		MEDICAID SERVICES				<u>). 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED C	
		345102	B. WING			24/2014
IAME OF PF	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CC		
	ALLEY NURSING AND I		75 F	ISHER LOOP		
			MA	GGIE VALLEY, NC 28751		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
F 000	INITIAL COMMENTS		F 000			
	No deficiencies were complaint investigation	e cited as a result of the on Event ID #6IP411.				
F 157 SS=D	483.10(b)(11) NOTIF (INJURY/DECLINE/R		F 157			8/16/14
	consult with the resid	iately inform the resident; ent's physician; and if dent's legal representative				
	or an interested famil accident involving the	y member when there is an resident which results in				
	intervention; a signific physical, mental, or p	tential for requiring physician cant change in the resident's sychosocial status (i.e., a				
	status in either life the	n, mental, or psychosocial reatening conditions or); a need to alter treatment				
	significantly (i.e., a ne existing form of treatment	ed to discontinue an				
	-	ion to transfer or discharge				
	and, if known, the rest or interested family m	promptly notify the resident ident's legal representative nember when there is a ommate assignment as				
	specified in §483.15(resident rights under	-				
	the address and phor	ord and periodically update the number of the resident's or interested family member.				
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	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.

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	· · ·	TE SURVEY
			A. BUILDING	i		
		245400				С
		345102	B. WING)7/24/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
	VALLEY NURSING AND	REHABILITATION		75 FISHER LOOP		
				MAGGIE VALLEY, NC 28751		
(X4) ID			ID			(X5) COMPLETIO
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	DATE
F 157	Continued From page	e 1	F 15	7		
		Γ is not met as evidenced				
	by: Based on record rev	iew and physician and staff		The lab results for Resident	#19 were	
		/ failed to procure lab results		received by the facility on 7/2		
		o physician and medical staff		results were within normal ra	-	
		ampled for unnecessary		family Nurse Practitioner was		
	medication use. (Real	sident #19).		the Quality Assurance Nurse		
	The findings included	i:		on 7/24/14, no further laborative were obtained.	tory orders	
	Resident #19 was ad	lmitted to the facility on		Any resident requiring lab wo	ork could be	
		ses including chronic airway		affected, therefore current ph		
	obstruction, urinary tr			laboratory orders and docum	•	
		onic obstructive asthma.		reviewed by the Quality Assu	rance Nurse	
				and the RN Supervisor on 7/2	24/14	
	Review of Resident #			comparing the physician orde		
		as completed on 06/19/14.		monthly laboratory log. Curre		
		n the lab sheet showed		were found to have physiciar		
		en prescribed antibiotics for		orders up to date and docum		
		on and pneumonia. Follow e written on the lab sheet for		the physician has been notified was present.	eu or results	
		epeat complete blood count		was present.		
		one week. Further review of		The Quality Assurance Nurse	e and the RN	
	Resident #19's medic			Supervisor were re-educated		
		written on 06/19/14 for		Director of Nursing on 7/24/1		
		mpleted and results provided		procuring laboratory results a	-	
		26/14. No CBC lab work or		notification of the physician w	when results	
		physician or nursing notes		of the labs are obtained.		
		art regarding a follow up CBC				
	completed on or after	r U6/26/14.		The Quality Assurance Nurse		
	Intonviow with the ave	ality assurance purce (OA		the laboratory log on a daily l		
	-	ality assurance nurse (QA at 11:09 AM revealed the		a physician's laboratory orde received, the RN Supervisor		
		ble for logging in lab work		second check to identify any		
		ch reminded her to ensure		discrepancies. The Staff Dev	elopment	
	-	orted back and reported to		Coordinator re-educated the		
		medical staff in a timely		nurses on 8/14/14 on the pol		
		ents could receive up to date		procedure for physician labor	•	
		e stated she had documented		physician notification. The re		

