STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTHCARE AND REHABILITATION CENTE	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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 CI. Event ID X7SL11.	F 000	Britthaven acknowledges receipt of the Statement of Deficiencies and purposes 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 the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Britthaven's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Britthaven reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident,family and staff interviews, the facility failed to determine the ability to self administer over the counter Tums medication for one of one sampled residents (Resident # 1) The findings are: Resident # 1 was admitted to the facility on 12/21/10 and was readmitted on 01/12/11. Diagnoses included Stage IV chronic kidney disease, Wegeners granulomatosis, and esophageal reflux among others. The most recent Minimum Data Set (MDS) indicated the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident is cognitively intact. A facility policy entitled " Self Administration of Medications" reads in part " Residents who are competent and physically able to self administer their medications if 1. The self administration is ordered by the physician and documented in the resident's record and " the interdisciplinary team	F 176	F176 The TUMS were removed from Resident #1's room on 02/23/11 by the Licensed Nurse. Follow-up occurred with Resident #1's MD on 02/23/11 with no new orders received for self administration of medication to include over the counter TUMS. A 100% check of residents' rooms was conducted on 02/24/11 by the facility staff with no medications to include over the counter medications found. An in-service for all staff will be completed to observe for medications to include over the counter medication in residents' rooms and the process for self administration of medication if residents desire by the SDC by 03/23/11. The QI nurse will monitor residents'	02/23/11 02/24/11 03/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ✓ William E Hennis | TITLE ✓ administrator | (X6) DATE ✓ 3/16/11

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.

RECEIVED
MAR 17 2011
BY: DRL

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F 176	Continued From page 1 assess the resident ...to determine that the resident is competent, and the attending physician shall be contacted to request a specific order for self administration of the medication." A facility form absent of a title reads in part "Each resident's physician to order treatments and medications, injections, creams ointments, inhalers...and any other form of oral/external medications for each individual resident." The form further reads " No resident is allowed any medication other than what the physician orders and the facility provides, therefore, no medication is to be allowed into the facility, other than what is provided by the facility." The record was reviewed for Resident #1 and contained a physician order dated 02/11/11 for Tums 2 tablets every two hours as needed for chest/esophageal gastroesophageal reflux(GERD). The Medication Administration dated 02/01/11 to 02/28/11 indicated the resident received a single dose of Tums as ordered on 2/12/11. The record contained a care plan dated 12/29/10, and reviewed on 01/25/11 with no indication of self medication administration. Resident # 1 was observed to have a bottle labeled Tums on her overbed table on 2/22/11 at 12:10 pm, 2/22/11 at 12:20 pm, 2/23/11 at 10:00 am and 11:10 am. The container was next to items such as tissues and food trays during the observations. Resident # 1 indicated during the observations on 2/22/11 and 02/23/11 she takes one or two Tums usually after she eats, and reports to the nurse that she has taken the Tums. Licensed Nurse # 2 was interviewed on 02/23/11	F 176	rooms to include Resident #1 for medications to include over the counter medications using a QI audit tool for 3 to 5 times for 1 week then weekly for 3 weeks and monthly for 3 months. Follow-up action as appropriate will be taken immediately by the QI nurse upon the identification of any potential concern with medications to include over the counter medication. At admission, residents and/or residents' representatives will be informed of the evaluation process and requirements for self administration of medications to include over the counter medication if the resident desires by the Admission Coordinator and/or Social Worker. Results of the audits will be reviewed monthly by the QI committee for follow-up action for potential issues as deemed necessary and to determine the need for and/or frequency of continued monitoring.	

