

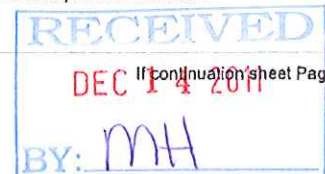
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2011
NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOVA, NC 28778	
(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 record review, interview with staff and resident interviews, the facility failed to transcribe a physician's order correctly for one (1) of four (4) sampled residents receiving pain medication via patch. (Resident #4). The findings are: 1. Resident #4 was admitted to the facility with diagnoses including osteoporosis, arthritis, and Alzheimer's disease. The latest Minimum Data Set (MDS) dated 08/23/11 indicated severely impaired cognition and dependent on limited staff assistance for transfers, ambulation, and hygiene. A review of Resident #4's medical record revealed a nursing progress note dated 10/13/11 at 6:30 AM. The note specified Resident #4 sustained a fracture of the left arm and left wrist as a result from a fall at 3:39 AM on 10/13/11. Continued medical record review revealed a physician's prescription dated 10/18/11 for a Lidoderm patch (a medication used to assist with pain management). The prescription contained instructions to apply the patch to the left shoulder for twelve (12) hours as needed for pain and then remove the patch for twelve (12) hours. Additional medical record review revealed a physician's comprehensive order sheet dated 10/18/11 with instructions for a Lidoderm patch to	F 281	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F281 How corrective action will be accomplished for each resident found to have been affected by the deficient practice – Physician for resident #4 was notified and order obtained for routine administration of Lidoderm patch. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – 100% audit of charts completed checking orders from last monthly physician orders to present to ensure that all orders have been transcribed as ordered.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Revised POC Administrator* (X6) DATE: 12-14-11

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>be applied to the resident's left shoulder at 8:00 AM and removed at 8:00 PM every day.</p> <p>A review of the Medication Administration Record (MAR) dated October 2011 revealed Resident #4 received the Lidoderm patch on at 8:00 AM and off at 8:00 PM beginning 10/18/11 through the end of the month.</p> <p>A review of the Monthly Physician Orders dated November 2011 revealed instructions for Lidoderm patch to be applied to the left shoulder on twelve (12) hours and off twelve (12) hours as needed for pain.</p> <p>A review of the MAR dated November 2011 revealed Resident #4 had not received the Lidoderm patch any day this month.</p> <p>An interview with Unit Manager (UM) #1 on 11/16/11 at 3:10 PM revealed the comprehensive physician's order was incorrectly transcribed. She stated the physician's prescription order dated 10/18/11 specified the Lidoderm patch was to be utilized as needed for pain. The comprehensive physician order sheet dated 10/18/11 specified use everyday. UM #1 stated the comprehensive physician order was transcribed incorrectly and did not reflect the instructions provided on the prescription. She stated the facility protocol for transcribing physician orders was a three (3) check system. UM #1 explained when a physician's order was written on a comprehensive physician order sheet, the yellow copy was removed and kept at the nurses' station. Nurses from each of the following two (2) shifts should review the order and initial indicating it was correctly transcribed.</p>	F 281	<p>Measures to be put in place or systemic changes made to ensure practice will not re-occur-</p> <p>Nurses were re-educated on transcribing orders by the Quality Improvement Nurse, to include transcription of verbal orders. The 11-7 Nurses will do a 24 hour chart check daily to ensure orders are carried out appropriately. Documentation of chart checks will be done on the telephone order. Nurses responsible for monthly physician orders will be re-educated, by the Quality Improvement Nurse, on checking monthly orders.</p> <p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-</p> <p>The Unit Managers/ Designee will randomly audit 5 charts daily Monday-Friday x one week, weekly x three weeks, then quarterly x 3. The Director of Nursing (DON) /Designee will report results of audit to the QA & A (Quality Assessment & Assurance) Committee monthly x one month then quarterly x three for continued compliance/revisions to the plan if needed.</p>	12-11-11

