STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 04/07/2016

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GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

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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: The facility failed to follow up on a resident ' s lab result that was negative for opiates when the resident received scheduled opioid medication for one of one resident tested for drugs (Resident #1). Findings included: Resident #1 was admitted to the facility on 7/1/14 from an acute hospital setting with diagnosis of chronic pain and arthritis. The Care Area Assessment (CAA) Summary dated 7/24/15 stated the resident was frequently in pain. The Minimum Data Set (MDS) Assessment dated 1/11/16 documented the resident was moderately cognitively impaired and able to make herself understood and understand others. The MDS further documented the resident received both scheduled and prn pain medication and was frequently in mild pain that did not affect her sleep or daily activities. The resident ' s care plan updated 1/12/16 listed	F 309	Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Grantsbrook Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Grantsbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F309 The MD was notified of resident #1 lab	4/25/16

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

Electronically Signed | 04/21/2016

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F 309	Continued From page 1 pain as an area of focus with staff interventions to document complaints and non-verbal signs of pain, to administer pain medication as per physician orders, to give prn medication for breakthrough pain and note the effectiveness and to notify MD if pain management ineffective. On 2/15/16 a physician order was written for " Oxycodone 5 mg (milligram) i (one) tab (tablet) po (by mouth) Q6H (every six hours). " Oxycodone is a narcotic opiate used for pain relief. Review of the nurse ' s notes for 3/12/16 at 8:26 PM revealed Resident #1 was transferred to the emergency room (ER) at a local hospital with altered mental status (unable to awaken the resident). Review of the local hospital records revealed the resident was admitted 3/12/16 to the emergency room for altered mental status and decreased oral intake and urinary output. The records documented the resident was on antibiotics for a urinary tract infection. The records documented a 7 panel urine drug screen was collected at 3/13/16 at 00:27 AM and tested negative for opiates at 300ng/ml. The ER final report documented Resident #1 was prescribed oxycodone 5 mg every 6 hours four times a day and according to the facility MAR, the patient had received almost every dose except for today (3/12/16). The resident was documented to have been discharged back to the facility on 3/13/15. The nurse ' s notes for 3/13/16 at 3:04 PM documented Resident #1 arrived from the hospital by ambulance with two medication	F 309	results that was negative for opiates when resident received scheduled opiate medications, on 4/7/16 by the Director of Nursing. Resident #1 opiate medication was changed to PRN (as needed) by the MD on 3/13/16. A 100% audit of residents that were re-admitted or had an ER visit from 3/13/16 to 4/8/16, to include resident #1, discharge summary, History and Physical, ER notes and lab results were reviewed to ensure that if resident was negative for opiates and received scheduled opiate medication, the lab results were followed up with an investigation and MD notification, completed by the Director of Nursing (DON) on 4/8/16. The DON initiated a review of 100% audit of labs from 3/13/16 to 4/19/16, for residents receiving scheduled opiate medication, to ensure that lab results that were negative for opiates was investigated and MD notified, was completed on 4/20/16 by DON. All identified areas of concern were immediately addressed by the DON. 100% inservice for all Licensed nurses to include nurse #2 was conducted on 4/11/16 by the DON regarding the nurse must review the hospital packet when a resident returns from the hospital for re-entries and ER visits. Any pertinent information to include labs and toxicology reports is to be verbally reported to the DON. The hospital packet will be placed in the DON□s door for review. On 4/19/16 the inservice was expanded to all license nurses to include nurse #2 regarding immediate reporting to the DON residents on scheduled opiate	

