

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/02/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CHARLOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2616 E 5TH ST CHARLOTTE, NC 28204
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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #DI8811.	F 000	<u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>	
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 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interview and record review, the facility failed to develop a care plan for aspiration precautions and urinary incontinence for two (2) of twenty-two (22) sampled residents (Residents #40 and #53). The findings are:	F 279	F279 COMPREHENSIVE CAREPLANS The facility will continue to 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. <u>Criteria I</u> Resident's # 53's care plan has been updated to reflect current aspiration needs. Resident #40's care plan has been updated to reflect current incontinence needs.	

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

[Handwritten Signature]

TITLE

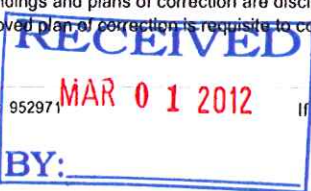
Administrator

(X6) DATE

2/23/12

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.

original signature date 2-23-12mh



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F 279	<p>Continued From page 1</p> <p>1. Resident #53 was admitted to the facility with diagnoses which included Anorexia, Diabetes Mellitus and Esophageal Reflux. The admission Minimum Data Set dated 11/17/11 assessed moderate cognitive impairment and the assistance on one person with eating.</p> <p>Review of a Speech Therapy discharge note dated 12/5/11 revealed Resident #53 was to receive a mechanical soft with aspiration precautions which included positioning at a 90 degree angle during oral intake and 20 minutes after oral intake.</p> <p>Review of Resident #53's record revealed a hospitalization from 12/15/11 to 12/20/11 for a fainting episode likely to volume depletion, hypotension and possible underlying Urinary Tract Infection with early sepsis. The hospital discharge summary dated 12/20/11 recommended a pureed diet with honey thick liquids with strict aspiration precautions. The precautions specified sitting up at 90 degrees while eating and 30 minutes after the meal to prevent aspiration.</p> <p>Review of Resident #53's care plan updated 1/17/12 revealed a focus on involuntary weight loss related to poor food intake. Interventions included monitoring of weight and meal consumption in addition to supplements between meals. A previous care plan dated 11/28/11 addressed inadequate oral intake with additional interventions of provision of assistance with meals, provision of food substitutes, physician and family notification of change and vitamin/mineral supplements as ordered. There was no indication of aspiration precautions.</p>	F 279	<p><u>Criteria 2</u> An audit will be completed for all residents at risk for aspiration to ensure appropriate care plan and interventions are in place. An audit will also be completed for all incontinent residents to ensure appropriate care plan and interventions are in place.</p> <p><u>Criteria 3</u> Nursing staff will be in-serviced in F279 requirement to include developing and revising the resident's plan of care. The plan of care will be reviewed for all residents who are at risk for aspiration on admission, quarterly and as needed to ensure appropriate care plan and interventions are in place.</p> <p>The plan of care will be reviewed for all residents who are incontinent on admission, quarterly and as needed to ensure appropriate care plan and interventions are in place.</p> <p>Director of Nursing Services and/or designee will review all new admission's plan of care in Clinical Start up meetings Monday-Friday. The Director of Resident Assessment and/or designee will review, revise and implement quarterly care plans</p>		

