STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345253	A. BUILDING _____ B. WING _____	C 01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT MILLS RIVER	5593 OLD HAYWOOD ROAD MILLS RIVER, NC 28759

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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 record review and staff interview the facility failed to clarify a physician order to restart coumadin for 1 of 3 residents reviewed for unnecessary medications. (Resident #1). Findings included: Resident #1 was admitted to the facility on 08/24/15 with diagnoses of abnormality of gait, open wound of leg, wound infection, orthopedic aftercare, atrial fibrillation, and peripheral vascular disease. Review of the Minimum Data Set (MDS) 14 day assessment dated 09/05/15 revealed Resident #1 had been identified as cognitively intact and receiving an anticoagulant. Review of a gastroenterology recommendation signed by the physician on 08/31/15 revealed a recommendation to restart coumadin on 09/01/15. Review of a Medication Administration record for the Month of September, 2015 revealed coumadin had not been started on 09/01/16 per physician order dated 08/31/15. An interview with the Director of Nursing (DON) on 01/21/16 at 11:49 AM revealed Resident #1 did not have a coumadin order upon admission. Resident #1 had gone out for a procedure on 08/31/15 and returned with instructions to restart coumadin on 09/01/15. She stated Resident #1 was not on coumadin at that time. She stated the family questioned the resident not being on coumadin after the procedure, and requested	F 281	**What corrective action will be accomplished by facility to correct deficient practice:** Recommendation to restart Coumadin for Resident #1 was written on August 31 from residents PCP follow up appointment to have Coumadin restart on September 1, 2015. The Coumadin for Resident #1 was restarted on September 8, 2015. Nurse who was directly involved with Coumadin order is no longer employed by the facility. Facility will request from any physician follow up appointment a copy of the resident's notes from there visit. The physician notes will be reviewed by the staff nurse and then double checked by another Staff Nurse, DON and / or Unit Manager for verification of any Medication Changes. New orders will be implemented/transcribed to the Medication Administration Record after being reviewed by the staff nurse and then double checked by another staff nurse, DON or unit manager. DON or Unit Manager will check the off-site doctors' appointment calendar Monday-Friday to verify that all physician follow up notes were received and that any new orders were implemented. Once the off-site orders have been verified as received, signed by two nurses, and accurately implemented and/or transcribed to the MAR, the DON or unit manager will initial the appointment and sign off on an audit sheet daily to show the audit is complete. Inservice will be conducted with all Nursing staff by January 26, 2016 outlining new documenting procedures. See attached Inservice Inservice was completed with Nursing staff on Order Transcription and Doctor's Appointment Follow up on January 26, 2016. See attached Inservice Physician Appointment Audit completed on all Resident appointments from December 1, 2015 – February 8, 2016. Any discrepancies noted were immediately corrected for those residents still residing in the facility. This audit was completed by Susan Chapman, LPN, Cathy Lewis Regional Nurse Consultant and Michael Salomone Administrator on February 11, 2016	2/11/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/11/16

DHSR & C Black Mountain RO Received Feb 17 2016 by: [illegible]

