

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

PRINTED: 12/16/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345493	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE COLLEGE DRIVE AND SOUTH ALLEN ROAD FLAT ROCK, NC 28731	

(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 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete criminal background checks as required for two (2) of two (2) unlicensed employees providing direct care.</p> <p>The findings are:</p> <p>Review of the facility Abuse and Neglect Policy, no date, revealed criminal background checks were to be conducted (according to the policy and procedures of North Carolina) on all applicants prior to employment.</p> <p>1. The employee file for Staff #4, a Nursing Assistant, revealed a criminal background check dated 07/06/11 and a hire date of 07/13/11. Review of the background check revealed a disclaimer statement that read in part "this information should not be used for employment screening."</p> <p>On 12/01/11 at 10:50 AM the Human Resource Director (HRD) was interviewed. The HRD confirmed the source of the criminal background check and revealed no further background check was completed for Staff #4.</p> <p>On 12/01/11 at 11:00 AM an interview was</p>	F 226	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>F 226</p> <ol style="list-style-type: none"> 1. The Company Home Office was contacted regarding the disclaimer that was printed on our background checks. Company Home Office started the process of acquiring a new resource to secure back ground checks on potential new hires. 2. After new Resource of background checks was secured. All employee background checks were re-done with new company to ensure employee met requirements of employment according to the policy and procedures of N.C. 3. A new resource was set up for the company to complete background checks for potential employees prior to hire to assure that a thorough screening was completed prior to employment. <p>A pre-employment check off sheet is completed on every new employee that indicates the Background check has been completed. The Background check resource cannot be changed unless done so by the Company Home Office.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maudie A. Roney "Cookie" TITLE: NHA (X6) DATE: 12-27-11

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.

DEC 28 2011
BY: M If continuation sheet Page 1 of 21

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F 226	<p>Continued From page 1</p> <p>conducted with the Administrator. The Administrator stated the source used for Staff #4's criminal background check was that utilized by the facility since December 9, 2011. The Administrator stated, prior to the survey, she was not aware of the disclaimer statement and that the source utilized for the criminal background checks was not to be used for employment screening.</p> <p>Follow up interview with the Administrator on 12/01/11 at 2:15 PM revealed a new source for criminal background checks had been contacted and would be utilized effective 12/01/11.</p> <p>2. The employee file for Staff #5, a Nursing Assistant, revealed a criminal background check dated 10/07/11 and a hire date of 10/17/11. Review of the background check revealed a disclaimer statement that read in part "this information should not be used for employment screening."</p> <p>On 12/01/11 at 10:50 AM the Human Resource Director (HRD) was interviewed. The HRD confirmed the source of the criminal background check and revealed no further background check was completed for Staff #5.</p> <p>On 12/01/11 at 11:00 AM an interview was conducted with the Administrator. The Administrator stated the source used for Staff #5's criminal background check was that utilized by the facility since December 9, 2011. The Administrator stated, prior to the survey, she was not aware of the disclaimer statement and that the source utilized for the criminal background checks was not to be used for employment</p>	F 226	<p>4. All new background checks will be assessed by the Administrator for final approval of employment. Any discrepancies of these findings will be presented to the QA committee monthly x 3, then quarterly until resolved.</p> <p>5. December 29, 2011</p>	12-29-11

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F 226	Continued From page 2 screening. Follow up interview with the Administrator on 12/01/11 at 2:15 PM revealed a new source for criminal background checks had been contacted and would be utilized effective 12/01/11.	F 226			
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 observations, record review, and staff interviews the facility failed to transcribe a physician's order for pain medication to the November 2011 Medication Administration Record (MAR) for one (1) of ten (10) residents sampled for medication review (Resident #33) and failed to obtain a physician's order for supplemental oxygen for one (1) of five (5) sampled residents receiving oxygen therapy (Resident #293). The findings are: 1. Resident #33 was admitted to the facility with diagnoses including Dementia, Cardiovascular Accident (CVA/Stroke), and Osteoarthritis. On the most recent Minimum Data Set (MDS), completed 10/31/11 for a significant change in condition, Resident #33 was assessed as having long and short term memory problems, severely impaired cognitive skills for daily decision making, limited range of motion in upper and lower extremities on one side, and as having frequent	F 281	F281 1. Resident #33 record was thoroughly assessed for any documentation or indication that resident had break through pain. Attending physician was notified of Tylenol 650mg. tid routinely was not transcribed to the Nov M.A.R. and resident did not receive Tylenol as ordered. Physician clarified order for Tylenol 650mg at HS ordered on 11/17/11 and gave additional Tylenol orders for prn break through pain not to exceed 4 gm per 24 hr. period. Licensed Nurse that failed to do the double check on the MAR at the end of the month was disciplined and re- educated regarding monthly M.A. R. checks. All licensed nurses were educated on procedure of M.A. R. transfers. 2. All December M.A. R.'s for current residents were reviewed for accurate completion of physician orders written in Nov. and current orders written during the month of Dec. 2011. Review completed by Unit Managers and Director of Nursing.		

