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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	516 BARBOUR ROAD SMITHFIELD, NC 27577

(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 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administer the correct medications as ordered by the physician for 1 of 6 residents with medication reviews (Resident #171). The findings included: Resident #171 was admitted to the facility on 7/31/14 and had a diagnosis of high blood pressure, dementia and psychotic disorder. The Quarterly Minimum Data Set (MDS) Assessment dated 2/7/16 revealed the resident was rarely/never understood and had short and long term memory problems and severe cognitive impairment. Review of a facility report dated 2/20/16 signed by Nurse #1 revealed after administering medications to Resident #171, she realized the medications she administered belonged to Resident #97. The nurse documented she immediately contacted the supervisor who notified the physician and the responsible party. A review of Resident #171 ' s medical record revealed a physician ' s order dated 2/20/16 for staff to monitor the blood pressure and pulse of Resident #171 every shift for 24 hours and to give the resident her normally scheduled medications that morning. Review of Resident #97 ' s February 2016 Medication Administration Record (MAR) revealed the following medications were administered in error to Resident #171: Aspirin 81mg (milligrams), Miralax 17 grams (medication	F 333	Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes the plan o correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Barbour Court Nursing and Rehabilitation Centers Response to this statement of deficiencies does not denote agreement with the statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbour Court reserves the right to refute any of the deficiencies through the informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	3/31/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deanne C. Crell — TITLE: RN DON — (X6) DATE: 3/24/16

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.

for Moses Mundine - Adm.

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F 333	Continued From page 1 for constipation), Seroquel 25mg (Antipsychotic), Requip 0.5mg (medication for tremors), Citracal with Vitamin D 200/250 (Calcium with Vitamin D), Senokot 8.6mg (medication to prevent and treat constipation), Lotrel (medication to treat high blood pressure) Midorine 2.5mg (medication to treat symptoms of low blood pressure when standing) and Oxycodone 5mg (narcotic medication given for pain). The package insert for Seroquel advised the medication may cause drowsiness. The package insert for Requip revealed taken in combination with a narcotic could add to the sleepiness caused by Requip. The package insert for Oxycodone noted the medication may cause drowsiness and/or sedation. Continued review of the clinical record for Resident #171 revealed the first vital signs taken after the medications were given (no time documented) was blood pressure 118/78 and pulse was 78. On 2/20/16 at 2:42 PM the resident ' s blood pressure was documented as 118/70 and pulse 76 and regular. Another blood pressure documented on the MAR (no time documented) was 140/80 and pulse 93. A nursing progress note dated 2/20/16 at 10:29 PM signed by Nurse #2 revealed Resident #171 was alert, ate 100% of her evening meal and tolerated her evening medications. The resident ' s blood pressure was documented as 139/74 and pulse 78. A nursing progress note dated 2/21/16 at 7:48 AM signed by Nurse #3 revealed the resident was alert and oriented to self and rested throughout the night with no concerns. The note revealed the resident ' s vital signs were within normal limits. A nursing progress note dated 2/21/16 at 4:38 PM signed by Nurse #4 revealed the resident was alert with no distress noted. The note revealed	F 333	1. The MD was notified of the medication error for resident #171 on 2/20/16 by the licensed hall nurse. Resident #171 was administered the correct medications per physician order by the licensed hall nurse on 2/20/16. Nurse #1 is no longer an employee of the facility. 2. On 2/23/16 the Medical Records Director updated all resident pictures to include resident #171 in the Medication Administration Records to assure resident's photographs were current for identification during medication pass. 3. An in-service was initiated on 3/14/16 by the DON to 100% of all licensed nurses regarding medication administration to include administer medications as ordered by the physician and the process used to identify residents. All newly hired licensed nurses will be in-serviced regarding medication administration to include administering medications as ordered n the physician and the process used to identify residents by the Staff	3/31/16