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F 281	Continued From page 2 UM #1 continued the yellow slips were given to her after the checks are completed. At that time, UM #1 found the yellow slip dated 10/18/11 containing the Lidoderm order written for daily use. She observed the slip did not contain the initials from the following shifts. UM #1 stated the Monthly Physician Orders are checked for accuracy by a nurse before the orders are utilized. She stated the nurse that checks them should sign in the space marked Meds Reviewed By on the monthly order sheet. UM #1 observed Resident #4's Monthly Physician Orders dated November 2011. She stated there was no signature to indicate which nurse checked Resident #4's orders. Small check marks were observed by each medication block. UM #1 stated these check marks indicated the orders were checked before use. She added the facility system to ensure accuracy of physician orders failed on 10/18/11 when the order was first transcribed. UM #1 stated the nurse performing the check on the monthly order sheet should have recognized the conflicting frequencies from the October to November Monthly Physician Orders and obtained a clarification order. An interview with Licensed Nurse (LN) #1 was conducted on 11/16/11 at 3:15 PM. He stated it was facility protocol to transcribe a physician's order written on a prescription slip to a comprehensive physician order sheet. He stated when he transcribed the order for the Lidoderm patch for Resident #4 on 10/18/11, he did not notice the prescription slip contained "prn" (as needed). He stated he incorrectly transcribed the order by indicating to administer the Lidoderm patch everyday for 12 hours.	F 281			
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309			

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F 309 Continued From page 3
SS=D HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interviews with resident, staff and the facility consultant pharmacist the facility administered a medication to one (1) of two (2) residents reviewed for allergies. (Resident #7).

The findings are:

Resident #7 was identified by facility staff as alert and interviewable. Review of the latest Minimum Data Set (MDS) dated 8/28/11 revealed Resident #7 was assessed as cognitively intact with no impairment of short or long term memory.

During the initial tour of the facility on 11/16/11 at 9:05 AM, Resident #7 reported that two nights prior at approximately 10:00 PM she was given a dose of Levaquin (an antibiotic) along with Mucinex. Resident #7 stated shortly after taking the medication she began shaking and wanted to "jump out of her skin". Resident #7 stated it took almost 24 hours for her to get over the shaking feeling. In a follow-up interview on 11/16/11 at 3:50 PM Resident #7 stated she reported the symptoms to the licensed nurse that worked the

F 309

F 309
How corrective action will be accomplished for each patient found to have been affected by the deficient practice –

The physician for patient # 7 was contacted and made aware of the patient allergy. A new order for a different antibiotic was obtained.

How corrective action will be accomplished for those patients having the potential to be affected by the same deficient practice –
Audit of patients' chart currently residing in the facility was accomplished to compare the POS (Physician Order Sheet) to their H&P (History and Physical) to ensure all allergies were listed on the POS.

Any allergies not listed were placed on a physician telephone order and faxed to the pharmacy.

