

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

PRINTED: 04/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/12/2012
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF ASHEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA RD ASHEVILLE, NC 28801	
(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 272 SS=B	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272	<p>Asheville Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes the following Plan of Correction. It does not constitute admission or agreement with the facts and conclusions set forth in 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 Federal and State Requirements.</p> <p>The below response to the Statement of Deficiency and Plan of Correction does not denote agreement with the citations.</p> <div style="text-align: center; border: 1px solid blue; padding: 5px; margin: 10px auto; width: fit-content;"> <p>RECEIVED</p> <p>MAY 8 2012</p> <p>BY: _____</p> </div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Mary E. Hunter *Administrator* *5/2/2012*

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to complete an analysis of findings in the decision making process when doing the Care Area Assessment (CAA) for four (4) of thirteen (13) sampled residents. (Residents #95, #13, #92 and #73) The findings are: 1. Resident #95 was hospitalized from 2/22/12-3/3/12 for pneumonia. Prior to hospitalization on 2/22/12 Resident #95 was taking 10 milligrams (mg) of Zyprexa (an antipsychotic medication). Upon readmission 3/3/12 Resident #95 was placed under the services of Hospice. Readmission orders from the hospital included 30 mg of Zyprexa. Review of hospital records from the 2/22/12-3/3/12 admission did not address the need for the increased Zyprexa. A significant change Minimum Data Set (MDS) was done for Resident #95 on 3/11/12 with the following areas triggered: Cognition, Visual, Communication, Activities of Daily Living (ADL), Continenence, Falls, Nutrition, Dehydration, Pressure Sore and Psychotropic Medication. Review of each CAA noted nothing in the summary to determine staff decision making in whether or not to proceed to the care plan. In particular, the psychotropic review did not address the increased Zyprexa from 10 mg to 30 mg.	F 272	F272 The named residents as well as all residents have the potential to be affected by this practice. No residents were identified as at risk, no residents identified as having been affected. Residents #95, #13, #92, #73 experienced no negative outcome. Resident #95, #13, #92, #73 Care Area Assessment Analyses to be completed by MDS Coordinators to ensure complete anlysis of findings in the decision making process. MDS Coordinators in-serviced on understanding and completing the Care Area Assessments and Care Area Triggers on 4/30/12. Audits will be conducted bi-weekly for 3 months by Director of Nursing/Staff Development Coordinator/Corporate Nurse Consultant to ensure facility completes an analysis of findings in the decision making process when doing the Care Area Assessment. Audits will be conducted based on the monthly Minimum Data Set calendar. All audits will be reported to the monthly Quality Assurance and Assessment Meeting by the MDS Coordinators for 3 months. Recommendations will be made as deemed necessary.	5/8/12

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F 272	<p>Continued From page 2</p> <p>On 4/12/12 at 9:45 AM the MDS nurse that completed the 3/11/12 MDS and CAA assessments stated a significant change MDS was done because Resident #95 was started on Hospice services. The MDS nurse stated she did not realize she had to write an analysis of findings for each triggered area. The MDS nurse stated the responses that triggered the CAA from the MDS are automatically carried over and she checked at the end of the CAA whether or not the area would be care planned. The MDS nurse stated when trained she was told all she had to check in each individual CAA assessment was whether or not the area triggered would be care planned.</p> <p>2. Resident #13 was readmitted to the facility with diagnoses including malignant hypertension, abnormality of gait, and debility.</p> <p>The admission Minimum Data Set (MDS) dated 12/12/11 coded her with intact cognition, requiring extensive assistance with most activity of daily living, and being occasionally incontinent. The areas triggered in the Care Area Assessment (CAAs) Summary on the MDS were: Visual Function, Activities of Daily Living (ADL), Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, and Return to Community Referral.</p> <p>Review of each of the CAAs for the triggered areas revealed there was no information recorded in the analysis of findings section. The section was empty and did not provide descriptions of the problems, causes and contributing factors and risk factors related to the care areas.</p> <p>A joint interview with the facility's two (2) MDS</p>	F 272		

