine if there are other interventions that would be beneficial for resident #45.

As an auditing tool, On 2/12/18 and 2/13/18 Social Worker interviewed all alert

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F 550	Continued From page 4	F 550		

assistance with most activities of daily living and stated she did ambulate in short distances but it was a very slow pace. NA #1 stated Resident #45 was mostly continent of bladder but as soon as she stood up she would start to urinate. She added she was not aware of how long the call light had been on but stated she was toileting another resident when Nurse #3 came and told her Resident #45 needed to use the bathroom. NA #1 stated she had already toileted Resident #45 at 2 other times that morning and each time she was able to urinate. She added most of the time Resident #45's pull up was dry but when she toileted her at 11:15 AM the pull up was heavily wet. NA #1 further stated Resident #45's family had informed her numerous times that Resident #45 only had 1 kidney and had to be toileted frequently. NA #1 stated she toileted Resident #45 as frequently as possible. Again NA #1 explained she answered the call lights in the order in which they came on and there was 5 other people in front of Resident #45 and she got to her as quickly as possible.

An interview was conducted with the Administrator on 01/25/18 at 3:00 PM. The Administrator confirmed that the facility had the capability to measure call bell response time but since moving into the new building they were not aware of how to perform the task. She explained the new system would not be fully functioning until the entire new facility was complete and that would be another year or so. The Administrator again confirmed that she could not pull a report to identify how long Resident #45's call light had been on.

An interview was conducted with the Director of Nursing (DON) on 01/26/18 at 4:05 PM. The DON

and oriented residents using Quality Indicator Survey Questionnaire (QIS) to determine if resident's feel that staff treat them with dignity and respect, if staff take time to listen to them, and if staff are responsive to them in a timely manner when requesting assistance with toileting needs.

On 2/14/18 residents identified to have an area of concern through the QIS had a care plan initiated and plan of action developed for their specific need by the Social Services Team. Any resident behaviors or areas of concern should be brought to Interdisciplinary Team to be care planned.

On 2/15/18 education was provided to nursing staff by Director of Quality and Education and Social Services Team regarding any resident behaviors or areas of concern.

On 2/15/18 Director of Quality and Education educated all nursing staff including CNAs, Nurses, and Med Aides on resident rights and how to triage call light response time.

Randomly, social worker will select three alert and oriented residents weekly for one month using the QIS Questionnaire to determine if residents are being toileted in a timely manner and that staff are treating them with dignity and respect. These results will be turned into Administrator weekly to monitor for compliance.

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F 550	Continued From page 5 stated she expected the nursing staff to toilet Resident #45 when she requested and further stated that waiting 45 minutes to be toileted was not acceptable. She added she expected the staff to make each resident feel dignified and respected while providing care to them. The DON stated she had tried to pull the call bell response time report but with the new system they had not fully implemented the features of the new system and would not until the building was complete in the future.	F 550	After a month, social worker will randomly select three alert and oriented residents monthly for eleven months using the QIS Questionnaire to determine if residents are being toileted in a timely manner and that staff are treating them with dignity and respect. These results will be turned into Administrator monthly to monitor for compliance. When a resident has a change in environment, the social worker and activates aide will interview resident weekly for four weeks to ensure they are adjusting to new setting, documentation will be found in resident's electronic health record. Upon each quarterly assessment, social worker will ask resident if there are any questions/concerns regarding his/her care or routine using the Care Plan Concerns form. Upon admission each new admit receives the grievance policy and procedure. Director of Transitional Services introduces resident and family to social services team and encourages them to report any questions/concerns to their Interdisciplinary Team. Quarterly care plans are held for families to express any concerns. Families and residents are reminded in care plan meeting of grievance procedure. 3) The monitoring and procedure to ensure that the plan of correction is	

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F 550	Continued From page 6	F 550	effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: These corrective measures will be monitored by the Social Worker with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Social Worker will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter a Performance Improvement Project when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		2/19/18

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Continued From page 7

that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and staff interviews the facility failed to keep an accurate account of controlled medications on the Controlled Medication Utilization Record for 2 of 5 residents sampled for unnecessary medications (Resident #89 and Resident #93).

