STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and Medical Doctor interview, the facility failed to transcribe medications to the Medication Administration Record, obtain medications from the pharmacy and administer medications as ordered by the physician for 1 of 3 residents reviewed for providing care according to professional standards (Resident #8). The findings included: Resident #8 was admitted to the facility on 02/21/19 from the hospital and discharged from the facility on 02/22/19. Resident #8's diagnoses included diabetes mellitus, hypertension, left heel wound infection, and neuropathy. Due to the date of the facility admission, there was no Minimum Data Set (MDS) assessment or care plan to review. Review of a nursing note, dated 02/21/19, indicated in part, that Resident #8 arrived at the facility approximately 6:30 PM. Vital signs were stable. Resident #8 was alert and oriented to person, place, and time and was without any signs of distress. Review of a nursing note, dated 2/21/19 at 9:43 PM, written by Nurse #1, revealed that	F 658	F658 1. How Corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #8 no longer resides at the facility; transferred on 2/22/19. All licensed nurses currently employed at the facility able to verbalize and demonstrate how to enter orders into the facility Electronic Medical Record (EMR) system. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Any resident(s) admitted since survey exit, until 5/16/19 were reviewed to ascertain ordered medications were transcribed to the medication administration record (MAR), medications were received from the pharmacy, and administered as ordered. No discrepancies found. 3. What measures will be put into place or systemic changes made to ensure that	5/16/19

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

Electronically Signed | 05/22/2019

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F 658	Continued From page 1 medications were verified with an on-call family nurse practitioner and faxed to pharmacy. The medications were called to pharmacy due to cut off time (5:00 PM was the cut-off time for new admission orders to be processed). Review of the hospital discharge summary medication list, dated 02/21/19, revealed orders that included: - Atorvastatin (Lipitor) 20 milligram (mg) (1 tablet) by mouth (po) daily for high cholesterol. - Escitalopram (Lexapro) 10 mg (1.5 tablets) po daily for mood symptoms. - Ferrous Sulfate 325 mg (1 tablet) po twice a day for anemia. - Ranitidine (Zantac) 150 mg (1 tablet) po daily for stomach acid. Review of Resident #8's Electronic Medication Administration Record (EMAR) for 02/21/19 to 02/22/19 revealed none of the medications from the hospital discharge summary had been transcribed to the EMAR. Review of Resident #8's History and Physical, dated 02/22/19, read in part, patient was seen for initial admission evaluation without apparent distress and no pain identified. Vital signs: Temperature-98.3 degrees Fahrenheit; Pulse-79 beats per minute; Respiratory Rate-17 breaths per minute; Blood Pressure-134/61; and Oxygen Saturation-94% on room air. A phone interview was conducted with Nurse #3 on 05/06/19 at 2:28 PM. He indicated he received very little training regarding inputting orders on the EMAR. He stated that he came in to work on 02/21/19 at 8:00 PM and remembered Resident	F 658	the deficient practice will not recur? Licensed nurse education was completed by the Assistant Director of Nursing on 5/9/2019 which included Admission/readmission required procedures; verify all orders with the physician, orders verified with second nurse after medication orders were entered correctly into the facility electronic medical record medication administration record, fax all pharmacy orders to pharmacy as soon as they are received and put a copy of the faxed confirmation in the Director of Nursing (D.O.N.) or Assistant Director of Nursing box, call pharmacy for verification that orders were received and that they will be delivered with the next pharmacy run, document in nurses progress note who spoke to at the pharmacy with date and time. Any nurse not receiving the education by 5/9/2019 will not be allowed to work shift until completed. New licensed nurses will be educated during their new-hire orientation. New resident orders and any new admission/readmission charts will be reviewed starting 5/9/19 during AM clinical meeting by the Interdisciplinary team (IDT) members that includes at a minimum the Director of Nursing (D.O.N.), Minimum Data Set (MDS) Nurse, and Administrator PRN, Monday-Friday, and weekends by the RN Weekend Supervisor. Review to include; new orders	