Facility ID: 923055

If continuation sheet Page 2 of 14

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 093 (X3) DATE SURVE	ΞY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345102	B. WING		07/24/20	14
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MAGGIE V	ALLEY NURSING AND F	REHABILITATION		5 FISHER LOOP IAGGIE VALLEY, NC 28751		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COME	(X5) PLETIO DATE
F 157	Continued From page	2	F 157			
	the lab order on 06/19 but could find no cone Resident #19's chart. not followed up with la had not provided resu physician or other me	9/14 in physician's orders curring lab results in QA Nurse stated she had ab to obtain lab results and ults of lab work to the edical staff to ensure the 19 had received had been		these review will be taken to the mon QAPI meeting for 3 months for review recommendations by the Quality Assurance Nurse.		
	1:40 PM revealed he results of Resident #1 06/26/14 and it was h nursing staff would er	is expectation the facility nsure lab results were d to physicians and other				
F 333 SS=D	to log the lab order in ordinarily reminded h get results in order to physician and other n stated the missing lab oversight on her part.	revealed she had neglected to her logging system which er to follow up with the lab to provide them to the nedical staff. The QA nurse o sheet had been an ENTS FREE OF	F 333		8/16/	/14
	The facility must ensu any significant medica	ure that residents are free of ation errors.				
	by: Based on observatio interviews, the facility instructions for a med	is not met as evidenced ns, record review, and staff failed to clarify conflicting lication for 1 of 5 residents ion administration. (Resident		Administration times for the medicati ordered for Resident #11 were verifie with the physician, and a clarification order was written by the Quality	-	

Facility ID: 923055

If continuation sheet Page 3 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	08/18/2014 APPROVED 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345102	B. WING			C 07/2	4/2014
NAME OF P	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ALLEY NURSING AND F	REHABILITATION			5 FISHER LOOP		
			_	М	AGGIE VALLEY, NC 28751		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From page	23	F 3	33			
	#11).				Assurance Nurse on 7/23/14.		
	,						
	05/07/14 with diagnost esophageal reflux and A review of Resident a revealed a discharge report from the hospit report included misop for the prevention of s micrograms (mcg) wa mouth after meals and order was observed of dated 05/07/14 throug Medication Administra 05/07/14 through 05/3 instructions for misop PM, 6:00 PM, and 9:0 administration.	readmitted to the facility ses which included d a hip fracture repair. #11's medical record medication reconciliation al dated 05/07/14. The rostol (a medication used stomach ulcers) 200 as to be administered by d at bedtime. The same on a physician monthly order gh 05/31/14. The ation Record (MAR) for 31/14 contained the same rostol with 9:00 AM, 1:00 00 PM as times listed for monthly orders dated			Any resident receiving medications at specific times can be affected, therefore the Director of Nursing verified the facilities times for medications given before and after meals on 7/23/14. A report identifying residents with medications given before and after me was generated by the pharmacy and times were reviewed with clarification orders written by the Quality Assurance Nurse on 8/5/14. The pharmacy manager re-educated th pharmacists and technicians on administration times for medications gi before and after meals on 8/15/14. Weekly reviews by the pharmacy manager will be performed to assess accurate/correct administration times for total of 8 weeks. The results of these reviews will be shared with the facility Director of Nurses at the end of each	als e ven	
	07/31/14 was conduct with instructions to ad	30/14 and 07/01/14 through ted. Misoprostol 200 mcg Iminister the tablet before			Director of Nurses at the end of each month.		
	orders. The MARs wi contained the same in before meals. The tin be administered were 6:00 PM, and 9:00 PM	was observed on the ith corresponding dates nstructions to administer nes the medication was to listed as 9:00 AM, 1:00 PM, M. The MARs contained ach day through 07/23/14			The Facility Director of Nursing re-educated the licensed nursing staff 8/5/14 and provided a copy of the facili triple check policy and procedures for checking monthly medication administration records for accuracy.		
	which indicated the m administered.	AM, Nurse #1 was observed			The pharmacy manager's results will b addressed during the monthly QAPI Meeting for 2 months for review and recommendations. The Quality	e	
		stering medications for			Assurance Nurse will bring results of the	ie	
L	7(02-99) Previous Versions Obs	-					