The findings included:

1. Review of Resident #89's physician order sheet dated 01/01/18 through 01/31/18 revealed he was prescribed Ativan (antianxiety medication) 0.5 milligrams (mg) by mouth twice a day and every 4 hours as needed for anxiety.

An observation, interview and reconciliation of the narcotic medications on the Harmony Court

F 755

Prefix Tag: F755
It is the intent of this facility to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs are maintained and periodically reconciled.

1) The plan of correcting the specific deficiency:

A Root Cause Analysis (RCA) was utilized to evaluate our processes to determine a root cause for the deficiency cited. The RCA verified that on 1/25/18 the third shift

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neighborhood where Resident #89 resided was made on 01/25/18 at 11:04 AM with Nurse #3. The reconciliation revealed Resident #89 had 15 tablets of Ativan and the Controlled Medication Utilization Record indicated he had 14 tablets. Nurse #3 stated she had counted the narcotics at the beginning of her shift with the off going nurse which was Nurse #2. She added that to her knowledge the narcotic count was correct and stated she had a nursing student from the local community college who also observed the narcotic count. Nurse #3 stated she would alert her supervisor immediately of the discrepancy.

Review of the Shift Change Controlled Substance Inventory Count Sheet for the Harmony Court Medication cart revealed on 01/25/18 at 7:00 AM both Nurse #2 and Nurse #3 had signed the sheet indicating the narcotic count was correct at that time.

An interview was conducted with Nurse #2 on 01/25/18 at 4:56 PM. Nurse #2 confirmed she had worked 11:00 PM to 7:00 AM on 01/25/18 on Harmony Court. Nurse #2 stated at 7:00 AM on 01/25/18 she had counted the narcotics on the medication cart with Nurse #3 and to her knowledge the narcotic count was correct. She added she had also counted the narcotics at 11:00 PM on 01/24/18 with Nurse #1 and to her knowledge the narcotic count on Harmony Court was correct at that time as well. Nurse #2 stated there was nursing student from the local community college that had observed the narcotic count on 01/25/18 at 7:00 AM. She added that during 3rd shift she did not have to administer any narcotic medications to the residents on Harmony Court.

on-coming nurse #2 and the second shift off-going nurse #1 did not verify the declining count sheet and the medication cards to ensure there were no narcotic discrepancies. These nurses did not complete reconciliation by looking at declining inventory sheet and medication card together, and it was determined that the narcotic count was not correct.

2) The procedure for implementing the plan of correction for the specific deficiency:

On 1/25/18 Assistant Director of Nursing and RN Care Coordinator were notified of discrepancy and began investigation to determine where discrepancy occurred. Discrepancy was investigated and reconciled.

On 1/25/18 Director of Nursing and Assistant Director of Nursing completed a narcotic count audit on all medication carts to ensure there were no further discrepancies. There were none found.

On 1/25/18 Director of Nursing and Assistant Director of Nursing contacted Nurse #1, #2, #3 and educated them on proper procedure for narcotic reconciliation.

On 2/15/18 Director of Quality and Education completed education with all nursing staff, RN and LPN, on proper procedure for narcotic reconciliation and when to notify RN Care Coordinator of discrepancies.

