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	345539	A. BUILDING _____ B. WING _____	C 08/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARBOR	300 CLYNELISH CLOSE PITTSBORO, NC 27312

(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 There were no deficiencies cited as a result of the complaint investigation (NC107684).	F 000		
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 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and observations, the facility failed to monitor freezer temperatures in one of one nourishment freezer. The findings included: A review of the "Nightly Fridge Temps" log for August 2015 revealed the temperature of the nourishment freezer was not monitored and documented. An observation of the nourishment freezer was made on 8/12/15 at 10:14 AM. A thermometer was not observed in the nourishment freezer. One container of vanilla ice cream, one container of Oreo ice cream, multiple containers of orange cream ice cream and multiple containers of mighty shakes were observed in the nourishment freezer. One opened container of sorbet labeled with a resident ' s name was observed in the	F 371	*For residents found to have been affected by the deficient practice & For residents having the potential to be affected: All items in the freezer were discarded 08-12-15. A thermometer was placed in Freezer 08-12-15. Education began immediately to all nurses full time, part time and pro re nata (PRN) that daily log of freezer temperatures are required. Nightly logs of freezer temperatures began 08-12-15.(see attachment A) *Systemic changes: A new policy to obtain freezer temperatures daily was written. (see attachment B) A new log was created for floor nurses to log temperatures every night. (see attachment C) Log started 08-12-15. Procedure initiated whereby the night nurse on the last night of each	8/28/15

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

Electronically Signed | 08/28/2015

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F 371	Continued From page 1 nourishment freezer. An interview was conducted with Administrative Staff #1 on 8/12/15 at 10:21 AM. She stated the facility did not have a policy regarding the monitoring of temperatures in the nourishment freezer. Administrative Staff #1 stated the ice cream contained in the nourishment freezer was provided to the residents during activities.	F 371	month will turn in completed form to Registered Nurse (RN) Unit Manager (Unit RN) and start a new log for the next month. After review, the Unit RN will turn into Director of Nursing (DON) for her review for compliance. *How facility plans to monitor: Unit RN or other designated nurse will monitor new log sheet completed by floor nurses at least five (5) times a week through August 2015, minimally two(2)times a week through September 2015, minimally one (1)time a week through October 2015 and at least two (2)times a month after that or as indicated by Quality Assurance/Performance Improvement Committee. A quality assurance log was created for RN's to document checks. (see attachment D) Any issues noted will immediately be addressed to nurse responsible for nightly check by the Unit RN. Performance issues will be handled as indicated per facility policy and procedure handbook. These logs will be turned into DON at the end of each month for her review for compliance. DON to report findings along with any trends or concerns in compliance to Quality Assurance/Performance Improvement Committee in October 2015 and January 2016 and then followed as indicated by committee. *Date corrective action will be completed: Education of all active full time nurses was completed by August 27, 2015. In-service logs will be compared to active nurse roster by DON to assess for any	

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F 371	Continued From page 2	F 371	that failed to attend. Any PRN nurses or any other nurse out on leave who missed training will have education completed by DON or other designated RN prior to next shift worked.(see attachment E)	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and record reviews, the facility failed to respond to the pharmacist's request for a gradual dose reduction (GDR) of Cymbalta (antidepressant drug)for 1 or 5 sampled residents (Resident #15) reviewed for unnecessary medications. The findings included: Resident #15 was admitted to the facility on 9/11/12 with multiple diagnoses including dementia, depression, psychosis and Alzheimer's disease. A review of the Physician's orders revealed an order dated 9/11/12 which read " Cymbalta 60 milligrams (mg) by mouth every morning for depression. "	F 428	Pharmacist visited on 5-22-15 and left note for MD to evaluate resident #15's depression and, IF APPROPRIATE consider a trial at 30 mg qd. The chart contains documentation which shows that an evaluation was conducted on 5-21-15 by resident's mental health provider, Erin De Guzman,PMHNP, with listed reason for follow up: medication check. During that visit recommendations listed were: "continue medication(s) as prescribed, the patient is stable at current dose and/or needs more time to see beneficial effects. Dose reduction attempted and/or reduction will cause decompensation of patient". (see attachment Q) Furthermore,	8/28/15