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F 309	Continued From page 2 changes and two prescriptions that were faxed to the pharmacy. Review of the discharge records revealed that discharge orders, prescriptions and lab results were included in the packet sent with the resident upon return to the facility. The toxicology report dated 3/13/16 00:27 AM was part of the packet and listed the urine opiate screen negative for opiates. An interview with a laboratory technician on 4/7/16 at 8:23 AM revealed the urine specimen collected 3/13/16 at 00:27 AM for drug testing was not sent for confirmatory testing. The physician stated in an interview on 4/7/16 at 8:56 AM that Resident #1 was on Oxycodone every 6 hours for chronic pain. He stated no one had informed him that the resident had a negative urine drug screen for opiates in ER on 3/13/16. He stated the codeine should show up in the urine up to two or three days after the last dose of codeine was taken. Stated he has had questionable results from the hospital urine drug screen in the past and unless confirmatory testing was done, he was not concerned about possible diversion in a case like this. The physician stated he would have liked to have been notified of the results. On 4/7/16 at 4:35 PM Nurse # 2 stated in an interview that she re-admitted the resident back into the facility from the hospital on 3/13/16. She stated she took off the resident ' s orders and reviewed the paperwork and noted a section concerning pain medicine with a negative drug screen done. She stated she had told the other nurses that it was weird that the drug screen was	F 309	medications that toxicology report was negative, was initiated by the DON and will be completed on 4/24/16. All newly hired license nurses will be inserviced regarding the nurse must review the hospital packet when a resident returns from the hospital for re-entries and ER visits. Any pertinent information to include labs and toxicology reports is to be verbally reported to the DON. The hospital packet will be placed in the DON□s door for review. Immediate reporting to the DON residents on scheduled opiate medications that toxicology report was negative by the DON during orientation. The hall nurse will review the information packet for residents being re-admitted or returning from the ER visit to include the discharge summary. If resident was negative for opiates and received scheduled opiate medication the hall nurse will immediately notify the DON for all concerns and place a copy of the hospital information packet in the DON□s box. The DON will review all re-admissions and ER visits hospital packets, discharge summary, History and Physical and lab results to ensure that if resident was negative for opiates and received scheduled opiate medication that DON was notified and lab results were followed up with an investigation and MD notification weekly X 8 weeks then monthly X1, using a Hospital visit review tool. The Administrator will initial and review the Hospital visit QI Tool to ensure all concern were addressed. The Director of Nursing will compile the results of the Hospital visit QI Tool and	

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F 309	Continued From page 3 negative with the resident on scheduled pain medication. She stated she did not call the DON about the results that night because it was not " life or death " and she understood that the MDS nurse would review all hospital/ER records and she would report all irregularities up the chain of command as needed. Nurse #2 stated she put the packet under the MDS door before leaving work the evening of 3/13/16. The MDS nurse stated in an interview on 4/7/16 at 9:55 AM that when a resident comes back from the ER or hospital the admission nurse gets a packet from the hospital and she processes the new orders and then sends the packet to medical records for scanning of documents and then the MDS nurse for review. The nurse stated she had noted the negative urine drug screen for opiates lab result and had done a generic on line search for information regarding reliability of urine drug screens. The nurse stated she then determined the negative urine drug screen was not an unusual or concerning result and dropped the issue. The MDS nurse stated she did not notify anyone including the DON or pharmacist of the results. The DON stated in a joint interview with the Administrator on 4/7/16 at 9:05 AM that when a resident returned to the facility from the ER, there would be a packet of information and new orders that would come with them. She stated the receiving nurse reviews the packet for medication changes or orders and she expected the nurse to put those changes in place before sending the packet to medical records and then to the MDS nurse. The DON stated the MDS nurse looked at all new hospital packets and she would review them to see if any changes need to be made.	F 309	present to the Quality Improvement Committee Meeting monthly x 3 months. 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 309	Continued From page 4 The DON stated the MDS would notify her by email or phone of any changes and also make MDS changes as needed. The DON stated she knew Resident #1 was on scheduled oxycodone but was not aware that the urine drug screen done at the hospital on 3/13/16 was negative for opiates. The DON stated she would have liked to be notified even if the MDS nurse had done her research and she would have consulted the pharmacist and her nurse consultant as to what should be done in this situation. The DON verified the information packet received from the ER and verified the urine drug screen results were part of the packet the facility had received. The administrator stated in a joint interview with the DON on 4/7/16 at 9:05 AM that he was not aware of the negative drug screen report and would have recommended a 24 hour suspicion of crime report be started if he had known. The pharmacist stated in an interview on 4/7/16 at 10:15 AM that she had not been notified Resident #1 had a urine drug screen negative for opiates. She further stated that there had not been any report of missing narcotics at the facility.	F 309		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		4/25/16