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F 309	<p>Continued From page 4</p> <p>day shift on 11/15/11. Resident #7 stated she refused to take the Levaquin the evening of 11/15/11 and told nursing staff she wanted to talk to her physician before taking another dose of the medication.</p> <p>Review of the medical record of Resident #7 revealed an allergy alert sticker located on the inside cover of the chart binder which listed multiple medications the resident was allergic to. These medications included Levaquin. This list of medications was also located on the Permanent Problem List located in the resident's medical record. The monthly November 2011 Physician Order sheet in the medical record of Resident #7 included all medications the resident was taking. In addition, this form contained an area to note any allergies. The specified area for allergies on the November 2011 Physician Order sheet for Resident #7 noted, "No allergies defined." The November 2011 Medication Administration Record (MAR) for Resident #7 listed all medications for the resident as well as an area to note any allergies. The specified area for allergies on the November 2011 MAR noted, "No allergies defined."</p> <p>Review of the medical record of Resident #7 revealed a physician's order dated 11/14/11 for Levaquin, 500 milligrams every day for 10 days secondary to pneumonia. Review of the November 2011 MAR for Resident #7 revealed a handwritten entry for the Levaquin on 11/14/11 with dosage administration recorded at 2100. The Levaquin was signed off as given on 11/14/11, circled as not given on 11/15/11 and available to be given subsequent days in November through 11/23/11.</p>	F 309	<p>Measures to be put in place or systemic changes made to ensure practice will not re-occur-</p> <p>On admission, allergies will be recorded on the POS under allergies if more space is needed the allergies will be continued on the first sheet under medications on the POS, by the admission nurse. Licensed Nursing staff will be educated on the process required for recording allergies on to the POS during the admission process. Nurses that check the monthly orders will be re-educated on checking orders and ensuring all allergies are on the monthly orders. Any discrepancies noted will be sent to the pharmacy if found. The above education will be provided by the Quality Improvement Nurse.</p> <p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-</p> <p>The Unit Managers/Designee will audit new admissions for recording of allergies during morning meeting Monday – Friday to ensure all allergies are recorded appropriately. This will ongoing. Any discrepancies noted will be documented on a physician telephone order and faxed to the pharmacy.</p>

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F 309	<p>Continued From page 5</p> <p>On 11/16/11 at 3:15 PM the unit manager over the unit Resident #7 resided stated she was not aware Resident #7 had received a medication she was allergic to and/or that the resident had a reaction to the medication. The unit manager reviewed the medical record of Resident #7 and stated the listing of allergies should have been noted on the Physician Order sheet as well the MAR. The unit manager stated the allergies are noted in these areas to alert the physician when writing orders, to alert nursing staff providing medications to residents and for the pharmacy to alert facility staff if orders are written for a medication with a known allergy. The unit manager stated when residents are admitted to the facility a complete listing of medications and allergies would be provided to the dispensing pharmacy and subsequent MARs and monthly physician order sheets should contain the information, including any known allergies.</p> <p>In a telephone interview on 11/16/11 at 3:30 PM the facility consultant pharmacist reported he checked with the pharmacy that dispensed medications for the facility and they were not aware of any allergies for Resident #7. The consultant pharmacist stated if Levaquin had been listed as an allergy the order would have been flagged when entered into the system and the facility/physician called to alert them to the discrepancy.</p> <p>On 11/16/11 at 4:15 PM the licensed nurse (LN #1) that worked the day shift on 11/15/11 (and the nurse identified by Resident #7 as the person she reported the reaction to the Levaquin) stated he recalled Resident #7 reporting she had a reaction</p>	F 309	<p>The DON/Designee will report results of audits to the QA&A Committee monthly x 3, then Quarterly x 3 for continued compliance/revisions to the plan if needed.</p> <p>12-14-11</p>

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F 309	<p>Continued From page 6</p> <p>to the Levaquin. LN #1 stated he was not aware Resident #7 had any allergies because the MAR indicated "no defined allergies". LN #1 stated he was not aware Resident #7 was allergic to Levaquin and had not informed the resident's physician of her reaction to the medication.</p> <p>On 11/16/11 at 6:10 PM the medical records director stated when residents are admitted she utilizes information sent to "set up the chart". The medical records director stated this included completing the allergy alert sticker which is placed on the inside cover of the chart binder as well as the Permanent Problem List which notes diagnoses as well as allergies. The medical records director stated she filled these out utilizing the information sent from the skilled facility Resident #7 was admitted from. The medical records director stated she expected nurses to communicate information regarding allergies to the pharmacy when the initial physician orders were sent.</p> <p>Review of the admission handwritten physician orders for Resident #7 revealed a notation "see allergy list" in the area on the form to record "allergies". Subsequent monthly physician orders and MARs in the medical record of Resident #7 all listed "no defined allergies" in the area on the form designated for "allergies".</p> <p>On 11/16/11 at 6:20 PM facility staff attempted to contact the physician of Resident #7 to obtain orders regarding the Levaquin.</p>	F 309	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	The facility must provide routine and emergency