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F 279	<p>Continued From page 2</p> <p>Observation on 2/1/12 at 8:50 AM revealed Nursing Assistant (NA) #2 removed Resident #53's breakfast meal after 50 % consumption. Resident #53's head of the bed elevation was approximately at a 45 degree angle.</p> <p>Observation on 2/1/12 at 1:41 PM revealed Resident #53's head of the bed was elevated at approximately a 45 degree angle while he consumed 100% of a nutritional supplement independently.</p> <p>During an interview on 2/1/12 at 1:51 PM, NA #3 reported she was not aware Resident #53 required the head of the bed to be elevated at 90 degrees during eating and for 30 minutes after the meal. NA #3 reported she delivered the afternoon supplement to the Resident and did not raise the head of the bed.</p> <p>Interview with NA #2, who was assigned to Resident #53, on 2/1/12 at 1:57 PM revealed he was not aware of the head of the bed elevation requirement during and after meals.</p> <p>Interview with Licensed Nurse (LN) #4 on 2/1/12 at 2:20 PM revealed she did not know of the head of the bed elevation requirement. During this interview, LN #4 observed the head of the bed elevation and estimated an angle of 45 degrees. LN #4 explained a sign was usually posted in the room when aspiration precautions were required.</p> <p>Interview with the Speech Therapist on 2/1/12 at 3:01 PM revealed Resident #53 should be seated at a 90 degree angle or as close as possible. She explained a sign is usually posted in the room but</p>	F 279	<p><u>Criteria 4</u> The Director of Nursing and/or designee will report the review in the monthly Quality Assurance Meeting for 3 months. The Committee will make recommendations as necessary. The Executive Director is responsible for overall compliance.</p> <p>3/1/2012</p>	
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F 279	<p>Continued From page 3</p> <p>the resident returned to a different room after his hospitalization.</p> <p>Observation on 2/2/12 at 8:26 AM revealed Resident #53 seated in a wheelchair. The breakfast meal was delivered at 8:35 AM.</p> <p>Observation on 2/2/12 at 8:55 AM revealed Resident #53 in bed with the head of the bed elevated at approximately 30 degrees.</p> <p>Interview with NA #1 on 2/2/12 at 9:00 AM revealed Resident #53 consumed 25% of the breakfast meal and she assisted him back to bed. NA #1 reported she did not know he was to remain upright after the meal.</p> <p>Interview with Minimum Data Set Nurse #1 on 2/2/12 at 9:12 AM revealed aspiration precautions would be added to the care plan by the dietary department in addition to the directions posted in Resident #53's room.</p> <p>Interview with the Registered Dietician (RD) on 2/2/12 at 9:15 AM revealed she added interventions related to nutritional requirements to the care plan. The RD explained aspiration precautions which included direction for head of the bed elevation would be a nursing intervention.</p> <p>Interview with the Director of Nursing (DON) on 2/2/12 at 9:25 AM on 2/2/12 revealed nursing would be expected to add the interventions for aspiration precautions to the care plan.</p> <p>2. Resident #40 was admitted to facility on</p>	F 279			

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F 279	Continued From page 4 09/07/11. Record review revealed the resident had impaired mobility due to a history of CVA (cerebral vascular accident). Review of the admission Minimum Data Set (MDS) dated 09/14/11 triggered incontinence and assessed the resident needed extensive assistance with ADLS (Activities of Daily Living). The CAAS (Care Area Assessment Summary) documented the resident as being frequently incontinent of urine and that this would be addressed in the care plan. Review of the original care plan dated 09/13/11 revealed no focus on incontinence nor was incontinence addressed the resident's plan of care. Review of a significant change MDS dated 11/14/11 assessed Resident #40 as always being incontinent of urine. The CAAS documented the resident was incontinent of bowel and bladder all times and dependent on staff for incontinence care and hygiene and wore adult briefs for dignity. Per the CAAS, incontinence would be addressed in the plan of care. Review of an updated plan of care for Resident #40 dated 12/05/11 revealed no focus on incontinence nor was incontinence addressed in the resident's plan of care. During an interview on 02/01/12 at 10:00 AM, Resident #40 stated she could not always tell when she had to void until it was too late. The Resident stated that staff would assist with toileting but sometimes she could not always tell before she had already had an accident.	F 279			

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F 279	Continued From page 5	F 279			
F 309 SS=D	<p>During an interview on 02/02/12 at 3:30 PM, MDS Nurse #1 verified that incontinence had triggered on both MDSs but that this had not been addressed in the resident's care plan. The MDS Nurse #1 also stated that Resident #40's care plan should have included a focus on incontinence with appropriate goals and interventions.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and hospice nurse interviews, and record review, the facility failed to provide and maintain positioning to prevent aspiration and implement a free water protocol for two (2) of four (4) sampled residents who received thickened liquids (Residents #53 and #127).</p> <p>The findings are:</p> <p>1. Resident #53 was admitted to the facility with diagnoses which included Anorexia, Diabetes Mellitus and Esophageal Reflux. The admission Minimum Data Set dated 11/17/11 assessed moderate cognitive impairment and the</p>	F 309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>The facility will continue to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p><u>Criteria 1</u> Resident #53 is being provided and maintaining appropriate positioning to prevent aspiration. Resident #127 has been re-evaluated by Speech Therapy, and a free water protocol has been implemented per Therapy recommendation and MD order. The care plans have been updated appropriately.</p> <p><u>Criteria 2</u> An audit will be conducted for any resident that is at risk for aspiration to ensure appropriate positioning is being provided and maintained. An audit will be conducted for any resident with a physician's order for free water protocol to ensure protocol is in place.</p>		