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F 755	Continued From page 9 Review of the Shift Change Controlled Substance Inventory Count Sheet for the Harmony Court Medication cart revealed that on 01/24/18 at 11:00 PM both Nurse #1 and Nurse #2 had signed the sheet indicating the narcotic count was correct at that time. An interview was conducted with Nurse #1 on 01/25/18 at 5:05 PM. Nurse #1 confirmed she had worked Harmony Court on 01/24/18 from 7:00 PM to 11:00 PM and had counted the narcotic's at 11:00 PM with Nurse #2 and to her knowledge the narcotic count was correct. Nurse #1 stated she had given Resident #89 his Ativan as prescribed last evening and had documented that on the Controlled Medication Utilization Record. Nurse #1 again confirmed that when she had counted the narcotics at 11:00 PM on 01/24/18 all were accounted for. An interview was conducted with the Consultant Pharmacist (CP) on 01/26/18 at 10:25 AM. The CP stated she visited the facility monthly. She stated the narcotics on each medication cart should be kept under lock and key and should be counted with each shift change and then the staff should sign the Shift Change Controlled Substance Inventory Count Sheet indicating that both shifts had verified the count and it was correct. She added the facility could notify her of any discrepancies in narcotics but they had policies and procedures in place on how to handle the issue. An interview was conducted with Nursing Student (NS) #1 on 01/26/18 at 11:39 AM. The NS student confirmed he had been working on Harmony Court on 01/25/18 and had observed Nurse #2 and Nurse #3 count the narcotic's on	F 755	First shift RN Care Coordinator will audit one narcotic reconciliation count from third shift to first shift and one narcotic reconciliation count from first shift to second shift weekly for one month using Medication Pass/Reconciliation Auditing Tool. Third shift RN Care Coordinator will audit one narcotic reconciliation count from second shift to third shift weekly for one month using Medication Pass/Reconciliation Auditing Tool. This auditing tool will be turned into Director of Nursing at the end of each week for one month to ensure compliance. After completing monthly audits, First shift RN Care Coordinator will audit one narcotic reconciliation count from third shift to first shift and one narcotic reconciliation count from first shift to second shift monthly for eleven months using Medication Pass/Reconciliation Auditing Tool. Third shift RN Care Coordinator will audit one narcotic reconciliation count from second shift to third shift monthly for eleven months using Medication Pass/Reconciliation Auditing Tool. This auditing tool will be turned into Director of Nursing at the end of each month for eleven months to ensure compliance. 3) The monitoring and procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:	

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01/25/18 at 7:00 AM. The NS stated during the narcotic count Nurse #3 stated to Nurse #2 there was a discrepancy but he was not sure what the discrepancy was or for which resident. The NS stated he recalled it was a pill they were referring to but was not sure which pill. NS #1 further stated after Nurse #2 and Nurse #3 had counted the narcotics on the medication cart they discussed checking the medication room for the missing pill but that was the last he had heard about the discrepancy that was discovered while they were counting the narcotics.

An interview was conducted with the Director of Nursing (DON) on 01/26/18 at 4:05 PM. The DON stated she expected the narcotic count to be accurate at all times and for the staff to count the narcotic's at the beginning and ending of their shift and at any time staff changed positions to a different unit.

2. Review of Resident #93's physician order sheet dated 01/01/18 through 01/31/18 revealed she was prescribed Klonopin (antianxiety medication) 0.5 milligrams (mg) by mouth at bedtime.

An observation, interview and reconciliation of the narcotic medications on the Harmony Court neighborhood was made on 01/25/18 at 11:04 AM with Nurse #3. The reconciliation revealed Resident #93 had 4 tablets of Klonopin and the Controlled Medication Utilization Record indicated she had 5 tablets. Nurse #3 stated she had counted the narcotics at the beginning of her shift with the off going nurse which was Nurse #2. She added that to her knowledge the narcotic count was correct and stated she had a nursing student from the local community college who also

F 755

These corrective measures will be monitored by the Director of Nursing with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter a Performance Improvement Project when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.

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ABERNETHY LAURELS	**102 LEONARD AVENUE NEWTON, NC 28658**

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F 755	Continued From page 11	F 755		

observed the narcotic count. Nurse #3 stated she would alert her supervisor immediately of the discrepancy.

Review of the Shift Change Controlled Substance Inventory Count Sheet for the Harmony Court Medication cart revealed that on 01/25/18 at 7:00 AM both Nurse #2 and Nurse #3 had signed the sheet indicating the narcotic count was correct at that time.

