STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING _____ B. WING _____	C 07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGGIE VALLEY NURSING AND REHABILITATION	75 FISHER LOOP MAGGIE VALLEY, NC 28751

(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 the complaint investigation Event ID #6IP411.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		8/16/14

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

Electronically Signed | 08/14/2014

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and physician and staff interviews, the facility failed to procure lab results and make available to physician and medical staff for 1 of 5 residents sampled for unnecessary medication use. (Resident #19). The findings included: Resident #19 was admitted to the facility on 06/10/14 with diagnoses including chronic airway obstruction, urinary tract infection, site unspecified, and chronic obstructive asthma. Review of Resident #19's medical record revealed lab work was completed on 06/19/14. Notes documented on the lab sheet showed Resident #19 had been prescribed antibiotics for a urinary tract infection and pneumonia. Follow up phone orders were written on the lab sheet for a chest x-ray and a repeat complete blood count (CBC) to be done in one week. Further review of Resident #19's medical record revealed a physician order was written on 06/19/14 for repeat CBC to be completed and results provided to medical staff on 6/26/14. No CBC lab work or documentation from physician or nursing notes were observed in chart regarding a follow up CBC completed on or after 06/26/14. Interview with the quality assurance nurse (QA Nurse) on 07/23/14 at 11:09 AM revealed the facility was responsible for logging in lab work when completed which reminded her to ensure the results were reported back and reported to physicians and other medical staff in a timely manner so that residents could receive up to date treatment. QA Nurse stated she had documented	F 157	The lab results for Resident #19 were received by the facility on 7/24/14 and the results were within normal range. The family Nurse Practitioner was notified by the Quality Assurance Nurse of the results on 7/24/14, no further laboratory orders were obtained. Any resident requiring lab work could be affected, therefore current physician laboratory orders and documentation were reviewed by the Quality Assurance Nurse and the RN Supervisor on 7/24/14 comparing the physician order to the monthly laboratory log. Current residents were found to have physician laboratory orders up to date and documentation that the physician has been notified of results was present. The Quality Assurance Nurse and the RN Supervisor were re-educated by the Director of Nursing on 7/24/14 concerning procuring laboratory results and notification of the physician when results of the labs are obtained. The Quality Assurance Nurse will update the laboratory log on a daily basis. When a physician's laboratory order has been received, the RN Supervisor will do a second check to identify any discrepancies. The Staff Development Coordinator re-educated the licensed nurses on 8/14/14 on the policy and procedure for physician laboratory and physician notification. The results of	

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F 157	Continued From page 2 the lab order on 06/19/14 in physician's orders but could find no concurring lab results in Resident #19's chart. QA Nurse stated she had not followed up with lab to obtain lab results and had not provided results of lab work to the physician or other medical staff to ensure the treatment Resident #19 had received had been sufficient to resolve her infection. Interview with the facility physician on 07/23/14 at 1:40 PM revealed he had not been notified of results of Resident #19's repeat CBC after 06/26/14 and it was his expectation the facility nursing staff would ensure lab results were returned and provided to physicians and other medical staff in a timely manner. Follow up interview with the QA nurse on 07/23/14 at 2:34 PM revealed she had neglected to log the lab order into her logging system which ordinarily reminded her to follow up with the lab to get results in order to provide them to the physician and other medical staff. The QA nurse stated the missing lab sheet had been an oversight on her part.	F 157	these review will be taken to the monthly QAPI meeting for 3 months for review and recommendations by the Quality Assurance Nurse.	
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 observations, record review, and staff interviews, the facility failed to clarify conflicting instructions for a medication for 1 of 5 residents observed for medication administration. (Resident	F 333	Administration times for the medication ordered for Resident #11 were verified with the physician, and a clarification order was written by the Quality	8/16/14

