STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345298	A. BUILDING _____ B. WING _____	C 08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 No deficiencies were cited as a result of the complaint investigation. Event ID #H5F611.	F 000	**F 428** **Specific action taken to correct the deficiency:** • MD was notified of recommendations for residents #14 and #49 and has addressed those recommendations. **Corrective Action will be accomplished for residents having potential to be affected by:** • Upon finding missing recommendations a complete audit was conducted of all recommendations to ensure that no other residents had been missed. An in-service was then conducted by the Director of Nursing with nursing supervisors and our pharmacy consultant to outline the necessary steps to prevent this in the future. **Measures taken to ensure deficient practice does not occur again:** • A copy of all MD recommendations will be printed and given to the nursing supervisor by the pharmacy consultant upon completion of review each month. The nursing supervisor will then forward recommendations to appropriate MD for follow up. When the nursing supervisor receives all MD recommendations back the results will be forwarded to DON for cross check of original recommendations and an additional audit done by DON to ensure all recommendations were completed. **We will monitor our performance to**	
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 record review and staff interviews, the facility failed to act upon pharmacy recommendations for two (2) of ten (10) sampled residents (Residents #14 and #49). The findings are: 1. Resident #14's diagnoses included insomnia, dementia, and major depression. Resident #14's physician orders for June 2012 through August 2012 included the antidepressant Trazodone 50 mg at hour of sleep every night. Review of the pharmacy review form revealed a recommendation was made on 06/26/12 for the physician to try a gradual dose reduction of	F 428		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/5/12

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.

RECEIVED
OCT 0 9 2012
BY:

Original Signature Date: 9-24-12

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F 428	Continued From page 1 Trazodone. The physician visited Resident #14 on 07/20/12, however, the physician's note made no reference to the pharmacy recommendation related to Trazodone. The next pharmacy review dated 07/26/12 indicated the gradual dose reduction of Trazodone was "pending." On 08/31/12 at 11:30 PM the Director of Nursing (DON) stated when a pharmacy recommendation was made, the pharmacist gave a typed sheet describing the recommendation, reason and suggestions to the DON to give to the physician. The DON stated that if the resident's physician was the medical director, the recommendation was left in his box as he visited weekly. If the physician was not the medical director, as in the case of Resident #14, the recommendation was faxed to that physician. The DON stated that the next time the pharmacist completed the monthly review, if the physician had not responded, the pharmacist noted that the recommendation was pending and verbally informed the DON. The DON then followed up by asking the nurses on the floor about the status of the recommendation. The DON stated there was no log or system to tract when the recommendations were sent to the physician. She could not provide any evidence the recommendation was faxed to Resident #14's physician. In regard to Resident #14, the DON could not recall what she did when informed in July 2012 that the physician had not responded to the pharmacy recommendation. On 08/31/12 at 11:35 AM the pharmacist stated she gave the written recommendations to the DON each month. If the physician had not responded	F 428	**make sure that solutions are sustained.** • Findings from crosscheck by DON of MD recommendations will be compared to nursing supervisor's documentation and brought to QAA for review x 3 months and then quarterly thereafter. **Date of Completion:** • Facility will achieve substantial compliance by October, 8 2012	

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F 428	Continued From page 2	F 428		

by the next month, she verbally informed the DON the recommendation was still pending. If there was not response by the next month (60 days) she resubmitted the same written recommendation to the DON again.

2. Resident #49's diagnoses included anxiety, depression, depression induced insomnia, and dementia.

Review of physician orders for June 2012 through August 2012 revealed she received the antianxiety medication Xanax 0.25 mg three times per day.

Review of the pharmacy review form revealed a recommendation was made on 06/26/12 for the physician to try a gradual dose reduction of Xanax. The next pharmacy review dated 07/23/12 indicated the gradual dose reduction of Xanax was "pending" and indicated that there was a failed trail reduction 01/2012.

The physician visited Resident #49 on 08/03/12, however, the physician's note made no reference to the pharmacy recommendation related to Xanax.