An interview was conducted with Nurse #2 on 01/25/18 at 4:56 PM. Nurse #2 confirmed she had worked 11:00 PM to 7:00 AM on 01/25/18 on Harmony Court. Nurse #2 stated that at 7:00 AM on 01/25/18 she had counted the narcotics on the medication cart with Nurse #3 and to her knowledge the narcotic count was correct. She added she had also counted the narcotics at 11:00 PM on 01/24/18 with Nurse #1 and to her knowledge the narcotic count on Harmony Court was correct at that time as well. Nurse #2 stated there was nursing student from the local community college that had observed the narcotic count on 01/25/18 at 7:00 AM. She added that during 3rd shift she did not have to administer any narcotic medications to the residents on Harmony Court.

Review of the Shift Change Controlled Substance Inventory Count Sheet for the Harmony Court Medication cart revealed on 01/24/18 at 11:00 PM both Nurse #1 and Nurse #2 had signed the sheet indicating the narcotic count was correct at that time.

An interview was conducted with Nurse #1 on 01/25/18 at 5:05 PM. Nurse #1 confirmed she had worked Harmony Court on 01/24/18 from

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F 755	Continued From page 12 7:00 PM to 11:00 PM and had counted the narcotic's at 11:00 PM with Nurse #2 and to her knowledge the narcotic was correct. Nurse #1 stated she had given Resident #93 her Klonopin as prescribed last evening and had documented that on the Controlled Medication Utilization Record. Nurse #1 again confirmed when she had counted the narcotic at 11:00 PM on 01/24/18 all were accounted for. An interview was conducted with the Consultant Pharmacist (CP) on 01/26/18 at 10:25 AM. The CP stated she visited the facility monthly. She stated the narcotic's on each medication cart should be kept under lock and key and should be counted with each shift change and then the staff should sign the Shift Change Controlled Substance Inventory Count Sheet indicating that both shift had verified the count and it was correct. She added the facility could notify her of any discrepancies in narcotics but they had policies and procedures in place on how to handle the issue. An interview was conducted with Nursing Student (NS) #1 on 01/26/18 at 11:39 AM. The NS student confirmed he had been working on Harmony Court on 01/25/18 and had observed Nurse #2 and Nurse #3 count the narcotic's on 01/25/18 at 7:00 AM. The NS stated during the narcotic count Nurse #3 stated to Nurse #2 there was a discrepancy but he was not sure what the discrepancy was or for which resident. The NS stated he recalled it was a pill they were referring to but was not sure which pill. The NS further stated after Nurse #2 and Nurse #3 had counted the narcotics on the medication cart they discussed checking the medication room for the missing pill but that was the last he had heard	F 755		

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F 755	Continued From page 13 about the discrepancy that was discovered while they were counting the narcotics. An interview was conducted with the Director of Nursing (DON) on 01/26/18 at 4:05 PM. The DON stated she expected the narcotic count to be accurate at all times and for the staff to count the narcotic's at the beginning and ending of their shift and at any time staff changed positions to a different unit.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff,	F 757	Prefix Tag:	2/19/18

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Nurse Practitioner, and Medical Doctor Interviews the facility failed to administer the correct antianxiety medication to the correct resident as ordered for 1 of 5 residents sampled for unnecessary medications (Resident #89). Resident #89 was administered Clonazepam (antianxiety medication) instead of Lorazepam (antianxiety medication) as he was prescribed.

The findings included:

Resident #89 admitted to the facility on 06/06/17 with diagnoses that included chronic obstructive pulmonary disease and anxiety.

Review of the most recent quarterly minimum data set (MDS) dated 12/18/17 indicated Resident #89 was cognitively intact. The MDS also indicated Resident #89 had received 7 days of antianxiety medication during the assessment reference period.

Review of the physician order sheet dated 01/01/18 through 01/31/18 revealed Resident #89 was prescribed Lorazepam 0.5 milligrams (mg) by mouth twice a day and every 4 hours as needed.

An observation of the narcotic count on the Harmony Court where Resident #89 resided was made on 01/25/18 at 11:00 AM with Nurse #3 and revealed a discrepancy. The declining narcotic sheet indicated Resident #89 had 14 Lorazepam pills remaining and there were 15 Lorazepam pills in the medication cart. Nurse #3 confirmed the discrepancy and stated she would notify her supervisor immediately.

