STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HWY SYLVA, NC 28779

(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 514 SS=D	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 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 observation, medical record review and staff interview, the facility failed to ensure medications were accurately transcribed to the Medication Administration Record and available for administration as ordered for two (2) of ten (10) residents reviewed for unnecessary medication. (Residents # 11 and # 99). The findings are: 1. Resident #11 was admitted to the facility 10/18/10 with diagnoses that included Leukocytosis, Atrial fibrillation, Congestive Heart Failure and Anxiety with depression. Review of physician's orders for Resident #11 included an order dated 7/30/12 to increase Adderall to 10mg after breakfast and lunch every day. Review of the July and August 2012 Medication	F 514	This facility's response to this report of survey does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are filing the POC because it is required by law • F514 483.75 1. The attending physician was notified and drug regimen reviewed for resident #11 & #99 to ensure accurate medication administration record (MAR). For resident #11, the decision was made by the nurse practitioner to provide Adderall 5mg after breakfast and lunch. Resident #99 had their orders reviewed by the attending physician and an order was obtained to discharge the Nucynta. 2. Chart audits will be performed on current residents by September 21, 2012 by the director of nursing and/or her administrative team to assure accuracy of the medication administration record. In addition, the facility's physician orders will be verified with the E-Mar system and corrections made as needed by September 21, 2012.	Aug. 31, 2012 Sept. 21, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mistie Cooley — TITLE: Administrator — (X6) DATE: 9/14/2012

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 514	Continued From page 1 Administration Record (MAR) revealed Adderall 5mg one tablet after breakfast and lunch was listed and documented as administered from 7/16/12 at 2:00 PM through 8/29/12 at 2:00 PM. Review of physician progress notes revealed a note by the Psychiatric Nurse Practitioner dated 7/30/12 which indicated resident was acting more depressed and reporting increased anxiety and depression. The note indicated the Adderall was being increased to 10mg after breakfast and lunch. Observation on 8/29/12 at 2:30 PM revealed (Licensed Nurse)LN #1 administering Adderall 5mg one tablet by mouth to Resident # 11. On 8/29/12 at 3:12 PM LN #1 reviewed the physician's orders for Resident #11 and confirmed the current physician's order was for Adderall 10mg after breakfast & lunch. ON 8/29/12 at 4:21 PM the Director of Nursing (DON) reviewed the physician's orders for Resident #11 and confirmed the order to increase the Adderall dosage to 10mg after breakfast and lunch was the most recent order on the medical record. She also reviewed the July and August MARs and confirmed the dosage change had not been transcribed to the July 2012 or August 2012 MAR. On 8/30/12 at 2:50 PM the DON stated mid-July 2012 the facility transitioned from a paper MAR to an electronic MAR. Review of the July 2012 electronic MAR for Resident #11 revealed the transition to the electronic MAR started on 7/16/12.	F 514	3. The facility reviewed its E-MAR system and a system of triple check was implemented to assure accuracy of the medical record. This included the order being verified by 2 nurses and an administrative nurse. Nurses will be in-serviced by September 19, 2012 on system for triple check. The triple check system has also been added to our new nurse orientation check list to ensure the system is reviewed for all potential newly hired nurses. 4. The director of nursing and/or her administrative nurses will conduct monthly chart audits for three months and at least quarterly thereafter to ensure accuracy of the medical administration record. Findings of the audits will be presented through the facility QA program and addressed as necessary including additional and more frequent audits, retraining, and nurses will be held accountable in accordance with the facility's progressive disciplinary policy to ensure results are sustained.	Sept. 19, 2012

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F 514	Continued From page 2 On 8/30/12 at 5:48 PM the DON stated there is a triple check system for every new medication order that is received. The LN receiving the order removes the order from the chart and faxes it to the pharmacy. The LN working the 11 - 7 shift checks the new orders against the (electronic) E-MAR. The next day after the order is received, the DON checks the orders against the E-MAR. If the order is not in the E-MAR, she calls the pharmacy to inquire as to why the E-MAR hasn't been updated. The DON stated she thinks perhaps the pharmacy didn't get the fax with the new order and she and the LN working the 11 - 7 shift missed that it hadn't been entered in the E-MAR. The DON could not explain why it had been missed. 2. Resident #99 was admitted to the facility 3/22/12 with diagnoses that included neuropathy and osteoporosis. Review of physician progress notes for Resident #99 included a notation on 5/7/12 to change a pain medication to Nucynta every four to six hours as needed due to an intolerance to Oxycodone. Resident #99 was discharged to the hospital 6/3/12 and readmitted to the facility 6/6/12. Readmission orders 6/6/12 included to discontinue use of the Nucynta. Review of physician orders revealed on 6/14/12 an order to restart Nucynta, 50 milligrams every four hours as needed for pain. Review of the June 2012 Medication Administration Record (MAR) and controlled drug record revealed Resident #99 took 24 doses of	F 514		

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F 514	Continued From page 3 the Nucynta from 6/14/12 to 6/30/12. Review of the July 2012 MAR and controlled drug record revealed Resident #99 took six doses of Nucynta from 7/1/12 to 7/14/12. On 8/30/12 at 2:50 PM the Director of Nursing (DON) stated mid-July 2012 the facility transitioned from a paper MAR to an electronic MAR. Review of the July 2012 electronic MAR for Resident #99 revealed the transition to the electronic MAR started on 7/17/12. Review of July 2012 MAR for Resident #99 revealed the Nucynta was not listed as a medication available for use. Review of physician orders for Resident #99 revealed there were no orders to discontinue use of the Nucynta for Resident #99 since it was ordered on 6/14/12. Review of the August 2012 MAR for Resident #99 revealed the Nucynta was not listed as a medication available for use. On 8/30/12 at 3:00 PM the DON reviewed physician orders for Resident #99 and confirmed there had not been a physician's order to discontinue the Nucynta. The DON also reviewed the July and August 2012 MARs for Resident #99 and confirmed the Nucynta had been omitted from the MAR. On 8/30/12 at 3:30 PM the DON stated when the facility transitioned from paper MARs to electronic MARs licensed nursing staff reviewed the electronic MARs against the paper MARs for each resident. The DON stated she did not have a record to indicate which licensed nurse reviewed the electronic MAR for Resident #99. The DON stated the omission of the Nucynta should have been identified and could not explain why it had been missed.	F 514		

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

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