STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN HOME HEALTH AND REHAB	200 HERITAGE DR HENDERSONVILLE, NC 28739

(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 No deficiencies were cited as a result of the complaint investigation.	F 000	**The submission of the Plan of Correction does not constitute agreement on the part of Mountain Home Health and Rehabilitation Center that the deficiency cited with the report represent deficient practices on the part of Mountain Home Health and Rehabilitation Center. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.**	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**Tag: F272---Comprehensive Assessments** **Corrective action for identified residents:** Care Area Assessments were completed for residents #136 and #118. **How other residents with the potential for deficient practice identified:** MDS nurse will audit most recent comprehensive assessment of all residents by August 9, 2012. Any resident's comprehensive assessment found without a CAA will be corrected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa
TITLE: Administrator
(X6) DATE: 8/9/12

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.

Original signature 8/13/12 mh

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review the facility failed to complete Care Area Assessments on admission comprehensive Minimum Data Sets for two (2) of sixteen (16) sampled residents. (Residents #136 and #118). The findings are: 1. Resident # 136 was admitted to the facility on 04/26/12. A review of the comprehensive admission Minimum Data Set (MDS) dated 05/10/12 revealed no Care Area Assessments (CAA) were available. An interview with the MDS Coordinator was conducted on 07/11/12 at 3:59 PM. She stated the comprehensive admission MDS for Resident # 136 was done in combination with the fourteen (14) day Prospective Payment System (PPS) assessment. The MDS Coordinator added PPS assessments did not require CAA. After consulting the Resident Assessment Instrument, the MDS Coordinator stated she should have completed CAA that were required with all comprehensive MDS assessments. 2. Resident #118 was admitted to the facility on 04/27/12. A review of the comprehensive admission Minimum Data Set (MDS) dated	F 272	**Systematic changes made to ensure deficient practice does not reoccur:** MDS nurse will audit Comprehensive Assessments for the completed CAA weekly for two months, monthly for three months and then quarterly for compliance. The information will be forwarded to Director of Nursing. **Facility monitoring process:** Director of Nursing or Designee will monitor weekly for two months and monthly for 3 months and then quarterly for one year to insure continued compliance and report to the Quality Assurance.	8-9-12

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F 272	Continued From page 2 05/11/12 revealed no Care Area Assessments (CAA) were available. An interview with the MDS Coordinator was conducted on 07/12/12 at 11:57 AM. She stated the comprehensive admission MDS for Resident # 118 was done in combination with the fourteen (14) day Prospective Payment System (PPS) assessment. The MDS Coordinator added PPS assessments did not require CAA. After consulting the Resident Assessment Instrument, the MDS Coordinator stated she should have completed CAA that were required with all comprehensive MDS assessments.	F 272		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 325	**Tag: F325---Maintain Nutrition Status Unless Unavoidable** **Corrective action for identified residents:** Resident #118's diet order was changed in the Meal Tracker System on 7/12/12. **How other residents with the potential for deficient practice identified:** 100% of all diet orders will be audited to ensure accuracy with Meal Tracker system by Registered Dietitian/Certified Dietary Manager. This process will be completed by 8/9/12.	

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F 325	Continued From page 3 medical and facility record reviews, the facility failed to implement a physician's order for fortified foods as an intervention for unintended weight loss for one (1) of three (3) residents reviewed for weight loss. (Resident #118). The findings are: Resident #118 was admitted to the facility with diagnoses including diabetes mellitus and anemia. Medical record review revealed Resident #118's weight was recorded as 165 pounds on 05/02/12. Continued medical record review revealed a physician order dated 05/03/12. The order specified to discontinue a no added salt restriction and add fortified foods every meal for nutritional support. An admission Minimum Data Set (MDS) dated 05/11/12 indicated no cognitive impairment. The MDS specified the resident required meal tray set up and supervision with eating and weighed 169 pounds at the time of admission. A note dated 05/26/12 and signed by the Registered Dietician (RD) specified a current weight of 163.2 pounds. The note stated the resident's diet order was regular with fortified foods with every meal and the resident demonstrated an overall weight loss of 3.6% in three (3) weeks. The note documented the weight loss was not desired and the resident's weight was expected to stabilize with diet utilization. No new recommendations were prescribed at this time.	F 325	**Systematic changes made to ensure deficient practice does not reoccur:** Following completion of the full house audit of 8/9/12, 100% if all residents will have their diet order audited monthly X 3 months, then quarterly thereafter. Audits will be completed by the Registered Dietitian/Certified Dietary Manager. **Facility monitoring process:** Results of the physician prescribed diet orders and Meal Tracker system audits will be reviewed monthly by the Registered Dietitian and results communicated to the Director of Nursing for 3 months. Thereafter, the results will be reviewed quarterly. Results will be reviewed at the monthly Quality Assurance meetings as indicated.	8912

