STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

(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 attached to this survey Event ID # ENO011.	F 000		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility had a medication administration error rate of 8.00% observed during the 25 medication administration opportunities. Novolog Insulin was not administered and Calcium plus Vitamin D was not administered (Residents #16 and #69). The findings included: 1. Resident #16 was admitted to the facility on 04/19/15 with diagnosis of diabetes mellitus. Minimum Data Set (MDS) was not available due to recent admission. A record review of nursing admission assessment dated 04/19/15 revealed Resident #16 was disoriented to person, place, and time. A review of physician's order dated 04/19/15 indicated Resident #16 was to receive Novolog Insulin 5 units subcutaneous three times a day before meals at 7:30 AM, 11:30 AM, and 4:30 PM. Resident #16 was to receive Novolog sliding	F 332	Preparation and/or execution of this 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. Resident #16 and #69 were administered omitted medications immediately. The residents are receiving their medications as ordered. No negative outcome resulted from the delay of administration. Current residents receiving medication have the potential to be affected. All licensed nurses to be in-serviced by the Director of Nursing using Relias Learning course MED-medication administration with objectives of instructing those responsible for	5/21/15

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

Electronically Signed | 05/14/2015

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F 332	Continued From page 1 scale insulin based on blood sugar results before meals and at bedtime. 201-250 = 2 units 251-300 = 4 units 301-350 = 6 units 351-400 = 8 units >400 = 10 units and call MD A record review of the MAR dated 04/19/15 to 04/30/15 for Resident #16 was conducted on 04/21/15 and revealed Novolog insulin 5 units was to be administered subcutaneously before meal at 4:30 PM. Sliding scale Novolog insulin was to be administered at 4:30 PM based on blood sugar results. Resident #16 was observed for medication administration on 04/21/15 at 4:45 PM. Nurse #2 was observed obtaining a finger stick blood sugar result of 360 for Resident #16. Nurse #2 was observed administering a blood thinner tablet by mouth and sliding scale Novolog insulin 8 units subcutaneously to Resident #16. Nurse #2 indicated she had completed medication administration for Resident #16 and was prepared to administer medication to a different resident. Nurse #2 omitted the administration of Novolog 5 units subcutaneously to Resident #16. An interview with Nurse #2 was conducted on 04/21/15 at 5:25 PM. Nurse #2 stated she thought Resident #16 was only on sliding scale Novolog insulin before dinner meal. Nurse #2 stated she administered Novolog insulin 8 units because Resident #16's finger stick for blood sugar was 360. Nurse #2 stated she did not think Resident #16 had a scheduled dose of Novolog insulin to be administered prior to dinner meal. Nurse #2 stated she would administer to Resident	F 332	medication administration in proper ways to perform a medication pass. Medication administration observations will be conducted by the Administrative Nurses and DON weekly for (4) four weeks, then randomly thereafter. Variances will be corrected at the time of observation. Continued compliance will be monitored through routine random medication administration observations and through the facility's quality assurance program for (3) three months for ongoing compliance. Additional education and monitoring will be initiated for any identified concerns.	

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F 332	Continued From page 2	F 332		

#16 the missed dose of Novolog insulin now.

An interview was conducted with Nurse #2 on 04/22/15 at 5:22 PM. Nurse #2 stated she had been off for two days and thought Resident #16 had Novolog insulin administered with meals and not before meals. Nurse #2 further revealed she had not checked physician's order to verify that Novolog insulin was to be administered to Resident #16 before meals.

An interview was conducted with the Director of Nursing (DON) on 04/23/15 at 2:46 PM. The DON stated her expectations were for nursing to administer all medications per physician's order.

2. Resident #69 was admitted to the facility on 10/27/13 with diagnoses of osteoporosis and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 04/02/15 indicated Resident #69 was cognitively intact.

A review of physician's order dated 04/01/15 to 04/30/15 and signed by the physician indicated Resident #69 was to receive Calcium 600 milligrams (mg) plus Vitamin D one tablet by mouth twice daily at 8:00 AM and 5:00 PM.

A record review of the Medication Administration Record (MAR) dated 04/01/15 to 04/30/15 for Resident #69 was conducted on 04/21/15 and revealed Calcium 600 mg plus Vitamin D one tablet was scheduled to be administered to Resident #69 at 8:00 AM and 5:00 PM.

