

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345193</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/12/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW MANOR NURSING CE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 BUCKNER BRANCH ROAD</b> <b>BRYSON CITY, NC 28713</b>		
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F 000	INITIAL COMMENTS	F 000			
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to administer a medication to 1 of 5 sampled residents as ordered by the physician. (Resident #55)</p> <p>The findings included:</p> <p>Resident #55 was admitted to the facility 02/09/12 with diagnosis which included Alzheimers disease, psychosis and constipation. The Minimum Data Set (MDS) dated 02/02/15 assessed Resident #55 as continent of bowel and bladder.</p> <p>A physician's progress note dated 01/29/15 noted Resident #55 had a "complaint of constipation." On 01/29/15 the physician ordered Miralax (a laxative) 17 grams mixed in 8 ounces of water to be given on a daily basis. Review of the January Medication Administration Record (MAR) noted the Miralax was handwritten on the MAR and</p>	F 309	<p>On March 12, 2015 Miralax was added to Resident #55's medication administration record by a licensed nurse. The physician was notified by a licensed nurse that Miralax had not been given to Resident #55 since January 31, 2015 but was given to Resident #55 on March 12, 2015 and continues daily as ordered.</p> <p>All residents' medication administration records were reviewed by the Director of Nursing and/or the Asst. Director of Nursing to verify that all new orders had been added to the medication administration records. No other concerns were identified.</p> <p>On April 10, 2015 all licensed staff will be inserviced by the Director of Nursing on the importance of all physician orders getting on the next month's medication</p>	4/10/15	

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

TITLE

(X6) DATE

Electronically Signed

04/02/2015

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 309	<p>Continued From page 1</p> <p>administered to Resident #55 01/30/15 and 01/31/15. Review of the February 2015 and March 2015 MAR noted the Miralax was not included and was not administered to Resident #55.</p> <p>On 03/12/15 at 11:00 AM the Director of Nursing (DON) reviewed the 01/29/15 physician order and February 2015 and March 2015 MARs for Resident #55 and noted the Miralax had not been given to Resident #55 after 01/31/15 as ordered by the physician. The DON stated the February MAR had been checked by Nurse #1 on 01/27/15 (two days prior to the order for Miralax). The DON stated the night shift nurse was responsible to check all physician orders the night before the new MAR was implemented to ensure all orders (since the MAR had been checked) were transcribed on the next months MAR. The DON reviewed the staffing schedule and noted Nurse #1 was on duty 01/31/15 when the February MAR would have been checked. The DON stated Nurse #1 must have missed the order for the Miralax ordered on 01/29/15 for Resident #55 when the February MAR was checked prior to implementation 02/01/15. The DON stated Nurse #1 was not available for interview. The DON stated physician orders were sent to the pharmacy and the pharmacy provided the facility with residents MARs and monthly recap of physician orders. The Miralax was not included on the March 2015 MAR or monthly recap of physician orders for Resident #55. The DON stated she could not explain why the Miralax had been left off the March 2015 MAR and recap of physician orders. The February 2015 and March 2015 bowel records for Resident #55 were reviewed and no concerns were identified.</p>	F 309	<p>administration records and the importance of following physicians' orders.</p> <p>From the 20th of each month until the end of the month all new telephone orders (the yellow copy) will be put on a clipboard at A/B desk and at C/D desk. The night nurse that checks the new monthly physicians' orders will initial off on the yellow copy when new orders have been put on the new monthly physicians' orders. The yellow copy will then be put in a folder for the Director of Nursing</p> <p>On the 1st of the month the Director of Nursing or designee will do a second check to verify that all orders have been added to the new physician orders. Any missed orders will be added to the medication administration record, the physician will be notified, and it will be reported to the Administrator.</p> <p>The Administrator will monitor the completion of the two checks to verify that all new orders are added to the physician orders each month for 3 months or until substantial compliance is achieved. The Administrator will report compliance to the QA Committee for review and follow-up action if indicated.</p>		

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F 431 F 431 SS=D	Continued From page 2 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by:	F 431 F 431		4/10/15	