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F 309	<p>Continued From page 6</p> <p>assistance of one person with eating.</p> <p>Review of a Speech Therapy discharge note dated 12/5/11 revealed Resident #53 was to receive a mechanical soft diet with aspiration precautions which included positioning at a 90 degree angle during oral intake and 20 minutes after oral intake.</p> <p>Review of Resident #53's record revealed a hospitalization from 12/15/11 to 12/20/11 for a fainting episode likely to volume depletion, hypotension and possible underlying Urinary Tract Infection. The hospital discharge summary dated 12/20/11 directed a pureed diet with honey thick liquids with strict aspiration precautions. The precautions specified sitting up at 90 degrees while eating and 30 minutes after the meal to prevent aspiration.</p> <p>Observation on 2/1/12 at 8:50 AM revealed Nursing Assistant (NA) #2 removed the breakfast meal after 50 % consumption. Resident #53 was in bed with the head of the bed elevated approximately at a 45 degree angle.</p> <p>Observations on 2/1/12 during the lunch meal revealed Resident #53 was served the lunch meal and fed by a management nurse (Licensed Nurse #3) with the head of the bed elevated at a 90 degree angle.</p> <p>Observation on 2/1/12 at 1:41 PM revealed Resident #53 consumed 100% of a nutritional supplement independently with the head of the bed elevated at approximately a 45 degree angle.</p> <p>Interview with NA #3, who delivered the nutritional</p>	F 309	<p><u>Criteria 3</u></p> <p>Nursing staff will be in-serviced on F309 to include providing and maintaining proper positioning for residents at risk for aspiration, and providing free water protocol per physician's order.</p> <p>Physician's orders will be reviewed daily for residents at risk for aspiration, and residents with a physicians order for free water to ensure proper positioning and implementation of free water protocol is in place.</p> <p>The Director of Resident Assessment will audit quarterly.</p> <p><u>Criteria 4</u></p> <p>The Director of Nursing Services will report the review in the monthly Quality Assurance Meeting for 3 months. The Committee will make recommendations as necessary. The Executive Director is responsible for overall compliance.</p> <p>3/1/2012</p>		

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F 309	Continued From page 7 supplement, on 2/1/12 at 1:51 PM revealed she was not aware Resident #53 required the head of the bed to be elevated at 90 degrees during eating and for 30 minutes after eating. Interview with NA #2, who was assigned to Resident #53, on 2/1/12 at 1:57 PM revealed he was not aware of the head of the bed elevation requirement. Interview with Licensed Nurse (LN) #4 on 2/1/12 at 2:20 PM revealed she was not aware the head of the bed required a 90 degree angle during meals and 30 minutes after meals. During this interview, LN #4 observed the head of the bed elevation and estimated an angle of 45 degrees. LN #4 explained a sign was usually posted in the room when aspiration precautions were required. Interview with the Speech Therapist (ST) #1 on 2/1/12 at 3:01 PM revealed Resident #53 should be sitting at a 90 degree angle or as close as possible to 90 degrees. She explained the head of the bed should be elevated at least to 60 degrees in order to provide gravity for food to prevent aspiration. ST #1 explained this would be required not only for meals but also for a frozen nutritional supplement. She reported a sign is usually posted in the room but the resident returned to a different room after his hospitalization. Observation on 2/2/12 at 8:26 AM revealed Resident #53 seated in a wheelchair. The breakfast meal was delivered at 8:35 AM. Observation on 2/2/12 at 8:55 AM revealed Resident #53 in bed with the head of the bed	F 309			

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F 309	<p>Continued From page 8</p> <p>elevated at approximately 30 degrees.</p> <p>Interview with NA #1 on 2/2/12 at 9:00 AM revealed Resident #53 consumed 25% of the breakfast meal and she assisted him back to bed. NA #1 reported she did not know he was to remain upright after the meal.</p> <p>Interview with the Director of Nursing (DON) on 2/2/12 at 9:25 AM revealed directions for aspiration precautions were to be posted in the resident room for staff guidance, The DON reported she expected staff to provide aspiration precautions if indicated.</p> <p>2. Resident #127 was admitted to the facility with diagnoses which included Cerebral Vascular Accident, Aphasia, and Anxiety. A significant change Minimum data Set dated 12/29/11 assessed memory problems with the assistance of one person required for eating.</p> <p>Review of a physician's order dated 1/25/12 revealed Resident #127 was to receive a mechanical soft diet with pureed meat and nectar thickened liquids. A speech therapy evaluation was also ordered on 1/25/12.</p> <p>Review of Speech Therapy orders dated 1/26/12 revealed direction for a free water protocol to reduce risk of dehydration and increase the quality of life. Free water was to be given upon request, before meals and 30 minutes after meals. The order directed straws could be used with no water to be given during meals. An oral rinse was to be provided by nursing before and after meals to remove oral residue and reduce risk of aspiration pneumonia.</p>	F 309			

