STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____ JUL 11 2011	C 06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328

(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 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 review and staff interviews, the facility failed to administer scheduled medication as ordered for 2 of 4 sampled residents (resident #3, #2) whose medications were reviewed. Findings include: 1. The Facility's Backup Pharmacy Procedures, undated, read in part: "During normal business hours all medication orders should be sent to (pharmacy name). It will be necessary to place a telephone call to the pharmacy if you need any of the medication before the next scheduled delivery time. Procedure for ordering during business hours - 1. fax orders to (pharmacy name) 2. call staff if you need medication immediately or before faxing the order you may write a note on the order stating that you need an immediate dose. Procedure for ordering after business hours - 1. Fill out backup pharmacy form...fax your form and a copy of the orders to (backup pharmacy name)." Resident #3 was admitted to the facility on 12/22/10 with multiple diagnoses including rheumatoid arthritis, degenerative disk disease,	F 309	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. 7/5/11 **Corrective Action for Resident Affected** Resident #2 is no longer at our facility. Resident #3 is receiving his medications per physician orders. **Corrective Action for Resident Potentially Affected** All residents who receive medication have the potential to be affected by this alleged deficient practice. See systemic changes for interventions that address all potentially affected residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/30/11

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 309	Continued From page 1 history of fracture, and chronic pain. Record review of the resident ' s clinical record revealed physician orders dated 12/22/10 for Prednisone 7.5mg (milligram) daily. Prednisone is a corticosteroid used for a variety of diseases, including rheumatoid arthritis, of inflammatory or autoimmune origin. The resident also had orders for Tylenol (analgesic) ES (extra-strength) 1000mg three times daily, Lidoderm (lidocaine) 5% patch (topical analgesic) applied daily for 12 hours, Methotrexate (antineoplastic agent used for rheumatoid arthritis) 10mg every week, and Duragesic (narcotic analgesic) 25 mcg/hr (microgram/hr) one patch every 72 hours. Lexicomp's Drug Information Handbook, 14th edition, read in part: "Prednisone -Warnings/Precautions - withdraw therapy with gradual tapering of dose...should be used cautiously in the elderly." Review of the resident's medication administration records (MARS) revealed Prednisone was not given, indicated by the nurses' initials being "circled," on 5/27/11, 5/28/11, 5/29/11, 5/30/11, 5/31/11, 6/3/11, 6/4/11, and 6/5/11. Review of the back of the MARS revealed documentation that Prednisone was "not available" on 5/27/11, 5/28/11, 5/29/11, and 5/31/11. There was no explanation or reason documented for the dose omissions on 5/30/11, 6/3/11, 6/4/11, and 6/5/11. Review of the nursing notes revealed no documentation regarding the dose omissions or the unavailability of the resident's Prednisone. There was no documentation of any follow-up with the physician regarding the dose omissions.	F 309	**Systemic Changes** Nurse #1 & #2 were counseled individually on the policy and procedure for ordering medication through our facility pharmacy or our back-up pharmacy. All resident Medication Administration Records have been reviewed for medication availability/delivery; this was completed by our Unit Managers. Nurse(s) will be counseled individuality for any errors found. A list of our stat box medications was added to all 8 MAR notebooks. On June 22nd the Staff Development Coordinator and our Pharmacy Consultant completed an in-service with all nurses on our policy and procedure for ordering medications through our pharmacy or back-up pharmacy. The Staff Development Coordinator will ensure that any nurse who did not receive training on June 22nd will not be allowed to work until in-service training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 309	Continued From page 2 In an interview on 6/7/11 at 4:55PM, the nurse (nurse #1) responsible for administering the resident's medication stated she had been trained during orientation and periodically thereafter. She stated there had been a recent in-service about the procedure for ordering medications. The nurse stated she completed refill sheets for any needed medications and faxed them to the pharmacy. She stated the facility had a backup pharmacy but didn't usually call them for scheduled medications. The nurse reviewed the MARS and acknowledged the resident's prednisone had not been given on the days the nurses' initials were circled. She indicated she had faxed the pharmacy several times to refill the prednisone order. Nurse #1 stated she was going to call the pharmacy but then got busy. When asked if anyone had called the pharmacy regarding the prednisone, she stated not unless the first shift or weekend staff had called. The nurse stated she had been off for several days and would check the cart to see if the prednisone had been delivered. The nurse checked the medication cart, returned, and stated "I'll call pharmacy now before they close." In an interview on 6/7/11 at 5:05PM, the Unit Manager stated the staff was trained during orientation by the Staff Development Coordinator (SDC). She stated the facility had backup policies in place with a pharmacist on-call and a local backup pharmacy always available. If medications were faxed to the pharmacy but did not come in, she indicated the staff should follow-up by calling the pharmacy provider or the backup pharmacy. She reviewed resident #3's MARS and acknowledged the dose omissions	F 309	**Quality Assurance** The Staff Development Coordinator will monitor this issue using the "MAR Audit". The monitoring will include reviewing 10 MARs for proper medication administration. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 309	Continued From page 3 charted for the prednisone. In an interview on 6/7/11 at 5:33PM, the Director of Nursing (DON) stated the staff was trained by the SDC during basic orientation and on the halls with the staff nurses. She stated there were systems in place for ordering medications, calling the on-call pharmacist, and using the backup pharmacy if needed. She stated an on-call pharmacist was available 24 hours per day, 7 days per week. For any medication not available, her expectation was for the staff to order it immediately from the provider pharmacy and obtain it from the backup pharmacy if necessary. She expected the staff to communicate with the on-coming staff and follow-up the next day to ensure the medication was obtained. The DON stated she had no explanation for why the facility's policy had not been followed. 2. The Facility's Backup Pharmacy Procedures, undated, read in part: "During normal business hours all medication orders should be sent to (pharmacy name). It will be necessary to place a telephone call to the pharmacy if you need any of the medication before the next scheduled delivery time. Procedure for ordering during business hours - 1. fax orders to (pharmacy name) 2. call staff if you need medication immediately or before faxing the order you may write a note on the order stating that you need an immediate dose. Procedure for ordering after business hours - 1. Fill out backup pharmacy form...fax your form and a copy of the orders to (backup pharmacy name)." Resident #2 was admitted to the facility on 12/22/09 with multiple diagnoses including	F 309		