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F 431	<p>Continued From page 3</p> <p>Based on observations, record review and staff interview the facility failed to remove expired and out of date medications from 1 of 4 medication carts and from 1 of 2 medication room refrigerators. The findings included:</p> <p>A review of the manufacturer's instructions for Novolog insulin indicated vials should be refrigerated until opened and must be discarded 28 days after opening. A review of the manufacturer's instructions for Tuberculin aplisol indicated vials must be discarded 30 days after opening.</p> <p>A review of the facility's Medication Storage guidelines, which was posted on the wall of the medication rooms, indicated: Novolog insulin should be discarded 28 days after opening, Tuberculin aplisol should be discarded 30 days after opening and all eye drops except Xalatan eye drops should be discarded 90 days after opening.</p> <p>1. Observation on 03/11/15 at 11:30 AM of the B Hall Medication Cart revealed a partially used bottle of Novolog insulin labeled for Resident # 1 with a date opened sticker which indicated the bottle was opened on 02/09/15. The nurse, who was assigned to administer medications from the B hall cart, acknowledged that the insulin was currently in use for Resident # 1.</p> <p>An interview on 03/11/15 at 4:30 PM with the Director of Nursing (DON) revealed she expected the nurses to remove expired medications from the medication cart, medication room and refrigerator. The DON stated a pharmacy technician checked all the medication carts, medication rooms and refrigerators for expired</p>	F 431	<p>On March 11, 2015 the out of date Novolog insulin, Tuberculin PPD vial, Travatan Z eye drops, and Phenergan 25 mg syringes were disposed of by the Director of Nursing. The Asst. Director of Nursing and the Director of Nursing checked the A/B and C/D hall's medication storage refrigerators and medication carts for any out of date vials of multi-dose injectables, eye drops, or medications. No out of date items were found. The storage refrigerators were checked to verify that expiration dates and dates dispensed were on all labels. No labels were found without expiration dates or dates dispensed.</p> <p>On April 10, 2015 the Director of Nursing will inservice all licensed staff concerning the importance of disposal of out of date multi-dose injectables, eye drops, or medications. Proper labeling of medications will be covered. A makeup inservice will be provided.</p> <p>The medication storage area refrigerator and medication carts will be checked for expired items weekly by the Pharmacy Technician and the technician will initial a checklist indicating completion. Any outdated or expired items will be disposed of.</p> <p>The Pharmacy Consultant will check the refrigerators and medication carts monthly for 3 months then quarterly to monitor compliance.</p>		

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F 431	<p>Continued From page 4</p> <p>medications on 03/09/15 and must have missed seeing the expired medication.</p> <p>2. Observation on 03/11/15 at 11:30 AM of the B Hall Medication Cart revealed a partially used bottle of Travatan Z eye drops labeled for Resident # 60 with a date opened sticker which indicated the bottle was opened on 11/29/14. The nurse, who was assigned to administer medications from the B hall cart, acknowledged the eye drops were available for use for Resident # 60.</p> <p>An interview on 03/11/15 at 4:30 PM with the Director of Nursing (DON) revealed she expected the nurses to remove expired medications from the medication cart, medication room and refrigerator. The DON stated a pharmacy technician checked all the medication carts, medication rooms and refrigerators for expired medications on 03/09/15 and must have missed seeing the expired medication. The DON stated the Travatan Z eye drops for Resident # 60 had been discontinued and should have been removed from the medication cart at the time they were discontinued.</p> <p>3. Observation on 03/11/15 at 11:45 AM of the A/B Hall Medication Room refrigerator revealed a zip-top plastic storage bag containing 10 syringes. The label on the bag read: "Phenergan 25 milligrams (mg), QTY (Quantity): 10 for EDK (Emergency Drug Kit). The label did not indicate when the medication expired or when it was dispensed. Inspection of the syringes revealed there was no expiration date on the individual syringes. The nurse, who was assigned to administer medications from the B hall cart, acknowledged that she was unable to determine</p>	F 431	The Director of Nursing will monitor completion of the weekly checks and review the monthly findings of the consultant pharmacist and report compliance to the QA committee for review and follow-up action if indicated.		

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F 431	<p>Continued From page 5</p> <p>from the label when the Phenergan was dispensed or when it expired.</p> <p>An interview on 03/11/15 at 4:30 PM with the Director of Nursing (DON) revealed she expected the nurses to remove expired medications from the medication cart, medication room and refrigerator. The DON stated a pharmacy technician checked all the medication carts, medication rooms and refrigerators for expired medications on 03/09/15 and must have missed seeing the expired medication. The DON was unable to explain why the Phenergan label did not include a dispensed date or expiration date.</p> <p>4. Observation on 03/11/15 at 11:45 AM of the A/B Hall Medication Room refrigerator revealed a vial of Tuberculin Aplisol with a date opened sticker which indicated the vial was opened on 01/29/15. The nurse, who was assigned to administer medications from the B hall medication cart, acknowledged the Tuberculin Aplisol was available for use.</p> <p>An interview on 03/11/15 at 4:30 PM with the Director of Nursing (DON) revealed she expected the nurses to remove expired medications from the medication cart, medication room and refrigerator. The DON stated a pharmacy technician checked all the medication carts, medication rooms and refrigerators for expired medications on 03/09/15 and must have missed seeing the expired medication.</p>	F 431			