STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING _____ B. WING _____	C 12/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY CARE CENTER	3625 WILLARD FARROW DR CHARLOTTE, NC 28215

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer medications as ordered for 1 of 6 sampled residents. (Resident #5) The findings are: Resident #5 was admitted to the facility 09/17/12-10/13/12 with diagnoses which included hypertension. Prior to admission to the facility, Resident #5 had been hospitalized for surgical repair of a femur fracture. Hospital discharge orders (used to generate facility admission orders) included 25 milligrams of Metoprolol (a medication used to treat hypertension), twice a day. Facility handwritten admission physician orders on 9/17/12 noted the Metoprolol as 25 milligrams, once a day. The initial care plan for Resident #5 dated 9/27/12 included a problem area, "I take pills for blood pressure" which included the medication, Metoprolol. Review of the September 2012 Medication Administration Record (MAR) for Resident #5 noted the 25 milligrams of Metoprolol was given once a day. Review of physician orders in the medical record of Resident #5 revealed an order	F 281	Resident #5's physician adjusted Metoprolol dose on 10/02/12. Based on medical records, resident did not suffer harm. Resident was discharged from facility on 10/13/12. On or before 12/28/12, dedicated Medicare Admissions Nurse/Designee to audit all certified admissions for the month of December, to ensure no other residents were affected. During these audits of admissions for the month of December, the entire Admissions Checklist was utilized to complete these audits. In addition to other areas, the audit specifically included: The medications on the Discharge Summary, to ensure they were transcribed with the correct dose and frequency. This served as a third check on the medication transcription. On or before 12/28/12, Director of Nursing/Designee to provide formal counseling to the nurse that wrote the admission orders on 9/17/12. On or before 12/28/12, Director of Nursing/Designee to provide formal counseling to nurse that verified/ double checked the admission orders on 9/17/12.	12/28/12 12/28/12 12/28/12 12/28/12 EJM 12/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emily P. Nunn, NHA — TITLE: COO/Administrator — (X6) DATE: 12/28/12

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 12-21-12 nh

DHSR Mail Room Received Black Mountain WRO DEC 31 2012 By: PAM

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F 281	Continued From page 1 on 10/2/12 for the Metoprolol to be increased to 50 milligrams a day. Review of the medical record of Resident #5 revealed Nurse #1 did the initial nursing assessment on admission. On 12/3/12 at 2:20 PM Nurse #1 reviewed the initial nursing assessment, hospital discharge orders and handwritten admission physician orders for Resident #5. Nurse #1 stated she could tell the hospital discharge orders had been used to generate the admission orders because a checkmark had been placed by each medication on the hospital discharge documentation. In addition, Nurse #1 pointed to a handwritten note dated 9/17/12 indicating "all med verified and clarified" by the physician as well as a handwritten entry which indicated the hospital discharge orders had been sent to the facility pharmacy. Nurse #1 verified the hospital discharge orders noted the Metoprolol should be given twice a day. Nurse #1 reviewed the handwritten admission orders for Resident #5 and verified the Metoprolol had been written for once a day, as opposed to twice a day. Nurse #1 stated although she wrote some orders on the physician order sheet, she did not write the medications. Nurse #1 stated she could not tell who wrote the admission medication orders for Resident #5. Review of the admission physician orders for Resident #5 revealed Nurse #2 had verified the orders as complete and accurate. On 12/03/12 at 2:40 PM Nurse #2 verified her signature on the admission physician order sheets. Nurse #2 reviewed the hospital discharge orders and confirmed the order for Metoprolol read twice a	F 281	On or before 12/28/12, dedicated Medicare Admissions Nurse/Designee to review and revise Admissions Checklist. The revised Admissions Checklist now includes a section that reads: "Are medications verified by MD/NP and transcribed with correct dose and frequency of medication?", as well as another added section that reads: "Have two licensed nurses reviewed and validated orders?" On or before 12/30/12, Director of Nursing/Designee to educate all nurses on revised Admissions Checklist. On or before 12/30/12, Director of Nursing/Designee to re-educate all nurses on proper transcription of medications during admission process. Effective 12/28/12, dedicated Medicare Admissions Nurse/Designee to audit any admissions completed by other nurses. This will be continued on an on-going basis. During the on-going audits, the designated Medicare Admissions Nurse will utilize the entire revised Admissions Checklist to complete these audits. In addition to other areas, the audit will specifically include: The Medications on the Discharge Summary, to ensure they were transcribed with the correct dose and frequency. This will serve as a third check on the medication transcription. The audit will also include ensuring that two other licensed nurses have reviewed the medications.	12/28/12 12/30/12 12/30/12 12/28/12 ERN 12/30/12