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F 428	Continued From page 3 The Plan of Care dated 2/5/15 indicated the resident was assessed with the potential for drug related complications and injuries associated with use of psychotropic medications related the resident's use of antidepressant and antipsychotic medications. The interventions stated that a GDR, under close supervision, should be attempted to determine if symptoms, conditions or risks could be managed by a lower dose or if the medication could be discontinued. A review of the Minimum Data Set dated 6/5/15 revealed Resident #15 was assessed with the use of an antidepressant medication. A record review revealed a note to Attending Physician/Prescriber dated 5/22/15 and signed by the consultant pharmacist which read " This resident is currently receiving the following antidepressant: Cymbalta 60 mg every day. It is now time to review this resident for the possibility of GDR. Please evaluate resident's depression and, IF APPROPRIATE, consider a trial at 30 mg every day. " A review of the note revealed the physician did not respond to the pharmacist's request for a possible GDR of Cymbalta. An interview was conducted with Administrative Staff #1 on 8/12/15 at 10:41 AM. Administrative Staff #1 stated she expected the physician to respond to the pharmacist's request for a GDR and to document his or her response on the request form. She stated she expected the pharmacist to follow up with the physician if a response to a request for a GDR was not provided.	F 428	on 6-25-2015 resident #15's primary care physician made required physician visit. Per progress note, physician noted current dose of Cymbalta and stated "Continue present medications and management. Follow-up in 2 months". Physician made no new orders or medication changes at this visit. (see attachment P) There were no further recommendations from pharmacist for gradual dose reductions on visits 06-12-15 or 07-07-15. (see attachments N,O) (see attachments M-Q) *For residents found to have been affected by the deficient practice: Pharmacy note to attending Physician/Prescriber presented again to Jackie Campbell, Nurse Practitioner on 08-12-15 upon rounds. Ms. Campbell documented on pharmacy note that resident "has had decrease before and did not do well", and disagreed with gradual dose reduction of Cymbalta. (see attachment F) In addition on 08-13-15 Dr. Herbert W. Harris, resident's attending Psychiatrist, also noted in his progress note that resident was "stable, benefiting from Cymbalta with tolerability issues. Risk of recurrence of major depressive symptoms significant, would continue current medications no indication for dose reduction at this time". (see attachment G) Lastly, Dr. Uthe, resident's attending physician, also reviewed request again on 08-27-15 and again he disagreed with reduction at this time. (see attachment H)	

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F 428	Continued From page 4	F 428	*For residents having the potential to be affected: Pharmacist in to revisit the facility on 08-19-15. Informed of findings during annual recertification survey. Director of Nursing(DON) requested report of any outstanding requests for gradual dose reductions that were not addressed as indicated or that needed to be addressed. On 08-21-15 final written report was given to DON as well as verbal exit report. That report was given to the Registered Nurse (RN) Unit Manager (Unit RN) by DON to process by 08-27-15. On 08-27-15 DON reviewed notes to attending physician by pharmacist and submitted to attending MDs to make sure all were addressed. All completed by August 27, 2015. (see attachment I) *Systemic changes: Pharmacist consultant will be replaced as of September 2015. Successor pharmacy consultant will continue to provide written report to Director of Nursing (DON) but will also meet in person with DON prior to exit, alerting DON of any unaddressed previous notes. Pharmacist's written report will be issued to Unit RN for processing. Unit RN will return completed paperwork to DON within 7 business days of receipt of pharmacy report. DON will review for compliance. Issues in compliance will be brought to Facility Administrator (Administrator) and Consulting Pharmacist by DON as needed to develop plan of action. *How facility plans to monitor: The Director of Nursing (DON) will compare	

