1/23/2014

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

PRINTED: 01/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345278	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN SURRY SNF	830 ROCKFORD STREET MOUNT AIRY, NC 27030

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 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 observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.1%, for 2 of 8 residents (Resident #1 and Resident #37) observed during medication pass. The findings included: 1) Resident #1 was admitted to the facility on 9/30/05 with a cumulative diagnoses including asthma. On 1/7/14 at 4:35 PM, Nurse #1 was observed preparing and administering medications to Resident #1. The medications pulled for administration included a Flovent HFA 110 microgram (mcg) inhaler (a steroidal medication used for the management of asthma). Nurse #1 was observed as she instructed the resident to inhale one puff of the medication by mouth. A review of Resident #1 ' s January 2014 Physician ' s Monthly orders included an order for Flovent HFA 110 mcg inhaler with the physician ' s instructions to inhale two puffs twice daily. During an interview with Nurse #1 on 1/7/14 at 4:55 PM, the nurse confirmed Resident #1 only	F 332	Plan of Correction for deficiency 483.25 (m) (1) Free of Medication Error rates of 5% or more **Corrective Action for those residents found to have been affected by the deficient practice:** The nurse caring for resident # 1 was informed immediately of the deficient practice. Remedial education and counseling was provided to the nurse regarding appropriate medication administration per the physician's order and subsequent documentation if the administration deviated from the ordered dose. Remedial education and counseling was provided to the nurse regarding appropriate notification of the resident's physician in the event the resident is not complying with the ordered medication regimen. The physician was notified of the resident's noncompliance with ordered medication regimen. The nurse caring for resident #37 was informed immediately of the deficient practice. Remedial education and counseling was provided to the nurse regarding appropriate medication administration and clarification of orders with pharmacy staff and the in the event there is a discrepancy between the printed Medication Administration Record (MAR) and the substituted medication provided by the pharmacy for administration. The Director of	January 7, 2014 January 8, 2014

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

William Bowman | CEO | 01/20/2014

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.

MF X

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F 332	Continued From page 1 received one puff of Flovent HFA during the medication administration. Nurse #1 stated that she realized she only offered one puff of the inhaler after leaving the room and indicated that the resident often refused the second puff of his evening dose. When asked if she noted this anywhere in the resident ' s medical record, Nurse #1 stated, " No, we probably could let the doctor know though. " During an interview with the Director of Nursing (DON) on 1/8/14 at 10:00 AM, the administration of the Flovent HFA inhaler medication for Resident #1 was discussed. The DON reported she would have expected the nurse to call Resident #1 ' s physician and tell him the resident was only accepting one inhalation of the medication in the evening and requested a physician ' s order to reflect this. The DON also indicated that when the Medication Administration Record (MAR) was initialed for a medication such as Flovent HFA, it would be assumed that the entire dose (two inhalations) of that medication had been given. The DON stated, " We normally call the doctor; that ' s what we ' re supposed to do. " 2) Resident #37 was admitted to the facility on 1/2/14 with a cumulative diagnoses including hiatal hernia (a condition in which part of the stomach protrudes upward into the chest through an opening in the diaphragm) and gastro-esophageal reflux disease (GERD). On 1/8/14 at 8:38 AM, Nurse #3 was observed preparing and administering medications to Resident #37. The administered medications included one tablet of 40 milligrams (mg) pantoprazole (a medication used in the	F 332	Pharmacy was informed immediately of the deficient practice and failure to follow the protocol for Therapeutic/Formulary Substitution. The Director of Pharmacy immediately entered an order in the clinical record for resident #37 to validate the substitution. The physician was notified. The MAR was updated to reflect the therapeutic/formulary substitution. **Corrective Action for those residents having potential to be affected by the same deficient practice:** Education was provided to all nursing staff on the following practices/policies; Medication Administration/Documentation and Therapeutic/Formulary Substitution. Education was provided to all pharmacists on the proper process for Therapeutic/Formulary Substitution. **Measures put into place to ensure that the deficient practice will not occur:** Education and review with nursing staff of the process to ensure medications ordered by the physician are properly administered per the order and accurately reflected on the residents MAR. Education and review with the nursing staff of the process to follow if	January 17, 2014 January 17, 2014