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F 176	Continued From page 2 at 1:10 pm and stated she had no knowledge of the resident having the Tums in her room. The Director of Nurses(DON) was interviewed on 2/23/11 at 12:55 pm and stated the facility has to have a doctor's order for residents to self administer any medication and the care plan should indicate self administration. She further indicated Resident # 1 did not have an order to self administer the Tums. She also indicated that upon admission family members sign that no medication is to be brought to the facility for the residents. Additionally, the nurse on the floor was not aware of the bottle of Tums in the room of Resident # 1. The physician assigned to care for Resident # 1 was interviewed on 02/23/11 at 1:40 pm and stated Resident # 1 was not reliable for interview.	F 176		
F 281 SS=E	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 medical record review, hospital records, observations and interviews with staff and residents the facility failed to follow physician orders for medication administration (Residents # 4, #5, #8) and by not reporting elevated blood glucose levels (Resident #3). This affected four (4) of nine (9) sampled residents. (Residents #3, #4, #5, #8) The findings are:	F 281		

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F 281	Continued From page 3 1. Resident #4 was admitted from an acute care hospital to the facility 2/10/11 with diagnoses that included severe osteoporosis. Medical records from the hospital indicated that during the 2/7/11 admission process to the hospital Resident #4 reported that Fosamax was included in medications taken at home. Although the physician did not include Fosamax in the drug regimen during the three day hospital stay it was included in the list of discharge medications to the facility on 2/10/11. Facility admitting physician orders included Fosamax, 70 milligrams every week. The staff nurse that recorded the Fosamax on the resident's February 2011 Medication Administration Record (MAR) blocked off February 13th and 21st as days for the Fosamax to be given; with the administration time recorded as 6:30 A.M. Review of other medications on the resident's MAR noted the time listed to administer the medication was highlighted in one of three different colors; with each color representing one of three shifts (7-3: 3-11: 11-7). However, the 6:30 beside the Fosamax was not highlighted like the time for all other medications on the MAR for Resident #4. Review of the February MAR for Resident #4 noted the Fosamax was initialed as given on 2/21 but not initialed as given on the 13th. On 2/23/11 at 2:00 P.M. Licensed Nurse #2 pulled the Fosamax for Resident #4 from the medication cart. The Fosamax was dated 2/11/11 and three of four tablets dispensed from the pharmacy were in the box. Resident #4 was identified by the facility as alert, oriented and interviewable. The Minimum Data Set (MDS) dated 2/17/11 confirmed Resident #4 had no problems with short or long term memory.	F 281	F281 Resident #4 was reviewed by the DON for administration of medication as ordered with MD notification on 02/23/11 as appropriate. No new orders were received. Resident #5 was reviewed by the DON for administration of medication as ordered with MD notification on 02/23/11 as appropriate. No new orders were received. Resident #8 was reviewed by the DON for administration of medication as ordered with revision of the medication administration record with MD notification on 02/24/11as appropriate. No new orders were received. Resident #4's (per list is #3) physician was notified by the DON of the CBGs on 02/23/11 with revision of orders received. A 100% audit of all MARS/MD orders was completed on 02/28/11 by the DON/ Administration Nurses with no issues identified. All residents with order for CBG's were reviewed for Sliding scale parameters on 02/23/11 by the DON/Administrative Nurses with follow up action taken as appropriate. An in-service for all nurses and medication aides on the proper administration of	02/23/11 02/23/11 02/24/11 02/23/11 02/28/11 02/23/11