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F 425	<p>Continued From page 7</p> <p>drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, interview with the facility consultant pharmacist/dispensing pharmacy and interviews with staff and resident the pharmacy providing services to the facility failed to clarify allergies for one (1) of two (2) sampled residents with known allergies. As a result, the resident was dispensed and administered a medication that was a known allergy. (Resident #7).</p> <p>The findings are:</p> <p>Resident #7 was identified by facility staff as alert and interviewable. Review of the latest Minimum Data Set (MDS) dated 8/28/11 revealed Resident</p>	F 425	<p>F 425 How corrective action will be accomplished for each patient found to have been affected by the deficient practice –</p> <p>The physician for patient # 7 was contacted and made aware of the patient allergy. A new order for a different antibiotic was obtained. Patient chart was audited to ensure all allergies were documented and allergies faxed to pharmacy.</p> <p>How corrective action will be accomplished for those patients having the potential to be affected by the same deficient practice –</p> <p>Audit of patients' chart currently residing in the facility was accomplished to compare the POS (Physician Order Sheet) to their H&P (History and Physical) to ensure all allergies were listed on the POS. Any allergies not listed were placed on a physician telephone order and faxed to the pharmacy.</p>

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F 425	<p>Continued From page 8</p> <p>#7 was assessed as cognitively intact with no impairment of short or long term memory.</p> <p>During the initial tour of the facility on 11/16/11 at 9:05 AM, Resident #7 reported that two nights prior at approximately 10:00 PM she was given a dose of Levaquin (an antibiotic) along with Mucinex. Resident #7 stated shortly after taking the medication she began shaking and wanted to "jump out of her skin". Resident #7 stated it took almost 24 hours for her to get over the shaking feeling. In a follow-up interview on 11/16/11 at 3:50 PM Resident #7 stated she reported the symptoms to the licensed nurse that worked the day shift on 11/15/11. Resident #7 stated she refused to take the Levaquin the evening of 11/15/11 and told nursing staff she wanted to talk to her physician before taking another dose of the medication.</p> <p>Review of the medical record of Resident #7 revealed an allergy alert sticker located on the inside cover of the chart binder which listed multiple medications the resident was allergic to. These medications included Levaquin. This list of medications was also located on the Permanent Problem List located in the resident's medical record. The monthly November 2011 Physician Order sheet in the medical record of Resident #7 included all medications the resident was taking. In addition, this form contained an area to note any allergies. The specified area for allergies on the November 2011 Physician Order sheet for Resident #7 noted, "No allergies defined." The November 2011 Medication Administration Record (MAR) for Resident #7 listed all medications for the resident as well as an area to note any allergies. The specified area</p>	F 425	<p>When a new order is sent to the pharmacy the pharmacy will check the patient profile against the allergy list. If the patient is allergic to the medication, the pharmacy will call the physician and facility to alert them of the discrepancy.</p> <p>Measures to be put in place or systemic changes made to ensure practice will not re-occur-</p> <p>On admission allergies will be recorded on the POS under allergies. If more space is needed the allergies will be continued on the first sheet under medications of the POS. The physician orders will be faxed to the pharmacy for notification. Licensed nursing staff will be educated, by the Quality Improvement Nurse on the process required for recording allergies on to the POS and faxing the orders to the pharmacy. The nurses that check the monthly orders will be re-educated on checking orders and ensuring all allergies are on the monthly orders, by the Quality Improvement Nurse. Any discrepancies noted during the monthly check will be placed on the POS and sent to the pharmacy.</p>

