STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	C 12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	**405 SOUTH GREENE STREET WADESBORO, NC 28170**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 12/17/14. Event ID # O83911.	F 000		
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 record reviews and staff interviews, the facility failed to obtain stat (immediately) laboratory results as ordered by the physician for 1 of 5 (resident #49) residents reviewed for unnecessary medications and failed to administer lidoderm patch as ordered by the physician for 1 of 5 (resident #84) residents reviewed for unnecessary medications. 1. Resident #49 was admitted to the facility on 11/18/10 with multiple diagnoses including Stage III Renal Disease, Diabetes Mellitus II, Ascities, Dementia, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Cardiomyopathy, and Behavior Depressive Disorder. A review of the Minimum Data Set dated 11/20/14 revealed the resident was assessed with the use of a diuretic medication.	F 309	Preparation and /or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F309 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 plan of care. Corrective Action	1/5/15

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

Electronically Signed | 01/01/2015

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F 309	Continued From page 1 The Plan of Care dated 11/26/14 indicated the resident had the potential for dehydration secondary to use of diuretic medication. The interventions included to monitor labs as ordered, especially those that indicated dehydration and to notify the physician of any abnormal lab values. A review of the Physician ' s Orders revealed an order dated 11/27/14 which stated " Complete Blood Count, Comprehensive Metabolic Panel and Hemoglobin A1C (Glycated Hemoglobin) Stat. " A review of laboratory results collected 11/27/14 and dated as received and reviewed by the facility on 12/17/14 was conducted. The review revealed an elevated potassium level equal to 5.9 millimoles per liter (mmol/L) with a normal range equal to 3.5 mmol/L to 5.1 mmol/L. The review revealed a low hemoglobin count equal to 8.7 grams per deciliter (g/dl) with a normal range equal to 11.5 g/dl to 15.0 g/dl. The review also revealed a low hematocrit level equal to 27% with a normal range equal to 34% to 44%. A review of the Physician ' s Orders revealed an order dated 12/17/14 which stated " Repeat Complete Blood Count and Basic Metabolic Panel in the morning. " An interview was conducted with Administrative Staff #1 on 12/17/14 at 10:11 AM. She stated the specimen was drawn on 11/27/14 and sent to the local hospital for immediate evaluation and the hospital sent the specimen to another laboratory for evaluation. She stated Administrative Staff #4 had contacted the laboratory on more than one occasion and requested the lab results to be sent	F 309	Resident #49 had another CBC and BMP drawn on 12/18/2014 with results reported to the Physician. Resident #84□s Lidocaine patch was discontinued on 12/18/2014 per Physician□s order. Corrective Action for those with the potential to be effected An audit was done at the time of survey by the Director of Nurses (DON) and /or her nurse managers of all charts looking for any potential missing labs. No other resident was found to be affected by this alleged deficient practice. Also at the time of survey an audit of all MARs was completed by the DON and/or her nurse mangers for transcription errors. No other resident was found to be affected by the alleged deficient practice. Systemic Changes A Lab log has been instituted for both routine and Stat Labs. This Lab log will be reviewed in the morning Clinical Meeting by the DON and Nurse Managers for compliance. All licensed staff have been reeducated by the DON in the use of the Lab log system between 12/29/2014 and 01/02/2015. The Medical records clerk has been reeducated by the DON on 12/18/14 regarding proper thinning of charts as the missing Lidocaine patch was a result of improper thinning of orders. All Licensed staff has been reeducated	

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F 309	Continued From page 2 to the facility. She stated the facility had been unable to obtain the laboratory results. She did not indicate there was a specific process for the facility staff to follow up on lab results. She stated she expected the results for labs ordered stat to be received by the facility within twenty-four hours after being sent for evaluation. 2. Resident #84 was admitted to the facility 3/25/13. Diagnoses included: arthritis of knees and chronic complaints of pain. A Quarterly Minimum Data Set (MDS) dated 11/24/14 indicated Resident #84 was cognitively intact. The assessment noted that she was on scheduled pain medication regime and did not receive any prn (as needed) pain medication during the assessment period. Physician ' s orders were reviewed and revealed an order dated 10/24/14 for " Lidoderm patch (patch used to relieve pain at the area on which it is applied) -- on 12 hours, off 12 hours. " A review of the November 2014 physician orders and the November Medication Administration Record (MAR) revealed the order for the Lidoderm patch was not transcribed to the November physician orders and was not transcribed to the MAR. There was no documentation that Resident #84 received the Lidoderm patch for the entire month of November (30 days). On 12/15/14 at 3:54PM, Resident #84 stated she was not having any pain at this time but she had chronic pain in her legs and generalized pain due to arthritis. She stated the pain was mostly in her back and legs and she could not walk due to the	F 309	regarding the proper transcription of Medications between 12/18/2014 to 12/31/2014 by the DON and Clinical Managers. All new licensed staff will be in serviced during their orientation period regarding these two procedures. Monitoring The DON and/or her Nurse Managers will review the Lab log on a daily basis in the morning Clinical meeting in an ongoing basis. Results brought by the DON, will be reviewed in the monthly Quality Assurance Performance Improvement (QAPI) meeting for 2 months for any further recommendations. Any recommendations will be the responsibility of the DON to carry out as per the committee. The DON and/or her Nurse Managers will review 100% of the charts for transcription errors for 2 months and then 50% of the MARS for 2 months and then randomly thereafter. Results will be reported by the DON to the QAPI committee for 3 months for further recommendations by the committee. The DON will be responsible to carry out any further recommendation.	