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F 272	<p>Continued From page 3</p> <p>nurses on 4/12/12 at 3:00 p.m. revealed they were unaware they needed to complete the analysis of findings sections. The nurses stated they were told they only had to check in each individual CAA assessment whether or not the area triggered would be care planned.</p> <p>During an interview on 4/12/12 at 3:45 p.m., the Director of Nursing stated the MDS should have completed the analysis of findings section.</p> <p>3. Resident #92 was admitted to the facility with diagnoses including hypertension, diabetes, and cerebrovascular accident.</p> <p>The annual Minimum Data Set (MDS) dated 10/20/11 coded him with long and short term memory impairment, requiring limited to extensive assistance with most activities of daily living, and being frequently incontinent. The areas triggered in the Care Area Assessment (CAAs) Summary on the MDS were: Cognitive Loss, Visual Function, Communication, Activities of Daily Living (ADL), Urinary Incontinence, Mood State, Behavior, Pressure Ulcer, and Psychotropic Drug Use.</p> <p>Review of each of the CAAs for the triggered areas revealed there was no information recorded in the analysis of findings section. The section was empty and did not provide descriptions of the problems, causes and contributing factors and risk factors related to the care areas.</p> <p>A joint interview with the facility's two MDS nurses on 4/12/12 at 3:00 p.m. revealed they were unaware they needed to complete the analysis of findings sections. The nurses stated they were</p>	F 272			

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F 272	<p>Continued From page 4</p> <p>told they only had to check in each individual CAA assessment whether or not the area triggered would be care planned.</p> <p>During an interview on 4/12/12 at 3:45 p.m., the Director of Nursing stated the MDS should have completed the analysis of findings section.</p> <p>4. Resident #73 was admitted to the facility with diagnoses including hypertension and diabetes.</p> <p>The annual Minimum Data Set (MDS) dated 6/20/11 coded him with intact cognition, requiring supervision with eating and dressing and limited assistance with hygiene and bathing, and being always continent. The areas triggered in the Care Area Assessment (CAAs) Summary on the MDS were: Cognitive Loss, Visual Function, Activities of Daily Living (ADL), Behavioral Symptoms, Falls, Nutrition, Pressure Ulcer, and Psychotropic Drug Use.</p> <p>Review of each of the CAAs for the triggered areas revealed there was no information recorded in the analysis of findings section. The section was empty and did not provide descriptions of the problems, causes and contributing factors and risk factors related to the care areas.</p> <p>A joint interview with the facility's two MDS nurses on 4/12/12 at 3:00 p.m. revealed they were unaware they needed to complete the analysis of findings sections. The nurses stated they were told they only had to check in each individual CAA assessment whether or not the area triggered would be care planned.</p> <p>During an interview on 4/12/12 at 3:45 p.m., the</p>	F 272		

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F 272	Continued From page 5	F 272			
F 281 SS=D	<p>Director of Nursing stated the MDS should have completed the analysis of findings section.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to ensure medications were administered as ordered by the physician for one (1) of ten (10) sampled residents. (Resident #2)</p> <p>The findings are:</p> <p>Resident #2 was readmitted after a hospitalization 10/28/11-11/4/11. Readmission orders dated 11/4/11 were reviewed in conjunction with the November 2011 Medication Administration Record (MAR) and the following concerns were noted:</p> <p>1. Ten (10) milligrams (mg) of Lipitor (a medication to lower cholesterol levels) was ordered at bedtime on readmission 11/4/11. Review of November 2011-March 2012 MARs revealed the Lipitor was not given as ordered from 11/4/11-3/9/12. On 4/11/12 at 11:10 AM the facility Director of Nursing (DON) stated the 11/4/11 hospital discharge orders would have been used on readmission to the facility. The DON verified 10 mg of Lipitor was included with hospital discharge records and should have been included with readmission orders. The DON</p>	F 281	<p>F281</p> <p>The named resident as well as all residents have the potential to be affected by this practice. No residents were identified as at risk, no residents identified as having been affected.</p> <p>Resident #2 experienced no negative outcome.</p> <p>Resident #2: Lipitor order corrected on 3/9/12. Physician notified. Transcription error reports completed as needed.</p> <p>Resident #2: Senokot order written to include 2 tablets every night on 4/12/12 Physician notified.</p> <p>Resident #2 :Flonase order discontinued on 4/13/12. Physician notified.</p> <p>Resident #2 : PRN Lortab discontinued on 11/12/11. Physician notified.</p> <p>Resident #2: Insulin order updated on 4/13/12 to continue as currently ordered. Physician notified.</p>		

