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

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

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418		(X2) ML A BUIL B. WING	DING	сом	(X3) DATE SURVEY COMPLETED C 11/16/2011	
	IDER OR SUPPLIER HEALTH CARE C			1984	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 70 NNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D 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.

LABORATO	PRY DIRECTOR'S OR PROVIDER SUPPLIER RE	PRESENTATIVE'S SIGNATURE	TITLE	
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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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(X6) DATE

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

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	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPLE	(X3) DATE SURVEY COMPLETED C 11/16/2011	
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F 281 Continued From page 1

be applied to the resident's left shoulder at 8:00 AM and removed at 8:00 PM every day.

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.

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.

A review of the MAR dated November 2011 revealed Resident #4 had not received the Lidoderm patch any day this month.

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.

F 281 Measures to be put in place or systemic changes made to ensure practice will not

re-occur-

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.

How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-

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.

12-14-11

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

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F 281	her after the checks a UM #1 found the yello containing the Lidode use. She observed the initials from the follow Monthly Physician Or accuracy by a nurse the utilized. She stated the should sign in the span By on the monthly ord Resident #4's Monthly November 2011. She signature to indicate the Resident #4's orders, observed by each me stated these check mind were checked before system to ensure acceptailed on 10/18/11 what transcribed. UM #1 sthe check on the month have recognized the of the October to Novem Orders and obtained and interview with Lice conducted on 11/16/11 was facility protocol to order written on a precomprehensive physical when he transcribed the patch for Resident #4 notice the prescription needed). He stated the	yellow slips were given to are completed. At that time, ow slip dated 10/18/11 arm order written for daily the slip did not contain the ring shifts. UM #1 stated the ders are checked for pefore the orders are the nurse that checks them are marked Meds Reviewed the sheet. UM #1 observed by Physician Orders dated the stated there was nowhich nurse checked. Small check marks were adication block. UM #1 arks indicated the orders use. She added the facility uracy of physician orders en the order was first tated the nurse performing athly order sheet should conflicting frequencies from the monthly Physician a clarification order. The sensed Nurse (LN) #1 was the proposition of the physician order.	F	281	DEFICIENCY)		
	patch everyday for 12						

F 309 483.25 PROVIDE CARE/SERVICES FOR

F 309

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

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F 309 SS=D	Each resident must re provide the necessary or maintain the higher mental, and psychoso	NG eceive and the facility must or care and services to attain st practicable physical,	F 309	F 309 How corrective action will be accomplished for each patier to have been affected by the practice — The physician for patient # 7 v contacted and made aware of t allergy. A new order for a diffeantibiotic was obtained.	nt found deficient was the patient erent			
	by: Based on medical re with resident, staff an pharmacist the facility to one (1) of two (2) re allergies. (Resident # The findings are: Resident #7 was iden and interviewable. Re Data Set (MDS) date #7 was assessed as of impairment of short of During the initial tour 9:05 AM, Resident #7 prior at approximately dose of Levaquin (an Mucinex. Resident # the medication she be "jump out of her skin" almost 24 hours for h feeling. In a follow-up	tified by facility staff as alert eview of the latest Minimum of 8/28/11 revealed Resident cognitively intact with no rlong term memory. of the facility on 11/16/11 at reported that two nights		How corrective action will be accomplished for those patie having the potential to be aff the same deficient practice — Audit of patients' chart curren residing in the facility was acc to compare the POS (Physician Sheet) to their H&P (History a Physical) to ensure all allergie listed on the POS. Any allergies not listed were p physician telephone order and the pharmacy.	ents fected by tly complished n Order and s were			