Facility ID: 923055

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TID	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
					С	
		345102	B. WING		07	//24/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAGGIE \	ALLEY NURSING AND I	REHABILITATION		75 FISHER LOOP MAGGIE VALLEY, NC 28751		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 333	Continued From page	- A	F 33	2		
	Resident #11. Misop the medications admit An interview was con 07/23/14 at 8:58 AM. noted the instructions stated to give the me Nurse #1 added the t and 6:00 PM were tin note after meals. Nu medication before bre instructions on the M. always administered when she worked. N should have been cha the instructions. An interview was con Assurance (QA) Nurs The QA Nurse stated followed the discharg report from the hospit Resident #11's medic she had noted the or to be administered af after meals times as PM. She explained th the physician monthly month. The facility ph	rostol was not included in inistered at this time. ducted with Nurse #1 on The nurse stated she had to administer misoprostol dication before meals. imes of 9:00 AM, 1:00 PM, hes used by the facility to rse #1 stated she gave the eakfast to follow the AR. The nurse added she the medication before meals urse #1 stated the times anged to be consistent with ducted with the Quality se on 07/23/14 at 9:08 AM. the facility physician e medication reconciliation		monthly Medication Administrati changeover with any discrepand identified to the monthly QAPI n 3 month for review and recomm	cies neeting for	
	QA Nurse also noted the physician monthly 2014 and July 2014 s medication before me meal times. The QA protocol of checking of each month. She sta	ed by the physician. The the instructions written on y orders and MARs for June stated to administer the eals while providing the after Nurse explained the facility orders at the beginning of ted the new physician MARs were checked against				

Facility ID: 923055

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		ND HUMAN SERVICES			PRINTED: 08/18/2014 FORM APPROVED
					OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345102	B. WING		C 07/24/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
	ALLEY NURSING AND F			75 FISHER LOOP	
				MAGGIE VALLEY, NC 28751	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 333	physician's orders wri The QA Nurse descrift MARs was a 3 step p different nurses which Nurse stated these er for the administration overlooked by all 3 nu checks on the monthl continued interview a stated she called Res clarification order for noted to discontinue to misoprostol and to ini with meals/food and a specified in the order 5:00 PM, and at bedti also specified to hold resident refused mea An interview was con Pharmacy (RP) const AM. The RP stated m with food to make it e medications such as also took, from harmi	ers and MARs as well as any itten throughout the month. bed checking the orders and process and completed by 3 h included her. The QA rrors regarding instructions of misoprostol were urses performing accuracy ly orders and MARs. In a tt 9:58 AM, the QA Nurse sident #11's physician for a misoprostol. The new order the previous order for itiate misoprostol 200 mcg at bedtime. The times were 8:00 AM, 12:00 noon, ime. The clarification order the medication if the	F 3	33	
	representative from th 07/23/14 at 11:00 AM representative confirm	ducted via phone with a he facility pharmacy on			

Facility ID: 923055

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 08/18/201 FORM APPROVE //B NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		STRUCTION	(X3) DATE SURVEY COMPLETED	
		345102	B. WING			C 07/24/2014	
NAME OF PF	ROVIDER OR SUPPLIER	•	1	STREET	TADDRESS, CITY, STATE, ZIP COL	DE	
MAGGIE V	ALLEY NURSING AND	REHABILITATION			IER LOOP IE VALLEY, NC 28751		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	WAGG	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION
F 333	Continued From page	<u>e 6</u>	F 3	33			
		e o red before meals instead of	1.0.	55			
		ed by the physician. The					
		ative stated this error had					
		ttention earlier today by the					
		ne clarified order had been					
		nto the computer to reflect to					
	12:00 noon, 5:00 PM	ation after meals at 8:00 AM,					
	12.00 10011, 0.00 1 1	, and bedame.					
	An interview was con	ducted with the Director of					
		7/24/14 at 2:05 PM. The					
	-	ected nurses to catch					
		icies from month to month. an oversight and should have					
	been caught.	an oversight and should have					
F 334	-	A AND PNEUMOCOCCAL	F 3	34			8/16/14
SS=C	IMMUNIZATIONS						
		elop policies and procedures					
	that ensure that	:- f l					
	(I) Before offering the each resident, or the	e influenza immunization,					
	•	es education regarding the					
	benefits and potentia						
	immunization;						
	(ii) Each resident is o						
		er 1 through March 31					
	-	immunization is medically e resident has already been					
	immunized during thi						
	(iii) The resident or th	•					
	representative has th	e opportunity to refuse					
	immunization; and						
		edical record includes					
	following:	ndicates, at a minimum, the					
	-						
	(A) [hat the residen	it or resident's legal					