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F 281	Continued From page 4 In an interview on 2/23/11 at 2:10 P.M. Resident #4 reported she took the Fosamax at home every Thursday. Resident #4 stated the last dose she took was Thursday, February 3rd prior to admission to the hospital on February 7th. On 2/24/11 at 1:00 P.M. the Director of Nursing (DON) stated the Fosamax was supposed to be given at 6:30 A.M. by staff working the 11PM-7AM shift. The DON attempted to talk with licensed staff that worked third shift on 2/13/11 (when Resident #4 did not receive the Fosamax). On 2/24/11 at 2:30 P.M. the DON stated it appeared the Fosamax had not been given on the 13th and could offer no explanation for the omission of the medication. The DON stated although the time of administration of the Fosamax was not highlighted on the resident's MAR she expected nursing staff to review all medications to ensure they were given to residents as ordered. 2. Resident #5 was admitted to the facility 2/14/11 with medication orders that included Monistat, 100 grams every day X 7 days. Review of the February 2011 Medication Administration Record (MAR) noted the first dose of Monistat was given 2/15/11 and the medication was signed as given through 2/23/11; for a total of nine doses. On 2/24/11 at 9:55 A.M. the Monistat for Resident #5 was removed from the medication cart by Licensed Nurse #1. The package of Monistat included seven total doses dispensed, with two of the seven doses remaining. Licensed Nurse #1 (working on the hall Resident #5 resided) stated the Monistat had not been given yet for the day and one of the two remaining doses would be	F 281	medication per MD orders by the SDC will be completed by 03/23/11. The night shift nurse will check new MD orders and the Medication Administration records for all residents to include Residents #4, #5, and #8 to ensure that all medications are transcribed and administered as ordered by the MD by initialing the last order received. The QI Nurse will monitor the initialing of the second check of the medication orders to include Residents #4, #5 and #8 and monitor for any new orders for CBGs without parameters and the notification of the physician of results to include Resident #4 (listed as #3) 3-5 times for 1 week, weekly for 3 weeks then monthly for 3 months utilizing a QI audit tool. The QI nurse and/or the DON will follow up on any potential issue upon identification as indicated. Results of the audits will be reviewed monthly by the QI Committee for follow up action for potential issues as deemed necessary and to determine the need for and/or frequency of continued monitoring.	03/23/11

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F 281	Continued From page 5 used. Licensed Nurse #1 could not explain how seven doses were dispensed; nine doses were signed as administered and two doses were remaining in the package. The Director of Nursing (DON) was present at the time of the observation and could not offer any explanation why the dose was signed as given greater than seven days (as ordered by the physician) and/or why nine doses could be signed as given from a package dispensed containing seven doses that had two doses remaining. 3. Resident #8 was admitted to the facility 2/11/11 for rehabilitation services after knee surgery. Admission orders included Lortab (pain medication) every four hours as needed. On 2/12/11 the order for Lortab was changed to include an additional order of 2 Lortab every four hours as needed for severe pain. On 2/16/11 the physician wrote an order to discontinue all orders for Lortab and give Lortab 5/325 every four hours and an additional Lortab every six hours as needed for breakthrough pain. Review of the February 2011 MAR for Resident #8 noted the 2/11/11 and 2/12/11 orders were properly transcribed on the MAR. However, the 2/16/11 order only included the scheduled Lortab every four hours. The additional Lortab every six hours as needed for breakthrough pain was not included on the MAR. Resident #8 was identified by the facility as alert, oriented and interviewable. The Minimum Data Set (MDS) dated 2/18/11 confirmed Resident #8 had no problems with short or long term memory. On 2/24/11 at 12:30 P.M. Resident #8 stated the scheduled Lortab was fairly effective in managing her pain. Resident #8 stated although she does	F 281		

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F 281	Continued From page 6 have pain in between the four hour scheduled dose (to date) she had not needed to ask for an additional dose. In an interview on 2/24/11 at 2:30 P.M. the Director of Nursing (DON) stated the staff member that transcribed the order on the resident's Medication Administration Record (MAR) inadvertently left the "as needed" dose off the MAR. 4. Resident # 4 was admitted to the facility on 02/21/11 with diagnoses including Diabetes Mellitus. Review of the "Patient Transfer Form" used to communicate orders from the hospital setting to the facility, dated 02/21/11 included the following physician orders: Lantus (insulin) 42 Units every evening and Accuchecks (blood glucose monitoring test) before meals and in the evening. Review of the facility's Standing Physician Orders for Nursing Staff revealed in part the following; "If blood glucose is > (greater than) 200 mg/dl (milligrams per deciliter) and resident is not on sliding scale insulin, notify the physician." A review of Resident # 4's Medication Administration Record (MAR) revealed the following documentation of Accucheck results: · 02/21/11 at 9:00 p.m. 257 mg/dl · 02/22/11 at 6:30 a.m. 234 mg/dl, 11:30 a.m. 287 mg/dl, and 9:00 p.m., 326 mg/dl · 02/23/11 at 6:30 a.m. 202 mg/dl An interview on 02/23/11 at 1:55 p.m. with	F 281		

