STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345162	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 3/10/2011
NAME OF PROVIDER OR SUPPLIER: REHAB AND HEALTH CENTER OF GAS	STREET ADDRESS, CITY, STATE, ZIP CODE: 416 N HIGHLAND ST GASTONIA, NC		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to transcribe a physician order for a medication (Risperdal) to the Medication Administration Record (MAR) (Resident #54) and failed to document the administration of insulin on the MAR (Resident #13) for two (2) of twenty-nine (29) sampled residents.

The findings are:

1. A review of Resident # 54's medical record revealed Resident # 54 was readmitted to the facility on 01/17/07 with a diagnosis of dementia. A review of Resident # 54's most recent quarterly Minimum Data Set (MDS) assessment dated 02/11/11 revealed Resident # 54 had short and long-term memory problems and had severely impaired decision-making skills.

A review of Resident # 54's medical record revealed a physician's order dated 10/26/10 which revealed an order change for Risperdal. The physician's order revealed the Risperdal changed from 0.25 milligrams (mg) to be given twice a day to 0.25 mg to be given in the morning and 0.50 mg to be given at bedtime. A review of Resident # 54's MAR from November 2010 to March 2011 revealed Risperdal 5 mg to be given at bedtime.

A review of the facility's medication cart revealed Resident # 54's medications. The label for the Risperdal medication revealed 0.25 mg and to give one tablet orally twice a day.

An interview with Licensed Nurse (LN) # 2 on 03/10/11 at 10:32 AM revealed Resident # 54's medication for Risperdal was 5 mg according to the MAR.

An interview with the DON on 03/10/11 at 12:04 PM revealed the group of licensed nurses who reviewed the physician's orders and the MARs should have been compared, but Resident # 54's medication transcription error was overlooked.

Another interview with LN # 2 on 03/10/11 at 12:14 PM revealed Resident # 54's MAR revealed Risperdal 5 mg (mg) at bedtime, but the medication punch card in the medication cart was 0.25 mg and no 5 mg punch card for Risperdal was for Resident # 54. LN # 2 reported Resident # 54 was given two tablets of the 0.25

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	Continued From Page 1

mg to equal 0.50 mg at bedtime. LN # 2 further revealed she should have noted the transcription error and corrected the MAR.

2. Resident #13 was admitted to the facility on 2/6/06 and readmitted, most recently, on 8/25/10. Diagnoses included Insulin-Dependent Type 2 Diabetes Mellitus (IDDM).

Review of the medical record revealed a physician's telephone order dated 8/25/10 related to the diagnoses of IDDM and included the following: Lantus (insulin) 20 units subcutaneous every night at bedtime. The medication administration record (MAR) for October 2010 documented on 10/20/10 at 8 PM a blood sugar result of 107 mg/dl and the sign for zero to indicate the amount of insulin administered to Resident #13.

During an interview with licensed nurse #5 on 3/9/11 at 5:10 PM, LN #5 stated that he did administer 20 units of insulin to Resident #13 on 10/20/10 although the MAR documented that insulin was not given. He further stated "That's wrong; I always give her the Lantus (insulin). I don't know why I wrote that she did not get her Lantus."

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Event ID: 7VJ111.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *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 the 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.*	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility record review, a sampled resident (Resident #88) did not receive food preferences for 2 of 3 meals observed. The findings are: Resident #88 was admitted to the facility on 11/9/10. Diagnoses included cerebral vascular accident, coronary artery disease status post bypass grafting, and anxiety disorder. A quarterly Minimum Data Set, dated 2/1/11, assessed the Resident as having impaired recall function and independent with eating, requiring staff assistance with set up. Review of her February 2011 plan of care revealed that Resident #88 received a mechanical soft, no added salt diet. The plan of care identified that the Resident was at risk for nutritional decline related to medical diagnoses. Approaches included for staff to determine	F 242	Resident #88 is receiving whole milk as requested. Resident #88 is no longer receiving zucchini on her meal trays. The NSM (Nutrition Services Manager) audited the current resident population's tray card to highlight dietary dislikes per resident request. The dietary and nursing staff will be re-educated by the SDC regarding food preferences. The above in-service will be included in the new employee orientation program for nursing and dietary staff. The Nutrition Service Manager or Executive Director will monitor five resident's tray cards and meal trays 3x weekly for one month then 2x weekly x2 months to ensure ongoing compliance. Data results will be reviewed and analyzed at the facility's monthly Performance Improvement Meeting monthly for three months with a subsequent plan of correction as needed.	4/07/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: √ Shawna Brown — TITLE: √Executive Director — (X6) DATE: √4/1/11

