


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2013
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 245 OLD MURPHY ROAD FRANKLIN, NC 28734	
(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	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to administer medications consistent with physician orders for 1 of 5 sampled residents. (Resident #45)</p> <p>The findings included:</p> <p>Resident #45 was admitted to the facility 03/12/13 with diagnoses which included major depression and anxiety.</p> <p>The current care plan dated 09/12/13 for Resident #45 included the following problem areas:</p> <ol style="list-style-type: none"> 1. Problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to cognitive impairment, history of alcoholism, decreased safety awareness 2. Use of psychotropic drugs with the potential for or characterized by side effects of cardiac, neuromuscular, gastrointestinal systems as evidenced by or/duo to diagnosis of anti-depressant, anti-psychotic, diagnosis of depression and history of alcoholism. Approaches to this problem area included administration of medications per physician orders <p>Review of physician progress notes in the medical record of Resident #45 included</p>	F 281	<p>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.</p> <p>Macon Valley Nursing and Rehabilitation Center 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.</p> <p>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.</p> 	

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

TITLE

(X6) DATE

[Signature] Administrator 10/23/13

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 281	<p>Continued From page 1</p> <p>documentation dated 08/25/13 which read: "Seen for regular follow up. Nurses notes reviewed. Medications reviewed. She lately has been more agitated and restless. She is still very weak and unsteady and has been falling despite taking all of the appropriate measures and close supervision by the nursing staff. She has been very impulsive and all the time she has been on the Seroquel. She lately has been feeling sick in the stomach and she has been nauseated at times. She also has been constipated and her stools have been hard and lumpy. Increase Seroquel, 100 milligrams (mg), 1 tablet, orally, 2 times a day. We will increase the dose of the Seroquel as she is still quite anxious and restless and depressed at times. Start Carafate tablet, 1 gram orally twice a day as she lately has been sick in the stomach so we will add the Carafate. She could be having bile reflux. Start Amitiza capsule, 8 micrograms (mcg), 2 times a day. She may benefit from the addition of the Amitiza as she likely has idiopathic chronic constipation."</p> <p>Physician orders on 08/25/13 included:</p> <ol style="list-style-type: none"> 1. Increase Seroquel 50 mg every AM, 50 mg at noon and 100 mg at 06:00 PM. 2. Carafate 1 tablet 1 hour before lunch and bedtime. 3. Dulcolax suppository as needed. 4. Amitiza 8 mcg twice a day. <p>Review of the August 2013 Medication Administration Record (MAR) for Resident #45 included the transcription of the medications as ordered by the physician on 08/25/13. A review of the September 2013 MAR for Resident #45 revealed the absence of the Seroquel, Carafate, Amitiza and Dulcolax and the medications were not administered up through the time of the</p>	F 281	<p>For resident #45 the physician was notified and the medications were re-started on 09/18/2013.</p> <p>All residents have the potential to be affected by the deficient practice. Nursing completed a 100% review of all other residents physicians orders compared it to the Medication Administration Record (MAR's) for omissions.</p> <p>The Director of Nursing provided in-service training to the Licensed Staff i.e., RN/LPN and Administrative Nurses on the new protocol for reviewing the current MAR's to compare to the next month MAR's to ensure all medications are carried over properly.</p> <p>Now there will be a third review which will include an Administrative Nurse to ensure the MAR's are accurate. A monitoring tool was developed to ensure compliance is met by reviewing the questions on the tool to ensure all resident MAR's have been reviewed to ensure all physicians orders are carried over to the next month's MAR's.</p> <p>The monitoring of MAR's will be completed by the Director of Nursing/Designee monthly at the end of each month for six months to verify the orders have been carried over. The findings of these audits will be referred to the Quality Assurance/Quality Improvement Committee monthly for review.</p>	10-17-2013

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	<p>Continued From page 2 review on 09/18/13.</p> <p>On 09/18/13 at 02:40 PM Nurse #1 reviewed the September MAR and verified the Seroquel, Carafate, Amitza and Dulcolax had been left off the MAR and had not been given to Resident #45 from 09/01/13-09/18/13. Nurse #1 stated before the start of a new calender month, two separate nurses were responsible for reviewing physician orders and the prior month MAR and compared them to the new MAR to ensure medications were accurate. Nurse #1 identified Nurse #2 and Nurse #3 as the nurses that checked the September 2013 physician orders and MAR of Resident #45. Nurse #1 could not explain what might have happened that resulted in the four medications being left off the September MAR for Resident #45.</p> <p>On 09/18/13 at 03:19 PM the Director of Nursing (DON) stated resident MARs are typically printed the 22nd of the prior month. At the time of the interview the DON reviewed the September 2013 MAR for Resident #45 and verified the Seroquel, Carafate, Amitza and Dulcolax had not been administered in September as ordered by the physician on 08/25/13. The DON stated the September 2013 physician orders and MAR for Resident #45 had been signed as checked by Nurse #2 and Nurse #3 on 08/31/13. The DON stated a double check system was used to reconcile the new MARs and she expected the two nurses to compare physician orders and the prior month MAR to the new MAR to verify medications were accurate.</p> <p>On 09/18/13 at 03:45 PM Nurse #2 verified she checked the September 2013 MAR and physician orders for Resident #45 and signed the review</p>	F 281		