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F 658	Continued From page 2 #8 had admission orders that Nurse #1 did not complete during her shift and stayed after her shift to work on them. He revealed that Nurse #1 told him she would be back on 02/22/19 to finish the admission orders and asked him to put the orders on the EMAR. He indicated that he did not know how to add orders to the EMAR and did not remember if another nurse was working that night to help him. He further indicated that on 02/22/19, he notified Nurse #2 and the former Director of Nursing (DON) that the admission medications were not added to the EMAR. A phone interview was conducted with Nurse #1 on 05/06/19 at 3:19 PM. Nurse #1 stated that Resident #8 came in to the facility during shift change (close to 7:00 PM) on 02/21/19. She further stated that she called in the admission orders to the pharmacy and gave report to Nurse #3 and asked him to add Resident #8's medication orders to the EMAR. Nurse #1 indicated that she left the facility between 10:15 PM and 10:30 PM on 02/21/19. She further indicated that she double-checked with Nurse #3 before she left for the night and he told her he would take care of the admission orders. Nurse #1 revealed that she sent a phone text to the former DON at 10:28 PM and notified her that she was leaving and what work was left to complete on the new admission paperwork. A phone interview was conducted with Nurse #2 on 05/07/19 at 11:29 AM. She stated that she worked on the unit where Resident #8 resided on 02/22/19. She further stated that Nurse #1 received Resident #8's Depart Discharge Summary (Medication Orders) from the hospital at 2:30 PM on 02/21/19. She indicated that the resident had no other medications on the EMAR	F 658	and admission/readmission orders were properly faxed to the pharmacy, medication orders were entered correctly into the facility electronic medical record medication administration record, medications received as ordered and on the medication cart, and medications have been administered as ordered. 4. How will the facility monitor its performance to make sure that solutions are sustained? Starting 5/16/19 New order(s) and Admission/re-admission audits will be completed by the Director of Nursing (D.O.N.) and Minimum Data Set (MDS) Nurse, or a designated nurse administrator weekly M-F for 4 weeks, then Random 3x/week for 2 months. Audit to include; any new resident orders and admission/readmission orders were properly faxed to the pharmacy, medication orders were entered correctly into the facility electronic medical record medication administration record, medications received as ordered and on the medication cart, and medications have been administered as ordered. Results of the audits will be presented by the D.O.N. at the monthly Quality Assurance Performance Improvement (QAPI) x3 months or until a timeframe determined by the QAPI members.	

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F 658	Continued From page 3 except for Tylenol as needed for pain in which Nurse #3 called an on-call physician to get the order. She explained the process for admitting new residents after 5:00 PM which was to contact an on-call physician for approval of orders, fax medication orders to pharmacy, and add new medication orders to the EMAR. She stated that she notified the DON as soon as she found out the other orders were not added to the EMAR. Nurse #2 further stated that the DON instructed her to add the medication orders to the EMAR; however, she said she was not assigned to that hall and the DON then asked to speak to Nurse #1. An interview was conducted with the Admissions Director on 05/07/19 at 2:49 PM. She stated that on 02/21/19 at 1:00 PM, she distributed Resident #8's Depart Discharge Summary to the Administrator, DON, and nurse managers. She further stated that it was the DON's responsibility to distribute the Depart Discharge Summary to the floor nurse who was taking care of that resident. The former DON could not be reached for a phone interview. A phone interview was conducted with the Medical Doctor on 05/07/19 at 4:08 PM. He stated he was not notified of Resident #8 not receiving the medications on 02/21/19 and 02/22/19. He further stated he could not say the omission of the medications were harmful to Resident #8 because she was stable when he assessed her on 02/22/19. A phone interview was conducted with the former Administrator on 05/07/19 at 4:33 PM. He stated	F 658	The Director of Nursing is responsible for the Implementation of the Plan of Correction and the Administrator is responsible is for sustained compliance. Date of Correction: 5/16/19	

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F 658	Continued From page 4 that Resident #8 was admitted to the facility between 5:00 PM and 6:00 PM on 02/21/19. He further stated Nurse #1 was responsible for Resident #8's admission orders and she did not put Resident #8's admission orders on the EMAR. He further indicated he could not recall when her orders came in from the hospital. He indicated Nurse #1 stayed to work until 11:00 PM on 02/21/19 and she told Nurse #3 that the admission medications needed to be added to the EMAR. He further indicated Nurse #3 did not have time to add the admission medications to the EMAR. He explained that Nurse #2 informed the former DON that the medications were not on the EMAR and the DON told her to notify Nurse #1 to add the orders to the EMAR. The former Administrator further explained that Nurse #1 did not ask any of the staff for help in completing the admission. He stated that he did not know the reason why the medications were not entered into the EMAR as Nurse #1 did not provide a valid answer. An interview was conducted with the current DON on 05/07/19 at 4:58 PM. She stated that her expectation was the new admission orders would be completed the day the resident was admitted and expected medications to be verified by two nurses. An interview was conducted with the current Administrator on 05/07/19 at 5:01 PM. She indicated she expected admission orders to be completed within a few hours of a resident admitting to the facility.	F 658		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		5/16/19