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F 425	<p>Continued From page 9</p> <p>for allergies on the November 2011 MAR noted, "No allergies defined."</p> <p>Review of the medical record of Resident #7 revealed a physician's order dated 11/14/11 for Levaquin, 500 milligrams every day for 10 days secondary to pneumonia. Review of the November 2011 MAR for Resident #7 revealed a handwritten entry for the Levaquin on 11/14/11 with dosage administration recorded at 2100. The Levaquin was signed off as given on 11/14/11, circled as not given on 11/15/11 and available to be given subsequent days in November through 11/23/11.</p> <p>On 11/16/11 at 3:15 PM the unit manager over the unit Resident #7 resided stated she was not aware Resident #7 had received a medication she was allergic to and/or that the resident had a reaction to the medication. The unit manager reviewed the medical record of Resident #7 and stated the listing of allergies should have been noted on the Physician Order sheet as well the MAR. The unit manager stated the allergies are noted in these areas to alert the physician when writing orders, to alert nursing staff providing medications to residents and for the pharmacy to alert facility staff if orders are written for a medication with a known allergy. The unit manager stated when residents are admitted to the facility a complete listing of medications and allergies would be provided to the dispensing pharmacy and subsequent MARs and monthly physician order sheets should contain the information, including any known allergies.</p> <p>In a telephone interview on 11/16/11 at 3:30 PM the facility consultant pharmacist reported he</p>	F 425	<p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-</p> <p>The Unit Managers/Designee will audit new admissions for recording of allergies during morning meeting Monday – Friday to ensure all allergies are recorded appropriately. This will be ongoing. Any discrepancies noted will be documented on a physician telephone order and faxed to the pharmacy. The DON/Designee will report results of audits to the QA&A Committee monthly x 3, then Quarterly x 3 for continued compliance/revisions to the plan if needed.</p>	12-14-11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2011	
NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOVA, NC 28778		
(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 425	<p>Continued From page 10</p> <p>checked with the pharmacy that dispensed medications for the facility and they were not aware of any allergies for Resident #7. The consultant pharmacist stated if Levaquin had been listed as an allergy the order would have been flagged when entered into the system and the facility/physician called to alert them to the discrepancy.</p> <p>On 11/16/11 at 4:15 PM the licensed nurse (LN #1) that worked the day shift on 11/15/11 (and the nurse identified by Resident #7 as the person she reported the reaction to the Levaquin) stated he recalled Resident #7 reporting she had a reaction to the Levaquin. LN #1 stated he was not aware Resident #7 had any allergies because the MAR indicated "no defined allergies". LN #1 stated he was not aware Resident #7 was allergic to Levaquin and had not informed the resident's physician of her reaction to the medication.</p> <p>On 11/16/11 at 6:10 PM the medical records director stated when residents are admitted she utilizes information sent to "set up the chart". The medical records director stated this included completing the allergy alert sticker which is placed on the inside cover of the chart binder as well as the Permanent Problem List which notes diagnoses as well as allergies. The medical records director stated she filled these out utilizing the information sent from the skilled facility Resident #7 was admitted from. The medical records director stated she expected nurses to communicate information regarding allergies to the pharmacy when the initial physician orders were sent.</p> <p>Review of the admission handwritten physician</p>	F 425		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	Continued From page 11 orders for Resident #7 revealed a notation "see allergy list" in the area on the form to record "allergies". Subsequent monthly physician orders and MARs in the medical record of Resident #7 all listed "no defined allergies" in the area on the form designated for "allergies". On 11/16/11 at 6:40 PM in a telephone interview the regional director of the dispensing pharmacy reported the pharmacy admission/intake staff enter allergies into the computer system. The regional director stated if "no allergies defined" is entered on the monthly physician order sheet and MARs that means nothing was entered for allergies. The regional director explained the phrase "no allergies defined" is a system default and the admission/intake staff should have called or Fax'd the facility for clarification. The regional director stated when the admission/intake staff received the admission orders for Resident #7 which indicated "see allergy list" it should also have been a trigger to contact the facility if the list had not been provided.	F 425	