

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

PRINTED: 10/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2017
NAME OF PROVIDER OR SUPPLIER SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 329 SS=D	<p>483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p>	F 329		10/1/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/29/2017

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 329	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff, resident and physician interviews, the facility failed to accurately transcribe a physician's order to discontinue a medication for 1 of 5 of sampled residents (#30) reviewed for unnecessary medications. This resulted in an unnecessary continued administration of Amitriptyline to Resident #30 for 68 days.</p> <p>The findings included:</p> <p>Resident #30 was admitted to the facility on 09/13/16 with diagnoses including Type 2 Diabetes Mellitus (DM), psychosis, neuralgia, and depression.</p> <p>The most recent Minimum Data Set (MDS) dated 06/23/17 coded Resident #30 as cognitively intact, able to be understood and to understand others.</p> <p>A review of the Physician's Order Sheet (POS) signed by the physician on 06/22/17 indicated an order to discontinue Amitriptyline 50 milligram (mg), 1 tablet by mouth every night at bed time for depression/neuralgia.</p> <p>Review of Medication Administration Records (MAR) for the month of June 2017 indicated the order of Amitriptyline 50 mg was discontinued as ordered on 06/22/17. Review of the MAR for the months of July, August, and September 2017 revealed that the order of Amitriptyline 50 mg was re-started on 07/01/17. This medication was documented as continuously administered to Resident #30 once daily at 9 PM, without physician order, until 09/06/17 for a total of 68</p>	F 329	<p>Smoky Mountain Health and Rehabilitation Center acknowledged receipt of the Statement of Deficiencies and proposes 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 quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Smoky Mountain Health and Rehabilitation Center's response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Smoky Mountain Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>F0329</p> <p>On 9/07/2017 Resident #30 had Amitriptyline 50mg discontinued. On Resident #30 a comparison of current meds on Medication Administration Record (MAR) with physician orders/ telephone orders for the prior three months was completed by Director of</p>		

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F 329	<p>Continued From page 2 days.</p> <p>A telephone interview with the Consultant Pharmacist on 09/07/17 at 2:32 PM. She stated that when the physician wrote a medication order, the facility would fax the order over to the pharmacy and it would be reviewed by the pharmacist before making any changes to the MAR for the following month. She agreed the order of Amitriptyline 50 mg for Resident #30 should have been discontinued on 06/22/17 and it should not have been re-started without a physician's order. She attributed the error as being an oversight due to the physician's relatively small hand writing on the POS.</p> <p>A telephone interview with the Physician on 09/07/17 at 2:44 PM revealed the Amitriptyline should have been discontinued on 06/22/17 and he expected the nurse to follow his order accordingly. The Physician denied Resident #30 could have any negative health impacts from the unnecessary medication. According to the physician, Resident #30 had been on Amitriptyline for over 2 years prior to this incident and she was expected to tolerate this medication well.</p> <p>An interview with Resident #30 on 09/07/17 at 3:38 PM revealed her health conditions remained at baseline in the prior 2 months. She denied having increased episodes of constipation or dry mouth.</p> <p>An interview with Nurse #1 on 09/07/17 at 3:49 PM revealed when an order was initiated by the Physician or Nurse Practitioner (NP), the assigned nurse would have to hand write the order on the hard copy of MAR for the time being and faxed the order to the pharmacy. The</p>	F 329	<p>Nursing(DON)on 9/08/2017 with no irregularities noted. The position of Smoky Mountain Health and Rehabilitation Center regarding the process that lead to this deficiency was two nursing staff members failed to follow established facility protocol for monthly physician orders/MAR changeover.</p> <p>On 9/08/2017 all current residents had a comparison of their current meds on the MAR with physician orders/ telephone orders for the prior three months completed by the DON.</p> <p>On 9/28/2017 DON completed in-servicing 100% of licensed nurses on proper protocol for checking monthly physician orders/MARS that is to be done at the end of the month in preparation for the beginning of the new month. Licensed nurses will compare physician orders/MAR against the chart by going back three months of orders (physician order sheets, telephone order sheets, admission /readmission orders) and will check the new MAR to the current MAR. Changes are to be made to reflect accurate medication regimen. A copy of "MAR Checking Tips" were included in the in-servicing and a copy placed in the front of the binders that holds the upcoming new MARS.</p> <p>October Orders/MARs are currently being checked by Licensed nurses for accuracy comparing the MAR to the chart with the signed physician order sheets from September and against all order changes (telephone order sheets, admission</p>		

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F 329	<p>Continued From page 3</p> <p>pharmacy would verify the orders before sending the facility the type-written orders on the MAR at the end of the month in preparation for the new month. Once the facility received the new MAR, each MAR would be checked for accuracy and signed by the assigned nurse.</p> <p>An interview with Nurse #2 on 09/07/17 at 4:34 PM revealed she had been working for the facility for about 10 days and provided care for Resident #30 on regular basis. She stated shed did not observe Resident #30 having any excessive anticholinergic reactions such as constipation or dry mouth in the past 10 days.</p> <p>An interview with the Director of Nursing (DON) on 09/07/17 at 4:46 PM revealed the facility had a system set up to ensure the accuracy of MARs. Once the order was written by a physician or NP, it would be faxed to the pharmacy on the same day. The Pharmacist would review the order. At the end of the month, the pharmacy would send a hard copy of the type-written MAR for each resident to the facility. An assigned nurse would check the transcription accuracy from the physician's orders to the MAR. The second assigned nurse would check the transcription accuracy for the MAR of the current month to the MAR for the following new month. She stated the pharmacy should not have transcribed the order of Amitriptyline in the MAR for the month of July 2017 after it was discontinued on 06/22/17. It was her expectation for all the nurses to follow physician's orders and implement them accurately and in a timely manner.</p> <p>On 09/07/17 at 5:00 PM, an attempt to interview Nurse #3 who was responsible to check the transcription accuracy for Resident #30's July</p>	F 329	<p>/readmission orders) from July 1 through September and comparing October MAR to current MAR. To be completed by 9/30/17.</p> <p>The DON and/or Assistant Director of Nursing (ADON) will complete an additional chart to MAR check on the day prior to the first use of the upcoming month's MARs for three consecutive months. Irregularities will be corrected and recorded on the Quality Assurance Performance Improvement (QAPI) audit tool. The DON and/or ADON will report findings to the QAPI committee of the outcome of these additional checks for 3 months. The QAPI committee will determine the manner and frequency of additional audits, if necessary.</p>		

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F 329	Continued From page 4 2017 MAR was unsuccessful. Nurse #3 was no longer employed at the facility. An interview with the Administrator on 09/07/17 at 5:01 PM revealed she expected the Amitriptyline 50 mg should have been discontinued as ordered in a timely manner. She attributed this incident to human error.	F 329			