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F 514	Continued From page 5 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and pharmacist interviews, the facility failed to record administration of a prescribed narcotic medication on the Medication Administration Records (MAR) for one of three residents (Resident #1) reviewed that received narcotics and failed to consistently document verification of the narcotic count at shift change for 3 of 3 carts reviewed for March and April 2016 (100, 200, and 400 Hallway carts). Findings included: The facility's policy and procedures for the medication administration record (MAR) read in part that " all medication doses shall be charted immediately following administration, on the Medication Administration Record (MAR). " The facility ' s policy and procedure for controlled substances dated 10/1/15 stated " all controlled substances shall be counted at each shift change and reconciled to the declining inventory sheets by at least two staff members who are authorized to administer medications, preferably the staff member taking charge and the staff member relinquishing charge of these substances. " The policy and procedure further stated " After reconciling each controlled substance, the staff member going off shift and the staff member going on-shift shall sign their name on the	F 514	The Director of Nursing notified the MD on 4/13/16 that the facility failed to record the administration of a prescribed narcotic medication on the Medication Administration Record (MAR) for resident #1. No new orders were obtained. Nurse #1, #2 and #3 were in-serviced on documentation on the shift change control substance count sheet to include documenting Date, Time of Count, Signature of Staff On, Signature of Staff Off, Total # of Count Sheets, Count change Reason Code at each shift change on 4/19/16 by the DON. 100% audit of all current resident (MARs) who received Controlled Substances and Controlled Substance count sheet, to include resident #1 was initiated on 4/8/16 by the Facility Consultant and the Director of Nursing to ensure the nurse signed out the narcotics on the residents Control Substance Count sheet to include Quantity Start, Date Given, Time Given, Quantity Given, Given By or Destroyed By Quantity Destroyed, Method Destroyed, Witnessed By if Destroyed, Quantity Left at time of pulling Controlled Substance and initialed the front of the MAR that the narcotic was administered was completed on 4/21/16. The Director of Nursing	

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F 514	Continued From page 6 Shift-change Controlled Substance Count Check form. " Resident #1 was admitted to the facility on 7/1/14 from an acute hospital setting with diagnosis of chronic pain and arthritis. The Care Area Assessment (CAA) Summary dated 7/24/15 stated the resident was frequently in pain. The Minimum Data Set (MDS) Assessment dated 1/11/16 documented the resident was moderately cognitively impaired and able to make herself understood and understand others. The MDS further documented the resident received both scheduled and prn pain medication and was frequently in mild pain that did not affect her sleep or daily activities. The resident ' s care plan updated 1/12/16 listed pain as an area of focus with staff interventions to document complaints and non-verbal signs of pain, to administer pain medication as per physician orders, to give prn medication for breakthrough pain and note the effectiveness and to notify the physician if pain management ineffective. On 2/15/16 a physician order was written for " Oxycodone 5 mg (milligram) i (one) tab (tablet) po (by mouth) Q6H (every six hours). " On 3/13/16 a physician order was written to " D/C (discontinue) Oxycodone 5 mg/tab i tab (tablet) po Q6 scheduled for pain and start Oxycodone 5 mg/tab, take po (by mouth) prn (when necessary) for pain Q6H. " A complete review of the Resident #1 ' s paper	F 514	immediately addressed all identified areas of concern. In-servicing of 100% Licensed Nurses, to include nurses #1, #2, and #3, was initiated by the DON on 4/7/16 regarding initialing the front of the MAR immediately after administration of medications to include narcotics, Declining count sheet, proper documentation on signing out narcotics, and shift change Narc sheet counts, Count change Reason Code at each shift change and ensuring that the number of sheets to the right column is accurate and if you add or take away a sheet-make sure you explain why, was completed on 4/16/16. The in-service was expanded on 4/19/16 to all licensed nurses, to include nurse #1, #2 and #3 by the DON, to include documenting on the Shift Change Controlled Substance Count Check sheet the Date, Time of Count, Signature of Staff On, Signature of Staff Off, Total # of Count Sheets, Count change Reason Code at each shift change and on the residents Control Substance Count Sheet the Quantity Start, Date Given, Time Given, Quantity Given, Given By or Destroyed By Quantity Destroyed, Method Destroyed, Witnessed By if Destroyed, Quantity Left at time of pulling Controlled Substance, will be completed on 4/24/16. All newly hired license nurses will be in-serviced regarding initialing the front of the MAR immediately after administration of medications to include narcotics, documenting on the Shift Change Controlled Substance Count Check sheet the Date, Time of Count, Signature of	