Facility ID: 923055

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		ND HUMAN SERVICES MEDICAID SERVICES				PRINTED: 08/18/2014 FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		345102	B. WING			C 07/24/2014		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	ALLEY NURSING AND	REHABILITATION		7	75 FISHER LOOP			
				Ν	MAGGIE VALLEY, NC 28751			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 334	Continued From pag	e 7	F	334				
	immunization; and	ential side effects of influenza						
	()	nt either received the on or did not receive the						
	influenza immunizati							
	contraindications or r	efusal.						
	The facility must deve that ensure that	elop policies and procedures						
	(i) Before offering the	-						
		resident, or the resident's receives education regarding						
	the benefits and pote	ential side effects of the						
	immunization; (ii) Each resident is c	offered a pneumococcal						
	immunization, unless	the immunization is						
	already been immuni	ated or the resident has						
	(iii) The resident or th	ne resident's legal						
	representative has th immunization; and	e opportunity to refuse						
		edical record includes						
		ndicated, at a minimum, the						
	following: (A) That the resider	nt or resident's legal						
	representative was p	rovided education regarding						
	the benefits and pote pneumococcal immu							
	•	it either received the						
	pneumococcal immu	nization or did not receive						
	the pneumococcal in contraindication or re	nmunization due to medical						
	(v) As an alternative,	based on an assessment						
	-	mmendation, a second						
	years following the fill	nization may be given after 5						
	immunization, unless	medically contraindicated or						
	the resident or the re	sident's legal representative						

Facility ID: 923055

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/18/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345102	B. WING		C 07/24/2014
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
MAGGIE \	ALLEY NURSING AND	REHABILITATION		5 FISHER LOOP	
			N	MAGGIE VALLEY, NC 28751	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO
F 334	Continued From page		F 334		
		L is not mat as suideneed			
	by: Based on record rev facility failed to provid resident's medical red resident's responsible education about the b effects of the influenz opportunity to accept of 5 sampled residen and #47.) The findings include: Review of the medica #22, #31 and #47 rev documentation indica RP had been provide benefits and potentia vaccine. There was a	al records of Residents #9, vealed there was no ating that the resident or their ed education about the I side effects of the influenza also no documentation to e was accepted or declined		When influenza season begins, resid #9,#22, #31, and #47 or the resident's legal representative will be provided education about the benefits and pote side effects of the influenza vaccine a will be given the opportunity to accept decline the vaccine. The Infection Co Nurse will document the consent or declination in the resident chart. The resident or resident's legal representative will be provided educa about the benefits and potential side effects of the pneumococcal vaccine the opportunity to accept or decline the vaccine unless the vaccine is medical contraindicated. The Infection Contro Nurse will document the consent or declination in the resident chart.	s ential ind t or ntrol tion upon
	2 about the facility's s for administering the revealed the facility re that was signed when and did not get a new An interview on 07/24 Director of Nursing (I system for providing	4/14 at 4:19 PM with Nurse # system for obtaining consent annual influenza vaccine eferred to the consent form in the resident was admitted v consent every year. 4/14 at 4:19 PM with the DON) about the facility's education about the benefits fects of the influenza vaccine		Any other resident could be affected, therefore, October 1, through March 3 residents or the resident's legal representative will be provided educa about the benefits and potential side effects of the influenza vaccine and w given the opportunity to accept or dec the vaccine. The Infection Control Nu will document the consent or declinate the resident chart.	tion rill be cline rse

