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	345474	A. BUILDING _____ B. WING _____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES WEST	6100 W FRIENDLY AVENUE GREENSBORO, NC 27410

(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=E	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 observation, record review and interviews with facility staff and pharmacist, the facility failed to administer medications as ordered for 2 of 25 opportunities during medication pass resulting in a medication error rate of 7.6%. The findings included: 1. Resident #22 was admitted to the facility on 11/18/14 vertebrae. with diagnosis of compression fracture of thoracic vertebrae. Resident #22 had physician order dated 11/1/14 for Abreva to her lower lip three times daily. Record review of the MARS (Medication Administration Record) indicated that on 11/21/14, 11/22/14 and 11/23/14 facility staff had initialed the MARS with a circle around their initials, indicating the medication was not available. During the medication pass observation on 11/24/14 at 8:32 AM, the Abreva medication was not available to be administered. Interview on 11/24/14 at 8:32 AM with Nurse #1 revealed that Resident #22 had been out of the Abreva for three days. She pointed to the MARS,	F 332	F-332 It is the intent of the facility to provide medications to residents as ordered by the physician, and to not exceed an error rate of five percent or greater. Criteria 1. Corrective action to be accomplished for the resident found to have been affected by the alleged deficient practice. The Director of Nursing reviewed the medical records of resident #22 to ensure the resident did not have negative outcome related to the medications errors referenced in this report, specifically 2000 mg of Fish Oil one time a day and Abreva. Another 1000 mg of Fish Oil was given to R#22 at about 10:30 a.m. 11-24-14 to provide the 2000 mg dosage as ordered; Abreva was received at 11 a.m. on 11-24-14 and applied as ordered. On 11-25-14 the practitioner gave an order for R#22 to self-administer the Abreva. There were no further orders given by the practitioner when these findings were reported concerning R#22 attachment A.	12/22/14

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

Electronically Signed | 12/19/2014

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F 332	Continued From page 1 showing that the facility staff had initialed their initials and circled their initials. She continued that the 3 to 11 shift nurse had faxed the order to restock the Abreva on 11/21/14. As she said this, Nurse #1 was looking for Abreva in the automated backup supply machine but the machine did not carry Abreva. Observations on 11/24/14 at 8:32 AM of Resident #22's lip revealed a discolored area on her lower lip, about one-half centimeter wide. Interview on 11/24/14 at 9:41 AM with the Director of Nursing revealed that the pharmacy called her and said they would mail the Abreva out stat. She did not know when they would receive it. Interview with the pharmacist on 11/24/14 at 10:30 AM revealed that the order was faxed late on 11/21/14. He did not see the order until he came in Monday (11/24/14) morning. He did not know why the facility staff did not use the back up pharmacy over the weekend. Interview with the Director of Nursing on 11/24/14 at 12:03 PM revealed that she did not know why the facility staff did not contact the backup pharmacy. 2. Resident #22 was admitted to the facility on 11/18/14 with diagnosis of compression fracture of thoracic vertebrae. Record review of the physician's order dated 11/18/14 revealed " Fish Oil, Omega 3 fatty acid, 1000 milligram, 2 g (grams) by mouth, once daily. " Off to the side of the MAR was written 2 caps, indicating two capsules.	F 332	Criteria 2. Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice. Residents have the potential to be affected by improper administration of medication. The licensed nurses will be or have been educated by the Director of Nursing, her designee or the pharmacy, on the importance and means of medication administration, actions to take should a medication error take place and how to report medication errors properly, attachment B. The licensed nurse in the 2567 report, completed a medication pass worksheet audit, December 5, 2014, conducted by the pharmacist with a zero percent (0%) error rate, and the licensed nurse orientation "What I Need to Know about Nursing at Friends Homes West" checklist completed 12-4-14, attachment C. Criteria 3. Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Licensed nurses will be or have been educated by Director of Nursing, her designee or the pharmacy on the importance and means of medication administration and the actions to take should a medication error take place as well as the process to report medication	