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F 333	Continued From page 2 the resident had a good appetite for breakfast and lunch and took her medications without difficulty. The resident ' s blood pressure was documented as 111/64 and Pulse 93. A nursing progress note 2/21/16 at 9:26 PM and signed by Nurse #2 revealed the resident was alert with no signs or symptoms of pain or discomfort. The note revealed a blood pressure of 140/80 and a pulse of 93. The note revealed the resident ate well at dinner. An interview was conducted with the Administrator and the Director of Nursing (DON) on 3/2/16 at 10:11 AM. The DON stated Nurse #1 was a new nurse and when the nurse recognized the medication error, she notified the supervisor right away. The Administrator stated both residents looked very similar. The DON stated there were pictures of the residents on their Medication Administration Record (MAR) that were taken on admission. The DON stated they decided to update the pictures of the residents on that unit after the incident occurred. On 3/2/16 at 4:12 PM, Nurse #1 stated in an interview that she had been oriented to the unit several weeks prior to 2/20/16 and was assigned to the unit on 2/20/16 on the day shift. The nurse stated when she got to Resident #171 and prepared her medications, she asked staff where Resident #171 was and a staff member pointed to the resident sitting at the table she had already administered medications to. The nurse explained she realized she had misidentified the resident and administered the wrong medications to Resident #171. She called the supervisor immediately and checked the resident ' s vital signs which were within normal limits for the resident. Nurse #1 stated the supervisor came to the unit and called the physician and the responsible party. The Nurse stated the physician	F 333	Facilitator during orientation. A 100% medication pass audits will be conducted with all licensed nurses by 3/31 to ensure correct medications are being administered as ordered by the physician by the DON, QI Nurse, RN Supervisor, LPN Resource Nurse, Pharmacist or RN Pharmacy Consultant. Retraining will be immediately conducted during the medication pass audit by the DON, QI Nurse, RN Supervisor, LPN Resource Nurse, Pharmacist or RN Pharmacy Consultant for any identified areas of concern. The DON, QI Nurse, RN Supervisor, LPN Resource Nurse will conduct medication pass audits with 10% of licensed nurses 2X per week X4 weeks; then weekly for 4 weeks; then monthly for a month to ensure correct medications are being administered to residents to include resident #171 as ordered by the physician utilizing a medication pass audit tool.	

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F 333	Continued From page 3 told them to check the resident ' s vital signs every shift for 24 hours and to give Resident #171 her regularly scheduled medications and felt the resident would be fine. The Nurse stated she told one of the NAs (nursing assistants) to keep an eye on Resident #171 and let her know if the resident was excessively lethargic. The nurse added the resident was sleepy but responded by opening her eyes and grunting when her name was called. Nurse #1 stated the resident ' s vital signs remained stable. The nurse continued she received an in-service regarding medication administration by the pharmacist and the Staff Development Coordinator on Monday (2/22/16). The Nurse stated she was told they were going to update the pictures of the residents on the MAR. On 3/3/16 at 11:15 AM, NA #2 stated she worked on the unit on the day shift on 2/20/16. The NA stated after lunch the resident was sleepy but would respond when spoken to. The Weekend Supervisor on duty on 2/20/16 stated in an interview on 3/3/16 at 12:48 PM that he was called to the unit and the nurse told him she had made a medication error. The Supervisor stated he asked the nurse what medications were given and while the nurse was checking the resident ' s vital signs, he called the physician. The Supervisor stated the physician gave an order to check the resident ' s vital signs every shift for 24 hours and monitor the resident and to call back if any problems On 3/3/16 at 2:15 PM an interview was conducted with Nurse #2 who worked on the 3PM-11PM shift on the unit on 2/20/16. Nurse #2 stated Resident #171 was groggy but her vital signs were within normal limits. The nurse stated the resident was very drowsy from the medications and the staff monitored the resident ' s alertness and vital signs. The nurse added the staff fed the resident	F 333	The DON will review and initial the QI Medication Pass Audit Tool for compliance and to ensure all areas of concern were addressed weekly x8 weeks then monthly for one month. 4. The DON will compile the results of the medication pass audit tools and review with the Administrator for further follow up, retraining or recommendations as indicated. The Administrator will present to the Executive Quality Improvement Committee Meeting monthly X3 months for further recommendations as indicated. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