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F 309	Continued From page 3 pain and arthritis in her knees. On 12/16/14 at 3:30PM., Administrative staff #1 stated there were two checks for the end of the month physician orders and MARS. She said two nurses check both the physician orders and MARS on two different days. Administrative staff #1 noted that the orders for November were checked on 10/28/14 and no signature noted for the second check. The physician orders were signed by the family nurse practitioner on 11/12/14. She said she expected nursing staff to follow physician orders and they should have transcribed the order for the Lidoderm patch to the November physician order and the November MAR. The Lidoderm patch should have been administered as ordered. On 12/17/14 at 10:13AM, the family nurse practitioner (FNP) stated she was unaware that resident # 84 did not receive her Lidoderm patch for the month of November and expected that nursing staff would have administered the Lidoderm patch as ordered by the physician on 10/24/14.	F 309		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		1/5/15

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to operate the dishwashing machine properly in order to reach the wash temperature at 150 degrees Fahrenheit (F) and the final rinse temperature at 180 degrees F. Findings included: 1. On 12/17/14 at 11:15 AM, the dishwashing machine was observed with the administrative staff #2 present. Dietary Aide #1 was observed to turn on the dishwashing machine. She stated that the temperatures would start to go up after a few minutes. The machine was observed from 11:15 AM through 11:45 AM, and the wash temperature was 122 degrees F and the final rinse temperature was 148 degrees F. At 11:46 AM, Dietary Aide #1 started to turn another knob and stated that the temperatures would go up to more than 150 degrees for the wash and 180 degrees for the rinse. The machine was again observed from 11:50 AM through 12:00 noon and the wash temperature was 132 degrees F and the final rinse temperature was 158 degrees. Dietary Aide #1 further stated that she was just assigned to the dishwashing machine and was still learning on how to operate it. She indicated that Dietary Aide #2 was the person who was familiar with the machine and he would come at 4:00 PM. On 12/17/14 at 2:25 PM, administrative staff #2 was interviewed. She stated that she just started working at the facility about a week ago. She indicated that she was told that there was a problem with the dishwashing machine and the parts had been ordered. It was the first compartment (pre wash), the tray would not move	F 371	F371 The facility procures food from sources approved or considered satisfactory by the State and Local authorities and stores, prepares, and distributes the food under sanitary conditions. Corrective Action The Service company inspected and serviced the dishmachine 12/19/2014 and found both rinse tanks were heating properly and all temps looked good. Staff responsible for operating the dishwasher have been reeducated in the proper operation of the equipment. The temperature log is being used at each washing and monitored and reviewed by the Dietary Manager or her assistant daily. All Mighty Shakes were removed the nursing refrigerators and discarded by the Dietary Manager 12/17/2014. Corrective Action for those with the potential to be effected All residents have the potential to be affected by this alleged deficient practice. All nursing refrigerator in the facility were inspected for any undated supplements, including Mighty shakes by the Dietary Manager 12/27/2014. No other undated dietary product was found. Systemic Changes	

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F 371	Continued From page 5 and you have to manually push the tray to move forward. Administrative staff #2 acknowledged that there was a problem with the dishwashing machine temperatures not reaching 150 degrees F for the wash and 180 degrees F for the final rinse but she was not aware of the problem. On 12/17/14 at 5:15 PM, dishwashing machine was again observed. Dietary Aide #2 was observed to turn on the machine. At 5:30 PM, the final rinse temperature was 150 degrees F. On 12/17/14 at 5:45 PM, administrative staff #3 was interviewed. He stated that he had checked the dishwashing machine and there was no problem with the temperatures. He added that he thought the problem was the staff did not know how to properly operate the machine. He stated that he will educate the staff on how to operate the machine in the morning. The dish machine temperature logs were reviewed. Administrative staff #2 was not able to find the temperature log for the month of September and October, 2014. The November, 2014 log revealed that the machine was out of order from November 24 through December 1st and paper products were used. The December, 2014 log revealed no temperatures recorded from December 1 through 11. 2. The direction on the carton of the great shake read " Store frozen. Thaw at or below 40 degrees. Use thawed product with in 14 days. Keep refrigerated. " On 12/17/14 at 2:45 PM, the nourishment	F 371	Dietary staff, including the Dietary Manager,have been reeducated by the Maintenance Director on 12/18/14 to the proper operation of the dishwasher, including monitoring and documentation of temperatures. The Dietary Manager has been reeducated in the proper dating of dietary products by the Administrator on 12-18-14. Monitoring The Dietary Manager will utilize a Dietary Audit tool to monitor proper rinse temps of dishwasher, proper use of the dishwasher, and proper dating of the food products. This tool will be used on a daily basis for 2 weeks, then weekly for 2 weeks, then monthly x 2 months. The results will be reported by the Dietary Manger to the monthly QAPI committee x 3months for any further recommendations. The Dietary Manager and the Administrator will the responsible for carrying out any further recommendations by the committee.	

