STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 07/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TRACE REHABILITATION & NURSING CENTER	417 MOUNTAIN TRACE ROAD SYLVA, NC 28779

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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: Based on staff interviews and medical record review, the facility failed to administer available medications as ordered by the physician for one (1) of three (3) newly admitted residents (Resident #7). The findings are: Resident #7 was admitted 06/26/12 to the facility with diagnoses including chronic obstructive pulmonary disease, anxiety, and a history of anasarca (an accumulation of fluid in various body tissues). Review of the nursing admission assessment dated 06/26/12 revealed Resident #7 had no cognitive impairment. A review of Resident #7's medical record revealed physician's orders and a medication administration record (MAR) dated 06/26/12. The physician's orders included the following medications: Ativan (an antianxiety medication) 2 milligrams (mg) three times a day, Lasix (a diuretic medication) 40 mg twice a day, and	F 309	Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State law. F309 – Resident #7 is receiving Lasix, Potassium and Ativan per physician's order. All residents have the potential to be affected by this deficient practice although none were found to be affected.	

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

Elaine Elliott | Administrator | 7-31-12

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.

Original Signature Date: 7-30-12

RECEIVED
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BY:

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F 309	Continued From page 1 Potassium Chloride (an electrolyte replacement) 20 milliequivalents (meq) twice a day. A review of the MAR revealed the Ativan was scheduled for 8.00 AM, 1:00 PM, and 9:00 PM. The Lasix and potassium chloride were scheduled for 8:00 AM and 5:00 PM. Further MAR review revealed the 5:00 PM doses of Lasix and potassium chloride on 06/26/12 were not initialed as administered. The 9:00 PM dose of Ativan on 06/26/12 was not initialed as administered. An interview with Licensed Nurse (LN) #4 on 07/03/12 at 1:58 PM revealed Ativan was kept in an automated medication dispensing system located in the facility and provided by facility pharmacy. An interview with LN #3 on 07/03/12 at 3:40 PM revealed she was working on Resident #7's hall the evening of 06/26/12. She stated she did not have the MAR available to her and did not know medications were scheduled for 5:00 PM and 9:00 PM. LN #3 did not state why the MAR was unavailable. An interview was conducted with the Director of Nursing (DON) and the Corporate Consulting Nurse (CCN) on 07/05/12 at 11:18 AM. The CCN confirmed frequently used medications were kept in the automated medication dispensing system to include Lasix and Potassium Chloride. The DON stated she expected nurses to administer medications as ordered by the physician.	F 309	Re-education to the licensed staff by the Director of Pharmacy by 7/8/12 regarding the policy of obtaining medications from the pharmacy upon resident admission into the facility including utilizing medications from the Pyxis system. This education also included policy on administering new admission medications as ordered. An audit of current resident Medication Administration records will be completed by the Director of Nursing and the Assistant Director of Nursing by 7/ 31/12 to identify any medications not being administered per physician orders. An audit of current resident Medication Administration records will be completed by the Director of Nursing and the Assistant Director of Nursing comparing ordered medications with medications present in the medication cart for each resident. The pharmacy representative will conduct an audit of current resident medications present in each medication cart on 7/7/12. Any missing medications will be obtained as soon as possible. The Pyxus system contents were verified and medication replacements loaded into the system by the pharmacy representative on 7/10/12.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain			

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F 425	Continued From page 2 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff and pharmacy representative interviews and medical record reviews, the facility failed to obtain medications for two (2) of three (3) newly admitted residents. (Residents #6 and #7). The findings are: 1. Resident #6 was admitted to the facility 06/25/12 with diagnoses including fibromyalgia, chronic pain, and high cholesterol. A review of Resident #6's medical record revealed a nursing admission assessment dated 06/25/12 at 3:15 PM. The assessment specified the resident was alert and cognitively intact. A	F 309	The Director of Nursing or Assistant Director of Nursing will be responsible for maintaining the par levels in the Pyxis system on a weekly basis. The Director of Nursing or Assistant Director of Nursing will be responsible for completing an audit of the current resident MARs on a daily basis x 2 weeks, weekly basis x one month then monthly thereafter. New employees will receive same education upon hire. Agency contracted staff will receive the same education prior to working. The findings from the QA audits will be presented to the QA committee by the Director of Nursing or Assistant Director of Nursing monthly x 3 then quarterly thereafter to determine the need for additional monitoring and/or education. A planned directed In-service will be conducted by a licensed Pharmacist on July 30 and 31, 2012 for all licensed nurses. Compliance date 07/31/12	

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F 425	Continued From page 3 nurse's note written with the assessment indicated the resident was not in pain at the time of this assessment. A review of Resident #6's medical record revealed physician's orders and medication administration record (MAR) dated 06/25/12. The physician's orders included the following medications: Lyrica (a medication used to control pain) 75 milligrams (mg) four (4) times a day and Zedia (a medication used to lower cholesterol) 10 mg at bedtime. The MAR specified the Lyrica was to be administered at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. The Zedia was to be administered at 9:00 PM. Continued MAR review revealed the Lyrica was not initialed as administered until 4:00 PM on 06/26/12. The Zedia was not initialed as administered until 9:00 PM on 06/26/12. An interview with Licensed Nurse (LN) #2 on 07/03/12 at 2:50 PM revealed she admitted Resident # 6 and faxed medication orders that included Lyrica and Zedia to the facility pharmacy on 06/25/12 in the afternoon. An interview with LN #1 on 07/03/12 at 4:05 PM revealed medications routinely ordered from the pharmacy via fax in the afternoon were delivered to the facility around midnight. An interview with the facility pharmacy representative on 07/03/12 at 4:25 PM revealed the process the facility should utilize to obtain medications before the normal late night delivery was as follows: The facility should notify the pharmacy via telephone regarding medications needed that were not in the automated	F 425	Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State law. F425 – Resident #6 was discharged from the facility. Resident #7 is now receiving Requip and MS Contin per physician's order. All residents have the potential of being affected by this deficient practice although none were found to be affected.	