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F 281	<p>Continued From page 3</p> <p>pain of moderate intensity with no scheduled pain medication.</p> <p>Review of the medical record revealed a 10/27/11 physician's order for routine Tylenol 650 milligram (mg) to be administered by mouth three times daily for Osteoarthritis pain.</p> <p>Review of the November 2011 Medication Administration Record (MAR) revealed the 10/27/11 physician's order for routine Tylenol 650 mg three times daily was not transcribed/reflected on the MAR and Resident #33 did not receive Tylenol as ordered for pain during November 2011.</p> <p>During an interview, 12/01/11 at 10:30 AM, the Assistant Director of Nursing (ADON) reviewed the November 2011 MAR and confirmed the 10/27/11 order for Tylenol was not reflected on the MAR and Resident #33 did not receive Tylenol for pain as ordered. The ADON reported the facility practice for verifying that all physician's orders were reflected on the monthly MAR included: The last week of each month residents' MARs for the upcoming month were printed and reviewed for accuracy by two Licensed Nursing (LN) staff. The first nurse was responsible for reviewing the current and new MARs and all new orders through the date of the review. During the last twenty four hours of the month a second nurse was responsible for completing a final review of the MARs and physician's orders and for making changes as necessary to ensuring all physician's orders were accurately reflected on the new MAR. The ADON stated the first nurse reviewed the MAR for November prior to 10/27/11 when the physician's order was written and it</p>	F 281	<p>3. The implementation of new monthly M.A.R. will require the signature of 2 licensed nurses indicating that the M.A.R. is accurate and correct with all current orders. The new monthly M.A.R.s. will be reviewed by the Director of Nursing and Assistant Director of Nursing and or their designee for the two signatures of licensed nurses indicating compliance of policy to check accuracy of the M.A.R. All new orders obtained after the print date of the M.A.R. will be checked to assure that they were transferred to the New M.A.R. by Nursing Admin. Each month.</p> <p>4. Any discrepancy of this procedure will be brought to the QA committee monthly x 3, or Until QA committee assures compliance.</p>	December 29, 2011	

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F 281	<p>Continued From page 4</p> <p>appeared as if the second nurse missed the order and did not update the MAR to reflect the Tylenol order.</p> <p>On 12/01/11 at 6:05 PM a follow-up interview was conducted with the ADON. The ADON revealed the facility's usual practice was not followed and a second nurse did not review Resident #33's MAR for November 2011. The ADOM stated since the second review was not completed the omitted 10/27/11 order for Tylenol was not identified and added to the MAR. The interview further revealed the November 2011 MAR should have been reviewed by a second nurse and updated to reflect the Tylenol.</p> <p>2. A review of a facility policy that was undated and titled "Oxygen" stated in part "there must be a physician's order for oxygen use which includes the route and liter flow or specific oxygen concentration, and how long the oxygen is to be administered. When the unit nurse initiates oxygen therapy for a resident, she must: a. Transcribe the physician's order in the resident's chart and Treatment Administration Record (TAR)."</p> <p>Resident #293 was admitted to the facility with diagnoses including chronic lung disease and heart disease. The admission Minimum Data Set (MDS) dated 11/24/11 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The resident required extensive assistance by staff for activities of daily living and she required oxygen therapy.</p>	F 281	<p>F 281 continued for resident # 293</p> <ol style="list-style-type: none"> 1. Resident #293 was admitted on On her admitting FL2, which is used for physician orders indicated oxygen to be administered at 3/L per minute Resident had received oxygen as ordered at 3L/min and also had routine O2 Sat% done to assess effectiveness. Order for Oxygen was written on the M.A.R. per policy of which included the route and liter flow or concentration. Licensed nurse that transcribed admission orders was disciplined and re-educated on process of transcribing new admission orders. 2. All current residents receiving Oxygen records were assessed to assure that an order was written on the Medication Administration Record indicating liters/min, route and duration of tx 3. All new admission orders will require the signature of two licensed nurses to assure that all orders are transcribed accurately and to the proper record of administration. 4. Unit Managers will check the accuracy of new oxygen orders if written by physician and or implemented by licensed staff to assure the correct liters/min, route and duration of tx. Any discrepancies will be reported to the QA committee monthly x 3 or until committee assures compliance. 5. Dec. 29, 2011. 		