An interview was conducted with Nurse #3 on

F 757

It is the intent of this facility to provide a drug regimen free from unnecessary drugs.

1) The plan of correcting the specific deficiency:

A Root Cause Analysis (RCA) was utilized to evaluate our processes to determine a root cause for the deficiency cited. The RCA verified on 1/24/18 Nurse #1 did not properly verify label on medication with MAR and Narcotic Declining Record. Our best practice protocol for medication administration was not followed and therefore resulted in administration of the wrong medication on 1/24/18 for resident #89.

2) The procedure for implementing the plan of correction for the specific deficiency:

On 1/25/18 Assistant Director of Nursing educated Nurse #1 on Administration of Medication Policy and properly verifying label on medication with MAR. Assistant Director of Nursing observed Nurse # 1 complete a medication pass.

On 2/15/18, Director of Quality and Education educated all nursing staff including Registered Nurses, Licensed Practical Nurses, and Medication Aides on first, second, and third shifts. The education included General Dose Preparation and Medication Administration Policy which included the 5 rights to medication administration.

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01/25/18 at 11:04 AM. Nurse #3 confirmed she had counted her medication cart at shift change that morning with the off going nurse and to her knowledge the narcotic count was correct.

Review of a Medication Error Form dated 01/25/18 indicated on 01/24/18 Nurse #1 administered Resident #89 Clonazepam 0.5 mg by mouth that was prescribed for another resident instead of the Lorazepam 0.5 mg by mouth that was prescribed for Resident #89. The form indicated there was no adverse side effects noted and the physician had been notified.

An interview was conducted with the Assistant Director of Nursing (ADON) on 01/25/18 at 2:18 PM. The ADON confirmed that she was Nurse #3's supervisor and after researching the discrepancy determined that on 01/24/18 Nurse #1 had administered the Clonazepam that was prescribed for another resident by accident and not the Lorazepam that was prescribed for Resident #89. The ADON stated she determined the error had been made by reviewing the declining narcotic sheet for Resident #89 and the other resident and after speaking to Nurse #1 determined that the error had occurred.

An interview was conducted with Nurse #1 on 01/25/18 at 5:05 PM. Nurse #1 confirmed she had worked Harmony Court where Resident #89 resided on 01/24/18 from 7:00 PM to 11:00 PM. Nurse #1 stated she was not aware she had made the error until she was notified by the ADON. She stated she did not have to administer a lot of narcotics and remembered medicating Resident #89 but stated that if she had given him Clonazepam instead of his Lorazepam then it was completely by mistake. She stated she did

F 757

RN Care Coordinator will complete a medication administration observation audit on first, second, and third shift weekly for two months using the Medication Pass Audit Tool Worksheet.

If no discrepancies are found with medication administration observation, RN Care Coordinator will audit on first, second, and third shift monthly for ten months using the Medication Pass Audit Tool Worksheet.

The Medication Pass Audit Tool Worksheet will be turned into Director of Nursing weekly and monthly to audit for compliance.

3) The monitoring and procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

These corrective measures will be monitored by the Director of Nursing with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective

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F 757	Continued From page 16 recall medicating Resident #89 and the other resident fairly close together so it was possible that she just grabbed the wrong card of medication. An interview was conducted with the Nurse Practitioner (NP) on 01/26/18 at 9:57 AM. The NP confirmed the staff had made her aware of the medication error with Resident #89. She added there was no change in his mentation or his vital signs and she did not feel like there was any adverse reactions. She stated she did ask the staff to continue to monitor him closely but did not feel like there was any potential for harm because Resident #89 was on a similar antianxiety medication. The NP also stated that she expected the staff to administer the correct medications to the correct patient as prescribed. An interview was conducted with the Medical Doctor (MD) at 01/26/18 at 2:45 PM. The MD stated she expected the staff to administer the correct medications to the correct resident as prescribed. The MD added that she did not feel like Resident #89 had any signs of adverse reactions. An interview was conducted with the Director of Nursing (DON) on 01/26/18 at 4:05 PM. The DON stated she would expect the Nurses to administer the correct medications to the correct residents as prescribed by the MD.	F 757	measures as needed. The Committee is authorized to charter a Performance Improvement Project when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 761 SS=D	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	F 761		2/19/18

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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, record reviews, and staff interviews the facility failed to remove expired medication from 2 of 4 medication rooms (Friendship and Faith Household medication rooms).