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F 760	Continued From page 5 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, family interview, and Medical Doctor interview, the facility failed prevent a significant medication error by not transcribing physician prescribed medications to the Medication Administration Record and not obtaining the medications from the pharmacy for 1 of 3 residents (Resident #8) reviewed for medication errors. Resident #8 was not administered insulin, an antibiotic, blood pressure medication, and a medication used to treat nerve pain. The findings included: Resident #8 was admitted to the facility on 02/21/19 from the hospital and discharged from the facility on 02/22/19. Resident #8's diagnoses included diabetes mellitus, hypertension, left heel wound infection, and neuropathy. Due to the date of the facility admission, there was no Minimum Data Set (MDS) assessment or care plan to review. Review of a nursing progress note, dated 02/21/19, written by Nurse #1, indicated in part, that Resident #8 arrived at the facility approximately 6:30 PM. Vital signs were stable. Resident #8 was alert and oriented to person, place, and time and was without any signs of distress. Review of a nursing note, dated 2/21/19 at 9:46 PM, written by Nurse #1, revealed that	F 760	F760 1. How Corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #8 no longer resides at the facility; transferred on 2/22/19. All licensed nurses currently employed at the facility able to verbalize and demonstrate how to enter orders into the facility Electronic Medical Record (EMR) system. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Any resident(s) admitted since survey exit, until 5/16/19 were reviewed to ascertain ordered medications were transcribed to the medication administration record (MAR), medications were received from the pharmacy, and administered as ordered. No discrepancies found. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed nurse education was completed by the Assistant Director of Nursing on	

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F 760	Continued From page 6 medications were verified with an on-call family nurse practitioner and faxed to pharmacy. The medications were called to pharmacy due to cut off time (5:00 PM was the cut-off time for new admission orders to be processed). Review of the hospital discharge summary medication list, dated 02/21/19, revealed orders that included: - Amoxicillin-clavulanate 875 milligram (mg)-125 mg (1 tablet) by mouth (po) every 12 hours for 12 days to treat infection. - Chlorthalidone 25 mg (1 tablet) po daily to treat high blood pressure. - Insulin aspart 100 units/milliliter (mL)- inject 4 units subcutaneous (SQ) three times a day with meals to treat diabetes mellitus. - Insulin aspart 100 units/mL per sliding scale SQ three times a day before meals to treat diabetes mellitus. - Insulin detemir 100 units/mL- inject 14 units SQ at bedtime to treat diabetes mellitus. - Nifedipine 60 mg extended release (1 tablet) po daily to treat hypertension. - Pregabalin (Lyrica) 25 mg (1 capsule) po three times a day to treat pain. Review of the Electronic Medication Administration Record (EMAR) for 02/21/19 to 02/22/19 revealed the medications had not been administered to Resident #8 since admission. Review of Resident #8's History and Physical, dated 02/22/19, read in part, patient was seen for initial admission evaluation without apparent distress and no pain identified. Vital signs: Temperature-98.3 degrees Fahrenheit; Pulse-79	F 760	5/9/2019 which included Admission/readmission required procedures; verify all orders with the physician, have orders verified with second nurse after medication orders were entered correctly into the facility electronic medical record medication administration record, fax all pharmacy orders to pharmacy as soon as they are received and put a copy of the faxed confirmation in the Director of Nursing (D.O.N.) or Assistant Director of Nursing box, call pharmacy for verification that orders were received and that they will be delivered with the next pharmacy run, document in nurses progress note who spoke to at the pharmacy with date and time. Any nurse not receiving the education by 5/9/2019 will not be allowed to work shift until completed. New licensed nurses will be educated during their new-hire orientation. New resident orders and any new admission/readmission charts will be reviewed starting 5/9/19 during AM clinical meeting by the Interdisciplinary team (IDT) members that includes at a minimum the Director of Nursing (D.O.N.), Minimum Data Set (MDS) Nurse, and Administrator PRN, Monday-Friday, and weekends by the RN Weekend Supervisor. Review to include; new orders and admission/readmission orders were properly faxed to the pharmacy, medication orders were entered correctly	