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F 332	Continued From page 2 management of erosive esophagitis associated with GERD). A review of Resident #37 ' s January 2014 Physician ' s Monthly orders included an order for 30 mg lansoprazole (a medication used in the management of symptomatic GERD) given as one capsule once daily. During an interview with Nurse #3 on 1/8/14 at 9:02 AM, the nurse confirmed that Resident #37 ' s Medication Administration Record (MAR) indicated the resident was scheduled to receive 30 mg lansoprazole during the medication pass. The nurse also confirmed that a 40 mg pantoprazole tablet was given to the resident instead of the 30 mg lansoprazole capsule indicated on the MAR. Nurse #3 stated she did not realize the medication administered was not the medication indicated on the MAR. Upon inquiry, the nurse outlined the facility ' s procedures used when one medication was substituted for another as part of a therapeutic interchange (such as substituting pantoprazole for lansoprazole). Nurse #3 stated that if the pharmacy made a therapeutic interchange (or a formulary substitution), the resident ' s physician would need to be called and the order for the medication changed if he approved of the exchange. Once the order was changed, the order for the new medication would be transcribed onto the MAR. Nurse #3 stated that at this point, she would need to call the resident ' s physician for approval to change the order from 30 mg lansoprazole to 40 mg pantoprazole given once daily. During an interview with the Director of Nursing (DON) on 1/8/14 at 10:00 AM, the facility ' s policy	F 332	there is a deviation from the ordered medication therapy including accurate documentation on the MAR and notification of the physician. Education and review with the pharmacy staff of the process to ensure the standard process for therapeutic interchange/substitution on the SNF is followed; including writing an order for the approved therapeutic interchange and updating the resident MAR that a therapeutic interchange had been made. Education and review with the nursing staff of the process to ensure the standard process for therapeutic interchange/substitution on the SNF is followed including verification that when a therapeutic interchange occurs there is an order entered in the record by the pharmacist, the physician is notified, and the MAR updated. Education regarding these policies is included in nursing orientation. **Monitoring of performance to make sure the solutions are sustained:** Monitoring of the POC will be accomplished by observation of two medications passes per week for one month by the Director of Nursing. The Director of Nursing will report findings to the QA committee during the next quarterly meeting.	Ongoing

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F 332	Continued From page 3 for a therapeutic interchange was discussed. The DON reported that normally the pharmacy would call the nurse and let her know when a medication alternative was available. The nurse would then be expected to fax the resident ' s physician to tell him what the options were and the physician would let the facility know whether or not an alternative medication was acceptable. Once the physician ' s order was received, the nurse would fax the new order to the pharmacy and then write it on the MAR. The DON stated her expectation was that this issue should have been recognized the first time the pantoprazole was substituted for the lansoprazole and that it would have been taken care of. An interview was conducted with the facility ' s Director of Pharmacy Services on 1/8/14 at 10:42 AM. The standard process employed for a therapeutic interchange was discussed. The pharmacist stated that when a new order for a medication such as lansoprazole was received, the pharmacist would come up and write an order for an approved therapeutic interchange (an alternative medication such as pantoprazole). The pharmacist indicated that in addition to having a written order for the substituted pantoprazole on the resident ' s chart, the resident ' s MAR should have included a notation that a therapeutic interchange had been made. He confirmed that the medication administered to the resident needed to correspond to the medication order listed on the resident ' s MAR.	F 332	Plan of Correction for deficiency 483.60 (b), (d), (e) Drug Records, Label/Store Drugs and Biologicals **Corrective Action for those residents found to have been affected by the deficient practice:** The nurse caring for resident #8 was informed immediately of the deficient practice. Remedial education and counseling was provided to the nurse regarding checking the expiration date of a medication prior to medication administration. Remedial Education and counseling was provided to the nurse regarding appropriate labeling of the prefilled insulin pens with the resident name as well as the 28 day expiration date from the time opened or manufacturer expiration date; whichever comes first. Remedial education and counseling was provided to the nurse regarding discarding any insulin/medication past the expiration date or any insulin/ medication that failed to be properly labeled with the resident name. Upon discovery of the deficient practice, a new labeled insulin pen was immediately obtained from the pharmacy for resident #8.	January 7, 2014
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	F 431	**Corrective Action for those residents having potential to be affected by the same deficient practice:**	January 17, 2014

