STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLYS SPRINGS, NC 28612

(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 # DCXW11.	F 000		
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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow physician orders for 1 of 5 sampled residents. Resident #39 did not have platelets drawn weekly per the facility's lab protocol and physician's orders. The findings included: Review of the facility's lab protocol revised November 2013, noted that for the anticoagulant medication Lovenox, a platelet count was to be drawn weekly. Resident #39 was admitted to the facility on 05/30/14. Her diagnoses included rehab for a hip fracture, muscle weakness, anemia, hypertension, dementia, and disc degeneration. Physician orders dated 05/30/14 included Lovenox 40 milligrams (mg) via a subcutaneous injection every day. Resident #39's medical record contained the facility's lab protocol for weekly platelets. The laboratory test for weekly platelets was included on the monthly physician orders for June, July and August 2014. The admission Minimum Data Set dated 06/06/14	F 281	Correction action was accomplished for resident #39 on 8-6-14 when the platlets were drawn. Results of the platlet count drawn on 8-6-14 was normal. The Lab Protocol called for weekly platlet counts on all residents who were taking Lovenox, which was not followed for resident #39 resulting in deficient practice. It should be noted that Resident #39 was on Lovenox on a long term basis. Manufactuer guidelines call for platlet counts to be drawn periodically. Resident # 39 was admitted to short term rehabilitation and was discharged to home on 8-9-14. Upon discovering deficient practice administrative nursing had pharmacy to pull a list of any other resident on Lovenox. At that time no other residents in the facility were taking Lovenox. To prevent deficient practice or failure to monitor resident taking Lovenox, a new policy and procedure was written called "Execution of Lab Monitoring per Lab Protocol". All license personnel and nurse managers were in-serviced on the new	9/4/14

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

Electronically Signed | 08/28/2014

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F 281	Continued From page 1 revealed she was coded with moderately impaired cognition and having no behaviors. Review of the laboratory tests revealed Resident #39's platelets were checked on 06/02/14 and noted to be within the normal range. They were again tested on 06/09/14 and noted to be high registering 561 K/UL with the normal range being 140 to 440 K/UL. The third time the platelets were drawn was on 08/06/14 at which time they were noted to be in the normal range. On 08/06/14 at 1:40 PM the unit manager #1 stated that the platelets were not drawn every week per the lab protocol and physician orders. She stated that the pharmacist questioned her about it yesterday and that was how the platelets were checked on 08/06/14. Upon further interview, the unit manager #1 stated either she or the nurses transcribing the orders were responsible for placing the monthly platelet checks in the lab book for monthly draws. She further stated she was not sure how the scheduled labs were dropped after 06/09/14. The Assistant Director of Nursing stated on 08/07/14 that Resident #39 was on long term Lovenox injections and that the weekly laboratory tests should have been clarified in June. On 08/07/14 at 10:50 AM Resident #39's physician was interviewed. Per the physician, Resident #39 was on long standing Lovenox for deep vein thrombosis, in addition to hip surgery. He stated that he clarified the need for continued Lovenox with her surgeon and should have then changed the laboratory testing of her platelets to every other month. He further stated the facility's	F 281	policy and procedure by the DON and/or ADON. A review of the November 2013 Lab Protocol was reviewed with all license personnel and the nurse managers. Measures that have been put in place to to ensure that deficient practice will not occur are : 1. Audits on Lovenox Drug Monitoring shall be completed by the DON, ADON, and or designee weekly for one month, and then monthly times three. If monthly audits arrive at 100% compliance for three consecutive months then the audits will be done at random at the discretion of the DON. 2. The Lab Protocol will be reviewed and revised by the consultant pharmacist on a quarterly basis. This will ensure the latest manufactuer recommendations and safety for the residents. 3. A new policy and procedure called "Execution of Lab Monitoring per Lab Protocol" was written to ensure safe and prompt drug monitoring for all residents completed by physician orders and the Lab Protocol. The facility will monitor the performance of Lovenox drug monitoring by performing audits on a weekly basis time four and then monthly times three. If compliance is not maintained at 100 % for three consecutive months then the audit will continue monthly until that compliance rate is achieved. The facility will on a continual basis perform random Lovenox Drug Monitoring. All audit results will be reported monthly in the QAPI meeting. In	