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 242	Continued From page 1 food/beverage preferences/eating patterns and determine food intolerances and avoid. The dietary tray card for Resident #88 documented dislikes including zucchini and beverages of choice included whole meal for each meal. Resident #88 was observed continuously on 3/9/11 from 1:45 to 1:55 PM in bed. The head of bed was elevated approximately 45 degrees and her lunch meal was observed on her over-bed table which was across her lap. Resident #88 was observed feeding herself independently. She received her meal on a divided plate; rice with beef and gravy, California blend vegetables which included zucchini, congealed fruit salad, whole milk, and iced tea. Resident #88 did not eat the California blend vegetables and stated when asked "I don't like that." Zucchini was listed as a dislike on her dietary tray card which was on her lunch tray. Resident #88 was observed again for dinner on 3/9/11 at 6:15 - 6:27 PM. She was observed in bed with the head of bed elevated approximately 45 degrees. Her dinner meal was received on a divided plate and included meatloaf, scalloped potatoes, strawberries, skim milk and iced tea. Whole milk was listed on her dietary tray card as a beverage of choice. When asked, she stated that she was not asked what kind of milk she wanted for dinner, staff just gave her "this one" (skim milk) and then she confirmed that she preferred whole milk. She stated "I have already told them that." She fed herself dinner, but she did not drink the skim milk. An interview with the certified dietary manager (CDM) on 3/10/11 at 11:30 AM revealed that the CDM and the kitchen supervisor both usually	F 242		

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F 242	Continued From page 2 assisted during meals on the tray line. The CDM further stated that on average he received one to two phone calls to the kitchen per meal regarding residents who did not receive an item on their tray or received the wrong items on the meal tray. He confirmed that the dietary department was responsible for sending meal trays from the kitchen according to the tray card which listed the residents' diet and food preferences. A follow-up interview with the CDM occurred on 3/10/11 at 5:35 PM. During this interview, the CDM confirmed that Resident #88 did receive California Blend vegetables with zucchini for lunch on 3/9/11. The alternate vegetable was squash and staff thought that Resident #88 would not want squash since it was in the same family of vegetables as zucchini, so the California blend vegetables were provided. The CDM also confirmed that Resident #88 received skim milk for dinner on 3/9/11 instead of whole milk because individual cartons of whole milk were not delivered in time for the dinner tray line. The CDM stated that he instructed dietary staff to pour cups of whole milk, from gallons of whole milk which were available, for the dinner meal, but he did not ensure that this was done. The CDM further stated that a concern was identified in 12/10 regarding tray line accuracy which resulted in dietary staff receiving an in-service. Since 12/10, the CDM and the kitchen supervisor monitored for tray line accuracy while they were in the kitchen, but monitoring was not done if they were unable to be in the kitchen during the meal service.	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to 1) failed to obtain a physician's order to monitor blood sugar levels, 2) obtain a physician's order to hold insulin (Resident #13) and 3) follow physician's orders for a medication (Colace 100 milligrams daily) (Resident #47), for two (2) of ten (10) sampled residents reviewed for unnecessary medications. The findings are: 1. The facility's policy "Diabetes Mellitus, Guidelines for Management", revised 10/31/10, recorded in part, "General Guidelines for Assessment, 1. Obtain the resident's finger stick blood glucose level. Frequency of finger stick blood sugars are determined by the attending physician." Resident #13 was admitted to the facility on 2/6/06. The Resident was hospitalized from 8/23/10 to 8/25/10 and re-admitted to the facility on 8/25/10 under Hospice/Comfort Care Services. Diagnoses included Insulin-Dependent Type 2 Diabetes Mellitus (IDDM), End-stage Dementia, Failure to Thrive, stage 4 sacral wound and a history of Acute Renal Failure. Prior to the 8/23/10 hospitalization, the Resident's blood sugars (BS) were monitored by the facility each morning and before supper as order by her physician. Review of the August 2010 care plan, last reviewed by the facility January 2011, identified Resident #13 with a potential for	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *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 the 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.* Resident #13 is no longer receiving blood sugar levels. Her insulin order has been discontinued. Resident #47 medication order for Colace has been clarified; he is receiving the medication as ordered. The Unit Manager and/or Supervisor conducted a one-time audit of current resident population receiving insulin to identify physician orders for blood sugar monitoring and parameters for notifying the physician of the results. The Unit Manager's also performed a one- time audit on current resident population receiving Colace to ensure that the medication order is transcribed accurately to the MAR. The SDC re-educated the License Nurses on the center's policy for monitoring blood sugars, physician notification for abnormal blood sugar results, and Colace medication transcription to the MAR's. This in-service will be included in the new employee orientation program for License Nurses The DNS and or Staff Development Coordinator will monitor 5 resident physician's orders and MAR's documentation for blood sugar orders, parameters, physician notification and Colace medication transcription errors 2x	4/7/2011