On 08/31/12 at 11:30 PM the Director of Nursing (DON) stated when a pharmacy recommendation was made, the pharmacist gave a typed sheet describing the recommendation, reason and suggestions to the DON to give to the physician. The DON stated that if the resident's physician was the medical director, as such was the case with Resident #49, the recommendation was left in his box, as he visited weekly. The DON stated that

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F 428	Continued From page 3 the next time the pharmacist completed the monthly review, if the physician had not responded, she noted that the recommendation was pending and verbally informed the DON. The DON would then asked the nurses on the floor where the recommendation was and request followup. The DON stated there was no log or system to tract when the recommendations were sent to the physicians. In regards to Resident #49, the DON could not recall what she did when informed in July 2012 that the physician had not responded to the pharmacy recommendation. On 08/31/12 at 11:35 AM the pharmacist stated she gave the written recommendations to the DON each month. If the physician had not responded by the next month, she verbally informed the DON the recommendation was still pending. If there was not response by the next month (60 days) she resubmitted the same written recommendation to the DON again.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	**F 441** **Specific action taken to correct the deficiency:** • Immediate in-service was given by pharmacy consultant and DON with all nurses to properly instruct on correct method of medication preparation and preventing spread of infections. **Corrective Action will be accomplished for residents having potential to be affected by:**	

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F 441	Continued From page 4 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews facility staff failed to dispense medication directly into a medicine cup from bubble packages and bottles for one (1) of six (6) nurses observed during medication pass. The findings are: A review of a facility policy titled "Administering Oral Medications" and not dated indicated in part	F 441	• Instructing all new nurses in orientation on proper medication preparation techniques including instruction on not pouring pills into their hands. Additional in-service was conducted with nursing staff by Infection Control nurse on proper medication preparation techniques including not pouring pills into hand. **Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:** • Infection Control nurse will randomly audit 5 medication passes on a weekly basis, 5 total nurses, to ensure continued compliance. **We will monitor our performance to make sure that solutions are sustained.** • We will monitor results monthly in QAA meeting x 2 months to discuss effectiveness and ensure compliance. Any further incidents will be brought to QAA for further evaluation x 2 additional months and nurse in question will receive disciplinary action. **Date of compliance:** • October 8, 2012	

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F 441	Continued From page 5 under a section titled "procedure" to: Prepare Medication: · Tablets or capsules packaged in bubble packaged containers described as "Bingo Cards" - punch the medication directly into the medicine cup. · Medications in bottles - pour amount ordered into the medication cup. During an observation on 08/29/12 at 9:15 AM Nurse #1 was standing in the 300 hallway next to a medication cart and poured tablets and capsules one by one directly into her left (L) hand and dropped them from her hand into a medicine cup. Nurse #1 picked up the medicine cup and walked away from the medicine cart and into Resident # 160's room. She walked out of the resident's room to the medication cart in the hallway, picked up the Medication Administration Record (MAR) notebook on top of the cart and did not wash her hands. During an observation on 08/29/12 at 9:20 AM Nurse #1 opened the (MAR) notebook on top of the medication cart and wrote her initials with an ink pen for each of the medications she gave to Resident #160. She then turned the pages of the notebook to Resident #46's medications. Nurse #1 opened the drawers of the medication cart and picked up pill bottles and poured each capsule and tablet from the bottles directly into her (L) hand and then dropped them into a medicine cup. She then opened another drawer in the medication cart and searched through the cardboard "Bingo Card" containers until she found the medications for Resident #45. Nurse #1 stacked the "Bingo Card"	F 441		

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F 441	Continued From page 6 containers on top of the medication cart and then picked up each one and pushed the tablets and capsules out of the containers directly into her (L) hand and dropped them into the medicine cup. Nurse #1 touched a total of eight (8) tablets and capsules with her hands before she placed them in the medicine cup. She then carried the medicine cup into Resident #46's room and gave the medications to the resident. During an interview on 08/29/12 at 9:31 AM Nurse #1 stated sometimes she popped the tablets and capsules out of the containers or pill bottles into her hand but usually she poured the tablets and capsules directly into the medicine cup. Nurse #1 further stated she realized she placed the medications directly into her hand before she put them in the medication cup and she knew she was not supposed to touch them with her hands. During an interview on 08/30/12 at 10:36 AM the Director of Nurses stated it was her expectation for nurses to pour tablets and capsules directly into a medicine cup and they should not put them in their hand or touch them with their fingers.	F 441		