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F 371	Continued From page 6 refrigerator #1 (magnolia and rose halls) was observed. There were four cartons of great shakes observed with no date on them. The shakes were observed to have been thawed. On 12/17/14 at 2:50 PM, nourishment refrigerator #2 (dogwood and sunflower halls) was observed. There were five cartons of great shakes observed with no sticker/date. On 12/17/14 at 4:20 PM, administrative staff #2 was interviewed. She stated that she was just told that she was responsible for checking the nourishment refrigerator for expired snacks/supplement products. She also stated that it was her fault for not putting the sticker/date on the great shakes when she put them in the nourishment refrigerator. She added that the facility ' s policy was to discard the great shakes 14 days after they were placed in the refrigerator.	F 371		
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	F 431		1/5/15

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F 431	Continued From page 7 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: 0431 Based on observation, record review and staff interviews, the facility failed to date three opened multi-dose vials of influenza vaccine and one multi-dose vial of Novolin 70/30 insulin located in one of two medication refrigerators and failed to date one Ventolin inhaler when opened. The findings included: 1. Manufacturer ' s instructions for Afluria influenza vaccine 2014-2015 formula stated, in part, " 16.2 storage and handling. Once the stopper of the multi-dose vial has been pierced, the vial must be discarded within 28 days " .	F 431	F431 The drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles. Corrective action The undated multidated vials of Flu vaccine, one insulin vial, and Ventalin inhaler were removed and discarded by the DON at the time of survey. Corrective Action for those with the potential to be effected	

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F 431	Continued From page 8 On 12/17/14 at 11:48AM, an observation of the medication refrigerator in the main medication room revealed three (3) opened and undated vials of Afluria influenza vaccine. On 12/17/14 at 11:48AM, Nurse #1 and Nurse #2 both stated the policy of the facility was to date all multi-dose vials when opened and the influenza vaccine should have been dated when it was first opened. On 12/17/14 at 11:55AM, Administrative staff #1 stated nursing staff should follow the policy and should have dated the influenza vaccine when it was opened. 2. Manufacturer ' s instructions for Novolin 70/30 insulin reads, in part, " Throw away an opened vial after six (6) weeks (42 days) of use, even if there is insulin left in the vial " . On 12.17.14 at 11:48AM, an observation of the medication refrigerator in the main medication room revealed one opened and undated vial of Novolin 70/30 insulin. On 12/17/14 at 11:48AM, Nurse #1 and Nurse #2 both stated the policy of the facility was to date all multi-dose vials when opened and the insulin vial should have been dated when it was first opened. On 12/17/14 at 11:55AM, Administrative staff #1 stated nursing staff should follow the policy and should have dated the insulin vial when it was opened.	F 431	At the time of notification of an undated medicine, an audit of all med rooms and med carts was performed by the DON, her Assistant Director of Nursing, and her two RN unit managers on 12/17/2014. Any undated items found were corrected at that time. Systemic Changes All Licensed staff have been reeducated regarding proper dating of medications between 12/17/2014 and 12/31/2014 by the DON. All new licensed staff will be educated regarding labeling and dating medications during their orientation period. Monitoring Medications, including med carts and med rooms, will be inspected daily by the DON or her RN Supervisor, x 2 weeks and weekly x 2 weeks and then monthly x3 months. Results of monitoring will be reported by the DON to the monthly QAPI meeting. Any further recommendations by the committee will be the responsibility of the DON to carry out.	

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F 431	Continued From page 9 3. The manufacturer ' s Patient Information for Ventolin HFA Inhalation Aerosol dated October 2012 was reviewed. It stated " Throw the Ventolin HFA inhaler away as soon as the dose counter shows 000, after the expiration date on the Ventolin HFA packaging, or 12 months after you open the foil pouch, whichever comes first. " On 12/17/14 at 11:45 AM an observation of the Dogwood medication cart revealed one opened and undated ventolin inhaler. An interview was conducted with Nurse #1 on 12/17/14 at 12:00 PM. She stated the nurses were expected to mark all multi-dose medications with the date opened. An interview was conducted with Administrative Staff #1 on 12/17/14 at 3:44 PM. She stated the nursing staff was not expected to mark handheld inhalers with the date opened. She stated the nursing staff was expected to discard handheld inhalers based upon the manufacturer ' s expiration date.	F 431		