

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

PRINTED: 10/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345237</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/01/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BARBOUR COURT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 BARBOUR ROAD SMITHFIELD, NC 27577</b>		
(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 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, family interview and staff interviews the facility failed to clarify a physician ' s order following cryosurgery for 1 of 7 residents whose physician ' s orders were reviewed (Resident #3). The findings included: Resident #3 was admitted to the facility on 5/13/14 and had a diagnosis of Alzheimer ' s Disease. Review of the resident ' s medical record revealed information on a Cryosurgery Instruction form dated 8/11/15 that read: " A blister may develop within 24 hours. A dry flat scab will form and shed within one to two weeks. " A note on the form read: " Keep moist with Vaseline (sic). " Review of the physician ' s order sheet revealed an order dated 8/11/15 that read: " Vaseline applied to cryosurgery areas to keep moist. The order was followed by the dermatologist ' s name and the name of Nurse #1. There was a separate order for a follow-up visit with the dermatologist on 10/12/15. A nursing progress note dated 8/11/15 at 8:21PM read: " Resident returned to facility from (name of clinic), resident had several spots treated on his arms, received instructions to keep them moist with Vaseline. " Review of the nursing progress notes for August 2015 revealed no documentation that Vaseline was applied to the resident ' s arms. Review of the Medication Administration Record</p>	F 281	<p>F281 A clarification order was obtained from the physician regarding Resident #3's order for Vaseline and was discontinued on 9/8/2015. The Treatment nurse assessed resident #3 on 9/8/15 and no areas of redness or drying was present</p> <p>The Director of Nursing, Assistant Director, RN Staff Facilitator, or Quality Improvement Nurse will complete a 100% audit of all residents to include resident #3 Physician orders and compare to the medication administration record and the treatment administration record by 10/9/15 to assure all ordered medications have been transcribed, administered and/or clarified per the Physician order. The Director of Nursing or Assistant Director of Nursing will notify the physician and/or obtain clarification orders as needed immediately for any identified concerns during the audit. An in-service was initiated with 100% of all license nurses to include RN #1 regarding transcription, medication administration, and clarification of orders by 10/10/15 by the RN-Staff Facilitator. All newly hired license nurses will be in serviced regarding transcription medication administration, and clarifications of orders</p>	10/12/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/07/2015

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.

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F 281	<p>Continued From page 1</p> <p>(MAR) for August 2015 revealed an order that read: " Vaseline to cyrosurgery (sic) areas to keep moist PRN (as needed). The MAR contained initials on 8/19/15 to show Vaseline had been applied. Then " tx (treatment) nurse " was written on the MAR. There was no date or initials by the entry to show who wrote the notation and during the survey it could not be determined who wrote the notation or when it was written.</p> <p>On 9/28/15 at 5:37PM an interview was conducted with Family Member #1 who was observed to roll up the resident ' s shirt sleeves and the skin on the resident ' s arms were observed to be intact without redness or scabs and with minimal scarring.</p> <p>An interview was conducted with Nurse #2 on 9/29/15 at 11:11AM. The Nurse was observed to review the order and stated if she had received this instruction sheet she would have called the clinic to find out how often the physician wanted the Vaseline applied and to what areas.</p> <p>On 9/29/15 at 11:45AM, Treatment Nurse #1 stated in an interview that she did not receive a skin referral for Resident #3. The Treatment Nurse provided a copy of the Treatment Administration Record (TAR) for August 2015. There was no information on the TAR regarding the application of Vaseline for the resident.</p> <p>On 9/29/15 at 2:58PM, Nurse #1 stated she received the order from the clinic when the resident returned to the facility on 8/11/15. The Nurse stated the order did not say how often to apply the Vaseline and she thought they were just supposed to keep Vaseline on the areas. The Nurse stated she did not call the physician to clarify the order.</p> <p>On 9/30/15 at 9:51AM the Director of Nursing (DON) stated in an interview the order should have been clarified with the doctor because the</p>	F 281	<p>during orientation by the RN Staff Facilitator.</p> <p>The Rn Supervisor or Resource Nurse will review the physician orders daily and compare to the medication administration and treatment administration records for all new orders to assure the medication have been transcribed, administered and/or clarified per the physician order. The Director of Nursing, Assistant Director or Quality Improvement Nurse will complete a 10% random audit on the physician orders and compare to the medication administration records and the treatment administration records to include resident #3 to ensure the medication was transcribed, administered and/or clarified for 4 weeks then weekly times for weeks then monthly times x 2 months to ensure professional standards of nursing practice are followed during medication administration. The clarification monitoring tool will be utilized. Retraining will be conducted immediately by The Director of Nursing, Assistant or Director of Nursing, Staff Facilitator, and/or QI for all identified areas of concern.</p> <p>The Director of Nursing will compile audit results of the QI Clarification Monitoring Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need</p>		

