

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

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2012
NAME OF PROVIDER OR SUPPLIER YADKIN NURSING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 903 W MAIN ST BOX 879 YADKINVILLE, NC 27055	
(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 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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 applicable.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 431	<p>F 431 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).</p> <p>No residents were specifically identified as having been affected by this alleged deficient practice.</p> <p>For those residents having the potential to be affected by the same alleged deficient practice, all facility medication staff were inserviced on 8/13/12 and 8/14/12 on the proper storage of drugs, proper discarding of expired drugs and/or biologicals, and locking the medication cart while it is unattended.</p> <p>The Director of Nursing will monitor proper storage of drugs, proper discarding of expired drugs and/or biologicals, and locking the medication cart weekly for 4 weeks and monthly thereafter. Director of Nursing and/or appropriately trained staff will monitor by completing the Medication/Biologicals & Medication Cart Observation Worksheet weekly for 4 weeks and monthly thereafter to ensure proper storage of drugs, proper discarding of expired drugs and/or biologicals, and locking the medication cart locked when unattended. Medications/biologicals determined to be expired shall be discarded/returned to the pharmacy for proper disposal. Additionally, the pliers have been replaced with a SilentNight®, a device designed for the crushing of medications.</p> <p>The Director of Nursing shall report any identified discrepancies to the QA Committee monthly for three months, and quarterly thereafter. In addition, the Pharmacy Consultant shall report any additional identified discrepancies in accuracy to the QA committee quarterly.</p>	8/16/12

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

TITLE

(X6) DATE

Nolan D. Brown

Adm

9/18/12

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.

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F 431	<p>Continued From page 1</p> <p>Based on observations and staff interviews the facility failed to ensure medications were not expired.</p> <p>Medication cart for 400 and 600 halls were observed at 10:20 AM. the following medications were expired:</p> <p>Mary Weatherman-Hydroxyzine 10 mg-24 unit dose tablets Expiration date-6/30/12 and Meclizine 12.5 - 5 unit dose tabs dated 5/10/12</p> <p>Betty Lane-Mucinex 600 mg tabs dated with exp date 7/28/12; 4 tabs with exp date of 1/19/12; 4 tabs with exp date of 4/4/12; 4 tabs with exp date of 1/19/12; 5 tabs with exp date of 3/2/12; 2 tabs with exp date of 4/14/12.</p> <p>One bottle of Zenpep DR 20,000Units containing 25 caps containg no expiration date on pharmacy label.</p> <p>Interview with Cassandra Hutchens, med aide on 8/9/12 at stated she checks meds daily and the pharmacist also checks for expired meds. Medication cart for 400 and 600 halls were observed at 10:20 AM. the following medications were expired:</p> <p>Mary Weatherman-Hydroxyzine 10 mg-24 unit dose tablets Expiration date-6/30/12 and Meclizine 12.5 5 unit dose tabs dated 5/10/12</p> <p>Betty Lane-Mucinex 600 mg tabs dated with exp date 7/28/12; 4 tabs with exp date of 1/19/12; 4</p>	F 431		

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F 431	<p>Continued From page 2</p> <p>tabs with exp date of 4/4/12; 4 tabs with exp date of 1/19/12; 5 tabs with exp date of 3/2/12; 2 tabs with exp date of 4/14/12.</p> <p>One bottle of Zenpep DR 20,000Units containing 25 caps containg no expiration date on pharmacy label.</p> <p>Interview with Cassandra Hutchens, med aide on 8/9/12 at stated she checks meds daily and the pharmacist also checks for expired meds.</p> <p>100 cart- 3:20 PM- Pearl Luffman-one simvastin 20 mg tab exp date 4/6/12</p> <p>200 cart-3:00 PM-Lutrelle Chipman-5 1/2 tabs of Seroquel 25 mg exp date of 6/10/12.</p> <p>Interview with med aides, Stephanie Pinnix and Rose Baustista at 2:50 PM revealed they check the expiration dates on medications and the pharmacist checks for expired medicallons every 2-3 months.</p> <p>6 of 6 medication carts were observed for medication storage on 8/9/12. The The med cart for 400 and 600 halls were observed at 10:20 to 10:45 AM. The 2 carts for 500 and 700 halls were observed at 1:15 PM. There were pliers contained in the drawers of all the carts. The pliers were all observed to have caked on residue in their teeth.</p> <p>Carts for 100, 200 and 300 halls were observed from 2:45 through 3:30 PM. The pliers in the carts contained caked on residue in their teeth.</p>	F 431			

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F 431	Continued From page 3 Interview with the Jerri Love, consulting pharmacist for the facility was interviewed on 8/9/12 at 4:25 PM. They have a nurse that goes to the facility and checks for expired medications and the nurse was at the facility in July, 2012. The nurses and med aides also check the dates when they give the medications.	F 431			
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, 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	F 441			

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F 441	<p>Continued From page 4 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to ensure staff performed hand hygiene during the administration of medications for 3 of 11 residents (#5, #21 and #130) observed for medication administration.</p> <p>The findings were:</p> <p>Observation of medication administration for three residents (# 5, #21 and #130) from 8:19 AM through 8:44 AM on 8/9/12 revealed medication aide #4 administered oral medications without performing any hand hygiene between residents. The medication aide did not perform hand hygiene prior to giving medications to the identified residents. Sinks and soap dispensers were located in each resident room and no hand sanitizer was observed on the medication cart.</p> <p>At 8:30 AM the medication aide administered medications to resident # 21. He returned to the medication cart and prepared nine oral medications for resident # 5 including a chewable Calcium Carbonate tablet. When the resident stated the Calcium Carbonate tablet was too big, the medication aide removed the tablet from the medication cup with his hands and held the tablet</p>	F 441	<p>F 441</p> <p>STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).</p> <p>Resident #'s 5, 21, and 130 currently have their medications administered in accordance with good hand hygiene practice(s).</p> <p>For those residents having the potential to be affected by the same alleged deficient practice, a licensed nurse and/or pharmacist shall perform 20 medication pass observation(s) per week for 4 weeks, then 20 per month for 3 months, then 20 per quarter thereafter. The medication pass observation(s) are designed for specific observations of hand hygiene to ensure medication staff are using proper hand hygiene between residents and shall be documented on the Medication Pass Observation for Hand Hygiene audit form. All licensed nurses and medication aides have been inserviced on the importance of proper hand hygiene.</p> <p>The Director of Nursing shall report any identified inconsistencies to the QA committee monthly for three months and quarterly thereafter.</p>	09/06/12	

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F 441	<p>Continued From page 5</p> <p>In his hand until the resident finished the rest of her medications.</p> <p>Medication aide # 4 then prepared oral medications for resident # 130 and administered them.</p> <p>No hand hygiene was observed during the medication pass.</p> <p>An interview with the infection control nurse at 10:45 AM on 8/9/12 revealed hands are to be cleansed between residents during medication administration.</p> <p>Medication aide # 4 was interviewed at 11:33 AM and stated that he does not always cleanse his hands between every resident when administrating medications.</p> <p>There was no policy regarding the performance of hand hygiene during medication administration.</p>	F 441			

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 02249 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system.</p> <p>There were no deficiencies noted during the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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