The findings included:

Review of a facility policy titled "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" dated 12/01/07 read in part, the facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with the Pharmacy return/destruction guidelines or other applicable

F 761

Prefix Tag: F761
It is the intent of this facility to label and remove any expired medication in accordance with the current accepted professional principles.

1) The plan of correcting the specific deficiency:

A Root Cause Analysis (RCA) was utilized to evaluate our processes to determine a root cause for the deficiency cited. The RCA verified that staff responsible for checking expired medications were not aware that the weekly medication audit

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F 761

Continued From page 18

law.

1a. An observation of the Friendship Household medication room and refrigerator was conducted on 01/24/18 at 4:42 PM with Medication Aide (MA #1). The observation revealed a unopened bottle of Oyster Shell calcium 500 milligrams (mg) that expired 08/17 and a whole unopened bottle of liquid pain relief that expired 11/17 both were in the medication room cabinets and available for use. There was an open bottle of tuberculin (TB) serum that was dated as being opened on 10/18/17.

An interview was conducted with MA #1 on 01/24/18 at 4:47 PM. MA #1 confirmed she was working on the Friendship household and stated that every Wednesday the Nurses or the MA's would go through the medication carts and remove any expired medication. She added she was unsure of who monitored the medication room but thought it was the nurses. MA #1 stated the expired medications should have been removed from the medication room and she was not sure how long the TB serum was good for but would have to ask her nurse.

An interview was conducted with Nurse #4 on 01/24/18 at 4:49 PM. Nurse #4 stated she was responsible for overseeing MA #1 and she would discard the expired medication. She added the TB serum was only good for 30 days after opening and it should have been discarded. Nurse #4 stated she only worked as needed but to her understanding the Nurses on the medication carts went through the medication carts and medication rooms weekly and removed any expired medications. Nurse #4 stated she would discard the expired medications and TB

F 761

included over the counter medications in the cabinets and refrigerators in the medication rooms on Faith and Friendship households. Due to recent move in new healthcare building, cabinet was unnecessarily locked and was overlooked in weekly audit. Weekly audit form did not specify all areas that nurses/med aides were to check for expired medications.

2) The procedure for implementing the plan of correction for the specific deficiency:

On 1/24/18 Director of Nursing and Assistant Director of Nursing physically examined all medication room and med carts for expired medication and OTC meds. No other expired items were found.

On 1/24/18 Director of Nursing completed education with Medication Aide who was responsible for checking expired meds in med room. Director of Nursing emphasized to Medication Aide that she should be checking expired medications on medication caret and in medication room, looking in refrigerator and cabinet. Education also provided to oncoming third shift nurse by Director of Nursing on responsibility for checking expired medications weekly.

On 2/19/18 Director of Facilities Management disabled lock from all cabinets in medication rooms where over the counter medications are stored in medication rooms.

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serum.

b. An observation of the Faith Household Medication room was conducted on 01/24/18 at 5:00 PM with Nurse #4. The observation revealed: 1 bottle of 16 ounce (oz.) Mineral Oil that expired 11/17, 1 unopened fleet enema that expired 12/17, 1 opened box of Nasal decongestant that expired 02/17, 1 unopened box of nasal decongestant that expired 11/17 and 2 unopened bottles of Vitamin D that expired 12/17. All the expired medications were in the medication room in the cabinets and available for use.