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F 309	Continued From page 9 Observation on 2/1/12 at 8:10 AM and 9:02 AM revealed Resident #127 consumed the breakfast meal with thickened liquids. Resident #127 remained seated outside the main dining room after the meal and did not receive an oral rinse. Observation on 2/1/12 at 10:41 AM revealed Resident #127 drank thickened liquid from lidded cup with a straw. Resident #127 was not offered free water. Observation from 11:55 AM to the completion of the lunch meal on 2/1/12 revealed Resident #127 ate in his room and consumed nectar thick tea and water. Resident #127 did not receive an oral rinse prior to the meal. Interview with Nursing Assistant (NA) #2 on 2/2/12 at 12:55 PM revealed he supervised Resident #127's meal intake. NA #2 assisted Resident #127 out of the room without an oral rinse. Interview with Licensed Nurse (LN) #4 on 2/1/12 at 2:35 PM revealed she was not aware of the order to rinse before and after meals and to offer free water between meals. Interview with NA #2 on 2/1/12 at 2:48 PM on 2/1/12 revealed he was not aware to offer water between meals or assist with oral rinses before and after meals. Interview with the Speech Therapist (ST) #2 on 2/2/12 at 9:36 AM revealed Resident #127 should be offered water between meals. ST #2 reported he informed the nursing staff last week when he	F 309			

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F 309	Continued From page 10 wrote the order. The ST #2 explained the free water protocol enhanced Resident #127's quality of life and the rinses decreased the risk of aspiration. Interview with the Director of Nursing (DON) on 2/2/12 at 10:19 AM revealed she expected the speech therapist to orally inform the nursing staff of the new order so it could be carried out. The DON added the therapist usually placed it on the Medication Administration Record for staff guidance. Interview with the hospice nurse on 2/2/12 at 11:35 AM revealed the free water protocol would enhance Resident #127's quality of life because Resident #127 did not like thickened liquids.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record reviews, the facility failed to follow sterile (aseptic) techniques appropriately to flush	F 328	<p>F328 TREATMENT/CARE FOR SPECIAL NEEDS The facility will continue to ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p><u>Criteria 1</u> A clean syringe was obtained to ensure sterile technique flush for resident #172.</p> <p><u>Criteria 2</u> An audit will be conducted for any resident requiring sterile flush to ensure appropriate sterile technique is provided.</p>	

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F 328	Continued From page 11 the open Intravenous line (IV line) with Normal Saline injection syringe for one (1) of one (1) resident observed. (Resident #172). The findings are: Resident #172 was originally admitted to the facility on 1/12/2012. The admitting diagnoses included Bacterial Infections, Urinary Tract Infections and End Stage Renal Disease. A review of the physician's orders dated 1/25/2012 included to flush the left side Midline Catheter (A catheter inserted in the arm vein) with 20 milliliter (ml) of Normal Saline injection each shift. Further review of physician orders dated 1/29/2012 included an order to administer Rocephin 1 gm (gram) intravenously for 10 days at 6:00 PM. Resident #172 was observed for medication administration on 2/1/2012 at 7:38 AM. After administering the ordered medications orally Licensed Nurse (LN) #7 stated that she had to flush the Midline with 2 syringes of 10ml Normal Saline injection. She got all the supplies including the Normal Saline syringes and using an alcohol swab cleaned the tip of the midline catheter end with a gloved hand and removed the sterile cap of the Normal Saline syringes. Prior to flushing the midline, the Normal Saline's syringe tip touched the residents clothing and bed sheets. When the nurse was ready to flush, the nurse was interrupted by the surveyor to use a clean sterile syringe for completing the flushing procedure. An interview with LN #7 on 2/1/2012 at 7:50 AM revealed that she did not realize that the syringe tip had touched the unsterile clothing and bed sheet. The nurse confirmed that she did not hold	F 328	<u>Criteria 3</u> Licensed Nurses will be in-serviced on F328 to include providing sterile (aseptic) technique for Intravenous lines. The Director of Clinical Education will observe flushing technique with all Licensed Nurses to ensure appropriate sterile (aseptic) technique. This will also be conducted upon hire, annually and as necessary. <u>Criteria 4</u> The Director of Nursing Services will report the review in the monthly Quality Assurance Meeting for 3 months. The Committee will make recommendations as necessary. The Executive Director is responsible for overall compliance.	3/1/2012	