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F 514	Continued From page 7 and electronic chart for March 2016 revealed from 3/1/16 to 3/12/16 two out of forty eight scheduled oxycodone doses signed out on the Controlled Substance Receipt Count Sheet as given were not documented on the resident ' s March MAR (3/8/16 11:30 PM, 3/12/16 6:00 AM). The review further revealed from 3/13/16 to 3/31/16 ten out of thirty five prn oxycodone doses signed out on the Controlled Substance Receipt/Count Sheet as given were not documented on the resident ' s March MAR (3/17/16 12:20 PM, 3/18/16 9:30 AM, 3/18/16 4:00 PM, 3/20/16 12:00 AM, 3/21/16 8:00 AM, 3/22/16 8:00 AM, 3/23/16 8:00 AM, 3/25/16 10:00 AM, 3/27/16 8:00 AM, 3/28/16 8:30 PM). Nurse # 1 stated in an interview on 3/23/16 at 2:52 PM that she had given Oxycodone 5 mg po to Resident #1 on 3/18/16 at 4 PM and had signed it out on the Controlled Substance Receipt/Count Sheet but had failed to document giving the medication on the MAR. Nurse # 2 stated in an interview on 3/23/16 at 3:16 PM that she gave Oxycodone 5 mg po to Resident #1 on 3/17/2016 12:20 and 3/18/2016 9:30 AM and had signed it out on the Controlled Substance Receipt/Count Sheet but had failed to document giving the medication on the MAR. Since the interview on 3/23/16, a further review was conducted and it was noted that Nurse #2 had documented on 3/21/16 8 AM, 3/22/16 8 AM, 3/23/16 8 AM and 3/27/16 8AM she gave Oxycodone 5 mg to Resident #1 and had signed the administration of the drug out on the Controlled Substance Receipt/Count Sheet, but failed to document giving the mediation on the MAR.	F 514	Staff On, Signature of Staff Off, Total # of Count Sheets, Count change Reason Code at each shift change and on the residents Control Substance Count Sheet the Quantity Start, Date Given, Time Given, Quantity Given, Given By or Destroyed By Quantity Destroyed, Method Destroyed, Witnessed By if Destroyed, Quantity Left at time of pulling Controlled Substance during orientation by the DON. The Quality Improvement Coordinator will audit Controlled Substance Count Sheets for completed documentation and compare to the resident□s MAR for 10% of residents receiving narcotic medications to include resident #1, 3 x per week for 4 weeks, then weekly for 4 weeks, then monthly for 1 months utilizing the QI Tool: Controlled Substance (CS) Sheet Documentation Monitoring to ensure that the administration record is accurate. Re-training and Physician notification will be conducted by the Quality Improvement Coordinator immediately for any identified areas of concern. The Quality improvement nurse will audit the Shift change control substance count sheet 3x per week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month to ensure each area is documented at shift change to include the nurse□s signature utilizing the Shift Change Count Sheet QI Tool. Re-training will be conducted by the Quality Improvement Coordinator immediately for any identified areas of concern. The Director of Nursing will review and initial the CS weekly x 8 weeks then monthly x 1 months for completion and to ensure all	

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F 514	Continued From page 8 Nurse # 3 stated in an interview on 3/24/16 stated she gave Oxycodone 5 mg po to Resident #1 on 3/3/20/16 at 12 noon and had signed it out on the Controlled Substance Receipt/Count Sheet but had failed to document giving the medication on the MAR. Two nurses were not available after multiple attempts to verify their administration/documentation of oxycodone to Resident #1. The Director of Nursing stated in an interview on 3/10/16 at 3:58 PM that she expected the nurses to always document the administration of narcotics on both the Controlled Substance Receipt/Count Sheet and the MAR. In an interview with the consultant Pharmacist on 4/7/16 at 10:15 AM, she stated she expected the nurses to sign out narcotics on the both the Controlled Substance Receipt/Count Sheet and the MAR. Medical Record Review of the Shift Change Controlled Substance Count Check sheets for March and April 2016 for 100, 200, and 400 Medication Carts revealed multiple empty spaces that did not have a nurse ' s signature at shift change count. The administrator stated in an interview on 3/10/16 at 4:10 PM that the nurses should document per the policies and procedures that are in place. In an interview with the consultant Pharmacist on 4/7/16 at 10:15 AM, she stated in between shift change two nurses have to verify that the number	F 514	areas of concern were addressed. The Director of Nursing will compile the results of the CS Documentation QI Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. 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 514	Continued From page 9	F 514		

on the declining count sheet was the same as the number left in the inventory. She further stated that if a nurse is working more than one 8 hour shift then that nurse is expected to count when she ends her shift with the oncoming nurse. The Pharmacist stated she expects that each nurse who counts should document their signature on the Shift Change Controlled Substance Count Check form.

The Director of Nursing stated in an interview on 4/7/16 at 11:57 AM that at the change of shift, the on-going and off-going nurses verify together that the sheets (Controlled Substance Receipt/Count Sheets) and the pill count match. The DON stated if the count matches, both nurses are to sign their signature on the Controlled Substance Shift Change Sheet. After review of the sign out sheets for March and April 2016 the DON stated that the nurses had not always signed out at the shift change and should have.