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F 281	Continued From page 6 stated a former unit manager was the nurse that readmitted Resident #2 and wrote orders on the November 2011 MAR. The DON stated the former unit manager no longer was employed by the facility. On 4/11/12 at 11:20 AM the current unit manager (over the unit Resident #2 resided) stated the Lipitor for Resident #2 was found in the medication cart in March. The unit manager stated the medical record of Resident #2 was reviewed and it was then they realized the Lipitor had been left off readmission orders. The unit manager stated the resident's physician was notified and Lipitor was started on 3/9/12. The DON stated the MARs are printed by facility staff utilizing the prior month MAR. The DON stated, because of this, the omission of Lipitor had not been identified until the medication was found in the medication cart in March. Attempts were made to contact the former unit manager but the last contact information was no longer valid. 2. Prior to discharge to the hospital on 10/28/11 Resident #2 had been taking two (2) tablets of Senokot at bedtime (to prevent constipation). Two tablets of Senokot was ordered at bedtime for Resident #2 on readmission 11/4/11. Review of November 2011-April 2012 MARs revealed the Senokot was not given as ordered. On 4/11/12 at 11:10 AM the facility Director of Nursing (DON) stated the 11/4/11 hospital discharge orders would have been used on readmission to the facility. The DON verified two (2) tablets of Senokot was included with hospital discharge records and should have been included with readmission orders. The DON stated a former unit manager was the nurse that readmitted Resident #2 and wrote orders on the November 2011 MAR. The DON stated the former unit	F 281	All residents upon admission/re-admission to the facility will have hospital discharge summaries reviewed in the daily morning meeting by Director of Nursing/Unit Coordinators to ensure transcription of all medications and dosage is accurate daily (Monday-Friday) for 3 months. Unit Coordinators/Weekend Supervisor will be in-serviced regarding importance and proper review of transcribing medications and dosages from hospital discharge summaries and or physician orders. All findings will be reported to the monthly Quality Assurance and Assessment Meeting by the Director of Nursing for 3 months. Recommendations will be made as deemed necessary.	5/10/12

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F 281	<p>Continued From page 7</p> <p>manager was no longer employed by the facility. The DON stated the MARs are printed by facility staff utilizing the prior month MAR. The DON stated, because of this, the omission of Senokot had not been identified. Attempts were made to contact the former unit manager but the last contact information was no longer valid.</p> <p>3. A daily dose of Flonase nasal spray was ordered for Resident #2 on readmission 11/4/11. Review of November 2011-April 2012 MARs revealed the Flonase nasal spray was not given as ordered. On 4/11/12 at 11:10 AM the facility Director of Nursing (DON) stated the 11/4/11 hospital discharge orders would have been used on readmission to the facility. The DON verified the Flonase nasal spray was included with readmission orders. The DON stated a former unit manager was the nurse that readmitted Resident #2 and wrote orders on the November 2011 MAR. The DON stated the former unit manager was no longer employed by the facility. The DON stated the MARs are printed by facility staff utilizing the prior month MAR. The DON stated, because of this, the omission of Flonase had not been identified. Attempts were made to contact the former unit manager but the last contact information was no longer valid.</p> <p>4. Prior to discharge to the hospital on 10/28/11 Resident #2 had been taking Lortab 10/500 every six (6) hours as needed (PRN) for back pain. Lortab had not been ordered on readmission 11/4/11. Review of the November 2011 MAR revealed the PRN order for Lortab every six hours was included on the MAR with doses given to Resident #2 on 11/4/11, 11/7/11, 11/8/11, 11/9/11, 11/10/11, 11/12/11 and 11/13/11. On</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>4/11/12 at 11:10 AM the facility Director of Nursing (DON) stated the 11/4/11 hospital discharge orders would have been used on readmission to the facility. The DON verified the PRN Lortab was not included with readmission orders. The DON stated a former unit manager was the nurse that readmitted Resident #2 and wrote orders on the November 2011 MAR. The DON stated the former unit manager was no longer employed by the facility. After review of the November 2011 MAR the DON stated the former unit manager had modified the November 2011 MAR (which had already been printed in house prior to discharge 10/28/11) with readmission orders but had not removed the PRN Lortab. The PRN Lortab was discontinued 11/12/11 when new orders for pain management were received. Attempts were made to contact the former unit manager but the last contact information was no longer valid.</p> <p>5. Prior to discharge to the hospital on 10/28/11 Resident #2 had been taking sliding scale Novolog insulin 2-10. Readmission orders on 11/4/11 included sliding scale Novolog insulin 2-12. Review of the November 2011-April 2012 Medication Administration Records (MAR) revealed Resident #2 had been receiving sliding scale Novolog insulin 2-10. On 4/11/12 at 11:10 AM the facility Director of Nursing (DON) stated the 11/4/11 hospital discharge orders would have been used on readmission to the facility. The DON verified the sliding scale Novolog was ordered on a 2-12 scale, not a 2-10 scale. After review of the November 2011 MAR the DON stated the former unit manager had modified the November 2011 MAR (which had already been printed in house prior to discharge 10/28/11) with</p>	F 281		