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F 328 Continued From page 12
the syringe appropriately to keep it clean and was aware of the aseptic techniques while flushing or accessing the open vein catheter for Resident #172.

F 328

An interview with the Director of Nursing on 2/2/2012 at 2:10 PM stated that it was her expectation that all sterile (aseptic) techniques had to be completed accurately to minimize any contamination and confirmed that all nurses had been in-serviced on the sterile procedures handling catheter veins.

F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE
SS=D

F 332

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff interview the facility failed to ensure it was free of medication error rate greater than 5% as evidenced by 4 medication errors out of 50 opportunities, resulting in a medication error rate of 8 % for 2 of 11 residents observed during medication pass. (Residents # 77 and # 99).

The findings are:

1. Resident # 77 had diagnoses which included osteoporosis, urinary frequency, generalized pain, constipation, anxiety, depressive disorder, anemia and hypertension (high blood pressure).

Observations on the morning medication pass on

F332
FREE OF MEDICATION ERROR RATES OF 5% OR MORE
The facility will continue to ensure that it is free of medication error rates of five percent or greater.

Criteria 1

A medication error report was completed with MD notification for residents #77 and #99.

Criteria 2

All licensed nurses in serviced on F332 to include administering medications per physician's order.
All licensed nurses have been observed for medication passes with satisfactory demonstration.

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F 332	<p>Continued From page 13</p> <p>02/01/12 beginning at 07:38 AM through 07:42 AM revealed Licensed Nurse (LN) #6 prepared the following medications for Resident #77: Celebrex 200 milligrams (mg) (1) capsule, Citalopram 20mg (1) tablet, Vitamin D 1000 units (2) tablets, Colace 100mg (1) capsules, Oxybutynin 5mg (1) tablet, Senna 8.6 mg (1) tablet, Calcium 600 mg with 400 IU (International Units) Vitamin D (1) tablet, Iron 325mg (1) tablet, and Xanax 0.5mg (1) tablet.</p> <p>Interview with LN # 6 on 02/01/12 at 07:45 AM confirmed the above medications observed completed Resident # 77's scheduled morning medications and then proceeded to administer the medications to Resident #77.</p> <p>Review of the physician orders for Resident #77 dated 01/31/12 revealed orders for Lisinopril 20mg every day.</p> <p>The MAR (Medication Administration Record) for February 2012 for Resident #77 was reviewed on 02/01/12 at 08:20 AM. Lisinopril 20 mg was printed on the MAR as one of the 8 AM scheduled medications and had been documented as given by LN #6.</p> <p>During an interview on 02/01/12 at 8:30 AM, LN #6 stated he thought he had given the Lisinopril but verified it had not been included when preparing Resident #77 's other medications observed between 07:38 and 07:42 AM. At this time LN #6 proceeded to administer the Lisinopril to Resident #77.</p> <p>During an interview on 02/1/12 at 3:30 PM, LN #2 (the unit manager) stated her expectations were</p>	F 332	<p><u>Criteria 3</u> Licensed Nurses will be observed for medication administration per physician's order weekly for 4 weeks, then monthly to ensure satisfactory administration. All newly hired Licensed Nurses will complete a satisfactory medication administration competency during orientation.</p> <p><u>Criteria 4</u> The Director of Clinical Education will report the review in the monthly Quality Assurance Meeting for 3 months. The Committee will make recommendations as necessary. The Executive Director is responsible for overall compliance.</p> <p>3/1/2012</p>		