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F 281	Continued From page 2 day as opposed to what was written on the handwritten admission order sheet and September MAR. Nurse #2 stated it was an oversight and verified the Metoprolol should have been given twice a day to Resident #5. Nurse #2 identified Nurse #3 as the staff member that wrote the admission orders for Resident #5. Nurse #3 was not on duty the day of the investigation. Attempts were made to contact Nurse #3 but were unsuccessful. On 12/03/12 at 4:10 PM (after a review of the medical record of Resident #5) the Director of Nursing (DON) verified the Metoprolol should have been written for twice a day on the handwritten admission physician orders and MAR. The DON stated it was missed by Nurse #3 (that wrote the orders) and Nurse #2 (that verified the orders). The DON located lab results in the medical record of Resident #5 from 09/25/12 with handwritten notes on the labwork from the physician dated 10/02/12 to "increase Toprol". The physician wrote a corresponding order on 10/02/12 to increase Metoprolol to 50 milligrams a day. The DON stated the physician that wrote the orders was the acting medical director (at the time of the order) but was no longer employed by the facility. The DON had no explanation why Resident #5 received the wrong dose of Metoprolol from 09/17/12-10/03/12.	F 281	Effective 12/28/12, dedicated Medicare Admissions Nurse/Designee to submit a report of admission audits to Quality Assurance Committee. These audits will be reviewed in Quality Assurance Meeting on a monthly basis X 3 months, then quarterly thereafter. Effective 12/30/12, the Director of Nursing/Designee to audit 25% of admissions completed by designated Medicare Admissions Nurse on a monthly basis. During these audits, the Director of Nursing/Designee will utilize the entire revised Admissions Checklist. In addition to other areas, the audit will specifically include: The medications on the Discharge Summary, to ensure they were transcribed with the correct dose and frequency. This will serve as a third check on the medication transcription. The audit will also include ensuring that two other licensed nurses have reviewed the medications. The results of the audits completed by the Director of Nursing/Designee will be reviewed by the Quality Assurance Committee. These audits will be reviewed in Quality Assurance Meetings on a Monthly basis X 3 months, then Quarterly thereafter.	12/28/12 12/30/12 12/30/12 EPM

ADMISSIONS CHECKLIST
Internal Document – NOT Part of Medical Chart

Name of Admission _____Room #_____

Date of Admission _____ Time of Admission _____

The skin inspection must be done within the first 2 hours of admission.

Please initial as you complete each section/item on the admission check list. The admission paper work should be done within **first 24 hours of arrival.**

Please pass this sheet to the next shift, so that they can continue with the admission paperwork. When complete, place in the resident's chart flagged up for the supervisor to collect. Admissions are the responsibility of all 3 shifts, not just the arrival shift.

Skin Inspection: _____
Place PPD on MAR, 1st and 2nd steps with dates_____
VS: _____
Orders faxed to Pharmacy: _____
Entry into Census Book: _____
Resident Care Sheet: _____

Height & Weight _____
CCRx FORM: _____
Transit Form completed: _____
Confirm Caretracker Entry: _____
Initial Care Plan: _____

Are medications verified by MD/NP and transcribed with correct dose and frequency of medication? _____ If yes, order medications from pharmacy, Pyxis or back-up pharmacy as indicated. Have two (2) licensed nurses reviewed and validated orders? _____

Admission Assessment Section:
#1_____; #2_____; #3_____; #4_____#5_____; #6_____; #7_____; #8_____; #9_____; #10_____; #11_____; #12_____; #13_____;

Fall Risk Assessment: _____
Apply fall interventions if needed.

Contracture Assessment: _____

Dehydration Assessment: _____

Elopement Assessment: _____

Pain Assessment: _____

Pain Scale placed on MAR & Pain Scale rating sheet placed in MAR: _____

Is patient on any of the following: Antipsychotic, sedative/hypnotic, anti-anxiety medications? No _____Yes ____
If yes obtain consent, place documentation of behavior record, and intervention record on MAR _____

Date/Shift: _____ Signature: _____ Initial _____Date/Supervisor Signature_____
Date/Shift: _____ Signature: _____ Initial _____Date/Supervisor Signature_____
Date/Shift: _____ Signature: _____ Initial _____Date/Supervisor Signature_____
Date/Shift: _____ Signature: _____ Initial _____Date/Supervisor Signature_____

Aldersgate

A United Methodist Retirement Community

December 2012

Disclaimer Statement

Aldersgate United Methodist Retirement Community, Inc. is filing this Plan of Correction to comply with state and/or federal law governing the certification of nursing facilities. Neither the filing of this Plan of Correction, nor any of its contents, are or should be construed as an admission of the accuracy or correctness of any of the deficiencies cited herein and this Plan of Correction is being submitted solely to comply with applicable law.

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