Resident #69 was observed for medication administration on 4/21/15 at 4:56 PM. Nurse #2 was observed administering pain medication and respiratory treatment to Resident #69. Nurse #2

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F 332	Continued From page 3 indicated she had completed medication administration for Resident #69 and was prepared to administer medication to a different resident. Nurse #2 omitted the administration of Calcium 600 mg with Vitamin D to Resident #69. An interview with Nurse #2 was conducted on 04/21/15 at 5:22 PM. Nurse #2 stated she missed administering Calcium 600 mg with Vitamin D to Resident #69. Nurse #2 stated she must have overlooked the medication on the MAR. Nurse #2 stated she would administer the Calcium 600 mg with Vitamin D to Resident #69 now. An interview was conducted with the Director of Nursing (DON) on 04/23/15 at 2:46 PM. The DON stated her expectations were for nursing to administer all medications per physician's order.	F 332		
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 observation, record reviews, and staff interviews the facility failed to prevent a significant medication error by not administering Novolog insulin for diabetes mellitus as ordered in 1 of 5 sampled residents observed for medication errors (Resident #16). The findings included: Resident #16 was admitted to the facility on 04/19/15 with diagnosis of diabetes mellitus.	F 333	Resident #16 was administered omitted medication immediately. The resident is receiving their medication as ordered. No negative outcome resulted from the delay in administration. Audit of medication administration records for all residents that receive insulin was completed by the Administrative Nurse on 4/27/15 with no negative outcomes found.	5/21/15

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F 333	Continued From page 4 Minimum Data Set (MDS) was not available due to recent admission. A review of physician's order dated 04/19/15 indicated Resident #16 was to receive Novolog insulin 5 units subcutaneous three times a day before meals at 7:30 AM, 11:30 AM, and 4:30 PM. Resident #16 was to receive Novolog sliding scale insulin based on blood sugar results before meals and at bedtime. 201-250 = 2 units 251-300 = 4 units 301-350 = 6 units 351-400 = 8 units >400 = 10 units and call MD A record review of the MAR dated 04/19/15 to 04/30/15 for Resident #16 was conducted on 04/21/15 and revealed Novolog insulin 5 Units was to be administered subcutaneously before meal at 4:30 PM. Sliding scale Novolog insulin was to be administered at 4:30 PM based on blood sugar results. Resident #16 was observed for medication administration on 04/21/15 at 4:45 PM. Nurse #2 was observed obtaining a finger stick blood sugar result of 360 for Resident #16. Nurse #2 was observed administering a blood thinner tablet by mouth and sliding scale Novolog insulin 8 units subcutaneously to Resident #16. Nurse #2 indicated she had completed medication administration for Resident #16 and was prepared to administer medication to a different resident. Nurse #2 omitted the administration of Novolog 5 units subcutaneously to Resident #16. An interview with Nurse #2 was conducted on 04/21/15 at 5:25 PM. Nurse #2 stated she	F 333	All licensed nurses will be in-serviced by the Director of Nursing using Relias Learning MED medication pass course. Course objectives to instruct those responsible for medication administration in proper way to perform a medication pass. Medication administration observations will be conducted by the Administrative Nurses and DON weekly for (4) weeks, then randomly thereafter. Variances will be corrected at the time of observation. Observation results will be reported to the DON weekly for (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through random medication administration observations and through the facility's quality assurance program for (3) three months for ongoing compliance. Additional education and monitoring will be initiated for any identified concerns.	

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F 333	Continued From page 5	F 333		

thought Resident #16 was only on sliding scale Novolog insulin before dinner meal. Nurse #2 stated she administered Novolog insulin 8 units because Resident #16's finger stick for blood sugar was 360. Nurse #2 stated she did not think Resident #16 had a scheduled dose of Novolog insulin to be administered prior to dinner meal. Nurse #2 stated she would administer to Resident #16 the missed dose of Novolog insulin now.

An interview was conducted with Nurse #2 on 04/22/15 at 5:22 PM. Nurse #2 stated she had been off for two days and thought Resident #16 had Novolog insulin administered with meals and not before meals. Nurse #2 further revealed she had not checked physician's order to verify that Novolog insulin was to be administered to Resident #16 before meals.

An interview was conducted with the Director of Nursing (DON) on 04/23/15 at 2:46 PM. The DON stated her expectations were for nursing to administer all medications per physician's order.

Division of Health Service Regulation

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D 000	Initial Comments No deficiencies were cited as a result of the complaint investigation attached to this survey Event ID # ENO011.	D 000		

Division of Health Service Regulation

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

Electronically Signed | 05/14/15