STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	245 OLD MURPHY ROAD FRANKLIN, NC 28734

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F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to administer an eye medication for glaucoma for 7 days for 1 of 6 residents reviewed for medication administration (Resident #2). The findings included: Review of a Question and Answer section of the Glaucoma Research Foundation's web site, review date of 8/25/17, revealed "taking your eye drops consistently (compliance) reduces the likelihood of pressure fluctuation (diurnal variation). Inconsistent use of drops will vary the intraocular pressure (IOP) and has been scientifically proven to be detrimental to your glaucoma." Resident #2 was admitted to the facility on 2/22/16 with diagnoses including hemiplegia, dysarthria (slurred or slow speech that can be difficult to understand) and glaucoma. Review of Resident #2's Care Area Assessment (CAA) from an annual Minimum Data Set (MDS) of 2/17/17 triggered the care area of vision, summarized as the resident with a diagnosis of glaucoma and as receiving eye medication. Her care plan based on this CAA summary included	F 333	Macon Valley Nursing and Rehabilitation Center acknowledges 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. Macon Valley Nursing 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, Macon Valley Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution or formal appeals procedure and or any other administrative or legal proceeding.	9/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/08/2017

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F 333	Continued From page 1 the problem of her inability to focus on objects, discriminate color and adjust to changes in light and dark characterized by pain, decreased and impaired vision related to glaucoma and macular degeneration. The care plan goal for this problem was for the resident to have no injuries and to feel safe and secure in her environment. Interventions for this problem included eye examinations per facility protocol and as needed, and to instill or apply eye medication as per physician orders. Review of Resident #2's most current quarterly MDS dated 5/20/17 revealed the resident to have unclear speech and moderately impaired cognition, with a review and continuation of her care plan goal as noted. Review of an ophthalmology note for Resident #2 dated 5/9/17 revealed an order for latanoprost (medication used to treat high pressure inside the eye due to glaucoma), 0.005% solution, one drop in the left eye due to a history of glaucoma in her left eye. Another ophthalmology noted dated 6/12/17 revealed the resident to have a cataract in her right eye with a plan for surgery. Review of a nurse practitioner note dated 7/11/17 revealed the resident's medication list was reviewed and included latanoprost, 0.005% solution, one drop in the affected eye in the evening once a day, and to see the medication administration records (MARs). Review of ophthalmologist postoperative cataract surgery orders for Resident #2 dated 7/27/17 included "start Latanoprost QD [every day] OS [left eye] ..." Review of medication orders for Resident #2 dated 7/27/17 included latanoprost one drop in left eye in the morning for eye disease. Review of a packing slip for a medication delivery from the contract pharmacy dated 7/27/17 and	F 333	F 333 Upon identification on 8/17/17 of the current eye drop medication not being available for resident #2 our pharmacy was called and the eye drops were sent to our local backup pharmacy for pick-up on 8/18/17. Upon identification on 8/17/17 the Nursing staff were advised of the issue. The entire policy on ordering Medications, re-ordering Medications that have run out, back up pharmacy E-Kit in facility, back up pharmacy locally was reviewed. The medication administration records of all residents were audited and med carts audited for missing medications by the Director of Nursing and QI Nurse for deficient practices. Upon identification the medication administration records of all residents were audited using a QI monitoring tool for deficient practices including circled or missing initials indicating not given or no medication, then the med carts were audited using a QI Monitoring tool for missing medications by the Director of Nursing and QI Nurse. Medications were returned or re-ordered on 8/23/2017. 100% of facility Nurses and Med-aides were in-serviced on the requirement of Medication Administration, the timely ordering and re-ordering Medications for residents, correct documentation and	

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signed for on 7/28/17 revealed delivery of ofloxacin (an antibiotic) 0.3% solution drops for Resident #2 but no other medications.

Review of the July 2017 MAR for Resident #2 revealed a transcribed order for "latanoprost QD OS 1 drop (left)" at 9:00 AM, with documented administration from 7/28/17 through 7/31/17. Review of the August 2017 MAR revealed the transcribed order for "latanoprost [L in a circle, signifying left] eye 1 drop daily" at 9AM, with the following documentation: documented as administered from 8/1/17 through 8/4/17, circled initials on 8/5/17, no documentation on 8/6/17, circled initials from 8/7/17 through 8/11/17, initials from 8/12/17 through 8/16/17 and circled initials on 8/17/17. On the reverse side of the August 2017 MAR there were no written comments for latanoprost.

Review of Daily Assignment Sheets for the 7:00 AM through 3:00 PM shift in August 2017 revealed the following assignments on the medication cart for Resident #2's hall:
For 8/5/17, Nurse Aide (NA) #1 was assigned
For 8/6/17, Nurse #3 was assigned
For 8/7/17 through 8/9/17, NA #2 was assigned
For 8/10/17, NA #3 was assigned
For 8/11/17, Nurse #1 was assigned
For 8/12/17, NA #4 was assigned