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F 332	<p>Continued From page 14</p> <p>for staff to give medications correctly as ordered and to document accordingly.</p> <p>2. Resident # 77 had diagnoses which included osteoporosis, urinary frequency, generalized pain, constipation, anxiety, depressive disorder, anemia and hypertension (high blood pressure).</p> <p>Observations on the morning medication pass on 02/01/12 beginning at 07:38 AM through 07:42 AM revealed Licensed Nurse (LN) #6 prepared the following medications for Resident #77: Celebrex 200 milligrams (mg) (1) capsule, Citalopram 20mg (1) tablet, Vitamin D 1000 units (2) tablets, Colace 100mg (1) capsule, Oxybutynin 5mg (1) tablet, Senna 8.6 mg (1) tablet, Calcium 600 mg with 400 mg Vitamin D (1) tablet, Iron 325mg (1) tablet, and Xanax 0.5mg (1) tablet.</p> <p>Interview with LN # 6 on 02/01/12 at 07:45 AM confirmed the above medications observed completed Resident # 77's scheduled morning medications and then proceeded to administer the medications to Resident #77.</p> <p>Review of the physician orders for Resident #77 dated 01/31/12 revealed orders for Colace 200mg every day.</p> <p>The MAR (Medication Administration Record) for February 2012 for Resident #77 was reviewed on 02/01/12 at 08:20 AM. Colace 200mg was printed on the MAR as one of the 8 AM scheduled medications and had been documented as given by LN #6.</p> <p>During an interview on 02/01/12 at 8:30 AM, LN</p>	F 332			

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F 332	<p>Continued From page 15</p> <p>#6 verified he had only given (1) 100mg of Colace and the order was for (2) 100mg tablets. At this time LN #6 proceeded to administer another 100mg of Colace to Resident #77.</p> <p>During an interview on 02/1/12 at 3:30 PM, LN #2 (the unit manager) stated her expectations were for staff to give medications correctly as ordered and to document accordingly.</p> <p>3. Resident # 77 had diagnoses which included osteoporosis, urinary frequency, generalized pain, constipation, anxiety, depressive disorder, anemia and hypertension (high blood pressure).</p> <p>Observations on the morning medication pass on 02/01/12 beginning at 07:38 AM through 07:42 AM revealed Licensed Nurse (LN) #6 prepared the following medications for Resident #77: Celebrex 200 milligrams (mg) (1) capsule, Citalopram 20mg (1) tablet, Vitamin D 1000 units (2) tablets, Colace 100mg (1) capsules, Oxybutynin 5mg (1) tablet, Senna 8.6 mg (1) tablet, Calcium 600 mg with 400 mg Vitamin D (1) tablet, Iron 325mg (1) tablet, and Xanax 0.5mg (1) tablet.</p> <p>Interview with LN # 6 on 02/01/12 at 07:45 AM confirmed the above medications observed completed Resident # 77's scheduled morning medications and then proceeded to administer the medications to Resident #77.</p> <p>Review of the physician orders for Resident #77 dated 01/31/12 revealed orders for Calcium 600mg twice a day. There was no order for 400 units of Vitamin D.</p>	F 332			

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F 332	<p>Continued From page 16</p> <p>The MAR (Medication Administration Record) for February 2012 for Resident #77 was reviewed on 02/01/12 at 08:20 AM. Calcium 600mg was printed on the MAR as one of the morning scheduled medications and had been documented as given by LN #6.</p> <p>During an interview on 02/01/12 at 8:30 AM, LN #6 stated he had used the house stock of Calcium and did not realize it contained Vitamin D. LN #6 proceeded to open the medication cart and verified the bottle of Calcium used for Resident #77 included 400 units of vitamin D.</p> <p>During an interview on 02/1/12 at 3:30 PM, LN #2 (the unit manager) stated her expectations were for staff to give medications correctly as ordered and to document accordingly. LN #2 stated the MARs were checked regularly but this must have been missed.</p> <p>4. Resident #99 was admitted on 9/02/2011. The admitting diagnoses included Asthma, Wheezing, Congestive Heart Failure, Hypothyroidism and Diabetes. A review of the admission physician orders dated 9/02/2011 included an order to administer two puffs of Symbicort (Budesonide-Formoterol Fumerate Dihydrate) 160-4.5 mcg (Microgram) aerosol Inhalation two times daily scheduled at 8:00 AM and 8:00 PM. Resident #99 was observed for medication administration on 2/01/2012 at 8:09 AM. Licensed Nurse #4 (LN #4) was observed administering medications to Resident #99. LN #4 administered all oral medications to Resident #99 as ordered and handed the prepared</p>	F 332			