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F 281	Continued From page 4 hypo/hyperglycemia episodes related to a diagnoses of IDDM with hypoglycemia. Approaches to this problem included to monitor blood sugars as ordered. Review of the medical record revealed a physician's telephone order dated 8/25/10 related to the diagnoses of IDDM, for the following: 1) notify the physician for BS less than 50 mg/dl (milligrams per deciliter) or greater than 450 mg/dl, 2) Glucagon 1 mg intramuscular as needed for BS less than 50 mg/dl and resident can not tolerate by mouth, may repeat once in 20 minutes as needed, and 3) Lantus (insulin) 20 units subcutaneous every night at bedtime. The physician's order, which was in place prior to the 8/23/10 hospitalization, for BS monitoring twice daily, was not included with this physician's order on re-admission, dated 8/25/10. There was no current physician's order to indicate when BS monitoring should occur for this Resident after the re-admission of 8/25/10. Further review of the medical record for Resident #13 revealed documentation (Medication Administration Record, Diabetic Monitoring Flow Sheet) that her BS was monitored without a current physician's order via a blood glucose finger stick on the following dates/times: · 7 times in August 2010: 8/25/10 thru 8/31/10 at 2100 (8 PM) · 12 times in September 2010: 9/4/10, 9/5/10, 9/9/10, 9/18/10, 9/19/10, and 9/21/10 thru 9/23/10 at 2100 (8 PM); 9/3/10 at 0740 (7:40 AM); 9/4/10 at 0725 (7:25 AM); 9/11/10 at 0800 (8 AM) and 1600 (4 PM) · 31 times in October 2010: 10/1/10 thru 10/26/10 and 10/28/10 thru 10/31/10 at 2100 (8 PM); 10/18/10 at 0800 (8 AM)	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *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 the 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.* weekly x4 weeks then weekly X4 to ensure ongoing compliance. Data results will be analyzed and reviewed at the facility's monthly Performance Improvement Committee Meeting (PI) monthly for three months with a subsequent plan of correction as needed.	

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F 281	Continued From page 5 · 29 times in November 2010: 11/1/10 thru 11/10/10 and 11/12/10 thru 11/30/10 at 2100 (8 PM) · 31 times in December 2010: 12/1/10 thru 12/31/10 at 2100 (8 PM) · 33 times in January 2011: 1/1/11 thru 1/30/11 at 2100 (8 PM); 1/9/11 at 1100 (11 AM) and 1600 (4 PM); and 1/16/11 at 1230 (12:30 PM) · 14 times in March 2011: 3/1/11 thru 3/8/11 at 2000 or 2100 (7 PM or 8 PM); 3/2/11 thru 3/4/11, 3/7/11 thru 3/9/11 at 1600 (4 PM) An interview on 3/9/11 at 5:00 PM with unit manager #1 revealed that she admitted Resident #13 on 8/25/10, but did not seek physician clarification regarding BS monitoring because Resident #13 was receiving Hospice services. Unit Manager #1 stated due to this change in the Resident's condition, the unit manager knew that most of the Resident's original physician's orders would not be resumed. An interview on 3/9/11 at 5:05 PM with the director of nursing (DON) revealed that she would have expected her nursing staff to clarify the physician's order for Resident #13 before routinely monitoring the Resident's BS with blood glucose finger sticks. An interview on 3/9/11 at 5:10 PM with licensed nurse #5 confirmed that he checked the BS for Resident #13 on that day (3/9/11) at 4:00 PM using blood glucose finger sticks, because "That is what we use to do with her before she went out to hospital (on 8/23/10)." Licensed nurse #5 also confirmed that this was his routine practice and that he also checked the BS for Resident #13 before giving her insulin at bedtime.	F 281		