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F 325	Continued From page 4 Further medical record review revealed weights recorded on 06/06/12 at 160.4 pounds, 07/04/12 at 152.8 pounds, and 07/12/12 at 152.4 pounds. An observation of the lunch meal on 07/12/12 at 12:10 PM revealed no fortified foods were served. A review of the lunch tray card revealed the diet specified no added salt with no mention of fortified foods. Observations of tray cards from breakfast for 07/12/12 and supper for 07/11/12 revealed no mention of fortified foods. An interview with the RD on 07/12/12 at 12:28 PM confirmed no fortified foods were listed on the tray cards for the past three (3) meals and were not served to the resident. An interview was conducted with the RD and Dietary Manager (DM) on 07/12/12 at 1:41 PM. The DM stated the physician order dated 05/03/12 for the addition of fortified foods was not added into the meal tracker that printed the tray cards. The DM added another DM was in the facility at time and the reason for this omission could not be determined. Both the RD and DM confirmed Resident #118 had not received fortified foods since 05/03/12. The RD stated residents with weight loss were discussed at a weekly weight meeting.. She added the weight of 152.8 pounds was obtained after the weight meeting was held last week and before this week's meeting which was held today, 07/12/12. The resident was weighed today and recorded at 152.4 pounds. The RD stated the total weight loss was 4.9% since admission. The RD stated meal tray cards were audited quarterly to ensure diet orders were correct. The DM stated no meal tray audit had been completed since the	F 325		

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F 325	Continued From page 5 physician ordered diet change for Resident #118 written on 05/03/12.	F 325		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility medication rate was greater than 5% as evidenced by three (3) medication errors out of fifty-three (53) opportunities, resulting in a medication error rate of 5.66%, for two (2) of ten (10) residents observed during medication pass (Residents #32 and #94.). The findings are: 1. a. On 07/11/12 at 9:40 AM, Licensed Nurse (LN) #1 was observed administering medication to Resident #32. She administered 5 cc of a liquid formulation of metoclopramide, equivalent to 5 mg, by mouth to the resident. A review of the medical record of Resident #32 revealed a physician order, dated 06/12/12, to administer 5 mg per 5 cc of metoclopramide by mouth before meals and at bedtime. A review of the Medication Administration Record (MAR) also revealed the order to administer 5 mg per 5 cc of metoclopraimde by mouth before meals and at bedtime. On 07/11/12 at 10:15 AM, LN #1 was interviewed.	F 332	**Tag: F332---Free of Medication Error Rates of 5% or More** **Corrective action for identified residents:** Residents #32 and #94 were monitored for any possible negative outcomes from medication error. **How other residents with the potential for deficient practice identified:** All residents have the potential to be adversely affected from the deficient practice of medication errors.	