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F 333	Continued From page 3 #11). The findings included: 1. Resident #11 was readmitted to the facility 05/07/14 with diagnoses which included esophageal reflux and a hip fracture repair. A review of Resident #11's medical record revealed a discharge medication reconciliation report from the hospital dated 05/07/14. The report included misoprostol (a medication used for the prevention of stomach ulcers) 200 micrograms (mcg) was to be administered by mouth after meals and at bedtime. The same order was observed on a physician monthly order dated 05/07/14 through 05/31/14. The Medication Administration Record (MAR) for 05/07/14 through 05/31/14 contained the same instructions for misoprostol with 9:00 AM, 1:00 PM, 6:00 PM, and 9:00 PM as times listed for administration. A review of physician monthly orders dated 06/01/14 through 06/30/14 and 07/01/14 through 07/31/14 was conducted. Misoprostol 200 mcg with instructions to administer the tablet before meals and at bedtime was observed on the orders. The MARs with corresponding dates contained the same instructions to administer before meals. The times the medication was to be administered were listed as 9:00 AM, 1:00 PM, 6:00 PM, and 9:00 PM. The MARs contained initials of nurses on each day through 07/23/14 which indicated the medication had been administered. On 07/23/14 at 8:36 AM, Nurse #1 was observed preparing and administering medications for	F 333	Assurance Nurse on 7/23/14. Any resident receiving medications at specific times can be affected, therefore the Director of Nursing verified the facilities times for medications given before and after meals on 7/23/14. A report identifying residents with medications given before and after meals was generated by the pharmacy and times were reviewed with clarification orders written by the Quality Assurance Nurse on 8/5/14. The pharmacy manager re-educated the pharmacists and technicians on administration times for medications given before and after meals on 8/15/14. Weekly reviews by the pharmacy manager will be performed to assess accurate/correct administration times for a total of 8 weeks. The results of these reviews will be shared with the facility Director of Nurses at the end of each month. The Facility Director of Nursing re-educated the licensed nursing staff on 8/5/14 and provided a copy of the facility's triple check policy and procedures for checking monthly medication administration records for accuracy. The pharmacy manager's results will be addressed during the monthly QAPI Meeting for 2 months for review and recommendations. The Quality Assurance Nurse will bring results of the	

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F 333	Continued From page 4 Resident #11. Misoprostol was not included in the medications administered at this time. An interview was conducted with Nurse #1 on 07/23/14 at 8:58 AM. The nurse stated she had noted the instructions to administer misoprostol stated to give the medication before meals. Nurse #1 added the times of 9:00 AM, 1:00 PM, and 6:00 PM were times used by the facility to note after meals. Nurse #1 stated she gave the medication before breakfast to follow the instructions on the MAR. The nurse added she always administered the medication before meals when she worked. Nurse #1 stated the times should have been changed to be consistent with the instructions. An interview was conducted with the Quality Assurance (QA) Nurse on 07/23/14 at 9:08 AM. The QA Nurse stated the facility physician followed the discharge medication reconciliation report from the hospital dated 05/07/14 for Resident #11's medication regime. She added she had noted the order for misoprostol 200 mcg to be administered after meals and confirmed the after meals times as 9:00 AM, 1:00 PM, and 6:00 PM. She explained the facility pharmacy printed the physician monthly orders and MARs each month. The facility pharmacy got the information from the facility via fax as medications were initiated or discontinued by the physician. The QA Nurse also noted the instructions written on the physician monthly orders and MARs for June 2014 and July 2014 stated to administer the medication before meals while providing the after meal times. The QA Nurse explained the facility protocol of checking orders at the beginning of each month. She stated the new physician monthly orders and MARs were checked against	F 333	monthly Medication Administration Record changeover with any discrepancies identified to the monthly QAPI meeting for 3 month for review and recommendations.	

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F 333	Continued From page 5	F 333		

the past monthly orders and MARs as well as any physician's orders written throughout the month. The QA Nurse described checking the orders and MARs was a 3 step process and completed by 3 different nurses which included her. The QA Nurse stated these errors regarding instructions for the administration of misoprostol were overlooked by all 3 nurses performing accuracy checks on the monthly orders and MARs. In a continued interview at 9:58 AM, the QA Nurse stated she called Resident #11's physician for a clarification order for misoprostol. The new order noted to discontinue the previous order for misoprostol and to initiate misoprostol 200 mcg with meals/food and at bedtime. The times specified in the order were 8:00 AM, 12:00 noon, 5:00 PM, and at bedtime. The clarification order also specified to hold the medication if the resident refused meals.

An interview was conducted with the Registered Pharmacy (RP) consultant on 07/23/14 at 10:15 AM. The RP stated misoprostol should be taken with food to make it effective. She stated the medication protected the stomach and prevented medications such as aspirin, which Resident #11 also took, from harming her stomach. She added taking the medication before meals was not harmful to the resident but did render the medication ineffective.