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F 428	Continued From page 5	F 428	completed documents/notes from attending practitioners against pharmacy report to ensure there are no omissions. Any issues noted will be addressed immediately by DON to those involved. Within 10 business days after receipt of pharmacist monthly report, report will be turned into Administrator by DON after compliance check has been completed. (see attachment I) If DON is absent another designated RN will conduct compliance check. Any trends or concerns will be brought to Quality Assurance/Performance Improvement Committee in October 2015 and January 2016 and then followed as indicated by committee. *Date corrective action will be completed: Education to all active RN coordinators completed on August 24, 2015. In-service logs were compared to active nurse roster by DON to assess for any that failed to attend. All RN coordinators completed training. (see attachment K)	
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	F 431		8/28/15

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F 431	Continued From page 6 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 record review, observation and staff interview, the facility failed to discard expired medications and failed to date the medication when the foil pouch was opened in one of one medication cart observed. Findings included: On 8/11/15 at 2:15 PM, the medication cart was observed. The following were observed: a bottle of Aspirin (used to treat pain, fever, inflammation and also prevents blood clots and stroke) 81 milligrams (mgs) tablet with an expiration date of 3/11, a bottle of Mucus Relief (Mucinex) (expectorant drug) tablet with expiration date of	F 431	*For residents found to have been affected by the deficient practice & For residents having the potential to be affected: Expired and undated medications found during inspection by surveyor were removed by floor nurse and reported by floor nurse to Director of Nursing (DON) on 08-11-15. Medications discarded. New medications ordered as indicated. All medication carts in facility were checked by DON. No other expired or undated medications were noted.	

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F 431	Continued From page 7 4/11 and a bottle of Aspirin 325 mgs tablet with an expiration date of 6/15. There were two opened boxes of Duoneb solution (Ipratropium/Albuterol), a bronchodilator drug, with vials stored outside the foil pouch. The foil pouch had no date of opening. The instruction on the foil pouch read " unit dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vial should be used within one week. " On 8/11/15 at 2:30 PM, Nurse #1 was interviewed. The nurse stated that the foil pouch should have been dated when opened and also indicated that she would discard the vials that were not inside the foil pouch. The nurse further indicated that it was the responsibility of all nurses to check the cart for expired medications.	F 431	*Systemic changes: Quality Assurance log sheet was created for third shift nurses to check medication carts nightly to discard expired medications and to ensure opened medications are properly labeled. Logs started 08-23-15.(see attachment J) Nurse education started 08-12-15 and continued through 08-27-15. Any nurses that missed training will be educated prior to next shift worked. (see attachment E) *How facility plans to monitor: DON or other designated nurse will monitor carts and floor nurse logs five (5) times a week through August 2015, minimally two (2) times a week through September 2015, minimally one (1) a week through October 2015 and at least two(2)times a month after that or as indicated by Quality Assurance Committee. A quality assurance log was created for Registered Nurse (RN) Unit Manager (Unit RN to document checks. These logs will be turned into DON at the end of each month for review for compliance. (see attachment L) Any issues noted will be immediately addressed to nurse responsible for nightly check by the Unit RN. Performance issues will be handled as indicated per facility policy and procedure handbook. Pharmacy representative will complete monthly inspection of medication carts and medication rooms. Full written report of these inspections will be provided to DON along with an in person interview with DON and/or Facility Administrator prior to exiting at the time of inspection. Report of all findings from Unit RN and pharmacy	

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F 431	Continued From page 8	F 431	inspections, along with any trends or concerns in compliance will also be brought to Quality Assurance/Performance Improvement Committee in October 2015 and January 2016 and then followed as indicated. *Date corrective action will be completed: Education of all active full time nurses was completed by August 27, 2015. In-service logs will be compared to active nurse roster by DON to assess for any that failed to attend. Any part time, pro re nata or any other nurse out on leave who missed training will have education completed by Unit RN prior to next shift worked. (see attachment E)	