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F 281	Continued From page 3 was completed on 08/31/13. Nurse #2 explained the double check system and stated her role was to compare new physician orders against the current MAR for accuracy. Nurse #2 explained the staff member that does the second check would compare the prior month MAR to the current MAR for accuracy. Nurse #2 reviewed the medical record of Resident #45 and verified the physician orders on 08/25/13 for the increased Seroquel, Carafate, Amitza and Dulcolax and could not explain why they had been missed when she checked the September 2013 MAR on 08/31/13. On 09/19/13 at 09:45 AM the DON stated she spoke to Nurse #3 and Nurse #3 told her she checked the August 2013 MAR for Resident #45 against the September 2013 MAR. The DON stated that Nurse #3 could not explain to her why the Seroquel, Carafate, Amitza and Dulcolax had not been identified as missing on the September MAR. The DON stated both Nurse #2 and Nurse #3 had been doing monthly MAR reconciliation for some time and should have identified the omitted medications for Resident #45.	F 281			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	For resident #42 the Medication Administration Record (MAR's) was corrected for clarification reasons. An audit was completed by Pharmacy to ensure that no other abbreviations existed (U) after this identification on any other resident MAR's. All residents have the potential to be affected by the deficient practice. Nursing completed a 100% review of all other residents MAR's for any abbreviations or written over.	10-17-2013	

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F 514	<p>Continued From page 4</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to ensure orders on the Medication Administration Record were accurate for 1 of 5 sampled residents. (Resident #42)</p> <p>The findings included:</p> <p>Resident #42 was originally admitted to the facility 11/04/11 and readmitted 05/01/13 with diagnoses which included diabetes. The current care plan included a problem area dated 07/08/13 of "Diabetes mellitus: potential for complications of hyper/hypoglycemia."</p> <p>Review of physician orders for Resident #42 included a daily 3 unit (U) dose of Novolog Insulin at 06:30 AM. The printed September 2013 Medication Administration Record (MAR) had the number 3 included on the MAR, but the computer printed letter U after the number 3 had been hand marked over with a pen and looked like a zero (0).</p> <p>On 09/17/13 at 3:35 PM Nurse #4 and Nurse #5 reviewed the September 2013 MAR for Resident #42 and stated it appeared 30 units of Novolog should be administered to Resident #42 at 06:30 AM. Nurse #4 and Nurse #5 reviewed the physician orders in the medical record of Resident #42 and stated the order was for 3 units, not 30. Nurse #4 and Nurse #5 could not</p>	F 514	<p>The Director of Nursing provided in-service training to the Licensed Staff, i.e., RN/LPN and Medication Aides to be aware that MAR's should have the medications written out and not abbreviated and in the event that it occurs, staff were in-serviced to ensure they know the protocol to correct the MAR's.</p> <p>A monitoring tool was developed to ensure compliance is met by reviewing the questions on the tool to ensure all residents MAR's have been reviewed to ensure no abbreviations exist.</p> <p>The monitoring of MAR's will be completed by the Director of Nursing/Designee weekly x4 weeks, twice monthly, monthly then quarterly. The findings of these audits will be referred to the Quality Assurance/Quality Improvement Committee monthly for review.</p>	

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F 514	<p>Continued From page 5</p> <p>explain why the computer printed letter U had been turned into a 0 on the MAR. Nurse #4 obtained the container of Novolog insulin used for Resident #42 and noted the prescription label was correct in identifying 3 units should be administered at 6:30 AM. Nurse #4 looked at the vial of Novolog insulin and compared the amount when the insulin was opened to what remained. Nurse #4 stated it appeared 3 units had been administered, not 30 as indicated on the MAR. The September 2013 blood sugars for Resident #42 were reviewed and did not indicate any abnormal levels.</p> <p>On 09/18/13 at 06:45 AM Nurse #6 stated she routinely worked third shift and administered insulin to Resident #42. Nurse #6 stated she had been off work for a few days and noticed on Sunday, 09/15/13, the Novolog dose on the MAR had been changed to 30 units for Resident #42. Nurse #6 stated it could be dangerous to give 30 units of Novolog and because it was such a big change from the Resident's usual 3 unit dose and she checked the physician orders. Nurse #6 stated when she did not see any changes to the physician orders, she administered the 3 units of Novolog to Resident #42 and meant to go back and correct the dose listed on the MAR. Nurse #6 stated she forgot to change the MAR and did not know who changed the letter U to a 0 on the order of Novolog for Resident #42.</p> <p>On 09/19/13 at 10:10 AM the Director of Nursing (DON) stated the concern involving the Novolog for Resident #42 had been brought to her attention. The DON stated she had interviewed all staff and was not able to determine who or why the letter U had been changed to a 0 on the September MAR. The DON stated what was on</p>	F 514			

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F 514	<p>Continued From page 6</p> <p>the September MAR for Resident #42 appeared to be 30 units of Novolog, not 3 units as ordered by the physician.</p> <p>The DON stated she spoke to Nurse #3 that worked third shift on 09/13/13. The DON stated Nurse #3 told her the dose of Novolog read 3 units when it was administered at 6:30 AM on 09/14/13.</p> <p>The DON stated she spoke to Nurse #7 that worked third shift on 09/14/13. The DON stated Nurse #7 reported she noticed the change in the 06:30 AM dose of Novolog for Resident #42 and checked physician orders before administering the insulin. The DON stated Nurse #7 verified the order was for 3 units which she administered on 09/15/13. The DON stated Nurse #7 reported she meant to correct the MAR to correct the Novolog to 3 units but forgot.</p> <p>The DON stated she spoke to Nurse #6 that administered the Novolog to Resident #42 on 09/16/13 and 09/17/13. The DON stated Nurse #6 told her she noticed the change in the 06:30 AM dose of Novolog for Resident #42 and checked physician orders before administering the insulin. The DON stated Nurse #6 verified the order was for 3 units before she administered it to Resident #42. The DON stated Nurse #6 reported she meant to correct the MAR to reflect the actual order but forgot. The DON stated if Resident #42 had received 30 units of Novolog instead of 3 units it could potentially have caused a problem. The DON stated she could not explain why the MAR had been changed and would have expected nurses to correct the MAR if a discrepancy was identified.</p>	F 514			