

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2019
NAME OF PROVIDER OR SUPPLIER MAGGIE VALLEY NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 75 FISHER LOOP MAGGIE VALLEY, NC 28751	
(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 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and Medical Director and staff interviews the facility failed to follow the physician's standing order parameters for an elevated temperature for 1 of 3 residents reviewed for providing care according to professional standards (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 07/17/17 with diagnoses which included Parkinson's disease and dementia.</p> <p>Review of physician's standing orders under the section named temperature/fever read in part:</p> <ol style="list-style-type: none"> Administer 325 milligrams acetaminophen or equivalent, give 2 tablets orally every 6 hours as needed for a temperature greater than 101.5 degrees Fahrenheit for 24 hours. Call the MD for a temperature greater than 100.5 degrees Fahrenheit or that last longer than 24 hours. <p>Review of a nurse note dated 02/12/19 at 4:53 AM, Nurse #1 documented Resident #1 had a congested cough with diminished lung sounds and a temperature of 102.4 degrees Fahrenheit at 4:00 AM. Acetaminophen (medication used to</p>	F 658	<p>The electronic MAR was updated on 3/14/19 by the Assistant Director of Nursing Services to reflect the physicians standing order parameters and physician notification requirements for an elevated temperature. The built-in electronic MAR templates were replaced by the facility standing orders on 3/14/19.</p> <p>The electronic MAR was updated on 3/14/19 by the Assistant Director of Nursing Services to reflect the physicians standing order parameters and physician notification requirements for an elevated temperature. The built-in electronic MAR templates were replaced by the facility standing orders on 3/14/19.</p> <p>100% of the current nurses were educated on physician standing order parameters and notifying the physician per standing orders on 2/27/19, 2/28/19 and 3/3/19 by the Director of Nursing Services, all new licensed nurses will be educated during orientation by the Staff Development Coordinator.</p> <p>Physician Standing Order Notification and Parameter documentation will be audited</p>	3/18/19

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

TITLE

(X6) DATE

Electronically Signed

03/19/2019

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 658	<p>Continued From page 1</p> <p>reduce a fever) was administered per physician's standing orders. After receiving acetaminophen Nurse #1 noted the resident's current temperature was 101.1 degrees Fahrenheit and she would continue to monitor and notify the Medical Doctor (MD) as needed.</p> <p>Resident #1 was sent to the hospital on 02/12/19 with admitting diagnoses which included urinary tract infection, sepsis, and pneumonia. The resident returned to the facility on 02/21/19.</p> <p>During an interview on 02/26/19 at 3:37 PM Nurse #1 confirmed she administered acetaminophen and provided care for Resident #1 on 02/12/19. After the Nurse Aide informed her Resident #1 felt hot to the touch she obtained a temperature reading of 102.4 degrees Fahrenheit and administered acetaminophen per physician's standing orders. She rechecked the temperature to obtain a second reading of 101.1 degrees Fahrenheit. She reported Resident #1's elevated temperature to the oncoming nurse but didn't notify the MD. Nurse #1 revealed physician's standing orders were the same for all residents and she wasn't aware of any parameters to notify the MD. She also stated the MD wasn't informed due to the time of day Resident #1 presented with a temperature. She thought the doctor would be at the facility later that morning and if not, the day shift nurse she reported to would call. After reviewing the physician's standing orders Nurse #1 revealed she didn't read the entire order which included guidance and confirmed the MD should've been notified of Resident #1's temperature readings.</p> <p>During an interview on 02/26/19 at 4:06 PM the Medical Director revealed he expected the nurses</p>	F 658	<p>three times a week by the Director of Nursing Services or Assistant Director of Nursing along with the IDT Team. The audits began on 2/27/19 and the results will be reviewed at the monthly QAPI Meeting for follow-up and compliance x 3 months The QAPI reviews are scheduled for the fourth Wednesday of each month beginning 3/27/19.</p>		

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F 658	Continued From page 2 to notify the physician and/or Nurse Practitioner when a resident presents with an elevated temperature per the physician's standing orders. He stated the physician's standing orders should be followed by the nurses. On 02/29/19 at 5:59 PM an interview was conducted with the Director of Nursing (DON) who revealed physician's standing orders were the same for all residents and included instructions of when to notify the MD. The DON revealed it was her expectation the nurse would read the entire physician's standing orders, follow the instructions, and would notify the MD regardless of the time a resident presented with an elevated temperature. She explained Nurse #1 didn't read the entire physician's standing order and therefore wasn't aware of the parameters and didn't notify the MD.	F 658			
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review, and Medical Director, and staff interviews the facility failed to promptly	F 777	100% of Licensed Nurses were re-educated on 3/14/19 by the Director of	3/18/19	