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F 281	Continued From page 6 An interview on 3/10/11 at 9:45 AM with the attending physician for Resident #13 revealed that the physician's order for BS monitoring twice daily for this Resident was not included in her physician's orders as of her readmission on 8/25/10. He further stated that he was not aware that an order for routine BS monitoring was not in place. 2. Resident #13 was admitted to the facility on 2/6/06 and readmitted, most recently, on 8/25/10. Diagnoses included Insulin-Dependent Type 2 Diabetes Mellitus (IDDM). Review of the August 2010 care plan, last reviewed by the facility January 2011, identified Resident #13 with a potential for hypo/hyperglycemia episodes related to a diagnoses of IDDM with hypoglycemia. Approaches to this problem included to administer meds as ordered. Review of the medical record revealed a physician's telephone order dated 8/25/10 related to the diagnoses of IDDM and included the following: 1) notify the physician for blood sugars (BS) less than 50 mg/dl or greater than 450 mg/dl, 2) Glucagon 1 mg intramuscular as needed for BS less than 50 mg/dl and resident can not tolerate by mouth, may repeat once in 20 minutes as needed, and 3) Lantus (insulin) 20 units subcutaneous every night at bedtime. The phys order did not include instructions for holding insulin. Further review of the medical record for Resident #13 documented on the Medication Administration Record/Diabetic Monitoring Flow Sheet that Lantus 20 units was held at bedtime,	F 281		

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F 281	Continued From page 7 as indicated by a sign for zero or a circle around the initials of the nurse on the following dates/results: 10/9/10 (89 mg/dl), 10/23/10 (66 mg/dl), 10/24/10 (88 mg/dl), 11/20/10 (90 mg/dl), and 12/1/10 9 (107 mg/dl). An interview with the director of nursing (DON) on 3/9/11 at 6:00 PM revealed that the DON expected her nursing staff to contact the physician and obtain an order to hold any medication for a resident. The DON reviewed the medical record for Resident #13 and stated she did not find a physician's order to hold insulin. In an interview on 3/10/11 at 9:45 AM, the attending physician for Resident #13 stated that he would not have wanted the insulin held for Resident #13 for BS above 50 mg/dl. An interview with licensed nurse #6 on 3/10/11 at 10:05 AM revealed that she administered insulin to Resident #13, usually on weekends. LN #6 stated that Resident #13 was a brittle diabetic because her BS would drop below 100 mg/dl. LN #6 further stated that if the BS for Resident #13 dropped below 100 mg/dl, LN #6 held the Resident's insulin based on her nursing judgment. LN #6 confirmed that a physician's order was not in place to hold the insulin for Resident #13. 3. A review of Resident # 47's medical record revealed Resident # 47 was readmitted to the facility on 05/25/09 with a diagnosis of dementia. A review of Resident # 47's most recent quarterly Minimum Data Set (MDS) assessment dated	F 281		

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F 281	Continued From page 8 12/14/10 revealed Resident # 47 had severely impaired cognition. A review of Resident # 47's medical record revealed a discharge summary and admission order record dated 05/29/09 which revealed a physician's order for Colace 100 milligrams given daily. A review of Resident # 47's Medication Administration Records (MAR) dated from March 2010 to February 2011 revealed Colace 100 milligrams given daily and the Colace was given to Resident # 47 twice a day. A continued review of Resident # 47's physician's order dated 02/28/11 revealed clarification order for Colace 100 milligrams given twice a day. A review of the facility's 'Medication Error Form' dated 03/09/11 revealed the error occurred repeatedly for Colace 100 milligrams and the potential error for multiple doses were given to Resident # 47, two pills were given instead of one pill. The form further revealed there was a transcription error, order was not correctly marked on the MAR and the error occurred that reached Resident # 47 but did not cause harm. An interview with the Director of Nursing (DON) on 03/09/11 at 4:18PM revealed the MARs were printed in the facility. The DON reported the original physician's order for Resident # 47's Colace was to be given daily, but when the Colace order was printed on the MAR, it printed as Colace 100 milligram given daily and two times were printed to be given. The DON stated due to the error, Resident # 47 was given the medication twice a day instead of once a day as ordered for many months. The DON further revealed the process involved a licensed nurse verified the physician's orders, the physician signed the	F 281		

