STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	**2275 RUIN CREEK ROAD HENDERSON, NC 27536**

(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 observation, record review, and staff interview, the facility failed to maintain a medication error rate less than 5%. Three [3] errors (for Residents #51 and #28) were identified from a total of 29 opportunities during the medication pass observation. This resulted in a 10% medication error rate. Findings included: 1.Resident #51 was re-admitted on 4/22/2014. His diagnoses included pneumonia, hypoxia, chronic obstructive pulmonary disease and anxiety. The Minimum Data Set (MDS) dated 2/9/15 indicated the resident was severely cognitively impaired, exhibited verbal and physical behaviors toward others 1-3 of 7 days and received anti-anxiety medication daily. Record review of the physician orders for April 2015 for Resident #51 revealed the following orders: Duoneb 1 ampule six times a day to be inhaled using a nebulizer. Ativan 1 milligram (mg) sublingually every 4 hours for anxiety. Record review of the Medication Administration Record (MAR) for April 2015 for Resident #51 revealed the following administration times: Duoneb - 8am, 12pm, 4pm, 8pm, 12am, and 4am. Ativan 1mg - 8am, 12pm, 4pm, 8pm, 12am,	F 332	Resident 51 has gotten his medication at the correct time. Resident 28 has had pulse checked. An inservice was held on 4-28-15 and Medications not given within an appropriate time frame and checking pulse during med pass were discussed. On a weekly basis, for 90 days, the D.O.N. will watch 2 resident medication passes to ensure meds are given at the correct time and that pulse is taken when necessary. She will use the Med Pass QA form to document her findings. Any negative findings will be sent to the next quarterly QA meeting for resolution.	5/8/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/07/2015

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F 332	Continued From page 1 and 4am. During the medication pass observation on 4/14/15 at 10:50 am Nurse #1 indicated she was giving Resident #51 his 8 am medications. She failed to administer his Duoneb during the medication pass and did give Ativan 1mg sublingual. During an interview with Nurse #1 on 4/14/15 at 1:15 pm, she indicated she failed to give the Duoneb that was scheduled for 8 am during the 10:50 am medication pass and that she " went back later " after the observed medication pass and gave the Duoneb. She further stated, " He is due for another now so I am on my way down there to give his 12:00 to him now. " During an observation on 4/14/15 at 2:02 pm, Nurse #1 administered Ativan 1mg sublingual and a Duoneb to Resident #51. She confirmed at that time that the medications being administered were the 12:00 pm doses. Resident #51 was awake and alert. During an interview with Nurse #2 on 4/14/15 at 4:15 pm she stated, " I gave [Resident #51] his Ativan and Duoneb that were scheduled at 4. " When asked if Nurse #1 had communicated to Nurse #2 that the resident ' s medications were not given on time and that his Duoneb and Ativan were most recently given at 2:02 pm, Nurse #2 indicated there had been no communication of that information. She indicated Nurse #1 did not inform her of any irregularity with medication administration times for the day and that the MAR was initialed at the usual administration times. She further stated, " We can [also] give information to the next shift by filling out the JOT sheet [located at the MAR on the medication cart] or writing on back of the MAR with an explanation as to why [a medication] was not given or given late. "	F 332		

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F 332	Continued From page 2	F 332		

During an observation on 4/14/15 at 4:15 pm Resident #51 was awake and alert.

Record review of the JOT sheet for 4/14/15, located on the mediation cart, revealed Resident #51 ' s name with no information noted in the 7am-3pm column.

Record review of the back of the April MAR revealed no information from Nurse #1 about Resident #51 ' s medications for 4/14/15.

During an interview on 4/14/15 at 4:40 pm with the Director of Nursing (DON) she stated, " I expect there to be communication between the nurses. " She further indicated medications that are not given or given at an irregular time should be communicated to the next shift nurse.

2. Resident #28 was admitted on 5/20/2014. His diagnoses included hypertension.
Record review of the physician orders for April 2015 for Resident #28 revealed the following order:
Lopressor 25 milligrams (mg) by mouth twice a day. Hold for a heart rate less than 50.
Record review of the Medication Administration Record (MAR) for April 2015 for Resident #28 revealed the following administration time:
Lopressor 25 mg - 8am and 8pm
During the medication pass observation on 4/14/15 at 11:00 am Nurse #1 indicated she was giving Resident #28 his 8 am medications. She failed to check his heart rate prior to administering his Lopressor.
During an interview with Nurse #1 on 4/14/15 at 11:07 am she indicated she works full time at the facility. When asked how she knew the resident '