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F 281	Continued From page 7 Licensed Nurse (LN) #1 working with Resident # 4 on 02/22/11 and 02/23/11 day shift confirmed he did not notify the physician of Accucheck results greater than 200 mg/dl and also stated the physician should have been notified. During the interview, 02/23/11 at 2:00 p.m., the Director of Nursing (DON) confirmed Resident #4's Accucheck results on 02/21/11, 02/22/11, and 02/23/11 were greater than 200mg/dl. The DON confirmed LN staff should have call the physician, per Physician's standing orders, for Accucheck levels greater than 200.	F 281		
F 431 SS=D	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,	F 431		

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F 431	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility record review, the facility failed to ensure foil packages of inhaled medications were dated when opened in 2 (two) of 2 medication carts observed for expired and undated open medications. The findings are: 1. An information sheet dated 03/10 and titled "Medication Discard Dates" used by the facility as a guideline for storage and discard dates for medications read in part: "Inhaled Medications: DuoNeb Solution discard one week after foil pouch is opened." On 02/23/11 at 8:33 a.m. the medication cart on the 300 hall was observed to contain an open box of DuoNeb (a respiratory inhalation solution) with a foil pouch inside containing single-dose ready to use vials which had been opened, not dated and ready for resident use. An interview with LN #2 at 12:45 p.m. on 02/23/11 stated only certain inhaled medications required dating when the foil pouch was opened and	F 431	F431 The packages of inhaled medication that were open and undated were removed and discarded from the medication carts on 02/23/11 by the DON/Unit nurses. Any additional packages of inhaled Medication that were open and undated were also removed and discarded as appropriate by the DON/Unit nurses on 02/23/11. Replacement medications were obtained as necessary. An in-service on the proper labeling and dating of medications upon opening to include inhaled medications for all nurses and medication aides by the SDC will be completed by 03/23/11. The QI Nurse will audit the labeling and dating of all medications upon opening to include inhaled medications 3 to 5 times for one week, weekly for 3 weeks then monthly for 3 months utilizing a QI audit tool. Upon identification, any potential issue with the labeling and/or dating of any medication upon opening will be followed up on as necessary by the QI Nurse. Results of the audits will be reviewed monthly by the QI committee for follow up action for potential issues as deemed necessary and to determine the need for and/or frequency of continued monitoring.	02/23/11 03/23/11

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F 431	Continued From page 9 uncertain DuoNeb needed an open date. The Director of Nursing (DON) was interviewed 02/24/11 at 12:30 p.m. and indicated that it was her expectation that all medications should be dated when opened. She further indicated the "Medication Discard Date" information sheet is posted in the medication room next to the refrigerators as a reminder. 2. On 02/23/11 at 10:40 am an observation of the100 hall and odd 200 hall medication cart was conducted and contained two (2)opened boxes labeled Albuterol 0.083% which held opened and undated foil pouches, each containing six (6) individual dose vials for inhalation, one opened box labeled Ventolin/Proventil 0.083% which held an open, undated foil pouch containing eighteen (18) individual dose vials, and one opened box labeled Ipratropium bromide 0/017% / 3 mg albuterol sulfate 0.083% which held an opened, undated foil pouch containg seven individual dose vials. Each box was labeled for resident use. An interview with Licensed Nurse # 1 on 02/23/11 at 10:40 am revealed the foil packages should be dated when opened. The Director of Nursing (DON) was interviewed 02/24/11 at 12:30 p.m. and indicated that it was her expectation that all medications should be dated when opened. She also indicated the "Medication Discard Date" information sheet provided to the facility pharmacy was posted in the medication room next to the refrigerators as a	F 431		

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F 431	Continued From page 10 guide to determine when medications should be discarded once opened.	F 431		