Observation on 8/16/17 at 3:55 PM of Resident #2 revealed her to be difficult to understand except for yes/no answers to questions. When asked if she received all her medications as ordered by her provider the resident responded with yes. When asked if she received all her eye drops the resident responded with yes. When asked if she ever missed any doses of her eye

reporting Medication Errors immediately to the Director of Nursing (DON) and/or Administrator. The quality team members DON, QI nurse, Staff Facilitator, Social Worker, and Administrator will monitor weekly using a QI auditing tool for compliance. The monitoring for compliance will occur weekly for three months for all residents' medication omissions and/or holes in the MAR; then bi-monthly for three months for all residents' medication omissions and/or holes in the MAR; then once a month for six months for all residents' medication omissions and/or holes in the MAR. An audit tool has been developed to be utilized to record the findings to ensure compliance. The findings of the audits will be reported monthly to the QAPI committee members DON, QI nurse, Staff Facilitator Social Worker, Consultant Pharmacy and Administrator to reflect identifications of patterns, additional concerns, and analysis of the progress of training and tools to ensure compliance. Quarterly the results will be reviewed in the Executive QAPI committee meeting, members are Medical Director, Administrator, Don, Qi Nurse, Consultant Pharmacist and Staff Facilitator. If an error is found it will be reported immediately and disciplinary action taken against employee not ordering or re-ordering the medication that is unavailable or by contacting DON and/or the Administrator. The LNHA is responsible to ensure communication and implementation of any Quality Assurance and Performance Improvement

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drops the resident responded no. When asked if she had any other concerns the resident responded no.

Observation on 8/17/17 at 10:00 AM of medication administration by Nurse #1 for Resident #2 revealed administration of various oral medications and three eye drops (Ilevro in the right eye, Trusopt in the left eye and Combigan in the left eye). Reconciliation of this medication administration observation with Resident #2's current medication orders and the August 2017 MAR revealed latanoprost was not administered as ordered.

Interview on 8/17/17 at 1:30 PM with Nurse #1 revealed when she reviewed the August 2017 MAR for Resident #2, she did not see the latanoprost eye drop order when the resident's other eye drops were administered with her morning medications, and latanoprost was not one of the eye drops she administered. She stated she looked through the medication cart and could not find latanoprost eye drops for Resident #2.

Interview on 8/17/17 at 1:40 PM with Nurse #2 revealed latanoprost should be refrigerated but when she checked the medication room refrigerator, she could not find any latanoprost for Resident #2.

Interview on 8/17/17 at 1:40 PM with the Director of Nursing (DON) revealed she reviewed the August 2017 MAR for Resident #2 and identified her initials in the administration block for latanoprost on 8/3/17 at 9:00 AM. She stated she was on that cart on 8/3/17 at approximately 9:00 AM and recalled giving the latanoprost. She

Committee recommendations.

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stated the circled initials on 8/5/17 and from 8/7/17 through 8/11/17 meant that the medication was not given and she expected staff to document a comment on the back side of the MAR as to why it was not given. She stated she could not explain why there was no documentation for the medication in the administration block for 8/6/17. She stated staff did not inform her or Nurse #2 of any problems regarding this medication and she would have expected nurses to communicate issues to her.

Interview on 8/17/17 at 2:15 PM with the Administrator revealed she reviewed the electronic record which documented Resident #2's latanoprost order was renewed on 7/27/17 and it was never delivered by the pharmacy. She stated a medication variance report was being completed.

Interview on 8/17/17 at 2:18 PM with NA #2 revealed she was a medication aide and her review of the August 2017 MAR for Resident #2 showed her initials as circled on 8/7/17 through 8/9/17 and this noted the medication as not given. She stated she would write down medications missing from the medication cart on a piece of paper, but she could not remember specifically writing down latanoprost. She stated she remembered giving the resident giving the resident three eye drops on 8/15/17 and 8/16/17 at approximately 9:00 AM and identified her initials on the August 2017 MAR for those days, but she did not give four eye drops. She stated it could have been the latanoprost that was not given, but she "went down the line" on the MAR and initialed all the medications as given.

Telephone interview on 8/17/17 at 2:35 PM with

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NA #1 revealed she was unable to talk and she did not return a telephone call as requested.

Telephone interview on 8/17/17 at 2:41 PM with Nurse #3 was attempted and unsuccessful.

Telephone interview on 8/17/17 at 2:44 PM with NA #3 was attempted and unsuccessful.

Interview on 8/17/17 at 2:52 PM with NA #4 revealed he was also a medication aide and recalled he passed medications on 8/12/17. He stated Resident #2 had recent eye surgery and received lots of eye drops. He stated a lot of her eye drops had been out and he only gave two, one in her right eye and one her left eye. He stated he did not give latanoprost as it was out. He stated he was expected to write down when medications were missing and to tell "someone" but he could not recall whom he told.

Interview on 8/17/17 at 2:59 PM with Nurse #1 revealed she usually went into Resident #2's room with three eye drops and she could not recall giving the resident latanoprost. She stated she did not give it the morning of the interview. She stated if she could not find a medication that was due she would look through all the drawers in the medication cart and if it still could not be located, she would look in the medication refrigerator. She stated she would review the resident's chart to confirm the order and contact the doctor if an order was needed. She stated she did not call a doctor to confirm the need for an order for latanoprost. She stated that the morning of the interview she grabbed the three eye drops she always grabbed. She stated she saw the order for the latanoprost when reviewing the MAR but she was not thinking of needing to

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F 333	Continued From page 6 get a fourth eye drop. Telephone interview on 8/17/17 at 3:47 PM with the Triage Nurse at the Ophthalmologist's office for Resident #2 revealed the Ophthalmologist was in surgery all day, would not be able to return a telephone call and she would leave a message for him to communicate directly with the facility to review the resident's eye medication orders. Interview on 8/17/17 at 6:00 PM with the DON revealed she expected staff to take off orders, transcribe them to the MAR and fax them to the contract pharmacy by 4:30 PM to permit delivery that same night. She stated that there was on duty a weekend pharmacist to permit processing of orders seven days a week. She stated the contract pharmacy could not tell the facility why latanoprost was not delivered.	F 333		