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F 333	Continued From page 4 supper and she ate 100% and was very alert after supper. On 3/3/15 at 3:30 PM an interview was conducted with the Administrator and the DON. The DON stated they had taken new pictures of the residents on the unit and put on their Medication Administration Records and had started to in-service some of the staff in the unit where the medication error occurred. The Administrator acknowledged they had not completed a full plan of correction.	F 333		
F 431 SS=E	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 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	F 431	1. The expired and unopened insulins were immediately pulled from the medication carts by the PLN floor nurse and returned to the pharmacy per policy on March 3, 2016. 2. All medication storage areas were audited to assure no outdated medication were present in the facility on March 3, 2016 by the Assistance Director of Nursing, Staff Development and Resource Nurse. Any medications identified as outdated/expired were returned to the pharmacy or discarded. Any identified medication that were outdated were reordered by the ADON on March 3, 2016. 3. A 100% in-service was initiated by the Director of Nursing on 3/14/16 to include nurse #5	3/31/16

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F 431	Continued From page 5 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, record review and staff interviews, the facility failed to Store unopened insulin in the refrigerator and failed to dispose of expired insulin for 4 of 7 medication carts. The findings included: 1. Review of the package insert for multi-dose vials of Humulog and Lantus Insulin revealed unopened multi-dose vials should be refrigerated between 36 and 46 degrees Fahrenheit. On 3/3/16 at 8:41 AM an inspection of the medication cart on the 800 Hall revealed one unopened multi-dose vial of Lantus Insulin and one unopened multi-dose vial of Humulog Insulin. On 3/3/16 at 4:02 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated that when insulin came in from the pharmacy it should be stored in the refrigerator until ready for use. 2. Review of the package insert for multi-dose vials of Lantus Insulin revealed vials of Lantus Insulin should be discarded 28 days after opening. Inspection of the medication cart on the 800 Hall on 3/3/16 at 8:41 AM revealed a vial of Lantus Insulin dated as opened on 1/6/16. Nurse #5 stated Lantus Insulin should be discarded 28 days after opened. On 3/3/16 at 4:02 PM an interview was conducted	F 431	regarding expiration dates for medications to include insulin, checking for expiration dates prior to medication administration to include insulin, and storage of medications per package insert to include insulins. The orientation process for newly hired nurses will be revised to include the medication storage, expiration dates for medications to include insulin, checking for expiration dates prior to medication administration to include insulin, and storage of medications per package insert to include insulins by 3/31/16. The Resource Nurse or Quality Improvement nurse will check the medication carts and medication room weekly X8 weeks, then monthly X1 month for expired medication and to assure medication are stored appropriately per package insert to include insulins utilizing the QI Tool for checking medications. Retraining will immediately be conducted by the Resource Nurse or QI Nurse, DON, ADON, Pharmacist or RN Pharmacy Nurse upon identification for any identified area of concern during	

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F 431	Continued From page 6 with the Administrator and the Director of Nursing (DON). The DON stated the nurses should be checking the expiration date of insulin before using. 3. Review of the package insert for multi-dose vials of Lantus Insulin revealed vials of Lantus Insulin should be discarded 28 days after opening. Inspection of the medication cart on the 400 Hall on 3/3/16 at 3:30 PM revealed a bottle of Lantus Insulin dated as opened on 1/24/16. During the inspection of the medication cart, Nurse #6 stated Lantus Insulin was good for 28 days after opening. On 3/3/16 at 4:02 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated the nurses should be checking the expiration date of insulin before using. 4. Review of the package insert for multi-dose vials of Humulin R Insulin revealed unopened vials should be refrigerated between 36 and 46 degrees Fahrenheit. On 3/3/16 at 3:10 PM an observation of the medication cart for the 100 Hall revealed one unopened multi-dose vial of Humulin R Insulin. On 3/3/16 at 4:02 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated that when insulin came in from the pharmacy it should be stored in the refrigerator until ready for use.	F 431	the audit. The DON will initiate and review the QI Too for checking medications weekly X 8 weeks then monthly X1 month for compliance and to assure all areas of concern have been addressed. 4. The Director of Nursing will compile the results of the QI Medication audit tool and review with the Administrator weekly. The Administrator will review the results of the QI Medication Storage audit monthly with the Executive Quality Assurance Team for further recommendation and follow up as indicated. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for further action and/or frequency of continued monitoring.	