An interview was conducted with Nurse #4 on 01/24/18 at 5:10 PM. Nurse #4 stated she was responsible for the Faith Household medication room and that she would discard the expired medication. Nurse #4 stated she only worked as needed but to her understanding the Nurses on the medication carts went through the medication carts and medication rooms weekly and removed any expired medications

An interview was conducted with the Consultant Pharmacist (CP) on 01/26/18 at 10:25 AM. The CP stated she visited the facility every month and each month she checked 1 medication room and 1 medication cart and looked for expired medications and any regulatory items that related to medication storage. She added the TB serum was only good for 30 days after opening and should have been discarded. The CP stated that her expectation was the facility staff would routinely check the medication room and medication carts and promptly remove any expired medications.

F 761

On 2/14/18 Director of Nursing revised weekly medication audit checklist on proper steps to take when completing audit for expired medications.

On 2/15/18 Director of Quality and Education educated all nurses and medication aides on checking for expired meds in medication cart and medication room, looking in cabinets and refrigerators.

Weekly, nurses and medication aides will audit all medication carts and medication rooms including cabinets and refrigerators for expired medications.

Monthly, RN Care Coordinators will audit all medication carts and medication rooms including cabinets and refrigerators for expired medications for next 12 months.

Quarterly, Director of Nursing and Assistant Director of Nursing will audit all medication carts and medication rooms including cabinets and refrigerators for expired medications for next twelve months.

3) The monitoring and procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

These corrective measures will be monitored by the RN Care Coordinator

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F 761	Continued From page 20 An interview was conducted with the Director of Nursing (DON) on 01/26/18 at 4:05 PM. The DON stated she expected the nurses to go through the medication carts and rooms weekly and remove any expired medications and return them to the pharmacy for destruction.	F 761	with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The RN Care Coordinator will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter a Performance Improvement Project when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		2/19/18

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F 880	Continued From page 21 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345161	A. BUILDING ______ B. WING ______	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERNETHY LAURELS	102 LEONARD AVENUE NEWTON, NC 28658

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F 880 Continued From page 22

Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and resident and staff interviews the facility failed to use hand sanitizer or wash hands with soap and water after removal of gloves after trash was discarded from an isolated resident room for 1 of 1 resident who had physician orders for isolation droplet precautions (Resident #29).

Findings included:

A review of physician's treatment orders dated 01/20/18 indicated isolation droplet precautions till the end of Tamiflu (antiviral medication used for the treatment of influenza (flu)).

During an observation on 01/23/18 at 3:49 PM a sign on Resident #29's door indicated isolation droplet precautions. The sign also indicated to wash hands, wear mask and gloves to enter room and a cabinet hanging from the door contained masks and gloves.

During an interview on 01/23/18 at 3:55 PM Resident #29 stated she was sick with the flu and everyone had to wear masks and gloves when they came into her room.

During an observation on 01/26/18 at 11:10 AM, Housekeeper #1 put gloves on and was standing in the hallway next to a trashcan outside of

F 880

Prefix Tag: F880
It is the intent of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

1) The plan of correcting the specific deficiency:

A Root Cause Analysis (RCA) was utilized to evaluate our processes to determine a root cause for the deficiency cited. The RCA verified that on 1/26/18 Housekeeper #1 failed to wash hands or sanitize hands once taking off her gloves prior to entering another resident's room. The RCA verified that the appropriate hand hygiene procedure was used for training staff and that this housekeeping aide had been properly trained, but the cause of her error was anxiety on her first day of her assignment alone, with surveyors present.

2) The procedure for implementing the plan of correction for the specific deficiency:

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F 880	Continued From page 23 Resident #29's room. She picked up a plastic trash bag from inside the trashcan with discarded gloves and masks that were visible and loosely tied the top of the bag and set the plastic bag on the floor. She then placed a clean plastic bag inside the trashcan and carried the trash bag from the floor to a linen cart and deposited the bag into a larger plastic bag with other trash. She removed her gloves and put them into the trash bag on the linen cart and then put on another pair of gloves without washing or sanitizing her hands and picked up housekeeping supplies from her cart and walked across the hall and started to enter another resident's room which did not have isolation precautions. During an interview on 01/26/18 at 11:13 AM, Housekeeper #1 confirmed she was getting ready to clean her next resident room. She explained this was only her 2nd week as housekeeper on resident hallways and she was new to housekeeping duties because she had been working in the laundry. She stated she thought a resident had the flu in the room next to where the trashcan was sitting in the hallway at Resident #29's room because there was an isolation sign on the resident's door. She explained she checked the trashcan about every 30 minutes and routinely carried the trash from the trashcan to her housekeeping cart and she changed her gloves after she touched the trash bag. She stated she was aware she was supposed to use hand sanitizer or wash her hands with soap and water after she removed her gloves but she was focused on emptying the trash and had forgotten to sanitize or wash her hands after she had removed her gloves. During an interview on 01/26/18 at 11:23 AM,	F 880	On 1/25/18, Infection Prevention RN observed housekeeper #1 using hand sanitizer prior to entering resident's room and putting on gloves. On 1/26/18, Housekeeper #1 was re-educated by Environmental Services Manager on proper hand washing and infection control policy. On 2/16/18, Director of Quality and Education educated all housekeeping staff on proper hand washing and infection control policy Environmental Services Manager will observe three housekeepers weekly for four weeks to monitor compliance and observe proper hand washing/sanitizing hands when changing gloves and entering another resident room using compliance rounds form from Infection Prevention Manual. After four weeks, Environmental Services Manager will complete compliance audit using compliance rounds form, observing one housekeeper using proper hand washing/sanitizing hands when changing gloves and entering another resident room monthly for twelve months. Infection Prevention Nurse will randomly observe two direct care staff monthly for the next twelve months to monitor compliance and observe proper hand washing/sanitizing hands when changing gloves and entering another resident room.	

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F 880	Continued From page 24 Nurse #5 confirmed she was assigned to Resident #29 and the resident was on isolation droplet precautions because she had the flu. She explained and all staff were expected to discard their masks and gloves in the trashcan and it was her expectation for staff to use hand sanitizer and then wash their hands with soap and water after they removed their gloves. She further stated staff should sanitize or wash their hands before they went into another resident's room. During an interview on 01/26/18 at 11:38 AM, the Environmental Services Manager explained he was responsible for housekeeping, laundry and floor technician staff. He stated if a resident had isolation precautions then housekeepers were supposed to look at the box on the resident's door with the sign to know what type of personal protective equipment to wear. He stated it was his expectation for housekeepers to take the trash bag from the trashcan next to Resident #29's room to the linen cart and then remove their gloves and use hand sanitizer to clean their hands. He stated then they should go into the spa which was a bath/shower room and wash their hands with soap and water. During an interview on 01/26/18 at 12:26 PM, the Director of Nursing stated it was her expectations for staff to dispose of masks and gloves from a resident's room who was ordered isolation precautions into a trashcan. She explained staff should then use hand sanitizer or soap and water to clean their hands after they removed their gloves. She further stated she was not familiar with housekeeping procedures but expected for them to empty trash and remove their gloves and use hand sanitizer or use soap and water to clean their hands before they put on clean gloves and	F 880	3) The monitoring and procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: These corrective measures will be monitored by the Infection Prevention Nurse with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Infection Prevention Nurse will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter a Performance Improvement Project when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 880	Continued From page 25 went into another resident's room. During an interview on 01/26/18 at 4:02 PM, the Treatment Nurse who was also in charge of infection control explained approximately 2 weeks ago some residents at the facility had influenza and now Resident #29 was positive for influenza. She stated it was her expectation for staff to remove their gloves after they handled trash from Resident #29's room and they were supposed to wash their hands with soap and water. She explained they could use hand sanitizer but after they had used it 3 times they had to wash their hands with soap and water. She confirmed infection control training had been done for housekeeping staff and Housekeeper #1 should have sanitized or washed her hands after she removed her gloves after she had handled trash from Resident #29's room. She stated it was her expectation for all staff to follow policy and procedures for infection control.	F 880		