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F 431	Continued From page 4 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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 review and staff interviews, the facility failed to discard expired insulin and failed to label insulin with a resident ' s name and/or expiration date stored in 1 of 2 medication carts.	F 431	Education provided to all nursing staff regarding appropriate labeling of drugs and the expiration date when applicable. Education provided to all nursing staff regarding appropriate verification of product expiration dates prior to administration of the medication. **Measures put into place to ensure that the deficient practice will not occur:** Education and review with nursing staff of the process to ensure insulin pens/vials are appropriately labeled with the resident name and the expiration date; either 28 days from opening or manufacturer's expiration date, whichever comes first. Education and review with pharmacy staff regarding labeling of insulin dispensed. Effective 1/17/14, pharmacy staff will convert insulin dispensing from insulin pen to insulin vials. Pharmacy staff will label the insulin vial with the resident name/label. Pharmacy staff will label the vial with the appropriate expiration date at the time the vial is dispensed to the unit. **Monitoring of performance to make sure the solutions are sustained:** Monitoring of the POC will be accomplished by observation of two medications passes per week for one month by the Director of Nursing. The	January 17, 2014 Ongoing

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F 431	Continued From page 5 The findings included: 1) An observation of the Hall medication cart for Rooms 320-336 on 1/7/13 at 4:03 PM revealed a prefilled NovoLog insulin pen stored on the medication cart was expired. The insulin pen was labeled with an expiration date of 1/3/14. The insulin pen was stored in a drawer containing medications for Resident #8 but was not labeled with a resident ' s name. Approximately 50 Units (U) were remaining in the insulin pen. A review of Resident #8 ' s January 2014 Physician Orders revealed there was a current order for NovoLog insulin to be used on a sliding scale basis (which indicated the insulin was to be used only as needed and that the insulin dose used was dependent on the resident ' s blood glucose level when checked daily). Information provided by Resident #8 ' s January 2014 Medication Administration Record (MAR) indicated the resident received a dose of NovoLog insulin 6 times after the insulin ' s expiration date of 1/3/14. An interview was conducted with the Charge Nurse (Nurse #2) for the Hall on 1/7/14 at 4:10 PM. During the interview, Nurse #2 indicated that prefilled insulin pens needed to have the resident ' s name on them as well as either the date they were opened or the date they expired. She acknowledged the NovoLog insulin pen was expired and needed to be discarded. Nurse #2 asked Nurse #1 (the nurse assigned to the hall) to call the pharmacy for a replacement insulin pen. An interview was conducted with Nurse #1 on	F 431	Director of Nursing will report findings to the QA committee during the next quarterly meeting	

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F 431	Continued From page 6 1/7/14 at 4:15 PM. Nurse #1 reported that insulin pens were typically sent from the pharmacy to the floor in a bag labeled with the resident ' s name. She noted that the insulin pens themselves should also be labeled with the resident ' s name. Nurse #1 stated that the nurse was supposed to date an insulin pen when it was opened. She indicated that an insulin pen was good for 28 days after opening and would need to be discarded after that. An interview was conducted with the Director of Nursing (DON) on 1/7/14 at 4:20 PM in regards to the expired insulin pen stored on the medication cart. During the interview, the DON reported that nursing staff was responsible to let the pharmacy know when a refill was needed for an insulin pen. Once the pen was delivered, it would be put into the resident ' s drawer on the cart. The DON indicated the staff nurse would be expected to put an expiration date on the pen when she received it and to discard any insulin past the expiration date. The DON also noted that an insulin pen would be expected to have the resident ' s name on it. 2a) An observation of the Hall medication cart for Rooms 320-336 on 1/7/13 at 4:03 PM revealed a prefilled NovoLog insulin pen that was not labeled with either a resident ' s name or the date opened was stored on the medication cart. The insulin pen was stored in a drawer containing medications for Resident #3. Approximately 110 Units (U) were remaining in the insulin pen. The manufacturer ' s product information indicated that prefilled NovoLog insulin pens which have been punctured (in use) may be stored at room temperature for up to 28 days.	F 431		