symptoms to the licensed nurse that worked the

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F 309	Continued From page	× 4	r	309	Measures to be put in place	or	
1 000		Resident #7 stated she	r	309	systemic changes made to en		
		evaquin the evening of			practice will not	ALEXANDER COS	
		sing staff she wanted to talk			re-occur-		
		e taking another dose of the					
	medication.				On admission, allergies will b	e recorded	
	5				on the POS under allergies if		
		I record of Resident #7			is needed the allergies will be		
		ert sticker located on the art binder which listed			on the first sheet under medic		
		the resident was allergic to.			the POS, by the admission nu	rse.	
		cluded Levaquin. This list			Licensed Nursing staff will l		
	of medications was al	the same of the sa			educated on the process requi		
		ist located in the resident's			recording allergies on to the F		
		monthly November 2011			the admission process. Nurses		
		t in the medical record of			check the monthly orders will		
		all medications the resident on, this form contained an			educated on checking orders a		
		gies. The specified area for			ensuring all allergies are on the		
	The second secon	mber 2011 Physician Order			orders. Any discrepancies not		
	sheet for Resident #7	5			sent to the pharmacy if found		
	defined." The Novem	ber 2011 Medication			above education will be provi		
		d (MAR) for Resident #7			Quality Improvement Nurse.	aca by the	
		for the resident as well as			Quanty improvement reason		
		llergies. The specified area ovember 2011 MAR noted,			How facility will monitor co	rrective	
	"No allergies defined.				action(s) to ensure deficient		
	uno.g.ou donniou.				will not re-occur-	practice	
	Review of the medica	I record of Resident #7			The Unit Managers/Designee	will audit	
	revealed a physician's	s order dated 11/14/11 for			new admissions for recording		1
		ams every day for 10 days			allergies during morning mee		
	secondary to pneumo				Monday – Friday to ensure al		
		for Resident #7 revealed a the Levaquin on 11/14/11			are recorded appropriately. The		
		ration recorded at 2100.			ongoing. Any discrepancies n		
	dobugo duministi	anon rootided at 2 100.			ongoing, mily discrepancies if	oten will	1

The Levaquin was signed off as given on

available to be given subsequent days in

November through 11/23/11.

11/14/11, circled as not given on 11/15/11 and

be documented on a physician telephone

order and faxed to the pharmacy.

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F 309			F	309 The DON/Designee will audits to the QA&A Con x 3, then Quarterly x 3 for compliance/revisions to needed.	nmittee mont or continued			
	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 allergie consultant pharmacis been listed as an alle been flagged when e	s for Resident #7. The st stated if Levaquin had ergy the order would have ntered into the system and						
	the facility/physician called to alert them to the discrepancy. 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 reporting she had a reaction						

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F 309	Resident #7 had any indicated "no defined was not aware Resid Levaquin and had no physician of her reac On 11/16/11 at 6:10 director stated when utilizes information semedical records director completing the allerg placed on the inside well as the Permaner diagnoses as well as records director state utilizing the informatif facility Resident #7 wedical records director	#1 stated he was not aware allergies because the MAR allergies". LN #1 stated he ent #7 was allergic to the informed the resident's tion to the medication. PM the medical records residents are admitted she ent to "set up the chart". The ctor stated this included y alert sticker which is cover of the chart binder as allergies. The medical dishe filled these out on sent from the skilled was admitted from. The ctor stated she expected ate information regarding macy when the initial	F	309			
	orders for Resident # allergy list" in the are "allergies". Subseque and MARs in the med	sion handwritten physician F7 revealed a notation "see a on the form to record ent monthly physician orders dical record of Resident #7 allergies" in the area on the allergies".					
	contact the physiciar orders regarding the 483.60(a),(b) PHARI ACCURATE PROCE	MACEUTICAL SVC - DURES, RPH	F	425			
1	The facility must prov	vide routine and emergency					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938						
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE COMPLETION	
F 425	drugs and biologicals them under an agreer §483.75(h) of this par unlicensed personnel law permits, but only supervision of a licensed personnel law permits, but only supervision of a licensed personnel law permits, but only supervision of a licensed (including procedures acquiring, receiving, cadministering of all drug the needs of each research the facility must empa licensed pharmaciston all aspects of the particles in the facility. This REQUIREMENT by: Based on medical rest the facility consultant pharmacy and intervision the pharmacy providing failed to clarify allergies sampled residents with result, the resident was administered a medical ellergy. (Resident #7) The findings are:	to its residents, or obtainment described in t. The facility may permit to administer drugs if State under the general sed nurse. It pharmaceutical services that assure the accurate dispensing, and ugs and biologicals) to meet ident. It provides consultation provision of pharmacy is not met as evidenced cord review, interview with pharmacist/dispensing ews with staff and resident and services to the facility es for one (1) of two (2) h known allergies. As a as dispensed and ation that was a known by.	F.	How corrective action will be accomplished for each patier to have been affected by the practice — The physician for patient # 7 w contacted and made aware of t allergy. A new order for a diffe antibiotic was obtained. Patient chart was audited to en allergies were documented and faxed to pharmacy. How corrective action will be accomplished for those patier having the potential to be affethe same deficient practice — Audit of patients' chart current residing in the facility was accomplished to their H&P (History and Physical) to ensure all allergies listed on the POS. Any allergies listed were placed on a physiciat telephone order and faxed to the pharmacy.	out found deficient vas he patient erent sure all lallergies ents fected by cly complished a Order and sewere es not an	
	Resident #7 was iden and interviewable. Re	tified by facility staff as alert eview of the latest Minimum				