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F 425	Continued From page 4 dispensing system. The pharmacy in turn ordered the medication from a local pharmacy utilized as a backup and provided delivery of the medication to the facility. On 07/05/12 at 11:18 AM the Director of Nursing (DON) and the Corporate Consulting Nurse (CNN) were interviewed. The CCN confirmed only frequently used medications were kept in the automated medication dispensing system. Lyrica and Zedia did not fall in this category. The DON stated she expected licensed nurses to call the pharmacy for backup delivery if the medications were not available in the automated dispensing system and were needed before the routine pharmacy delivery. The DON added if the medication could not be obtained timely, she expected licensed nurses to notify the physician for orders to either omit a dose or substitute another medication. Continued interview via telephone with LN #2 on 07/05/12 at 2:16 PM revealed she was usually not in the facility when routine medication delivery was made by the pharmacy and was not aware of what time they arrived. LN #2 stated she was unable to recall education provided by the facility instructing nurses to call for backup medication delivery if medications were not available in the automated delivery system. LN #2 added she did not call the pharmacy for backup delivery regarding Resident #6's medication. 2. Resident #7 was admitted to the facility with diagnoses including restless leg syndrome, chronic pain, and a history of anasarca (an accumulation of fluid in various body tissues).	F 425	continued Re-education to the licensed staff by the Director of Pharmacy by 7/8/12 regarding the policy of obtaining medications from the pharmacy upon resident admission into the facility including utilizing medications from the Pyxis system. This education also included policy on administering new admission medications as ordered. An audit of current resident Medication Administration records will be completed by the Director of Nursing and the Assistant Director of Nursing by 7/31/12 to identify any medications not being administered per physician orders. An audit of current resident Medication Administration records will be completed by the Director of Nursing and the Assistant Director of Nursing comparing ordered medications with medications present in the medication cart for each resident. The pharmacy representative will conduct an audit of current resident medications present in each medication cart on 7/7/12. Any missing medications will be obtained as soon as possible. The Pyxus system contents were verified and medication replacements loaded into the system by the pharmacy representative on 7/10/12. The Director of Nursing or Assistant Director of Nursing will be responsible for maintaining the par levels in the Pyxis system on a weekly basis. The Director of Nursing or Assistant Director	

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F 425	Continued From page 5 A review of a nursing admission assessment dated 06/26/12 at 12:50 PM described Resident #7 with no cognitive impairment. A review of Resident #7's medical record revealed physician's orders and a medication administration record (MAR) dated 06/26/12. The physician's orders included the following medications: Requip (a medication used to treat restless leg syndrome) 5 milligrams (mg) at bedtime and MS Contin (a medication for pain control) 15 mg every twelve (12) hours. The MAR specified 9:00 PM as the time both of these medications were to be administered. Continued MAR review revealed the 9:00 PM doses on 06/26/12 were not initialed indicating the medications were not administered. An interview with Licensed Nurse (LN) #4 on 07/03/12 at 1:58 PM revealed MS Contin was not kept in an automated medication dispensing system located in the facility and provided by the facility pharmacy. An interview with LN #1 on 07/03/12 at 4:05 PM revealed she faxed Resident #7's medication orders to the pharmacy on 06/26/12 at 2:35 PM. LN #1 stated she also faxed a hand written MAR to the pharmacy on that date at 3:25 PM. She added the medications usually were delivered from the pharmacy to the facility around midnight. An interview with the facility pharmacy representative on 07/03/13 at 4:25 PM revealed the process the facility should utilize to obtain medications before the normal late night delivery was as follows: The facility should notify the pharmacy via telephone regarding medications	F 425	continued Director of Nursing or Assistant Director of Nursing will be responsible for completing an audit of the current resident MARs on a daily basis x 2 weeks, weekly basis x one month then monthly thereafter. New employees will receive same education upon hire. Agency contracted staff will receive the same education prior to working. The findings from the QA audits will be presented to the QA committee by the Director of Nursing or Assistant Director of Nursing monthly x 3 then quarterly thereafter to determine the need for additional monitoring and/or education. A planned directed in-service will be conducted on July 30 and 31, 2012 for all licensed nurses by a Registered Pharmacist. Compliance date 7/31/12	

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F 425	Continued From page 6 not in the automated dispensing system. The pharmacy in turn orders the medication from a local pharmacy utilized as a backup and provides delivery of the medication to the facility. Continued interview with LN #1 on 07/05/12 at 10:58 AM revealed she should have looked in the automated medication dispensing system to see what medications were readily available. She added she should have placed a telephone call to the pharmacy so the medications that were not available could be secured from a local backup pharmacy. An interview with the Director of Nursing (DON) and the Corporate Consulting Nurse (CCN) was conducted on 07/05/12 at 11:18 AM. The CCN confirmed only frequently used medications were kept in the automated medication dispensing system. Requip did not fall into this category. The DON stated she expected licensed nurses to call the pharmacy for backup delivery if the medications were not available in the automated dispensing system. The DON added if the medication could not be obtained timely, she expected licensed nurses to notify the physician for orders to either omit a dose or substitute another medication.	F 425		