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	Continued From page 1 they get it restarted. A call was placed to the physician, and an order for an International Normalized Ratio (INR), a test used to monitor individuals who are being treated with blood thinning medications was obtained, and coumadin was restarted on 09/08/15. She stated she did not know why the nurse had not clarified the order for coumadin when it was received. An Interview with the DON on 01/21/16 at 3:52 PM revealed her expectation of the nurse receiving the order would have been to clarify that order with Resident #1's physician to see if he wanted the coumadin restarted.	F 281	**How will facility identify other issues having potential to affect residents and what corrective action will be taken.** Facility will request from any physician follow up appointment a copy of the resident's notes from there visit. The physician notes will be reviewed by the staff nurse and then double checked by another Staff Nurse, DON and / or Unit Manager for verification of any Medication Changes. New orders will be implemented/transcribed to the Medication Administration Record after being reviewed by the staff nurse and then double checked by another staff nurse, DON or unit manager. DON or Unit Manager will check the off-site doctors' appointment calendar Monday-Friday to verify that all physician follow up notes were received and that any new orders were implemented. Once the off-site orders have been verified as received, signed by two nurses, and accurately implemented and/or transcribed to the MAR, the DON or unit manager will initial the appointment and sign off on an audit sheet daily to show the audit is complete.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer significant medication as ordered by the physician for 2 of 3 sampled residents. (Residents #2 and #8) The findings included: 1. Resident #8 was admitted to the facility 02/15/12 with cumulative diagnoses which included chronic obstructive pulmonary disease, congestive heart failure, anxiety and altered mental status. The current care plan for Resident #8 dated 01/02/16 included the following problem areas:	F 333	**What measures will be put in place that you will make to insure deficient practice does not occur.** DON and / or Unit Manager will verify daily Monday – Friday that physician notes were received from the physician visit and insure new orders or medication changes have been transcribed accurately and verified with (2) two signatures by initialing the appointment calendar and daily audit sheet. Inservice was completed with Nursing staff on Order Transcription and Doctor's Appointment Follow up on January 26, 2016. See attached Inservice **How will corrective actions be monitored to ensure deficient practice will not recur** The results of the audit will be forward to the Facility Administrator 5 x weekly x 2 weeks, weekly x 6 weeks, then monthly x 1 to ensure audit compliance and evaluate plan of correction for any needed changes. The results of the audits will be reviewed by the Executive Quality Assurance Committee monthly x 3 for needed changes or extension of the plan of correction.	

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F 333	Continued From page 2 -Potential for dehydration related to diuretic medication due to edema/hypertension. Approaches to this problem area included, "Medications as ordered." -Potential for respiratory infections, shortness of breath and increased confusion related to diagnosis of chronic obstructive pulmonary disease and history of pneumonia. Approaches to this problem area included, "Administer medication as ordered." -Potential for signs/symptoms or injury related to the use of antianxiety meds for anxiety and depression. Approaches to this problem area included, "Administer medications as ordered." Resident #8 was admitted to the hospital 12/23/15 and readmitted to the facility 12/26/15. Hospital discharge records dated 12/26/15 indicated discharge diagnoses which included aspiration pneumonia, metabolic encephalopathy, advanced dementia with behavioral disturbance, acute respiratory failure and sepsis. A nurses note in the medical record of Resident #8 dated 12/26/15 at 4:34 PM and written by Nurse #1 noted, "Physician (physician's name) in house and verified orders and faxed to pharmacy, awaiting medication arrival." A list of 12/26/15 admission medications for Resident #8 that were signed by the resident's physician on 12/26/15 included the following medications: Advair Diskus (bronchodilator) 1 puff inhalation two times a day Lasix (diuretic) 40 milligrams (mg) every day Buspar (anti-anxiety medication) 10 mg twice a day	F 333	**What corrective action will be accomplished by facility to correct deficient practice:** For resident # 8, An order was obtained for Advair (complete order) on 1/21/16, an order was obtained for Lasix on 1/21/16 and a clarification order was obtained for Buspar on 1/21/16. Resident was assessed with no negative outcome noted. All Admission orders will be reviewed by the staff nurse and then inputted into the EChart system. A Physician Order sheet will be printed from the EChart system. Medications will be verified and signed by admitting nurse, then a second (2nd) verification will be completed by another Staff Nurse, DON and / or Unit Manager for proper transcription. Signed Physician Order sheet will be placed in the Resident's Chart under the Physician Order Tab Inservice was completed with all Nursing staff on January 26, 2016 outlining new documenting procedures. See attached Inservice Admission Medication Audit was completed by the facility for all admissions from December 1, 2015 – February 8, 2016. Any discrepancies noted were immediately corrected for those residents still residing in the facility. This audit was completed by Michael Salomone, Administrator Cynthia Hover, DON and Cathy Lewis, RN Regional Nurse Consultant was completed on February 11, 2016. **How will facility identify other issues having potential to affect residents and what corrective action will be taken.** Admission Medication Audit was completed by the facility for all admissions from December 1, 2015 – February 8, 2016. Any discrepancies noted were immediately corrected for those residents still residing in the facility. This audit was completed by Michael Salomone, Administrator Cynthia Hover, DON and Cathy Lewis, RN Regional Nurse Consultant was completed on February 11, 2016. All Admission orders will be reviewed by the staff nurse and then inputted into the EChart system. A Physician Order sheet will be printed from the EChart system. Medications will be verified and signed by admitting nurse, then a second (2nd) verification will be completed by another Staff Nurse, DON and / or Unit Manager for proper transcription. Signed Physician Order sheet will be placed in the Resident's Chart under the Physician Order Tab 2/11/16	