Data Set (MDS) dated 8/28/11 revealed Resident

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#7 was assessed as cognitively in impairment of short or long term in pairment of short or long to the medication she began shakin "jump out of her skin". Resident almost 24 hours for her to get ow feeling. In a follow-up interview of 3:50 PM Resident #7 stated she symptoms to the licensed nurse to day shift on 11/15/11. Resident #7 refused to take the Levaquin the 11/15/11 and told nursing staff shot her physician before taking and medication. Review of the medical record of Frevealed an allergy alert sticker to inside cover of the chart binder word multiple medications the resident. These medications included Leva of medications was also located of Permanent Problem List located in medical record. The monthly Nov Physician Order sheet in the medical record. The monthly Nov Physician Order sheet in the medical was taking. In addition, this form area to note any allergies. The sallergies on the November 2011 Medined."	y on 11/16/11 at last two nights she was given a along with ortly after taking g and wanted to #7 stated it took er the shaking on 11/16/11 at reported the hat worked the #7 stated she evening of he wanted to talk other dose of the Resident #7 ocated on the hich listed was allergic to requin. This list on the nother resident contained an pecified area for Physician Order allergies edication	When a new order is sent to the pharmacy the pharmacy will ell patient profile against the aller the patient is allergic to the me the pharmacy will call the physicality to alert them of the disconsisted will not re-occur- On admission allergies will be on the POS under allergies. If a space is needed the allergies we continued on the first sheet under medications of the POS. The profers will be faxed to the pharmacy will be faxed to the pharmacy in the profession. Licensed nursing be educated, by the Quality Improvement Nurse on the profession and faxing the orders to the pharmacy. The nurses that cheen monthly orders will be re-educe checking orders and ensuring a allergies are on the monthly orders will be placed on the POsent to the pharmacy.	recorded more sure ler hysician and crepancy. resure recorded more sill be ler hysician macy for staff will cess on to the ne ck the ated on ll ders, by se. Any monthly

an area to note any allergies. The specified area

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0.0000000000000000000000000000000000000	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SUI COMPLET	
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F 425	Continued From page	9	F	425	How facility will monitor corr		

for allergies on the November 2011 MAR noted, "No allergies defined."

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.

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.

In a telephone interview on 11/16/11 at 3:30 PM the facility consultant pharmacist reported he

action(s) to ensure deficient practice will not re-occur-

> 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.

12-14-11

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F 425	Continued From page	e 10	F	425				
	50 (50)	rmacy that dispensed						
		cility and they were not						
		s for Resident #7. The It stated if Levaquin had						
	been listed as an alle	rgy the order would have						
		ntered into the system and						
	discrepancy.	called to alert them to the						
		PM the licensed nurse (LN ay shift on 11/15/11 (and the						
	nurse identified by Re	esident #7 as the person she						
		to the Levaquin) stated he						
		reporting she had a reaction #1 stated he was not aware						
	Resident #7 had any	allergies because the MAR						
	indicated "no defined was not aware Resident	allergies". LN #1 stated he						
		t informed the resident's						
		tion to the medication.						
	On 11/16/11 at 6:10 F	PM the medical records						
		residents are admitted she						
		ent to "set up the chart". The stated this included						
		y alert sticker which is						
	· Contracting the same and the	cover of the chart binder as						
		nt Problem List which notes allergies. The medical						
	records director state							
		on sent from the skilled						
		as admitted from. The stor stated she expected						
		ite information regarding						
	allergies to the pharm	nacy when the initial						
	physician orders were	e sent.						

Review of the admission handwritten physician

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	345418	B. WNG	C 11/16/2011

NAME OF PROVIDER OR SUPPLIER

ASHEVILLE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1984 HIGHWAY 70

SWANNANOA, 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

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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.

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