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F 332	Continued From page 6 She reviewed the physician order and MAR and stated the metoclopramide was ordered to be given before meals. LN #1 acknowledged that Resident #32 had already had breakfast when she administered the medication. On 07/11/12 at 1:18 PM, the Director of Nursing (DON) was interviewed. The DON stated metoclopramide should be administered before meals for effectiveness, and as ordered by the physician. b. On 07/11/12 at 09:24 AM, LN #1 was observed administering medication to Resident #32. She administered Systane lubricant eye drops, one drop to each eye. LN #1 then waited for more than five minutes and administered brinzolamide ophthalmic suspension 1%, one drop to each eye. A review of the medical record of Resident #32 revealed a physician order, dated 07/02/12, to administer the brinzolamide five minutes before the Systane. A review of the Medication Administration Record (MAR) also revealed the order to administer the brinzolamide five minutes prior to the Systane. On 07/11/12 at 10:15 AM, LN #1 was interviewed. She reviewed the physician order and MAR and stated the brinzolamide should be administered before the Systane. LN #1 acknowledged she had given the Systane first. On 07/11/12 at 1:18 PM, the Director of Nursing (DON) was interviewed. The DON stated the brinzolamide eye drops should be administered five minutes before the Systane eye drops, as	F 332	**Systematic changes made to ensure deficient practice does not reoccur:** All licensed nurses will be in-serviced on Medication Administration (including eye drop administration), Crushing of Medications and Reglan Administration by the Director of Nursing/Assistant Director of Nursing by August 9, 2012. The Director of Nursing/Assistant Director of Nursing or Nurse Supervisor will complete and Medication Pass audit on all licensed nurses by August 9, 2012. The Director of Nursing/Assistant Director of Nursing or Nurse Supervisor will complete two Medication Pass audits weekly for a month and then two Medication Pass audits monthly thereafter. **Facility monitoring process:** Director of Nursing or Designee will monitor for continued compliance and report to the Monthly Quality Assurance Meetings as indicated.	8-9-12

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F 332	Continued From page 7 ordered by the physician. 2. On 07/11/12 at 9:33 AM, Licensed Nurse (LN) #2 was observed administering medication to Resident #94. She crushed a 5 mg bisacodyl (laxative) tablet and administered it to the resident in apple sauce. A review of the medical record of Resident #94 revealed a physician order, dated 08/22/11, for bisacodyl 5 mg by mouth twice a day. The order also indicated "Do not crush." A review of the Medication Administration Record (MAR) also warned not to crush the bisacodyl tablet. On 07/11/12 at 10:55 AM, LN #2 was interviewed. She stated she did not notice the warning not to crush the bisacodyl tablet on the MAR. On 07/11/12 at 1:13 PM the Director of Nursing (DON) was interviewed. The DON stated that the pharmacy designated on the MAR which medications should not be crushed. She stated she expected nursing staff to follow the instructions regarding crushing on the MAR and in the physician orders.	F 332		
F 431 SS=D	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.	F 431	**Tag: F431---Drug Records, Label/Store** **Corrective action for identified residents:** Expired Advair was discarded. Refrigerator in Medication Room was replaced during survey.	

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F 431	Continued From page 8 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: Based on observations, and staff interviews, the facility failed to discard an expired multiple dose inhaler on one (1) of four (4) medication carts, and failed to keep temperatures between 36 and 46 degrees Fahrenheit in one (1) of two (2) medication refrigerators. The findings are: 1. Review of packaging information, dated June 2010, containing manufacturer's storage	F 431	**How other residents with the potential for deficient practice identified:** All residents have potential for deficient practice. Medication Carts were audited for expired Advair and other expired medications during survey. Any opened Advair not dated was discarded immediately. **Systematic changes made to ensure deficient practice does not reoccur:** All licensed nurses were in-serviced on dating/storage of Advair during survey. Advair will be automatically discarded 30 days after opening per manufacturer's recommendation. Advair is automatically dated when opened now. List of Medication expiration dates is now located in the front of the Medication Administration Record books.	