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F 777	<p>Continued From page 3</p> <p>notify the physician of abnormal chest x-ray results for 1 of 3 residents reviewed for providing care according to professional standards (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 07/17/17 with diagnoses which included Parkinson disease and dementia. Resident #1 was discharged from the facility and admitted to the hospital on 02/12/19 with diagnoses which included urinary tract infection, sepsis, and pneumonia. Resident #1 returned to the facility on 02/21/19.</p> <p>Review of a nurse note dated 02/09/19 at 3:42 PM Nurse #2 documented Resident #1 was noted with an acute cough and the Nurse Practitioner (NP) was notified of the resident's condition. An order was received to obtain a 2-view chest x-ray. A mobile x-ray service was contacted, the order placed, and Resident #1 was awaiting the procedure.</p> <p>Review of Resident #1's medical record revealed a chest x-ray dated 02/09/19 concluded right lung airspace opacities (fluid or solid material within the airways) disease commonly related to pneumonia in the acute clinical setting with findings such as fever and leukocytosis (a sign of an inflammatory response, most commonly the result of infection). The chest x-ray results were available 02/09/19 but it was noted on the results the physician was notified on 02/11/19.</p> <p>Review of a nurse note dated 02/12/19 at 4:53 AM Nurse #1 documented Resident #1 was noted to have a congested cough with diminished lung</p>	F 777	<p>Nursing Services on timely physician notification when a Radiology Report indicates any abnormalities or inconclusive results.</p> <p>All resident radiology reports for the past 45 days were audited by the Quality Assurance Nurse on 2/27/19 for timely and proper notification, follow-up and signature by the physician. Notification and follow-up by the physician was done timely on all charts.</p> <p>100% of Licensed Nurses were educated on 2/27/19, 2/28/19 and 3/3/19 by the Director of Nursing Services on timely physician notification when a Radiology Report indicates any abnormalities or inconclusive results.</p> <p>All new Licensed Nurses will be educated by The Staff Development Coordinator on timely physician notification and follow-up when a Radiology Report indicates any abnormalities or inconclusive results.</p> <p>A tracking form has been implemented that will be reviewed daily (Monday through Friday) by the Director of Nursing Services or the Assistant Director of Nursing Services along with IDT team. The RN Supervisor will review Radiology Reports on the weekend and notify the physician in a timely manner of any abnormal Radiology Reports, and report to the Director of Nursing Services and the IDT team Monday morning for follow-up. The results of the these audits will be presented at the monthly QA</p>		

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F 777	<p>Continued From page 4</p> <p>sounds and a temperature of 102.4 degrees Fahrenheit at 4:00 AM. An Antipyretic (medication used to reduce a fever) was administered and Resident #1's temperature reduced to 101.1 degrees Fahrenheit. The nurse documented she would continue to monitor and notify the Medical Doctor as needed.</p> <p>A review of physician orders revealed an order dated 02/12/19 for Resident #1 to be sent to the emergency room per family request, fever, and altered mental status.</p> <p>During an interview on 02/29/19 at 4:06 PM the Medical Director stated providing a resident with antibiotic treatment was reviewed case by case and he would expect to be notified by the nurse at the time the chest x-ray results were received.</p> <p>On 02/29/19 at 4:34 PM an interview conducted with Nurse #3 revealed she worked from 7:00 AM to 7:00 PM on 02/09/19. She explained it was her responsibility to follow-up on pending x-ray results and notify the physician when she received the results. She stated Resident #1's chest x-ray results weren't received before her shift ended on 02/09/19. She did work on 02/10/19 but didn't follow-up on the chest x-ray results because she felt it was the responsibility of the nurse who received the results to call and notify the physician. She revealed the nurse who gave her report on the morning of 02/10/19 didn't inform her of Resident #1's chest x-ray results therefore she assumed the x-ray was done and everything was okay.</p> <p>An interview conducted on 02/29/19 at 5:08 PM, Nurse #4 revealed during shift report on 02/12/19 she was told Resident #1 had a difficult night and</p>	F 777	<p>Meeting the fourth Wednesday of each month beginning 3/27/19, for review and further education/training as needed and has been made a permanent audit form with no end date.</p>		

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

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F 777	<p>Continued From page 5</p> <p>was lethargic, congested, and presented with a low-grade temperature. She wasn't aware a chest x-ray had been done on 02/09/19. Nurse #4 revealed she thought Resident #1 was presenting with a new onset of decline. She revealed the NP spoke to a family member who didn't want Resident #1 treated at the facility but sent to the hospital. The NP ordered the resident be sent to the emergency room per family request.</p> <p>During an interview on 02/29/19 at 5:45 PM, Nurse #5 confirmed she had overseen Resident #1's care from 7:00 PM on 02/09/19 through 7:00 AM on 02/10/19. At the beginning of her shift she received report from Nurse #3 but didn't recall being informed Resident #1 received a chest x-ray and was waiting for results. She explained part of her shift duties were to review new physician orders over the past 24 hours but didn't recall seeing an order and/or results of a chest x-ray for Resident #1. She stated any abnormal x-ray results received she reported to the MD, or on-call physician.</p> <p>An interview conducted on 02/29/19 at 6:03 PM the Director of Nursing revealed it was her expectation nurses would notify the MD or NP with abnormal x-ray results related to pneumonia. The DON explained the nurse on duty was responsible for a 24-hour chart check and should've seen the chest x-ray order in Resident #1's chart and been watching for the results to come over the fax machine.</p>	F 777			