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F 309	Continued From page 4 glaucoma. Record review of the resident's clinical record revealed physician orders dated 12/22/09 for Xalatan 0.005% one drop in left eye every night at bedtime, Alphagan 0.1% 1 drop in left eye twice daily, and Timoptic XE 0.5% 1 drop in left eye every morning. Xalatan, Alphagan, and Timoptic XE are used to treat glaucoma. Review of the resident's medication administration records (MARS) revealed an administration time of 9:00PM for Xalatan. Review revealed Xalatan was not administered, indicated by the nurses' initials being "circled," on 5/20/11, 5/21/11, and 5/22/11. Review of the back of the MAR revealed documentation that Xalatan was "unavailable - pharmacy faxed several times" on 5/20/11 and 5/21/11. There was no explanation or reason documented for the omission on 5/22/11. Review of the nursing notes revealed no documentation regarding the dose omissions or the unavailability of the resident's Xalatan. In an interview on 6/7/11 at 2:34PM, nurse #2 stated she worked the day shift and had been assigned resident #2. Nurse #2 stated she worked 5/21/11 and received a note from the night nurse to call the pharmacy for the resident's Xalatan, which was to be given at 9PM. The nurse stated she called the pharmacy and was told they were out of stock. She stated the second shift nurse was told to call the backup pharmacy. Nurse #2 stated she told the second shift nurse again on Sunday 5/22/11 to call the backup pharmacy. Nurse #2 stated the nurse's initials were circled for several days on the MAR, which indicated the Xalatan was not given. She	F 309		

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F 309	Continued From page 5 stated the facility policy was to call the backup pharmacy if any medication was unavailable. Nurse #2 stated the pharmacy didn't deliver on Sunday, but there were two backup pharmacies available, and a pharmacist was on call at all times. In an interview on 6/7/11 at 5:33PM, the Director of Nursing (DON) stated the staff was trained by the SDC during basic orientation and on the halls with the staff nurses. She stated there were systems in place for ordering medications, calling the on-call pharmacist, and using the backup pharmacy if needed. She stated an on-call pharmacist was available 24 hours per day, 7 days per week. For any medication not available, her expectation was for the staff to order it immediately from the provider pharmacy and obtain it from the backup pharmacy if necessary. She expected the staff to communicate with the on-coming staff and follow-up the next day to ensure the medication was obtained. The nurse responsible for administering the resident's Xalatan on 5/20/11, 5/21/11, and 5/22/11 was not available for interview.	F 309		