An interview was conducted via phone with a representative from the facility pharmacy on 07/23/14 at 11:00 AM. The pharmacy representative confirmed a faxed order from the facility was received in the pharmacy on 05/07/14 for misoprostol 200 mcg after meals and at bedtime. She stated the order was keyed into the computer in the pharmacy incorrectly. The

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F 333	Continued From page 6 instructions were keyed before meals instead of after meals as ordered by the physician. The pharmacy representative stated this error had been called to their attention earlier today by the facility. She stated the clarified order had been received and keyed into the computer to reflect to administer the medication after meals at 8:00 AM, 12:00 noon, 5:00 PM, and bedtime. An interview was conducted with the Director of Nursing (DON) on 07/24/14 at 2:05 PM. The DON stated she expected nurses to catch medication discrepancies from month to month. She added this was an oversight and should have been caught.	F 333		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334		8/16/14

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F 334	Continued From page 7	F 334		

the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative

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F 334	Continued From page 8 refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation on the resident's medical record that the resident or the resident's responsible party (RP) was provided education about the benefits and potential side effects of the influenza vaccine and given the opportunity to accept or decline the vaccine for 4 of 5 sampled residents (Residents #9, #22, #31 and #47.) The findings include: Review of the medical records of Residents #9, #22, #31 and #47 revealed there was no documentation indicating that the resident or their RP had been provided education about the benefits and potential side effects of the influenza vaccine. There was also no documentation to indicate if the vaccine was accepted or declined by the resident or RP. An interview on 07/24/14 at 4:19 PM with Nurse # 2 about the facility's system for obtaining consent for administering the annual influenza vaccine revealed the facility referred to the consent form that was signed when the resident was admitted and did not get a new consent every year. An interview on 07/24/14 at 4:19 PM with the Director of Nursing (DON) about the facility's system for providing education about the benefits and potential side effects of the influenza vaccine	F 334	When influenza season begins, residents #9,#22, #31, and #47 or the resident's legal representative will be provided education about the benefits and potential side effects of the influenza vaccine and will be given the opportunity to accept or decline the vaccine. The Infection Control Nurse will document the consent or declination in the resident chart. The resident or resident's legal representative will be provided education about the benefits and potential side effects of the pneumococcal vaccine upon admission and will be given the opportunity to accept or decline the vaccine unless the vaccine is medically contraindicated. The Infection Control Nurse will document the consent or declination in the resident chart. Any other resident could be affected, therefore, October 1, through March 31, residents or the resident's legal representative will be provided education about the benefits and potential side effects of the influenza vaccine and will be given the opportunity to accept or decline the vaccine. The Infection Control Nurse will document the consent or declination in the resident chart.	

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F 334	Continued From page 9 to the resident or RP revealed staff called the resident's RP prior to administering the vaccine and provided information about the vaccine. She stated there was no documentation on the resident's chart about the education that was provided. An interview on 07/24/14 at 4:25 PM with the Administrator revealed the staff member who called the resident's RP got a verbal consent to administer the vaccine and provided information about the vaccine. She stated if the resident or their RP refused the influenza vaccine it was documented on the resident's medical record. The Administrator stated there was no documentation on the resident's chart of the consent or about the education that was provided.	F 334	The resident and/or responsible party will be provided education about the benefits and potential side effects of the pneumococcal vaccine upon admission and will be given the opportunity to accept or decline the vaccine unless the vaccine is medically contraindicated. The Infection Control Nurse will document the consent, declination and education in the resident chart. The Infection Control Nurse, MDS Coordinator, Quality Assurance Nurse, RN Supervisor were educated on 8/8/14 by the Director of Nursing about the Annual Influenza Vaccine Administration and the Pneumococcal Vaccine policies and procedures of offering the influenza and pneumococcal immunization, educating the resident or the resident's legal representative regarding the benefits and potential side effects of the immunizations including; That each resident is offered an influenza immunization October 1 through March 31 annually; That the resident or the resident's legal representative has the opportunity to accept or decline the immunization; That the resident's medical record includes documentation that indicates that the resident or resident's legal representative was provided education regarding the benefits and potential side	

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F 334	Continued From page 10	F 334	effects of the influenza or pneumococcal immunization; That the resident either received the influenza or pneumococcal immunization or did not receive the influenza or pneumococcal immunization due to medical contraindications; That based on assessment, and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. The Infection Control Nurse will track the administration of the Influenza Vaccination monthly during Influenza Season to ensure that all residents or resident's legal representative have been notified and educated prior to receiving the immunization and that the consent or declination has been documented in the resident medical record. The Quality Assurance Nurse will audit the pneumococcal immunizations monthly for any new admissions to ensure the resident or resident's legal representative has been notified and educated prior to receiving the immunization and that the consent or declination has been documented in the resident medical record. The Infection Control Nurse will bring the	

