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
	345168	A. BUILDING ______ B. WING ______	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREENVILLE	2910 MACGREGOR DOWNS GREENVILLE, NC 27834

(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, resident interview and staff interviews, the facility failed to administer a scheduled pain medication for 1 of 1 resident reviewed with pain (Resident #2). Findings included: Resident #2 was admitted to the facility on 9/2/16 and re-admitted on 9/6/16 with diagnoses including total knee Arthroscopy, aftercare following joint replacement surgery, Osteoarthritis, muscle weakness and Cellulitis. Review of the Admission Minimum Data Set Assessment, dated 9/13/16, identified Resident #2 as cognitively intact with a Brief Interview for Mental Status score of 15 out of 15. Resident #2 had no behaviors and did not refuse care. Section J - Health Conditions documented Resident #2 ' s pain frequency as almost constant. Resident #2 ' s pain ' s effect on function documented pain made it hard to sleep at night. The resident rated the pain level at a 9, on a scale of 1 being the least and 10 being the highest. Review of the Care Area Assessment dated 9/13/16 triggered for pain related to 1) pain made it hard for the resident to sleep at night, 2) resident #2 had limited day-to-day activities because of pain, 3) pain numeric intensity rating was valued at a 9, and 4) pain frequently was almost constant. Review of the plan of care dated 9/2/16 documented pain as a problem related to incisional pain and status post total knee	F 333	Please accept this Plan of Correction as Golden Living Center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement with the findings of noncompliance. The Plan of Correction is being provided pursuant to Federal and State requirements which require an acceptable Plan of Correction as a condition of continued certification. As has been our practice, the facility will continue to ensure residents are free from significant medication errors. 1) Resident #2 is no longer in the facility. He discharged safely home on 9/22/2016. Home health services were arranged by the facility, and the resident was provided with appropriate prescriptions by the Doctor prior to discharge. 2) All residents have the potential to affected by the alleged deficient practice. A 100% audit of all resident medication administration records to determine if all medications are available will be completed by 10/18/2016. Any medication identified as not available will be addressed immediately, to assure	10/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/11/2016

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 333	Continued From page 1 replacement. Interventions in relieving pain included Dilaudid 2 milligrams, one, by mouth, every four hours as needed (PRN) for pain. Review of the Physician ' s Progress Note dated 9/2/16 documented Resident #2 underwent a left Total Knee Arthroplasty on 8/30/16. The review of systems documented resident reported pain to left knee, relieved with current medications. Review of the Physician ' s admitting orders dated 9/2/16 documented an order for Dilaudid (used to relieve pain) 2 milligrams (mg) by mouth every four hours as needed for pain (PRN). The entry was added to the computers electronic Medication Administration Record (eMAR) at 12:19 PM. Review of the eMAR showed Resident #2 received Dilaudid 2 mg on 9/2/16 at 4:15 PM for a pain level of 9. Review of the Physician ' s orders documented the order for Dilaudid 2mg every 4 hours PRN was discontinued on 9/2/16 at 7:36 PM. Review of the Physician ' s Orders dated 9/2/16 documented an order for Dilaudid 2 mg by mouth every 4 hours for pain. The order was entered on the eMAR at 7:36 PM on 9/2/16. This order was a scheduled medication. Review of the eMAR documented Resident #2 received Dilaudid 2mg by mouth at 8:00 PM. There was no documentation of pain level. Further review of the eMAR showed Resident #2 did not receive the scheduled Dilaudid at 12:00 AM on 9/3/16 and did not receive the scheduled Dilaudid at 4:00 AM on 9/3/16. The entry on the eMAR documented the staff initials and the number 7. The chart codes listed at the bottom of the eMAR documented the #7 as see nursing notes. Review of the Nursing note dated 9/3/16 at 11:14 am documented Resident #2 had increased pain	F 333	availability. 3)All nurses will be inserviced by 10/21/2016 to assure all Physician medication orders are followed as written. In the event a ordered medication is not available, the nurse should contact the Attending Physician immediately for instruction. In the event the Attending physician does not contact the nurse within 15 minutes, the Nurse should contact the Medical Director, who will serve as the Emergency Physician, for instruction. In the event the Medical Director does not contact the Nurse within 15 minutes, the resident should be sent the Emergency Room for evaluation and treatment. 4) Audits on 100% of all medication availability will be conducted by the DNS, ADNS, and the Unit managers once per week for 4 consecutive weeks to assure compliance. These audits will be submitted to the Administrator for review, with findings discussed in the Monthly QAPI meeting for recommendations.Plans will be adjusted according to the results and success of the plan implemented. The audits will continue after the first 4 weeks of audits are completed , occurring once per month. Those findings will be discussed at the QAPI meeting for recommendations until substantial compliance is achieved, as determined by the QAPI Committee.	