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F 281	Continued From page 9 readmission orders but had not changed the sliding scale Novolog insulin from a 2-10 scale (as she had been on prior to discharge) to a 2-12 scale (which was ordered on readmission 11/4/11). Attempts were made to contact the former unit manager but the last contact information was no longer valid. On 4/12/12 at 1:30 PM the physician of Resident #2 stated staff had just informed him of the multiple medication errors for Resident #2. The resident's physician stated he did not feel the medication errors resulted in any harm to Resident #2 and planned on reviewing the record and addressing any needed changes.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to 1) administer a laxative as ordered and 2) implement bowel protocol standing orders for one (1) of six (6) sampled residents. (Resident #2) The findings are: Resident #2 was hospitalized 10/28/11 and	F 309	F309 The named resident as well as all residents have the potential to be affected by this practice. No residents were identified as at risk, no residents identified as having been affected. Resident #2 experienced no negative outcome.	

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F 309	<p>Continued From page 10</p> <p>readmitted to the facility 11/4/11. The care plan in place after readmission included a problem area dated 11/23/11 of: "Potential for constipation related to medications." Approaches to address this problem included: "Administer medication as ordered; Record all bowel movements every shift; Encourage to defecate when urge is felt, assist to toilet as needed; Encourage adequate fluid intake; Fresh water at bedside and within easy reach; Offer fluids during food related activities; Encourage to continue to ambulate daily as tolerated; Encourage to turn and reposition frequently, assist as needed; Encourage participation in activities involving physical mobility as tolerated; Observe for signs/symptoms constipation, document and report as appropriate."</p> <p>Prior to discharge on 10/28/11 Resident #2 had received two tablets of Senokot at bedtime. Readmission orders on 11/4/11 included 2 tablets of Senokot at bedtime. Review of readmission orders noted this was the only laxative medication ordered for Resident #2. Review of the Medication Administration Records (MAR) from November 2011-April 2012 noted Senokot was not administered to Resident #2 as ordered. On 4/11/12 at 11:10 AM the facility Director of Nursing (DON) stated the 11/4/11 hospital discharge orders would have been used on readmission to the facility. The DON verified 2 tablets of Senokot was included with hospital discharge records and should have been included with readmission orders. The DON stated a former unit manager was the nurse that readmitted Resident #2 and wrote orders on the November 2011 MAR. The DON stated the former unit manager was no longer employed by</p>	F 309	<p>Written Bowel Protocol added to each resident's physician orders. Protocol states: "If no bowel movement in 3 days, give Milk of Magnesium 30 CC by mouth times 1. If not effective in 1 shift, give Dulcolax Suppository per rectum times 1. If not effective in 1 shift, give Fleets enema times 1 rectally. If not effective call physician."</p> <p>Unit Coordinators/Weekend Supervisor responsible for reviewing resident bowel movement electronic flow sheet daily to ensure all residents have had a bowel movement within 3 days. Unit Coordinators will communicate to licensed nurses any resident who has not had a bowel movement within 3 days to initiate the bowel protocol.</p> <p>Unit Coordinators will be responsible for ensuring bowel protocol is followed by licensed nurse administrating medications by auditing electronic bowel movement flow sheets daily (Monday-Friday) for 3 months.</p> <p>All licensed personnel responsible for administering medications will be in-serviced regarding bowel protocol.</p> <p>All findings will be reported to the monthly Quality Assurance and Assessment Meeting by the Director of Nursing for 3 months. Recommendations will be made as deemed necessary.</p>	5/10/12 5/10/12

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F 309	<p>Continued From page 11</p> <p>the facility. The DON stated the MARs are printed by facility staff utilizing the prior month MAR. The DON stated, because of this, the omission of Senokot had not been identified. Attempts were made to contact the former unit manager but the last contact information was no longer valid.</p> <p>The facility had an electronic tracking system which nursing assistants used to record daily bowel movements. This data was entered every shift by the nursing assistant assigned to the resident. Review of this electronic record for Resident #2 from 11/4/11 through the time of the survey noted the following dates the resident went an extended time without a bowel movement: 1/5/12 -1/10/12 (five days) 1/26/12-2/1/12 (six days) 2/13/12-2/20/12 (seven days) 3/1/12-3/6/12 (five days)</p> <p>On 4/11/12 at 3:00 PM the unit manager (over the unit Resident #2 resided) as well as the DON stated a daily task of the unit manager was to pull up a list (from the electronic charting) of any resident that did not have a bowel movement in the past three days. The DON stated, from this information, a list is given to each nurse of any resident that has not had a bowel movement in three days. The DON stated the nurse is supposed to implement standing orders which includes an initial dose of Milk of Magnesium (MOM). The DON stated if there are no results from the MOM a suppository would be administered. The DON stated it was her expectation the standing orders would be implemented and any medication given would be</p>	F 309		