Facility ID: 923055

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/18/2014 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE SURVEY COMPLETED C	
		345102	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	I			REET ADDRESS, CITY, STATE, ZIP CODE	1 017	•
MAGGIE	ALLEY NURSING AND F	REHABILITATION			FISHER LOOP AGGIE VALLEY, NC 28751		
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 334	to the resident or RP resident's RP prior to and provided informa stated there was no or resident's chart about provided. An interview on 07/24 Administrator reveale called the resident's F administer the vaccin about the vaccine. Sh their RP refused the i documented on the re The Administrator sta	revealed staff called the administering the vaccine tion about the vaccine. She documentation on the t the education that was 4/14 at 4:25 PM with the ed the staff member who RP got a verbal consent to e and provided information ne stated if the resident or nfluenza vaccine it was esident's medical record. ted there was no e resident's chart of the	F	334	The resident and/or responsible party be provided education about the benefits and pote side effects of the pneumococcal vacc upon admission and will be given the opportunity to accept or decline the vaccine unless the vaccine is medicall contraindicated. The Infection Control Nurse will document the consent, declination and education in the reside chart. The Infection Control Nurse, MDS Coordinator, Quality Assurance Nurse Supervisor were educated on 8/8/14 b the Director of Nursing about the Annu Influenza Vaccine Administration and t Pneumococcal Vaccine policies and procedures of offering the influenza ar pneumococcal immunization, educatir the resident or the resident's legal representative regarding the benefits a potential side effects of the immunizat including; That each resident is offered an influe immunization October 1 through Marc annually; That the resident or the resident's legal representative has the opportunity to accept or decline the immunization; That the resident's medical record includes documentation that indicates the resident or resident's legal representative was provided educatior regarding the benefits and potential si	ntial ine y ent , RN y ial the nd ig and ions nza h 31 al that	

Event ID: 6IP411

Facility ID: 923055

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/18/2014 M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345102	B. WING			C / 24/2014	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ALLEY NURSING AND	REHABII ITATION			5 FISHER LOOP		
				М	AGGIE VALLEY, NC 28751		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 334	Continued From page	e 10	F	334			
					effects of the influenza or pneumoco- immunization;	ccal	
					That the resident either received the influenza or pneumococcal immuniza or did not receive the influenza or pneumococcal immunization due to medical contraindications;	ation	
					That based on assessment, and practitioner recommendation, a seco pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resid or the resident's legal representative refuses the second immunization.		
					The Infection Control Nurse will track administration of the Influenza Vaccin monthly during Influenza Season to ensure that all residents or resident's representative have been notified an educated prior to receiving the immunization and that the consent of declination has been documented in resident medical record.	legal d	
					The Quality Assurance Nurse will aud pneumococcal immunizations month any new admissions to ensure the resident or resident's legal represent has been notified and educated prior receiving the immunization and that to consent or declination has been documented in the resident medical record.	ly for ative to	
					The Infection Control Nurse will bring	the	
ORM CMS-256	7(02-99) Previous Versions Ob	solete Event ID:6IP	111	Fac	cility ID: 923055 If cont	invation she	et Page 11 of 14

Event ID: 6IP411

Facility ID: 923055

If continuation sheet Page 11 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/18/2014 M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345102	B. WING		07	C / 24/2014
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAGGIE \	ALLEY NURSING AND F	REHABILITATION		5 FISHER LOOP IAGGIE VALLEY, NC 28751		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 334	Continued From page	÷ 11	F 334	results of the monthly review of any resident who has not received the Influenza or Pneumococcal Vaccine monthly QAPI meeting x 6 months f review, recommendations, documentations, documentat	e to the for	
F 425 SS=D	483.60(a),(b) PHARM ACCURATE PROCEI		F 425			8/16/14
	drugs and biologicals them under an agreed §483.75(h) of this par unlicensed personnel law permits, but only supervision of a licens A facility must provide (including procedures acquiring, receiving, of administering of all dr the needs of each res The facility must emp a licensed pharmacis	t. The facility may permit to administer drugs if State under the general sed nurse. e pharmaceutical services that assure the accurate dispensing, and ugs and biologicals) to meet sident. loy or obtain the services of t who provides consultation provision of pharmacy				
	by: Based on record revi facility pharmacy tran computer to administe	is not met as evidenced ew and staff interview, the scribed instructions into the er a medication before meals as ordered by the sidents reviewed for		Administration times for the medica ordered for Resident #11 were verif with the physician, and a clarificatio order was written by the Quality Assurance Nurse on 7/23/14.	ied	