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F 332	Continued From page 2 Reviewing the Medication Administration Record revealed that the Fish Oil was initialed once a day from 11/18/14 through 11/23/14 indicating that the resident received the Fish Oil 2000 milligrams per physician's order. Interview with Nurse #1 on 11/24/14 at 8:32 AM revealed that Nurse #1 thought Resident #22 received the Fish Oil twice a day. Interview with the Director of Nursing on 11/24/14 at 10:30 AM expected that Nurse #1 should have given Resident #22 two capsules as ordered by the physician.	F 332	errors to the practitioner. The pharmacist has evaluated, and documented the RN supervisors are qualified to complete the Medication Pass Worksheet audits with licensed staff, attachment D. The licensed staff have been educated to contact the physician for clarification orders, should a medication, as prescribed by the practitioner, not be available from the pharmacy, attachment E. The Director of Nursing, her designee or the pharmacy will observe medication pass audits with licensed staff. Each nurse, working at least one shift on a calendar month basis, will have a Medication Pass Worksheet audit, attachment F, conducted by the Director of Nursing, her designee or the pharmacy. Licensed nursing staff who have not worked in a calendar month (such as P.R.N. licensed staff) will have a medication pass worksheet audit conducted in order to continue employment. Newly hired licensed nursing staff will have a Licensed Nurse Skills Verification Checklist completed, attachment G. This Checklist is inclusive of the Medication Pass Worksheet Audit. These will be completed upon hire and thereafter with the employee□s performance evaluation. Licensed nursing staff who are PRN employees and who have not been available to work at least one shift in the last 60 days will be removed from the	

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F 332	Continued From page 3	F 332	employment role with a Change of Status Worksheet, attachment H. Additional education, corrective and/or disciplinary action will be taken with the licensed staff, as indicated, based on the Licensed Nurse Skills Verification Checklist (which is inclusive of the medication pass worksheet audit). Audits of medication receipt will be conducted by the Director of Nursing or designee. These audits include a 24 hour New Admission Medication audit, Medication Receipt audit, and a Medication audit (attachments I, J and K respectively). Data for the 24 hour New Admission Medication audit will be collected to verify receipt of medications from the pharmacy within 24 hours of the order. These data collections will be re-evaluated at the quarterly QA/QAPI meetings. Data for the Medication Receipt audit will be collected bi-weekly for 4 weeks (2 times a week for 4 weeks), then collected weekly for 4 more weeks, then collected every other week for 4 more weeks and re-evaluated at the quarterly QA/QAPI meetings. Data for the Medication audit will be collected weekly for 4 weeks, then collected every other week for 4 weeks and re-evaluated at the quarterly QA/QAPI meetings.	

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F 332	Continued From page 4	F 332	Criteria 4. Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system. Data obtained from these audits, 24 hour New Admission Medication audit, Medication Receipt audit and Medication audit, the Medication Pass Worksheet, Licensed Nurse Skills Verification Checklist (inclusive of the Medication Pass Worksheet audit) will be analyzed by the DON and/or Pharmacist consultant for patterns, trends and/or the need for further educational opportunities based on analysis of the error. (An error could be by the prescriber, the nurse transcribing the physician□s order to the pharmacy, the dispensing pharmacy, or by the nurse administering the medication, individually or any combination of these.) The trends/patterns noted, education and disciplinary action taken will be reported to the Medication Management Committee of the Quality Assessment and Assurance/Quality Assurance Performance Improvement (QA/QAPI) Committee at its quarterly meetings. The QAPI Committee will evaluate the effectiveness of the plan and adjust the plan, as needed, based on trends identified in the audits. The Administrator is responsible to see that the QAPI recommendations are acted upon in a timely manner. Criteria 5. Date corrective action for alleged deficient practice will be	

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F 332	Continued From page 5	F 332	accomplished. December 22, 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 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.	F 431		12/22/14

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F 431	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff and pharmacist, the facility failed to remove outdated medications from the stock medication room for 1 of 1 medication rooms. The findings included: Record review of the Policy Statement revised April, 2007 revealed, " 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. " Observations on 11/24/2014 at 11:15 AM revealed the following medications out of date: Diabetic Tussin DM, 4 oz. (ounces), expired 10/14. Imodium, 2 mg. (milligram) tablets, 9 tablets, expired 10/14. Tucks Hemorrhoid, 51% supp. (suppository), 3 supp. expired 10/14. Interview with Staff Development Coordinator (SDC) on 11/24/2014 at 11:44 AM revealed she was responsible for checking the medication room monthly for expired medications and returning them back to the pharmacy. She continued that she was in the medication room on Friday, 11/14/2014, and did not see the expired medications. She continued that she checked for expired medications every month. The SDC also indicated that the pharmacist also checked the medication room every month.	F 431	F-431 - The facility must remove outdated medications from the facility in accordance with its policy and the requirements to do so. Criteria 1. Corrective action to be accomplished for those residents found to have been affected by the alleged deficient practice. Stock medications, Diabetic Tussin DM 4 oz. (ounces), expired 10/14; Imodium, 2 mg (milligram) tablets, 9 tablets, expired 10/14 and Tucks Hemorrhoid, 51% sup. (suppository), 3 supp. These expired 10/14 were removed immediatly from the from the stock medication room November 24, 2014 and destroyed as per protocol. Criteria 2. Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice. Residents have the potential to be affected by use of outdated medications if not removed as required by protocol and requirements. The licensed nurses will be or have been educated by the Director of Nursing her designee or pharmacy, on the importance and means of removing stock medications, which are expired, and disposing of those properly according to	