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F 334	Continued From page 11	F 334	results of the monthly review of any resident who has not received the Influenza or Pneumococcal Vaccine to the monthly QAPI meeting x 6 months for review, recommendations, documentation and education.	
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 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 record review and staff interview, the facility pharmacy transcribed instructions into the computer to administer a medication before meals instead of after meals as ordered by the physician for 1 of 5 residents reviewed for	F 425	Administration times for the medication ordered for Resident #11 were verified with the physician, and a clarification order was written by the Quality Assurance Nurse on 7/23/14.	8/16/14

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F 425	Continued From page 12 medication administration. (Resident #11). The findings included: Resident #11 was readmitted to the facility 05/07/14 with diagnoses which included esophageal reflux and a hip fracture repair. A review of Resident #11's medical record revealed a discharge medication reconciliation report from the hospital dated 05/07/14. The report included misoprostol (a medication used to prevent stomach ulcers) 200 micrograms (mcg) was to be administered by mouth after meals and at bedtime. The same order was observed on a physician monthly order dated 05/07/14 through 05/31/14. The Medication Administration Record (MAR) for 05/07/14 through 05/31/14 contained the same instructions for misoprostol with 9:00 AM, 1:00 PM, 6:00 PM, and 9:00 PM as times listed for administration. A review of computer-generated physician monthly orders dated 06/01/14 through 06/30/14 and 07/01/14 through 07/31/14 was conducted. Misoprostol 200 mcg with instructions to administer the tablet before meals and at bedtime was observed on the orders. Computer-generated MARs with corresponding dates contained the same instructions to administer before meals. The times the medication was to be administered were listed as 9:00 AM, 1:00 PM, 6:00 PM, and 9:00 PM. An interview was conducted with Nurse #1 on 07/23/14 at 8:58 AM. The nurse stated she had noted the instructions on the MAR for administration of misoprostol to be administered before meals. Nurse #1 added the times of 9:00	F 425	Any resident receiving medications at specific times can be affected, therefore the Director of Nursing verified the facilities times for medications given before and after meals on 7/23/14. A report identifying residents with medications given before and after meals was generated by the pharmacy and times were reviewed with clarification orders written by the Quality Assurance Nurse on 8/5/14. The pharmacy manager re-educated the pharmacists and technicians on administration times for medications given before and after meals on 8/15/14. Weekly reviews by the pharmacy manager will be performed to assess accurate/correct administration times for a total of 8 weeks. The results of these reviews will be shared with the facility Director of Nurses at the end of each month. The Facility Director of Nursing re-educated the licensed nursing staff on 8/5/14 and provided a copy of the facility's triple check policy and procedures for checking monthly medication administration records for accuracy. The pharmacy manager's results will be addressed during the monthly QAPI Meeting for 2 months for review and recommendations. The Quality Assurance Nurse will bring results of the monthly Medication Administration Record	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING _____ B. WING _____	C 07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 13 AM, 1:00 PM, and 6:00 PM were times used by the facility to note after meals. Nurse #1 stated each time she worked, she gave the medication before breakfast to follow the instructions on the MAR. An interview was conducted with the Registered Pharmacy (RP) consultant on 07/23/14 at 10:15 AM. The RP stated misoprostol should be taken with food to make it effective. She stated the medication protected the stomach and prevented medications such as aspirin, which Resident #11 also took, from harming her stomach. She added taking the medication before meals was not harmful to the resident but did render the medication ineffective. An interview was conducted via phone with a representative from the facility pharmacy on 07/23/14 at 11:00 AM. The pharmacy representative confirmed a faxed order from the facility was received in the pharmacy on 05/07/14 for misoprostol 200 mcg to be administered after meals and at bedtime. She stated the order was transcribed into the computer in the pharmacy incorrectly. The instructions were typed before meals instead of after meals as ordered by the physician. The pharmacy representative stated this error had been called to their attention earlier today by the facility. She stated the clarified order had been received and transcribed into the computer to reflect to administer the medication after meals at 8:00 AM, 12:00 noon, 5:00 PM, and bedtime.	F 425	changeover with any discrepancies identified to the monthly QAPI meeting for 3 month for review and recommendations.	