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F 333	Continued From page 2 in his left knee. There was a documentation of pain level at a 10. Review of the Nursing note dated 9/3/16 at 12:04 AM documented the medication was not on the medication cart, there was none available in the medication dispensing system and there was no ekit (emergency kit) approval. The note documented a call to the on call physician was made to telephone in new script to the pharmacy. There was no documentation of a return call from the physician. Further review of the Nursing note dated 9/3/16 at 5:50 AM documented the medication was not on the cart, not in the dispensing system and there was no ekit approval to remove the medication. The noted documented a call was placed to the on call physician. There was no documentation of a return call from the physician. Review of the Nursing note dated 9/3/16 at 2:39 PM documented Resident #2 was in his room at 8:00 AM on 9/3/16 and he was noted with facial grimacing. The note documented the resident stated he was extremely upset and that he had not been getting his pain meds as he needed them. There was no documentation of a pain level. Review of the Pain Level Summary form showed there were no documented pain assessments of Resident #2 ' s pain level after 9/2/16 at 4:15 PM until 9/3/16 at 11:14 AM. During a telephone interview with Resident #2 on 9/29/16 at 1:34PM he stated at times the nurse would tell him the computer said the medication wasn ' t in and staff told him their in house pharmacy was restocked from Georgia. He stated he had never heard of such a system. He stated if a medication was not in you had to wait. He stated his pain was high and the nurse never offered any other medication to help. He stated	F 333		

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F 333	Continued From page 3 he had been operated on before and did not remember ever going through anything like this. He stated during his first night in the facility he kept thinking of ways he could get something to help him get through the night. He further stated he felt he had needless suffering and he did not have the operation to have needless suffering. During an interview with Nurse #2 (who had worked with Resident #2 on 9/3/16 on the 11PM through 7AM shift) on 9/29/16 at 1:40PM, via telephone, she stated the e-kit is Alixia (dispensing system). She stated if a medication is not on med cart we have to place a call to the physician and receive an order before a medication can be released from the dispensing system. She stated she was not sure of any pain Resident #2 was having, but thought he was more stable without medications. She stated if he had been in pain that was uncontrolled than he would have been sent to the emergency room if the facility did not receive a release from the physician to pull medications from the dispensing system. During an interview with the pharmacist on 9/29/16 at 3:03PM she stated she could not speak a lot regarding the dispensing system because she was not in the dispensing department. She stated medications are delivered once daily and do come from Georgia. She stated there are situations where meds can be obtained from the back up pharmacy but with a controlled substance, like Dilaudid, it may be difficult. During an interview with the Administrator on 9/29/16 at 1:50PM he stated that 95% of meds are in house when a resident is admitted and if a medication is not here it is called in and delivered no later than the next morning. During an interview with the Director of Nursing	F 333		

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F 333	Continued From page 4 on 9/29/16 at 1:54PM she stated Dilaudid is kept in the dispensing system but Resident #2 may not have been admitted with a " hard script " since it was a narcotic. She stated after the pharmacy fills the prescription you cannot pull medications from the dispensing system. The medications would be delivered on the next day ' s drop off. She further stated, in this circumstance, the nurse should have continued to call the physician. If she was unable to reach the physician she should have called me or medical director. During an interview with the Nurse Practitioner on 9/29/16 at 2:00PM she stated she did see Resident #2 on admission and he was very particular about his pain medication. He had a history of pain and Dilaudid worked for him. She further stated she would have expected that he would have needed pain medication during those 8 hours. During a second interview with the Administrator on 9/29/16 at 4:02PM he stated the facility policy read when you have new admission by the next day the medication is expected to be " in house. " He stated it was fixed the next day. He stated he wished the facility would have had the medications for him but it was midnight and the nurse made two attempts to call the physician. During a follow up interview with the Administrator on 9/29/16 at 4:41PM he stated the facility did have a hard script and it was faxed to the pharmacy and the pharmacy filled the prescription somewhere between 7 PM and 9 PM on 9/2/16. He further stated, yes, we did not control his pain, but we were waiting on delivery the next morning. During an interview with Nurse #1 on 6/29/16 at 4:49pm she stated she worked the evening shift on 9/2/16. She stated she pulled Dilaudid from the dispensing system for the 4:15PM and	F 333		

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F 333	Continued From page 5 8:00PM medication pass because Resident #2 did not come in with any meds on admission. She stated Resident #2 was having pain and he wanted his pain meds every four hours.	F 333		