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F 281	Continued From page 2 order did not say how often or where to apply the Vaseline. The DON stated after clarifying the order a skin referral should have been made to the treatment nurse.	F 281	for action and/or frequency of continued monitoring.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to discontinue a diuretic medication (Lasix) as ordered for 1 of 3 sampled residents	F 329	F329 A clarification order was received by the MD on 10/5/15 to discontinue resident #7	10/12/15	

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F 329	<p>Continued From page 3</p> <p>reviewed for unnecessary medications (Resident #7).</p> <p>The findings included: Resident # 7 was admitted to the facility on 8/2/13 and had diagnosis of Hypertension. Review of the resident ' s medical record revealed a physician ' s order dated 9/3/15 that read: " D/C (discontinue) Lasix. " Lasix is a medication used in the treatment of Hypertension. Review of a physician progress note dated 9/3/15 revealed the resident was seen and evaluated by the nurse practitioner. Under Diagnosis and Assessment read: " Patients blood pressures have been reviewed and are on the lower side of normal. To reduce the risk for falls DC (discontinue) Lasix. "</p> <p>Review of the Medication Administration Record (MAR) for September 2015 revealed an entry to give Lasix 10mg every other day for hypertension. There was an arrow followed by D/C (discontinue), the date 9/3/15 followed by a name identified by the Director of Nursing (DON) as the signature of Nurse #3. The MAR revealed the medication was initialed as given on 9/13/15, 9/17/15, 9/19/15, 9/21/15 and 9/23/15. On 9/30/15 at 11:23AM the Director of Nursing (DON) stated in an interview that Nurse #3 took off the orders. The DON stated it was a mistake and the Lasix should have been discontinued on 9/3/15. On 9/30/15 at 12:04PM Nurse #3 stated in an interview that the day he took off the orders he did not have a yellow highlighter to highlight the Lasix to indicate the medication had been discontinued. The Nurse stated the staff could see he had written D/C (discontinue) by the order and know not to give the medication. On 9/30/15 at 12:10PM the DON stated the Lasix entry on the MAR should have been highlighted</p>	F 329	<p>Lasix and written on the medication administration record to discontinue along with highlighting by RN Supervisor to assure the medication was stopped. A follow up BMP was drawn per physician order by Resource Nurse on 9/30/15 with no negative findings.</p> <p>The Director of Nursing, Assistant Director, RN Staff Facilitator, or Quality Improvement Nurse will complete a 100% audit of all residents to include resident #7 Physician orders and compare to the medication administration record and the treatment administration record by 10/9/15 to assure all ordered medications have been transcribed, administered, clarified, and/or discontinued per the Physician order. The Director of Nursing or Assistant Director of Nursing will notify the physician and/or obtain clarification orders as needed immediately for any identified concerns during the audit.</p> <p>An in-service was initiated with 100% of all license nurses to include LPN #3 regarding transcription, medication administration, clarification of orders, and procedure for discontinuing medications by 10/10/15 by the RN-Staff Facilitator. All newly hired license nurses will be in serviced regarding transcription, medication administration, clarification of orders, and procedure for discontinuing medications during orientation by the RN Staff Facilitator.</p>		

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F 329	Continued From page 4 with a yellow highlighter to show the medication had been discontinued. The DON stated they had plenty of highlighters on the unit. The DON stated she could not explain why the staff continued to give the Lasix when D/C was written beside the medication.	F 329	When an order is received to discontinue a medication, the license nurse will write discontinue with the date and initials and highlight the medication administration record and remove the medication from the medication cart. The RN Supervisor or Resource Nurse will review the physician orders daily and compare to the medication administration record and treatment record to assure procedure was followed for new all orders to discontinue resident medications to include resident # 7 medication to include documentation on the MAR with date, initials, highlighting, and removal of the medication. The Director of Nursing, Assistant Director or Quality Improvement Nurse will complete a 10% random audit on the physician orders to ensure the medication was transcribed, administered, clarified, and/or discontinued for 4 weeks then weekly times for weeks then monthly times x 2 months to ensure professional standards of nursing practice are followed during medication administration. The clarification monitoring tool will be utilized. Retraining will be conducted immediately by The Director of Nursing, Assistant or Director of Nursing, Staff Facilitator, and/or QI for all identified areas of concern.  The Director of Nursing will compile audit results of the QI Clarification Monitoring Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential		

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F 329	Continued From page 5	F 329	trends will be used to determine the need for action and/or frequency of continued monitoring.		