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F 431	Continued From page 7 Interview on 11/24/2014 at 11:48 AM with the Director of Nursing (DON) revealed her expectation of expired medications was that the medications be removed from the stock medication room. The DON continued that the SDC did rounds on Friday, 11/14/14. The DON continued that the SDC did not have an explanation for the expired medications that were located in the stock medication room. Interview on 11/24/2014 at 2:40 PM with the pharmacist revealed that the medications were reviewed by a pharmacy technician on 11/19/2014. The pharmacist continued that the pharmacy technician typically did a spot check of the stock medications.	F 431	the facility□s policy, attachment B. Criteria 3. Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Licensed nurses will be or have been educated by the Director of Nursing her designee or pharmacy, on the importance and means of properly removing and handling the disposition of expired medications. The Director of Nursing or designee will evaluate the effectiveness of these educational measures through Med Room Expired Drug audit, (attachment L) and Med Care Expired Drug audit, (attachment M) conducted weekly for 4 weeks then every other week for 4 weeks and re-evaluated at the quarterly QA/QAPI meeting. Additional education, corrective and/or disciplinary action may be taken by the Director of Nursing or her designee based on the results of these audits. Criteria 4. Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system. Data obtained from these audits, Med Room Expired Drug audit and Med Cart Expired Drug audit will be analyzed by the DON and/or Pharmacist consultant for	

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F 431	Continued From page 8	F 431	patterns, trends and/or further educational opportunities, including education and disciplinary action. These data and analysis will be taken to the next meeting of the Medication Management Committee of the Quality Assessment and Assurance/Quality Assurance Performance Improvement (QA/QAPI) Committee. The next QA/QAPI meeting is scheduled for February 5, 2014. QA/QAPI Committee will review actions taken, may make recommendations of further actions based on the review and/or approve the actions at the quarterly QA/QAPI meetings until the Committee is satisfied the Corrective Action Program has been effective and has sustained the corrective action. Criteria 5. Date corrective action for alleged deficient practice will be accomplished. December 22, 2014	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		12/22/14

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F 520	Continued From page 9 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with staff and the pharmacist, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2013. These procedures and interventions were a result of (1) one federal deficiency originally cited November 21, 2013 on a Recertification and Complaint survey. The deficiency was recited on the current recertification survey. The deficiency was in the area of medication error rate of 5 % or more. The continued failure of the facility during two federal surveys of record showed a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 332: Free of medication error rate of 5% or	F 520	F-520 -- It is the intent of the facility to have a QA&A/QAPI Committee that functions to develop and implement appropriate plans of action to correct identified quality deficiencies and to sustain the corrective actions. Criteria 1. Corrective action to be accomplished for those residents found to have been affected by the alleged deficient practice. During the annual re-certification survey process (exit date 11-24-14) the survey team identified a 7.6% error rate for medication administration. There had been an error rate above 5% identified in the prior re-certification survey (exit date 11-01-13). The QAA Committee Corrective Action Plan from the prior year□s survey finding	

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F 520	Continued From page 10 more: Based on observation, record review and interviews with facility staff and pharmacist, the facility failed to administer medications as ordered for 2 of 25 opportunities during medication pass resulting in a medication error rate of 7.6%. (Resident # 22) The facility was cited for F 332 for failing to have a medication error rate of less than 5% during the November 21, 2013 Recertification and Complaint survey. Record reviews during an interview on 11/24/14 at 3:48 PM with the Quality Assurance Coordinator (QAC) revealed the committee met every month and, on November 26, 2013 and May 5, 2014, staff training for medication administration was done. The QAC indicated that random monitoring and audits of nurse medication administrations were started on 11/27/2013 with 2 nurses per week for one month ending in December 2013. Further interview revealed different nurses were observed for medication administration every other week for the month of January 2014. Continued interview with the QAC revealed in February 2014 two (2) nurses were randomly observed during a medication pass. According to the QAC these audits and random observations were completed by the previous director of nurses, the pharmacy consultant and herself without any problems identified. Additionally, the QAC revealed Nurse #1 cited in F332 during the Recertification survey ending 11/24/14 was hired at the facility on 5/16/2014 and had not been observed during medication administration. On 9/11/14 at 5:45 PM an interview with the Administrator revealed she had collaborated with	F 520	had ended after several months of audits that identified no deficient practice. The nurse involved in the deficient identified practice for the survey ending 11-24-14 was re-hired in May, 2014 and was not involved in a medication pass audit. Specific deficient practice affected one resident, Resident #22. The Director of Nursing reviewed the medical records of resident #22 to ensure the resident did not have negative outcome related to the medications errors referenced in this report, specifically 2000 mg of Fish Oil one time a day and Abreva. Another 1000 mg of Fish Oil was given to R#22 at about 10:30 a.m. 11-24-14 to provide the 2000 mg dosage as ordered; Abreva was received 11-24-14 at 11:00 a.m. and applied as ordered. The practitioner changed R#22□s Abreva order on 11-25-14 to self-administration. There were no further orders given by the practitioner when these findings were reported concerning R#22 attachment A. Criteria 2. Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice. Residents have the potential to be affected by improper administration of medication. The licensed nurses will be or have been educated by the Director of Nursing, her	