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F 281	Continued From page 9 orders and another licensed nurse signed the physician's order to verify the physician's signature. The DON reported Resident # 47's physician was not aware the resident was given the Colace twice a day instead of once a day as ordered. The physician was made aware and he signed off on a new order for Resident # 47 to be given the medication twice a day. An interview with Licensed Nurse (LN) # 2 on 03/09/11 at 4:29PM revealed she cared for Resident # 47 and she should have caught the discrepancy between the daily order for the Colace and being given twice a day. LN # 2 reported she should have clarified the order with the physician a long time ago whether the medication should have been given once a day or twice a day. LN # 2 further revealed she did not notice the discrepancy on the MAR and she was going by the times listed on the MAR of when to give the medication. An interview with Licensed Nurse (LN) # 3 on 03/09/11 at 4:58PM revealed she was a floating nurse and assisted with data entry. LN # 3 reported she wrote the clarification order when she did a check on Resident # 47's orders and noted the Colace was ordered to be given daily, but the medication was being given twice a day. LN # 3 stated when she consulted with the physician, the physician decided to continue the Colace to be given twice a day since the resident was given the medication that way for a long time and the physician signed off the order. LN # 3 further revealed the medication order and transcription error should have been caught much earlier during physician's order and MAR reviews.	F 281		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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	345162	A. BUILDING _____ B. WING _____	C 03/10/2011

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F 425	Continued From page 10 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to obtain medications timely (Digoxn tablets) and administered a medication (Questran) with other medications having interactions without accurate auxiliary labelling for a total of two (2) of ten (10) sampled residents observed during medication pass. (Resident #6 and #38) The findings include: 1. Resident #6 was admitted to the facility on 12/30/2010. Resident #6 had admitting	F 425	*This Plan of Correction is the center's credible allegation of compliance.* *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 the 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.* Resident #6 is receiving Digoxin medication timely. Resident #38 Questran medication is now administered without other medications. The Unit Manager's conducted a one-time audit on current resident population to ensure that Digoxin is available, administered timely, and Questran is administered without any other medications. The medication administration records (MAR's) have been updated to reflect that the medication is to be administered one hour before other meds or 4-6 hours later. The Licensed nurses were in serviced on the policy and procedure for administering Digoxin timely and medication availability. The Licensed Nurses were in serviced on Questran administration with an emphasis placed on administering it one hour before other medications or 4-6 hours later. The above in-service will be included into the new employee orientation program for License Nurses. The Director of Nurses and or the Unit Manager will monitor five MAR's and five medication cards 2x weekly x4 weeks then weekly x4 to ensure ongoing compliance.	4/7/2011

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F 425	Continued From page 11 diagnoses including Atrial Fibrillation, Acute Cardiovascular Accident and Seizure disorder. The admission medication orders from the physician included an order for Digoxin 125 mcg (Microgram) by mouth daily. Further review of the physician orders revealed that this medication was renewed every month and was scheduled to be administered at 8:00 AM. Resident #6 was observed for medication administration on 3/9/2011 at 8:35 AM and Licensed Nurse #2 (LN #2) was observed administering medications to the Resident #6. The nurse pulled all the medications scheduled at 8:00 AM and stated that the Resident #6 was suppose to get one tablet of Digoxin 125 mcg (Microgram) and this medication had been ordered and was not sure whether the pharmacy had sent it or not. The observation revealed that Digoxin 125 mcg was not administered and all other medications were administered. An interview with LN #2 on 3/9/2011 at 8:37 AM confirmed that the label for reordering had been pulled but was not sure when it was reordered. Further interview revealed that no proof was available for having ordered and the nurse was not able to find the copy of the faxed sheet to the pharmacy. A continued interview revealed that it was an usual practice to order medications when at least 5-6 days tablets were left on the medication card. An interview with the Director of Nursing (DON) on 3/9/2011 at 1:43 PM revealed that it was her expectations that all medications were to be present on the cart prior to medication administration and medications had to be ordered 5-6 days prior to the supply is finished or when	F 425	*This Plan of Correction is the center's credible allegation of compliance.* *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 the 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.* Data results will be analyzed and reviewed at the facilities monthly Performance Improvement Meeting (PI) for 3 months with a subsequent plan of correction as needed.	