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F 333	Continued From page 3 Review of the December 2015 Medication Administration Record (MAR) and January 2016 MAR for Resident #8 noted the Lasix and Advair were not included and had not been administered from the time of readmission 12/26/15 through the time of the investigation on 01/21/16. The Buspar was listed on the December 2015 MAR and January 2016 MAR after readmission on 12/26/15 and read, Buspar 10 mg give one tablet by mouth twice daily at 9:00 AM and 4:00 PM for anxiety. The only time listed for administration was 9:00 AM. The 4:00 PM dose of Buspar was not included on the MARs and had not been administered from the time of readmission through the time of the investigation on 01/21/16. On 01/21/16 at 3:00 PM The Director of Nursing (DON) stated medications should be administered to residents as ordered by the residents' physician. The DON stated admission orders were generated into the facility electronic system by the nurse that admitted the resident utilizing the discharge orders from the hospital. The DON stated a separate nurse was supposed to check the medications entered into the facility electronic system against the hospital discharge orders to ensure accuracy. The DON stated the nurse that did the second check did not sign or document the second check had been completed so it was impossible to track if a second check had been completed. The DON stated there was no monthly reconcilliation of orders once entered into the MAR in the facility electronic system. The DON reviewed the hospital discharge orders from 12/26/15 for Resident #8 with the December 2015 and January 2016 MARs for Resident #8 and could not explain why the Lasix, Advair and Buspar were not administered as ordered by the physician.	F 333	**What measures will be put in place that you will make to insure deficient practice does not occur.** DON and / or Unit Manager will review daily Monday-Friday all new admission orders to ensure they were reviewed by the staff nurse and then entered into the EChart system. A Physician Order sheet was printed from the EChart system. Medications were verified and signed by admitting nurse, then a second (2nd) verification was completed by another Staff Nurse, DON and / or Unit Manager for proper transcription and the signed Physician Order Sheet was placed in the Resident's Chart under the Physician Order Tab The DON or Unit Manager will use a New Admission Order's QI tool to verify they have reviewed the process for each new admission. **How will corrective actions be monitored to ensure deficient practice will not recur** The DON will forward the results of the audits to the Administrator 5 x weekly x 2, weekly x 6, then monthly x 1 to ensure audit compliance and to evaluate plan of correction for any needed changes. The results of the audits will be forwarded to the Executive Quality Assurance Committee monthly x 3 to review for evaluation of any required changes and continued need for the plan of correction.	

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F 333	Continued From page 4 On 01/21/16 at 4:20 PM Nurse #1 (who admitted Resident #8 on 12/26/15) reviewed the 12/26/15 hospital discharge orders with the December 2015 and January 2016 MARs for Resident #8 and verified he had entered the medications into the facility electronic record. Nurse #1 could not explain why the Advair and Lasix were not included on the 2015 December and 2016 January MARs for Resident #8. Nurse #1 could not explain why the 4:00 PM dose of Buspar was not included on the 2015 December and 2016 January MARs for administration to Resident #8. Nurse #1 stated usually another nurse checked orders entered into the facility electronic MAR to ensure accuracy but stated there was nothing to document if this had been done or who did the second check. On 01/21/15 at 4:30 PM attempts were made to contact the physician/nurse practitioner of Resident #8 but were unsuccessful. 2. Resident #2 was admitted to the facility 10/21/15 after hospitalization with diagnoses which included hypertension. Hospital discharge orders for Resident #2 noted medications which included Coreg, 12.5 milligrams (mg), two times daily. A nurses note in the medical record of Resident #2 included, Medications taken from FL2 (an admission form which included a listing of medications from the receiving facility) provided by family. The FL2 for Resident #2 listed medications which included Coreg, 12.5 milligrams, two times daily.	F 333		