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F 520	Continued From page 11 the medical director and believed that the facility ' s failure to administer medications without errors were corrected in 2013.	F 520	designee or the pharmacy, on the importance and means of medication administration, actions to take should a medication error take place and how to report medication errors properly, attachment B. The licensed nurse in the 2567 report, completed a medication pass worksheet audit, December 5, 2014, conducted by the pharmacist with a zero percent (0%) error rate, and the licensed nurse orientation, "What I Need to Know about Nursing at Friends Homes West" checklist completed 12-4-14, attachment C. Criteria 3. Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Licensed nurses will be or have been educated by Director of Nursing, her designee or the pharmacy on the importance and means of medication administration and the actions to take should a medication error take place as well as the process to report medication errors to the practitioner. The pharmacist has evaluated, and documented the RN supervisors are qualified to complete the Medication Pass Worksheet audits with licensed staff, attachment D. The licensed staff have been educated to contact the physician for clarification orders, should a medication, as prescribed by the practitioner, not be available from the pharmacy, attachment	

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F 520	Continued From page 12	F 520	E. The Director of Nursing, her designee or the pharmacy will observe medication pass audits with licensed staff. Each nurse, working at least one shift on a calendar month basis, will have a Medication Pass Worksheet audit, attachment F, conducted by the Director of Nursing, her designee or the pharmacy. Licensed nursing staff who have not worked in a calendar month (such as P.R.N. licensed staff) will have a medication pass worksheet audit conducted in order to continue employment. Newly hired licensed nursing staff will have a Licensed Nurse Skills Verification Checklist completed, attachment G. This Checklist is inclusive of the Medication Pass Worksheet Audit. These will be completed upon hire and thereafter with the employee□s performance evaluation. Licensed nursing staff who are PRN employees and who have not been available to work at least one shift in the last 60 days will be removed from the employment role with a change of status worksheet, attachment H. Additional education, corrective and/or disciplinary action will be taken with the licensed staff, as indicated, based on the Licensed Nurse Skills Verification Checklist (which is inclusive of the medication pass worksheet audit). Audits of medication receipt will be conducted by the Director of Nursing or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345474	A. BUILDING _____ B. WING _____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES WEST	6100 W FRIENDLY AVENUE GREENSBORO, NC 27410

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F 520	Continued From page 13	F 520	designee. These audits include a 24 hour New Admission Medication audit, Medication Receipt audit, and a Medication audit (attachments I, J and K respectively). Data for the 24 hour New Admission Medication audit will be collected to verify receipt of medications from the pharmacy within 24 hours of the order. These data collections will be re-evaluated at the quarterly QA/QAPI meetings. Data for the Medication Receipt audit will be collected bi-weekly for 4 weeks (2 times a week for 4 weeks), then collected weekly for 4 more weeks, then collected every other week for 4 more weeks and re-evaluated at the quarterly QA/QAPI meetings. Data for the Medication audit will be collected weekly for 4 weeks, then collected every other week for 4 weeks and re-evaluated at the quarterly QA/QAPI meetings. Criteria 4. Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system. Data obtained from these audits, 24 hour New Admission Medication audit, Medication Receipt audit and Medication audit, the Medication Pass Worksheet, Licensed Nurse Skills Verification Checklist (inclusive of the Medication Pass Worksheet audit) will be compiled	

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F 520	Continued From page 14	F 520	and analyzed by the DON and/or Pharmacist consultant for patterns, trends and/or the need for further educational opportunities based on analysis of the error, attachment N. (An error could be by the prescriber, the nurse transcribing the physician□s order to the pharmacy, the dispensing pharmacy, or by the nurse administering the medication, individually or any combination of these.) The trends/patterns noted, education and disciplinary action taken will be reported to the Medication Management Committee of the Quality Assessment and Assurance/Quality Assurance Performance Improvement (QA/QAPI) Committee at its quarterly meetings. The QAPI Committee will evaluate the effectiveness of the plan and adjust the plan, as needed, based on trends identified in the audits. The Administrator is responsible to see that the QAPI recommendations are acted upon in a timely manner. Criteria 5. Date corrective action for alleged deficient practice will be accomplished. December 22, 2014	