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F 281	Continued From page 2 lab protocol does not take into account long standing use of Lovenox.	F 281	addition the DON, ADON, and or designee will audit five percent of all drug monitoring labs to ensure compliance on a monthly basis. Corrective action will be made immediately and as needed. Reports of the audits will be given in the monthly QAPI meetings	
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		9/4/14

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F 441	Continued From page 3 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 observations, record review, and staff interviews the facility failed to follow manufacturer's instructions to disinfect a glucose meter (glucometer) for 1 of 1 resident observed for finger stick blood sugars (Resident #119). The findings included: A review of the facility policy entitled Glucometer Use, dated 01/25/12, specified glucometers used for more than one resident must be cleaned and disinfected before and after resident use, using an appropriate disinfecting solution, following the manufacturer's guidelines. The instructions provided on the container of the germicidal disinfectant used by the facility for cleaning glucometers indicated the surface to be cleaned should be thoroughly wiped and maintained "visibly wet" for four continuous minutes. The manufacturer's label stated extra wipes should be used if needed to maintain a wet surface for four minutes. On 08/05/14 at 3:25 PM an observation was conducted of Nurse #1 performing a finger stick blood sugar on Resident #119. The glucometer was retrieved from the medication cart and the finger stick was performed. Nurse #1 completed the blood sugar check and returned to the medication cart to clean the glucometer. He was observed removing a disinfect wipe from the	F 441	Corrective action for resident #119 was accomplished by in-servicing the individual nurse #1 on the proper procedure for disinfecting a glucometer used for more than one resident. Resident #119 suffered no adverse outcomes related to the glucometer use. Corrective action shall be accomplished for all residents who could be potentially affected by the deficient practice by in-service conducted by the DON and/or ADON for all personnell authorized to use the glucometers on proper disinfection of the glucometer. The Director of Nursing (DON) or designee will complete at least three random visual audits per week to ensure glucometers are properly disinfected. The observations will be conducted three times weekly for four weeks and then once a week for three weeks followed by once monthly for three months Any discrepancies will be noted by the DON or designee with corrective actions made immediately.	

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F 441	Continued From page 4 container, wiped the glucometer for 30 seconds, then placed the glucometer on the medication cart. On 08/05/14 at 3:30 PM an interview was conducted with Nurse #1. He stated the facility used the same glucometer on multiple residents for blood sugar checks. He indicated the facility policy for cleaning glucometers involved wiping the glucometer with a disinfectant wipe for 30 seconds and allow it to stay wet for one minute. Nurse #1 revealed he wiped for 30 seconds and then allowed the glucometer to air dry. He stated he did not keep the glucometer wet with the disinfectant wipe for four minutes. On 08/05/14 at 3:35 PM an interview was conducted with Nurse #2. She stated the facility policy for cleaning glucometers involved wiping the glucometers with a disinfectant wipe and allowing them to air dry. She stated she was not aware of a particular length of time to keep the glucometer wet. On 08/05/14 at 3:40 PM an interview was conducted with the Director of Nursing (DON). She stated the facility policy for cleaning glucometers was to follow the manufacturer's guidelines. She stated they were wiping the glucometers for 30 seconds and allowing them to air dry. She stated she was not aware of the need to keep the glucometers wet for four minutes, but expected staff to follow instructions on the containers. On 08/07/14 at 9:00 AM an interview was conducted with the Assistant Director of Nursing (ADON). She stated the facility was not aware that the disinfectant wipes they were using required them to maintain moist contact for four minutes. She revealed the facility had now changed their disinfectant wipes to a wipe that required less contact time.	F 441	The DON will present the audit results at the monthly Quality Assurance Process Improvement (QAPI) meeting. These results will be reviewed monthly for three months then quarterly thereafter, with revisions implemented as necessary to ensure 100% compliance.	

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F 441	Continued From page 5 On 08/07/14 at 9:50 AM an interview was conducted with the DON. She indicated she was aware of the issue with disinfectant wipes. The DON revealed the facility had now changed the disinfectant wipes to a different manufacturer that required less contact time. She stated it was her expectation that staff followed the manufacturer's guidelines when cleaning glucometers.	F 441		