Event ID: 6IP411

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/18/201 FORM APPROVE OMB NO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 07/24/2014	
	345102					
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAGGIE VALLEY NURSING AND REHABILITATION			75 FISHER LOOP MAGGIE VALLEY, NC 28751			
(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 SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE	
F 425	Continued From page	e 12	F 425			
		ation. (Resident #11).				
				Any resident receiving medications		
	The findings included:			specific times can be affected, there	efore	
	Resident #11 was readmitted to the facility 05/07/14 with diagnoses which included			the Director of Nursing verified the facilities times for medications given	1	
				before and after meals on 7/23/14.		
	esophageal reflux an	d a hip fracture repair.		report identifying residents with		
	A review of Resident #11's medical record revealed a discharge medication reconciliation report from the hospital dated 05/07/14. The			medications given before and after i		
				was generated by the pharmacy an times were reviewed with clarificatio		
				orders written by the Quality Assura		
		prostol (a medication used to		Nurse on 8/5/14.		
		ers) 200 micrograms (mcg)				
		ed by mouth after meals and		The pharmacy manager re-educated pharmacists and technicians on	a the	
	at bedtime. The same order was observed on a physician monthly order dated 05/07/14 through			administration times for medications	given	
	05/31/14. The Medic	ation Administration Record		before and after meals on 8/15/14.		
		rough 05/31/14 contained for misoprostol with 9:00		Weekly reviews by the pharmacy		
		M, and 9:00 PM as times		manager will be performed to asses	s	
	listed for administration.			accurate/correct administration time		
				total of 8 weeks. The results of thes		
	A review of computer	-generated physician 06/01/14 through 06/30/14		reviews will be shared with the facili Director of Nurses at the end of eac	-	
		07/31/14 was conducted.		month.		
	Misoprostol 200 mcg	with instructions to				
		before meals and at bedtime		The Facility Director of Nursing	~	
	was observed on the orders. Computer-generated MARs with corresponding			re-educated the licensed nursing sta 8/5/14 and provided a copy of the fa		
	dates contained the s			triple check policy and procedures for	-	
	administer before me			checking monthly medication		
		administered were listed as 00 PM, and 9:00 PM.		administration records for accuracy.		
				The pharmacy manager's results wi		
		ducted with Nurse #1 on		addressed during the monthly QAPI		
		The nurse stated she had		Meeting for 2 months for review and	1	
	noted the instructions administration of mise	oprostol to be administered		recommendations. The Quality Assurance Nurse will bring results o	of the	
		#1 added the times of 9:00		monthly Medication Administration F		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345102		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL A. BUILDING	(X3) DAT	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
		B. WING	07	//24/2014		
NAME OF PROVIDER OR SUPPLIER MAGGIE VALLEY NURSING AND REHABILITATION						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	MAGGIE VALLEY, NC 28751 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION	
F 425	AM, 1:00 PM, and 6:0 the facility to note after each time she worked before breakfast to for MAR. An interview was com Pharmacy (RP) const AM. The RP stated r with food to make it e medication protected medications such as also took, from harmit taking the medication harmful to the resider medication ineffective An interview was com representative from th 07/23/14 at 11:00 AW representative confirm facility was received if for misoprostol 200 m meals and at bedtime transcribed into the co incorrectly. The instr meals instead of after physician. The pharmit this error had been ca today by the facility. had been received ar computer to reflect to	00 PM were times used by er meals. Nurse #1 stated d, she gave the medication illow the instructions on the ducted with the Registered ultant on 07/23/14 at 10:15 nisoprostol should be taken effective. She stated the the stomach and prevented aspirin, which Resident #11 ng her stomach. She added before meals was not th but did render the e. ducted via phone with a he facility pharmacy on	F 425	changeover with any discrepance identified to the monthly QAPI m 3 month for review and recommendations	eeting for	

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