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F 309	<p>Continued From page 12</p> <p>documented on the residents MAR. The DON stated these lists (generated by the unit manager and provided to the nurse responsible for any resident that has gone greater than three days) are not retained so there was not a way to track the four time frames in question for Resident #2. Review of the facility signed standing orders in the record of Resident #2 included:</p> <p>"Constipation"</p> <ol style="list-style-type: none"> Milk of Magnesium 30 cc orally every day as needed for constipation. Fleets adult enema every three days as needed for constipation not relieved by Milk of Magnesium Do not use Milk of Magnesium or fleets on residents with renal failure. Call MD with these residents. Do not use standing orders for constipation. Notify physician via communication book unless considered an emergency. If emergency, notify on call or attending immediately. <p>The unit manager reviewed (Resident #2's) nurses notes and MARs during the four extended time frames in question. On 4/12/12 at 10:20 AM the unit manager reported she could not find evidence in nurses notes the resident had a bowel movement during these times and/or that nurses had initiated the bowel protocol as ordered by the physician.</p> <p>On 4/12/11 at 1:30 PM the resident's physician stated staff had just informed him that Resident #2 was not receiving Senokot as ordered since readmission 11/4/11 and that the resident had gone four extended times without a bowel movement. The resident's physician stated he</p>	F 309		

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F 309	Continued From page 13 expected staff to initiate the standing order bowel protocol if a resident went an extended time without a bowel movement. The resident's physician stated he would order the Senokot for Resident #2 to prevent future problems with constipation.	F 309			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 329	F329 The named resident as well as all residents have the potential to be affected by this practice. No residents were identified as at risk, no residents identified as having been affected. Resident #2 experienced no negative outcome. Monthly pharmacy reviews will continue to be conducted by the consulting pharmacist on each resident to ensure their drug regimen is free of unnecessary drugs.		

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F 329	Continued From page 14 interviews the facility failed to administer acetaminophen to one (1) of five (5) residents as ordered by the physician. (Resident #2) The findings are: Resident #2 was readmitted to the facility 11/4/11 after hospitalization. Readmission orders included: Acetaminophen 650 milligrams (mg), three times a day (a total of 1950 milligrams of acetaminophen a day). The November 2011 Medication Administration Record (MAR) for Resident #2 included a notation: "Do not exceed 3 grams of Tylenol from any source in 24 hours" Review of subsequent physician orders for Resident #2 included on 11/12/11, "Hydrocodone 10/500 mg every 8 hours". The 11/12/11 order added an additional 1500 mg of acetaminophen a day for a total of 3450 mg/every day (from the acetaminophen and Hydrocodone). On 11/15/11 the physician order was changed to Vicodin 10/500 every 8 hours along with an additional 10/500 Vicodin every 6 hours as needed. Review of the November 2011 MAR noted resident received 3450 mg of acetaminophen from 11/13-11/30 with an additional 500 mg a day when she was administered PRN Vicodin 11/24 and 11/27. Review of the 2011 December MAR for Resident #2 revealed she received the 3450 mg of acetaminophen as well as an additional 500 mg acetaminophen 12/5, 12/11 and 12/29 from the PRN Vicodin. On 4/11/12 at 11:10 AM the Director of Nursing (DON) stated she expected staff to not exceed 3000 milligrams of acetaminophen a day and notify a residents physician if current doses exceed that amount. The DON reviewed the 2011	F 329	100% audit of all resident Physician Orders reviewed by Unit Coordinators to ensure no resident is receiving greater than 3 grams of Tylenol from any source in a 24 hour period. Any resident noted ... to having been affected by this practice will have dosage adjustments to remain within 3 grams of Tylenol from any source within a 24 hour period. All licensed nurses will be in-serviced by the Director of Nursing/Staff Development Coordinator on the review of medications and the physicians order not to receive greater than 3 grams of Tylenol from any source in a 24 hour period. All new orders containing Tylenol will be compared to resident's current medication regimen daily (Monday – Friday) for 1 month by Unit Coordinators, weekly times 4 weeks and bi-weekly times 1 month. Dosage adjustments will be made as needed as to not exceed 3 grams of Tylenol from any source in a 24 hour period All audits will be reported to the monthly Quality Assurance and Assessment Meeting by the Director of Nursing for 3 months. Recommendations will be made as deemed necessary.	5/10/12	5/10/12