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F 760	Continued From page 7 beats per minute; Respiratory Rate-17 breaths per minute; Blood Pressure-134/61; and Oxygen Saturation-94% on room air. A phone interview was conducted with Nurse #3 (former agency nurse) on 05/06/19 at 2:28 PM. He stated that he came in to work on 02/21/19 at 8:00 PM and remembered Resident #8 had admission orders that Nurse #1 did not complete during her shift and stayed after her shift to work on them. He revealed that Nurse #1 told him she would be back on 02/22/19 to finish the admission orders and asked him to put the orders on the EMAR. He indicated that he did not know how to add orders to the EMAR and did not remember if another nurse was working that night to help him. He further indicated that on 02/22/19, he notified Nurse #2 and the former Director of Nursing (DON) that the admission medications were not added to the EMAR. A phone interview was conducted with Nurse #1 on 05/06/19 at 3:19 PM. Nurse #1 stated that Resident #8 came in to the facility during shift change (close to 7:00 PM) on 02/21/19. She further stated that she called in the admission orders to the pharmacy and gave report to Nurse #3 and asked him to add Resident #8's medication orders to the EMAR. Nurse #1 indicated that she left the facility between 10:15 PM and 10:30 PM on 02/21/19. She further indicated that she double-checked with Nurse #3 before she left for the night and he told her he would take care of the admission orders. Nurse #1 revealed that she sent a phone text to the former DON at 10:28 PM and notified her that she was leaving and what work was left to complete on the new admission paperwork.	F 760	into the facility electronic medical record medication administration record, medications received as ordered and on the medication cart, and medications have been administered as ordered. 4. How will the facility monitor its performance to make sure that solutions are sustained? Starting 5/16/19 New order(s) and Admission/re-admission audits will be completed by the Director of Nursing (D.O.N.) and Minimum Data Set (MDS) Nurse, or a designated nurse administrator weekly M-F for 4 weeks, then Random 3x/week for 2 months. Audit to include; any new resident orders and admission/readmission orders were properly faxed to the pharmacy, medication orders were entered correctly into the facility electronic medical record medication administration record, medications received as ordered and on the medication cart, and medications have been administered as ordered. Results of the audits will be presented by the D.O.N. at the monthly Quality Assurance Performance Improvement (QAPI) x3 months or until a timeframe determined by the QAPI members. The Director of Nursing is responsible for the Implementation of the Plan of Correction and the Administrator is	

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F 760	Continued From page 8 A phone interview was conducted with Nurse #2 on 05/07/19 at 11:29 AM. She stated that she worked on the unit where Resident #8 resided on 02/22/19. She further stated that Nurse #1 received Resident #8's Depart Discharge Summary (Medication Orders) from the hospital at 2:30 PM on 02/21/19. She indicated that the resident had no other medications on the EMAR except for Tylenol as needed for pain in which Nurse #3 called an on-call physician to get the order. She explained the process for admitting new residents after 5:00 PM which was to contact an on-call physician for approval of orders, fax medication orders to pharmacy, and add new medication orders to the EMAR. She stated that she notified the DON as soon as she found out the other orders were not added to the EMAR. Nurse #2 further stated that the DON instructed her to add the medication orders to the EMAR; however, she said she was not assigned to that hall and the DON then asked to speak to Nurse #1. An interview was conducted with the Admissions Director on 05/07/19 at 2:49 PM. She stated that on 02/21/19 at 1:00 PM, she distributed Resident #8's Depart Discharge Summary to the Administrator, DON, and nurse managers. She further stated that it was the DON's responsibility to distribute the Depart Discharge Summary to the floor nurse who was taking care of that resident. The former DON could not be reached for a phone interview. A phone interview was conducted with the Medical Doctor on 05/07/19 at 4:08 PM. He stated he was not notified of Resident #8 not	F 760	responsible is for sustained compliance. Date of Correction: 5/16/19	

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F 760	Continued From page 9	F 760		

receiving the medications on 02/21/19 and 02/22/19. He further stated Resident #8 seemed okay when he assessed her on 02/22/19.

A phone interview was conducted with the former Administrator on 05/07/19 at 4:33 PM. He stated that Resident #8 was admitted to the facility between 5:00 PM and 6:00 PM on 02/21/19. He further stated Nurse #1 was responsible for Resident #8's admission orders and she did not put Resident #8's admission orders on the EMAR. He further indicated he could not recall when her orders came in from the hospital. He indicated Nurse #1 stayed to work until 11:00 PM on 02/21/19 and she told Nurse #3 that the admission medications needed to be added to the EMAR. He further indicated Nurse #3 did not have time to add the admission medications to the EMAR. He explained that Nurse #2 informed the former DON that the medications were not on the EMAR and the DON told her to notify Nurse #1 to add the orders to the EMAR. The former Administrator further explained that Nurse #1 did not ask any of the staff for help in completing the admission. He stated that he did not know the reason why the medications were not entered on the EMAR as Nurse #1 did not provide a valid answer.

A phone interview was conducted with Resident #8's family member on 05/07/19 at 12:41 PM. She stated that the resident's blood sugar and blood pressure was stable, and the resident did not go to the hospital when the resident discharged to the other long-term care facility on 02/22/19.

An interview was conducted with the current DON on 05/07/19 at 4:58 PM. She stated that her

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F 760	Continued From page 10 expectation was the new admission orders would be completed the day the resident was admitted and expected medications to be verified by two nurses. An interview was conducted with the current Administrator on 05/07/19 at 5:01 PM. She indicated she expected admission orders to be completed within a few hours of a resident admitting to the facility.	F 760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

(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 000}	INITIAL COMMENTS On May 6, 2019 through May 7, 2019 the Division of Health Service Regulation, Nursing Home Licensure and Certification conducted a revisit. The deficiencies cited on March 22, 2019 were corrected effective May 7, 2019. The facility remains out of compliance due to deficient practice identified during the revisit.	{F 000}		

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

Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	R 05/07/2019

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