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F 333	Continued From page 5 A progress note by the physician of Resident #2 dated 10/23/15 noted a diagnoses of hypertension and that medications taken by Resident #2 to treat hypertension included Coreg 12.5 mg, twice a day. Review of the Medication Administration Records (MAR) from October and November 2015 for Resident #2 included an order for Coreg with orders to administer one 12.5 mg tablet by mouth daily for hypertension. The only time listed for administration on the MAR during the time of admission at the facility for Resident #2 was 9:00 AM. On 01/21/16 at 3:00 PM The Director of Nursing (DON) stated medications should be administered to residents as ordered by the residents' physician. The DON stated admission orders were generated into the facility electronic system by the nurse that admitted the resident utilizing the discharge orders from the hospital. The DON stated a separate nurse was supposed to check the medications entered into the facility electronic system against the hospital discharge orders to ensure accuracey. The DON stated the nurse that did the second check did not sign or document the second check had been completed so it was impossible to track if a second check had been completed. The DON stated there was no monthly reconcilliation of orders once entered into the MAR in the facility electronic system. The DON reviewed the hospital discharge orders from 10/21/15 for Resident #2 with the October 2015 and November 2015 MARs for Resident #2 and could not explain why the Coreg was not administered as ordered by the physician. The DON stated the nurse that admitted Resident #2 on 10/21/15 no longer worked at the facility and	F 333		

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F 333	Continued From page 6 contact information was not available. The blood pressures of Resident #2 were reviewed through time of admission at the facility with systolic pressures ranging from 118-164 and diastolic pressures ranging from 60-88. On 01/21/15 at 4:30 PM attempts were made to contact the physician/nurse practitioner of Resident #2 but were unsuccessful.	F 333		

In-Service Record

Name of In-service: orders / appts Time:

Date: 1/26/12 Instructor: Cynthia Hoover, RN

Description of In-service: see attached.

Employees Attending:

RN	Darren Buckner RN
Denise Metcalf Lpn	DENISE METCALF LPN
Molly Marshall LPN	Molly Marshall LPN
Barbee C Philips RN	Barbee Philips, RN
Ramil Collado	
Autumn Stephenson	Autumn Stephenson
Teresa Halford RN	Teresa Halford RN
Jackie Stonecipher	
Melody Jones LPN	Melody Jones LPN
R. Scott McLeod	D. Scott McLeod
Susan Chapman	SUSAN Chapman

Nursing Inservice Outline
Transcription of Medications and Doctor's Appointments

January 26, 2016

Doctor's Appointments:

- Facility will request from any physician follow up appointment a copy of the resident's notes from their visit.
- The physician notes will be reviewed by the staff nurse and then double checked by another Staff Nurse, DON and / or Unit Manager for verification of any Medication Changes.
- Staff Nurse, DON and / or Unit Manager will check daily doctors' appointment calendar to verify that all physician follow up notes were received.

Medication Transcription:

- Coumadin
    - Facility Unit Manager and / or DON will check daily orders written by facilities physician related to Coumadin.
    - There will be (2) two corresponding signatures to verify all Coumadin orders written by the facilities Physician or residents' Primary Care Physician.
    - Second (2^{nd}) check signature will consist of DON and / or Unit Manager.

- New Admission Medication Orders and Medication Changes after Admission
    - All medication orders upon Admission or after Admission will be reviewed by the staff nurse and then transcribed into the EChart system
    - A Physician Order sheet will be printed from the EChart system. Medications will be verified and signed by admitting nurse, then a second (2^{nd}) verification will be completed by another Staff Nurse, DON and / or Unit Manager for proper transcription
    - Signed Physician Order sheet will be placed into the Resident Chart located under the Physician Order Tab