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F 329	Continued From page 15 November and December MAR for Resident #2 and verified acetaminophen had been given in excess of 3000 milligrams a day. Review of the January 2012 and February 2012 MARs revealed only Vicodin 10/500 three times a day as well as 10/500 PRN Vicodin every six hours were on the resident's MAR. The order for 650 milligrams of acetaminophen three times a day had been "discontinued" from the MARs (though there was not a corresponding physician's order). On 2/27/12 a physician's order was written to discontinue the 650 milligrams of acetaminophen three times a day for Resident #2. On 4/11/12 at 11:20 AM the DON reviewed the January and February 2012 MARs and noted the former unit manager had discontinued the 650 milligrams of acetaminophen three times a day from the January and February 2012 MARs without a physician's order. The DON stated the former unit manager was no longer employed by the facility. Attempts were made to contact the former unit manager but the last contact information was no longer valid. On 4/12/12 at 1:30 PM the physician of Resident #2 stated he expected staff to not exceed 3000 milligrams of acetaminophen every day. The resident's physician stated he did not think Resident #2 was harmed from the exceeded doses of acetaminophen in November and December.	F 329			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431			

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F 431	<p>Continued From page 16</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and manufacturer product recommendations, the facility failed to remove expired medications from use in one (1) of four (4) medication carts.</p> <p>The findings are:</p>	F 431	<p>F431</p> <p>All residents have the potential to be affected by this practice. No residents were identified as at risk, no residents identified as having been affected.</p> <p>Insulin and Advair discarded 4/12/12.</p> <p>Licensed nurses responsible for medication Administration will be in-serviced on checking for expiration dates of prescribed medications, over the counter medication, and multi-dose containers of medication.</p> <p>All medication carts will be audited for expiration dates of medications by Unit Coordinators/Director of Nursing every week for 4 weeks, then bi-monthly for 2 months.</p> <p>Medication carts will continue to be audited monthly for expired medication by the Pharmacy Quality Assurance Nurse.</p> <p>All audits will be reported to the monthly Quality Assurance and Assessment Meeting by the Director of Nursing for 3 months. Recommendations will be made as deemed necessary.</p>	5/10/12

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F 431	<p>Continued From page 17</p> <p>The manufacturer's recommendations for open multi-dose vials of Lantus and Novolog insulin revealed vials must be discarded 28 days after opening. The manufacturer's recommendation for Advair Diskus revealed once it has been removed from the foil pouch the product must be discarded 30 days after opening.</p> <p>Review of a form used by the facility for suggested drug storage and expiration, dated 02/2011 indicated Advair Diskus expires thirty (30) days after the outer wrap is removed. The form also indicated multi dose vials of insulin expire twenty-eight (28) days from the date opened.</p> <p>On 04/12/12 at 10:30 a.m. during an observation of medication storage, the lower 100 Hall medication cart was observed to contain the following:</p> <ul style="list-style-type: none"> · Lantus 100 u (units)/100 ml (milliliter) insulin opened 03/10/12 · Novolog 100u/ml insulin opened 03/08/12 · Novolog 100u/ml insulin opened 03/10/12 · Two Advair Diskus 250/50, one with an open date of 03/03/12 and the other with an open date of 03/08/12 <p>The medications were in the active stock ready for resident use.</p> <p>On 04/03/12 at 10:55 a.m. Licensed Nurse (LN) #1 revealed multi dose vials of insulin should be discarded 28 days after opening and Advair Diskus, once opened, should be discarded after 30 days. LN #1 acknowledged all five (5)</p>	F 431			

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F 431	Continued From page 18 medications were past their expiration dates and should be discarded. An interview with the Director of Nursing (DON) on 04/12/12 at 11:15 a.m. revealed, based on facility policy, multi dose vials of insulin are to be discarded 28 days after opening. She also revealed it is the medication nurse's responsibility to date the vial of insulin when opened and to ensure the insulin is not expired prior to administration. The DON further indicated once an Advair Diskus is removed from the foil pouch the product is good for 30 days.	F 431			