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F 431	Continued From page 7 An interview was conducted with the Charge Nurse (Nurse #2) for the Hall on 1/7/14 at 4:10 PM. During the interview, Nurse #2 stated that prefilled insulin pens needed to have the resident ' s name on them as well as either the date opened or the expiration date. She indicated that without the required labeling, this pen needed to be discarded. Nurse #2 asked Nurse #1 (the nurse assigned to the hall) to call the pharmacy for a replacement insulin pen. An interview was conducted with Nurse #1 on 1/7/14 at 4:15 PM. Nurse #1 reported that insulin pens were typically sent from the pharmacy to the floor in a bag labeled with the resident ' s name. She noted that the insulin pens themselves should also be labeled with the resident ' s name. Nurse #1 stated that the nurse was supposed to date an insulin pen when it was opened. She indicated that an insulin pen was good for 28 days after opening and would need to be discarded after that. An interview was conducted with the Director of Nursing (DON) on 1/7/14 at 4:20 PM. During the interview, the DON noted that the resident ' s name would normally be stickered on the insulin pen when it was delivered from the pharmacy. In addition to the resident ' s name, she noted the insulin pen should have an auxiliary label placed on it for the nurse to write in its expiration date. The DON indicated the staff nurse would be expected to put an expiration date on the pen when she received it and to discard any insulin past the expiration date. 2b) An observation of the Hall medication cart for Rooms 320-336 on 1/7/13 at 4:03 PM revealed an undated prefilled pen of Levemir insulin	F 431		

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F 431	Continued From page 8	F 431		

labeled for Resident #3 was stored on the medication cart. The insulin pen was not labeled with the date as to when it had been placed on the cart. Approximately 30 Units (U) were remaining in the insulin pen. The manufacturer ' s product information indicated that an unopened or opened Levemir FlexPen prefilled insulin pen may be stored at room temperature for up to 42 days.

An interview was conducted with the Charge Nurse (Nurse #2) for the Hall on 1/7/14 at 4:10 PM. During the interview, Nurse #2 indicated that prefilled insulin pens needed to have the resident ' s name on them as well as either the date opened or the expiration date. She indicated that without the required labeling, this pen needed to be discarded. Nurse #2 asked Nurse #1 (the nurse assigned to the hall) to call the pharmacy for a replacement insulin pen.

An interview was conducted with Nurse #1 on 1/7/14 at 4:15 PM. Nurse #1 reported that insulin pens were typically sent from the pharmacy to the floor in a bag labeled with the resident ' s name. She noted that the insulin pens themselves should also be labeled with the resident ' s name. Nurse #1 stated that the nurse was supposed to date an insulin pen when it was opened. She indicated that an insulin pen was good for 28 days after opening and would need to be discarded after that.

An interview was conducted with the Director of Nursing (DON) on 1/7/14 at 4:20 PM. During the interview, the DON noted that the resident ' s name would normally be stickered on the insulin pen when it was delivered from the pharmacy. In addition to the resident ' s name, she noted the

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F 431	Continued From page 9 insulin pen should have an auxiliary label placed on it for the nurse to write in its expiration date. The DON indicated the staff nurse would be expected to put an expiration date on the pen when she received it and to discard any insulin past the expiration date.	F 431		

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is type I'(211) construction , with a complete automatic sprinkler system. The Deficiencies determined during the survey area s follows:	K 000	FEB 17 2014	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation on 1/29/14 at approximately 9:30 AM onward the following deficiencies were noted: 1) The radiation dampers located in the resident bathrooms were not maintained clean and in good operating condition. 42 CFR 482.41(a)	K 012	Plan of Correction for K 012 All radiation return dampers in residents room will be cleaned properly. All radiation dampers in Skilled Nursing Facility will be cleaned. Radiation dampers were added to the annual room maintenance to prevent this from happening again.	3/14/14
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056	Plan of Correction for K 056 A sprinkler head will be installed in the electrical room. The entire Skilled Nursing Facility has been surveyed for missing sprinkler heads. All rooms are compliant with sprinkler heads.	3/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President & CEO — (X6) DATE: 02/11/2014

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NORTHERN SURRY SNF	830 ROCKFORD STREET MOUNT AIRY, NC 27030

(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
K 056	Continued From page 1 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on 1/29/14 at approximately 9:30 AM onward the following deficiencies were noted: 1) The sprinkler head head in the resident room that are located in front of the vents were not maintained clean and in good condition. 42 CFR 482.41(a)	K 056	Plan of Correction for K 056 All sprinkler heads in residents room will be cleaned properly. All sprinkler heads in the Skilled Nursing Facility will be cleaned. Sprinkler heads were added to the annual room maintenance to prevent this from happening again.	3/14/14