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F 431	Continued From page 9 recommendations for Advair Diskus 100/50 mcg multiple dose inhaler revealed the following: "The device should be discarded one month after the removal from the moisture-protective foil overwrap pouch or after all the blisters have been used (when the dose indicator reads "0") whichever comes first." On 07/11/12 at 11:55 AM, during an inspection of the upper 200 hall medication cart, the following was observed: one multiple dose inhaler of Advair 100/50 mcg, dispensed by the pharmacy on 05/10/12. It was hand dated 05/31/12 to indicate when it was removed from the foil pouch and placed in use. It had eight doses left according to the built-in dose counter. Licensed Nurse (LN) #1 was interviewed at that time. She stated she was not aware the medication expired within thirty days of opening. LN #1 was shown the manufacturer's storage recommendations and she noted that, according to the recommendations, the multiple dose inhaler should have been discarded on 06/30/12. She discarded the medication. On 07/11/12 at 12:54 PM, the Director of Nursing (DON) was interviewed. She stated manufacturer's storage recommendations should be followed for all medications including Advair. The DON stated she was not aware of the thirty day discard recommendation and to her knowledge nursing staff had not been inserviced about it. 2. On 07/11/12 at 10:45 AM, the medication refrigerator in the 200 hall medication room was observed. A thermometer in the refrigerator	F 431	Medication carts will be audited 1-2 times per week for expired and undated medication by licensed nurses ongoing.. Any expired or undated medication will be returned pharmacy or discarded. All licensed nurses with access to Medication rooms were in-serviced on how to correctly monitor temperatures and when to report unusual temperatures to Maintenance Department. The Maintenance Director, Assistant Director, Administrator, Director of Nursing or Assistant Director of Nursing will also check refrigerator temperatures at least two times per week ongoing to verify refrigerator temperatures are within the manufacturer's recommendations for storage of medications (temperatures of 36-46 degrees Fahrenheit). The review will be of the Refrigerator Temperature Record which is completed daily by nursing. The reviewer will initial next to the temperature of the date that the review occurs.	

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F 431	Continued From page 10 indicated a temperature of 30 degrees Fahrenheit. Three 1 cc vials of Tuberculin Purified Protein Derivative (PPD - used for skin tests in the diagnosis of tuberculosis) were in this refrigerator. They did not appear to be frozen. Review of the undated manufacturer's recommendations for storage of the PPD vials read in part "Do not freeze. This product should be stored at 2 - 8 degrees Centigrade (36 - 46 degrees Fahrenheit) and protected from light." Review of the refrigerator temperature log for July, 2012, revealed the temperature of the refrigerator was checked every night between 11:00 PM and midnight by nursing staff. Temperatures in Fahrenheit degrees from 07/01/12 through 07/10/12 were as follows: 30, 34, 32, 36, 38, 34, 28, 28, 30, 28. On 07/12/12 at 10:35 AM, the medication refrigerator in the 200 hall medication room was again observed. A thermometer in the refrigerator indicated a temperature of 28 degrees Fahrenheit. The three PPD vials were still there and did not appear to be frozen. Review of the refrigerator temperature log for the previous evening of 07/11/12 at 11:00 pm was 30 degrees Fahrenheit. On 07/12/12 at 10:40 AM, the Maintenance Director was interviewed. He stated that if there were a problem with a medication refrigerator, it would be reported to him on a written work order by nursing staff or reported to him verbally at the morning staff meeting. He stated he had not received any reports of temperatures outside	F 431	If refrigerator is not functioning within the temperature guidelines it will be adjusted. If the adjustment does not correct the temperature issue, then maintenance will be informed and the refrigerator will be replaced. If this occurs during off work hours, then the medications will be moved to the refrigerator on the opposite wing until the refrigerator can be replaced. **Facility monitoring process:** Director of Nursing or Designee will monitor for continued compliance and report to the Monthly Quality Assurance Meetings as indicated.	8-9-12

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F 431	Continued From page 11 desired parameters in the medication refrigerators. On 07/12/12 at 10:44 AM, a tour of the 200 hall medication room was conducted with the Maintenance Director. He reviewed the temperature log and stated nursing staff should have alerted him to the temperatures below freezing. On 07/12/12 at 11:16 AM, a tour of the 200 hall medication room was conducted with the Director of Nursing (DON). The DON reviewed the temperature log and stated she expected nursing staff to keep medication storage temperatures within manufacturer's recommendations for PPD vials as well as other medications that needed refrigeration. The DON stated she expected nursing staff to promptly report temperature problems to the Maintenance Director.	F 431		