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F 332	Continued From page 3 s heart rate prior to giving his Lopressor she indicated she did not know what it was and should have checked it. She stated, " I check his heart rate sometimes when I can find the [pulse oximeter (a sensor device placed on a person ' s finger that will check the oxygen saturation in the blood, as well as the heart rate)]. Sometimes someone has it on another cart. " Nurse #1 then retrieved a pulse oximeter, went into Resident #28 ' s room and checked his pulse. The pulse oximeter indicated his heart rate was 58. Upon record review of the April MAR with Nurse #1 she stated, " On the 2nd, the 7th, and today I did not check a heart rate. I should have. " Nurse #1 verified she administered Resident #28 ' s 8 am dose of Lopressor on those dates and there was no heart rate documented. The nurse further indicated that if the pulse oximeter was not available that she could palpate to check a pulse and that she did not check a pulse on 4/14/15 because she " was nervous today. " She was unable to state why the resident ' s pulse was not checked on April 2nd or 7th. During an interview on 4/14/15 at 4:42 pm with the DON she indicated she expected the resident ' s HR to be taken prior to giving his Lopressor as indicated by the physician order.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		5/8/15

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F 356	Continued From page 4 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a daily posting of nurse staffing that included the facility name, census, and total number of nurse hours worked. Finding included: During initial tour of the facility on 4/13/15 at 11:00 am, there was no nurse staffing posted of licensed and unlicensed staff. During an interview with the Director of Nursing (DON) on 4/13/15 at 11:15 am, when asked about	F 356	Nurse Staffing form has been posted on a daily basis. A new posting form is being used that includes the facility name, census number, and the number of hours worked of licensed and unlicensed staff on each shift. The Administrator will check once a week, for 90 days, to ensure staffing form has been posted. The Administrator will use the Weekly Nurse Staffing Post QA form to document findings. Any negative findings will be sent to the next quarterly QA meeting for discussion and to be resolved.	

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F 356	Continued From page 5 posted nurse staffing, she stated, "I usually post it on the [bulletin board off the main hallway] but I have not had enough time to do it this morning. I have been on go since first thing." She indicated it was her responsibility to maintain and post the daily nurse staffing. Record review of the Medicare/Medicaid Daily Census sheets dated 4/5/15 through 4/12/15 indicated the posting used by the facility did not include the facility name, the census number, or the total number of hours worked of licensed and unlicensed staff on each shift. During an interview with the DON on 4/14/15 at 5:30 pm she stated, "This is all new to me. This is the form we have been using since I have been here." The DON indicated she had been with the facility approximately 9 years.	F 356		
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.	F 431		5/8/15

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F 431	Continued From page 6 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 observation facility policy and staff interview the facility failed to remove and properly dispose of loose pills and maintain a clean storage environment in 2 of 3 medication carts observed for medication storage. Findings include: On 4/14/2015 at 11:48 AM The Nursing supervisor unlocked cart number 1 and Nurse #1 unlocked cart #2 for inspection. Cart #1 observation included a loose green unidentified oval pill in the residents' card stock medication drawer. The drawer containing bottles of stock and labeled liquid prescriptions contained sticky medication bottles and layers of stuck paper lining the drawer. Cart #3 observation included 5 loose unidentified pills/capsules in the residents' card stock medication drawer. The drawer	F 431	Medication Carts have been cleaned and loose pills have been properly discarded. The drawers have been lined with material that can be cleaned easier or replaced if needed. An inservice was held on 4-28-15 and cleaning the medication carts was discussed. The D.O.N. will check the medication carts once a week, for 90 days, to ensure the carts are being cleaned. The D.O.N. will use the Weekly Med Cart Cleaning form to document her findings. Any negative findings will be sent to the next quarterly QA meeting for resolution.	

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F 431	Continued From page 7 containing bottles of stock and labeled liquid prescriptions contained sticky medication bottles and layers of stuck paper lining the drawer. On 4/14/2015 at 11:50 AM Nurse #1 who was assigned to cart #2 was aware the loose pills were in the residents' card stock medication drawer and the drawers were stick with liquid medication. Nurse #1 reported she had never done a thing about it. On 4/14/2015 at 11:52 AM an interview with the nursing supervisor revealed the responsibility of maintaining and cleaning the carts was on the 3rd shift staff. Her expectation was for the third shift staff to maintain high quality medication carts. On 04/16/2015 4:16:18 PM an interview with the Director of Nursing revealed the Administrator just implemented a new facility Policy (in part) The medication carts must be kept clean at all times. The cart must be cleaned after each shift. The drawers need to be cleaned once a week. She reported there was no official policy in process but she expected the staff to clean up their messes. If loose pills were not caught when the pills were being dispensed they should have been caught and disposed of per policy when the cart was cleaned.	F 431		