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F 425	Continued From page 12 the blue colored area on the medication card was reached. A telephone interview with the provider pharmacy dispensing pharmacist on 3/10/2011 at 10:01 AM revealed that the last Digoxin refill that was sent to the facility for Resident #6 was on 1/7/2011 and no other refill orders had been received till 3/9/2011. The interview also revealed that if the medication was obtained from the backup pharmacy Resident #6 would have a note on the profile and in this case no such note was present. 2. A most recent review of the product literature on Questran included a warning that Questran had to be given 1 hour prior to other medications or 4-6 hours later to reduce drug-drug interaction related to absorption of other drugs. Resident #38 was admitted to the facility on 1/5/2010. Resident #38's diagnoses included Coronary Artery Disease, History of Myocardial infarction, Coronary Artery bypass Graft and Hypertension. Resident #38 had an order dated 2/18/2011 to administer one packet (5 grams) of Questran light once daily. The Questran order was renewed for the month of March 2011. Resident #38 was observed for medication administration. On 3/9/2011 at 9:45 AM Licensed Nurse #4 (LN #4) was observed administering medications to Resident #38. LN #4 removed all medications including Vitamin D 2000 units one tablet, Zantac 150mg one tablet and mixed a Questran package with a glass of water and administered them together. A review of the pharmacy label did not have any auxiliary label to indicate the drug-drug interaction.	F 425		

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F 425	Continued From page 13 An interview with LN #4 on 3/9/2011 at 9:47 AM revealed that she was not aware that Questran was to be given one hour prior to other medications and the pharmacy had not sent any instructions related to this administration. LN #4 confirmed that Resident #38 had been getting Questran from 2/18/11 and she was not aware that Questran interacted with the absorption of medications like Vitamin D and Zantac. A telephone interview with the provider pharmacy dispensing pharmacist on 3/10/2011 at 10:01 AM revealed that no extra label was included related to Questran drug:drug interaction. The pharmacist stated that she was aware of the drug:drug interaction of Questran but this information was not provided to the facility. The interview also revealed that Resident #38's medications were reviewed in March 2011 prior to dispensing other medications but this was not communicated to the facility.	F 425	*This Plan of Correction is the center's credible allegation of compliance.* *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 the 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.*	
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	F 431	The expired multi-dose insulin vials were removed and discarded. An audit was performed on the four medication carts and the medication rooms to ensure that there were no other expired insulin's available. The Licensed Nurses were re-educated on the facility's policy and procedure for medication expiration dates with an emphasis placed on insulin vials. This in-service will be included into the orientation program for Licensed Nurses.	4/7/2011

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

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F 431	Continued From page 14 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 observation, staff interview and facility policy review, the facility failed to remove three expired vials of insulin from use in one (1) of four (4) medication carts. The findings are: Review of facility policy guidelines entitled Insulin With Special Expiration Date Requirement indicated that multi-dose vials of insulin should be discarded 28 to 30 days after opening depending on the product manufacturer. On 3/9/11 at 11:00 a.m. one medication cart on the 1st floor was observed to contain the following:	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *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 the 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.* The Director of Nursing and/or the Staff Development Coordinator will monitor four medication carts and med rooms 2 times weekly x4 weeks then once weekly x4 weeks to ensure ongoing compliance. Data results will be analyzed and reviewed at the facility's monthly Performance Improvement Committee Meeting (PI) for three months with a subsequent plan of correction as needed.	

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F 431	Continued From page 15 · One 10 ml vial of Novolin N 100 units/ml was labeled with an open date of 2/5/11 with a second label on the bottle to discard 28 days after opening. No discard date was observed on the vial and the medication was in active stock for resident use. · One 10 ml vial of Novolog 100 units/ml labeled with an open date of 2/5/11 with a second label on the vial to discard 28 days after opening. No discard date was observed on the vial and the medication was in active stock for resident use. · One 10 ml vial of Novolin 70/30 100 units/ml labeled with an open date of 1/26/11 with a second label on the vial to discard 28 days after opening. No discard date was observed on the vial and the medication was in active stock for resident use. Licensed Nurse #1 (LN #1) was interviewed at that time and stated that she was responsible for checking the expiration date on medications before administration to residents. LN #1 stated that insulin should be dated when opened and dated for discard. LN #1 confirmed that the vials of insulin were expired and should have been discarded 28 days after opening. LN #1 removed the expired vials of insulin from active stock and ordered new stock from the pharmacy. The Unit Manager was interviewed on 3/9/11 at 11:30 a.m. The Unit Manager stated the medication carts were checked periodically to remove expired insulin from stock. The Unit Manager stated that all licensed nursing staff was responsible for checking expiration dates before administering medications.	F 431		

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F 431	Continued From page 16 The Director of Nursing (DON) was interviewed on 3/10/11 at 4:00 p.m. The DON stated that her expectation was for licensed nursing staff to check expiration dates prior to insulin administration and discard expired insulin from storage.	F 431		