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F 332	Continued From page 17 Symbicort 160-4.5 inhaler unit to Resident #99 to inhale. Resident #99 inhaled two puffs and LN #4 walked away without offering her water to rinse/gargle the mouth. An interview with LN #4 on 2/1/2012 at 8:19 AM revealed that she was not aware that she was supposed to offer water to rinse/gargle the mouth after the use of Symbicort inhaler. An observation of the pharmacy label on the inhaler had a warning to rinse the mouth after use. The nurse stated that she had failed to read the instructions on the pharmacy label revealing the instructions to rinse the mouth after the administration of Symbicort. LN #4 also stated that she was not sure what all inhalers needed rinsing of mouth after use. An interview with Director of Nursing (DON) on 2/2/2012 at 2:10 PM confirmed that it was her expectation the nurses should read both MAR instructions and pharmacy labels.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff and physician interview and record review, the facility failed to administer a medication according to physician's orders for one (1) of ten (10) sampled residents (Resident #151). The findings are: Resident #151 was admitted to the facility with	F 333	F333 Residents free of significant Medication Errors The facility will continue to ensure that residents are free of any significant medication error. <u>Criteria 1</u> Medication error report has been completed for 151 and MD notified <u>Criteria 2</u> An audit has been conducted for a sample of 10% of current residents to ensure physicians orders are followed. Licensed nursing staff will be in serviced on following physician orders properly. Any medication errors found will have a medication error reporting form completed if necessary with physician notification.	

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F 333	<p>Continued From page 18</p> <p>diagnoses which included Benign Prostatic Hypertrophy (BPH). Admission medications included Flomax 0.8 mg. (milligrams) daily. (Flomax is a medication used to treat BPH.) The hospital discharge summary dated 9/26/11 indicated Resident #151 should receive Flomax 0.8 mg daily.</p> <p>Review of Resident #151's Medication Administration Records from 9/27/11 to 2/2/12 revealed documentation of daily Flomax 0.8 mg administration. The MAR transcription listed: "Flomax 0.4 mg total dose: 0.8 mg."</p> <p>Review of the pharmacy drug delivery slips for Resident #151's Flomax revealed the following quantity and delivery dates of 0.4 mg capsules: 30 on 9/26 (15 day supply); 30 on 10/14 (15 day supply); 30 on 11/1 (15 day supply), 30 on 11/28 (15 day supply); 30 on 12/12 (15 day supply), 30 on 12/28 (15 day supply) and 60 on 1/17/12 (30 day supply). (This was a total of 240 Flomax 0.4 mg capsules.)</p> <p>Observation on 2/2/12 at 11:50 AM revealed two medication cards of Flomax 0.4 mg filled on 1/17/12 with pharmacy directions to administer two tablets daily. One card contained 21 capsules and the other card contained 24 capsules (total of 45 capsules). The recorded delivered capsules of 240 minus the 45 capsules on hand resulted in 195 Flomax 0.4mg capsules. One hundred and ninety-five capsules contained 97 and one half doses of Flomax 0.8 mg instead of the documented 129 doses (a difference of 31 and one half doses).</p> <p>Interview with Licensed Nurse (LN) #5 on 2/2/12</p>	F 333	<p><u>Criteria 3</u> The Director of Nursing Services or designee will monitor all residents that have a physician's order for Flomax to ensure orders are followed. This will be done daily times two weeks, then weekly for one month, then monthly for two months, and as needed. These audits will be reviewed and monitored at the DNS start up.</p> <p><u>Criteria 4</u> The Director of Nursing will report results in the monthly Quality Assurance meeting for three months. The Executive Director is responsible for overall compliance.</p>	

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F 333	<p>Continued From page 19</p> <p>at 11:55 AM revealed she administered two capsules to Resident #151 that morning. She had no explanation for the difference between the ordered dose and the delivered amount of medication. LN #5 explained if a refill was required, a request was faxed to the pharmacy.</p> <p>Interview with the urologist on 2/2/12 at 2:49 PM revealed his records indicated Resident #151 should receive 0.8 mg of the Flomax daily.</p> <p>Interview with LN #2 on 2/2/12 at 3:06 PM revealed Resident #151 should receive 2 capsules of the Flomax 0.4 mg. She could not provide a reason for the difference in the amount of ordered medication and the amount which should have been administered.</p> <p>Interview with the Director of Nursing (DON) on 2/2/12 at 3:16 PM revealed she expected staff to administer the correct dose of medication. The DON could not provide a reason for the difference in the amount dispensed and the amount required for a correct dose.</p>	F 333			