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 08/07/2014

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 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 medical record review and staff interviews the facility failed to provide a protein supplement as ordered by the physician to one of three sampled residents reviewed for medication administration. (Resident #4) The findings included: Resident #4 was admitted to the facility 07/08/14 for intravenous (IV) antibiotic administration due to an infection from a prior hip replacement. The current care plan dated 07/21/14 included a problem area, At nutritional and dehydration risk due to diagnosis of infected left hip and underweight. Approaches to this problem area included, Obtain lab orders and report abnormal findings to physician. A review of the weight records noted Resident #4 weighed 98 pounds on admission 07/08/14. On 08/04/14, Resident #4 weighed 88 pounds. A review of physician orders in the medical record of Resident #4 noted a physician's order dated 07/14/14 which included, ProStat (a protein	F 309	Preparation and/or execution of his 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. Prostat order for resident #4 was clarified with the physician. Resident #4 refused Prostat (when the nurse attempted to administer it to him.) Physician notified of refusal and order received to discontinue Prostat. The physician did not order another protein supplement at this time. 100% chart audit for all residents have been completed to ensure any variances in physician order transciption have been addressed. Nurses will be retrained on proper procedures of monthly MAR changeover and transcriptionn of physicians orders by	9/5/14

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

Electronically Signed | 08/26/2014

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F 309	Continued From page 1 supplement) 30 cubic centimeters (cc), twice a day. 30 cc of ProStat taken twice a day would provide 30 grams of protein every day. A review of labwork in the medical record of Resident #4 noted the order for 30 cc of ProStat twice a day handwritten on a lab report dated 07/14/14 which indicated depleted albumin (a measure of protein stores) with a level of 2.80 with the normal range of 3.4-5.0. A review of the July 2014 Medication Administration Record (MAR) for Resident #4 noted the ProStat was not included on the MAR as ordered by the physician. Review of the August 2014 MAR noted the ProStat was listed on the pre-printed MAR to be given twice a day, but, there was a line through the order. The daily entry beside the ProStat revealed an initial of the nurse that administered medications on 08/01/14 which was circled; indicating the ProStat had not been given. There was no explanation on the MAR (in the area for explanation) to explain why the ProStat was not given to Resident #4. The ProStat was not documented as given from 08/01/14 through the time of the investigation on 08/07/14. There was not a physician's order addressing the ProStat since it was ordered on 07/14/14. Review of nurses notes in the electronic medical record of Resident #4 revealed no documentation related to the ProStat. A review of dietary progress notes in the medical Record of Resident #4 included the following: 07/14/14 Underweight. Lab values noted low albumin. 07/24/14 Regular diet and is eating very little related to poor appetite/pain. Does accept MedPass 2.0 (a caloric supplement) 120 cc three	F 309	the DON or SDC. Charts will be reviewed daily by the 11-7 charge njurse for new physiccian orders and accuracy of transcriptions using a QA monitoring tool on an ongoing basis. The auditing tool will be reviewed in the mornign Cin-ops meeting by the Administrative nurses daily x 4 weeks and then weekly x 2 months to ensure compliaance with transcription of new orders. In addition all new orders will be reviewed in ;morning Clin-ops by the Administrative nurses on an ongoing basis to ensure compliance Findings wil be reviewed monthly by the facility's quality assurance committee for the next 3 months for compliance with re-training or additional education provided for any identified concerns by the DON or other Administrative nurses. Continued compliance will be monitored through the monthly review of physician orders by the consulting pharmaccist and through the facility's quality assurance program with any variances being addressd by the administrative nurses as appropriate	

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F 309	Continued From page 2	F 309		

times a day. Status post spacer placed left hip secondary to infected left hip hemiarthroplasty. On IV Vancomycin (an antibiotic). Labs: Albumin low 3.0. ProStat 30 cc twice a day added related to low albumin. Provide preferences, continue supplements, encourage intake and follow-up weight, skin, labs.
07/31/14 Weight down 89.4 pounds 07/30/14
08/01/14 Weight declining despite MedPass and encouragement. On ProStat. Will continue weekly weights.

A review of lab results in the medical record of Resident #4 noted the following albumin levels after the initial test on 07/14/14:
07/14/14 albumin 2.8 with 3.4-5.0 the normal range
07/21/14 albumin 3.0 with 3.4-5.0 the normal range
07/28/14 albumin 2.7 with 3.4-5.0 the normal range
08/04/14 albumin 2.8 with 3.4-5.0 the normal range

On 08/07/14 at 3:50 PM the Director of Nursing reviewed the physician orders, nurses notes, MARs and physician progress notes in the medical record of Resident #4 and could not explain why the ProStat was not administered as ordered to Resident #4. The Director of Nursing spoke with the Nursing Unit Manager (over the unit where Resident #4 resided) about the ProStat for Resident #4 and the Nursing Unit Manager stated she did not know anything about the ProStat.

On 08/07/14 at 5:50 PM Nurse #1 (that wrote the order on 08/01/14 for the ProStat) was interviewed by telephone. Nurse #1 stated she

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F 309	Continued From page 3 could not explain why the ProStat was not included on the July 2014 MAR for Resident #4. Nurse #1 stated she remembered offering the ProStat to Resident #4 and the resident refused it. Nurse #1 stated she should have informed the physician that Resident #4 refused the ProStat the one time it was offered. On 08/07/14 at 6:00 PM Nurse #2 reviewed the August 2014 physician orders and August 2014 MAR for Resident #4 and verified he reconciled the physician orders for Resident #4 for the month of August 2014. Nurse #2 stated he had not been trained on how to reconcile orders but had compared the July 2014 MAR for Resident #4 to the August 2014 MAR. Nurse #2 stated he could not speak with certainty about the ProStat but most likely what happened was when he did not see the ProStat on the July 2014 MAR he crossed it off the August 2014 MAR for Resident #4. On 08/07/14 at 6:30 PM, in a follow-up interview, the Director of Nursing indicated the order for ProStat should not have been crossed off the August 2014 MAR for Resident #4 and that the omission of the ProStat since it was ordered on 07/14/14 for Resident #4 was an oversight.	F 309		