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F 281	<p>Continued From page 5</p> <p>A review of the medical record and November 2011 monthly physicians' orders revealed there were no physician's orders for Resident #293 to receive oxygen.</p> <p>During an observation on 11/29/11 at 11:52 AM Resident #293 was sitting in a chair next to her bed with oxygen on at three (3) liters per minute per nasal cannula.</p> <p>During an observation on 11/30/11 at 9:57 AM Resident #293 was lying in bed with oxygen on at three (3) liters per minute per nasal cannula.</p> <p>During an observation on 12/01/11 at 9:35 AM Resident #293 was lying in her bed with oxygen on at three (3) liters per minute per nasal cannula.</p> <p>During an interview on 12/01/11 at 9:40 AM with Licensed Nurse (LN) #5 she stated Resident #293 was admitted from a hospital with oxygen at three (3) liters per minute by nasal cannula because of chronic lung disease. She verified there were no physician orders for Resident #293 to receive oxygen. LN #5 stated the nurse who admitted the resident should have obtained a physician's order for oxygen and should have written it on the physician's order sheet.</p> <p>During an interview on 12/01/11 at 10:00 AM with the Director of Nurses (DON) she verified there were no physician's orders for Resident #293 to receive oxygen. She explained there was a physician's progress note in the medical record which indicated the resident required oxygen due to chronic lung disease and the nursing staff should have obtained a physician order for</p>	F 281			

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F 281	Continued From page 6 oxygen when Resident #293 was admitted and should have documented the order on the physician's order sheet and on the medication administration record.	F 281			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to withhold medication for systolic blood pressures below 110 millimeters of mercury	F 329	F329 1. Resident #288 medication record was reviewed. All licensed nurses that gave medication outside the parameters indicated by physician were disciplined and re-educated. Physican was notified of the dates medication was given when the B/P was below designated parameter. Parameters were highlighted and an area designated to document the B/P on the M.A.R. 2. The pharmacy supplied nursing admin with a list of current residents with medications ordered that required designated parameters. A.D.O.N. reviewed all residents on list to assure that parameters were on the M.A.R. and medication administered as indicated by the parameter. 3. When new orders are obtained that contains a parameter with the medication. The unit manager will check to assure that the M.A.R. clearly is designated to document the parameter and will check M.A.R. for all residents for proper compliance and administration weekly x 3 months. All licensed staff were re-educated on medication administration that involves parameters and the importance following parameters.		

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F 329	<p>Continued From page 7</p> <p>(mmHg) as prescribed for one (1) of ten (10) sampled residents reviewed for unnecessary medications. (Resident #288).</p> <p>The findings are:</p> <p>Resident #288 was admitted to the facility with diagnoses including Angina, Atrial Fibrillation, and Congestive Heart Failure. Review of the medical record and November 2011 Medication Administration Record (MAR) revealed a physician's order, dated 11/02/11, for extended release Diltiazem (for treatment of Angina) 180 milligrams (mg) to be administered by mouth daily. The order included specific directions to hold (not give) the medication if systolic (top number) blood pressure (BP) was less than 110 millimeters of mercury (mmHg). Documentation, Licensed Nursing (LN) staff initials, on the MAR revealed Resident #288 received Diltiazem 180 mg daily at 9:00 AM from 11/03/11 through 11/30/11 without interruption.</p> <p>Review of the November 2011 "WEIGHT AND VITAL SIGNS RECORD" utilized by the facility for documenting residents' blood pressure, revealed Resident #288's systolic blood pressure was below 110 mmHg as follows: 11/17/11 - 101/63, 11/18/11 - 83/58, 11/22/11 - 98/67, 11/23/11 - 99/60, and 11/27/11 - 100/50. Review of medical records revealed no further blood pressures for Resident #288 on 11/17/11, 11/18/11, 11/22/11 11/23/11 and/or 11/27/11 prior to administration of Diltiazem.</p> <p>During an interview, 12/01/11 at 12:50 PM, the Assistant Director of Nursing (ADON) stated Licensed Nursing (LN) staff were responsible for</p>	F 329	<p>4. Unit managers will check all new orders with parameters to assure that the M.A.R. is clearly designated to document those parameters.</p> <p>All residents M.A.R.'s with parameters will be checked weekly by Unit Mangers x 3 months and reported monthly to QA committee. Any discrepancies will be reported to the D.O.N. or A.D.O.N. for proper intervention.</p> <p style="text-align: right;">December 29, 2011.</p>		

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F 329	Continued From page 8 monitoring and documenting residents' blood pressure when physician's orders included specific parameters for administration of a medication. The ADON stated if blood pressure parameters were not met LN staff were responsible for holding the medication and documenting on the MAR by circling their initials and why the medication was not administered. During an interview on 12/01/11 at 3:15 PM LN #3, assigned to the resident, confirmed Resident #288's 11/02/11 physician's order for Diltiazem 180 mg daily included specific directions to hold the medication for systolic blood pressure under 110 mmHg. LN #3 reviewed the medical record, November 2011 vital sign record, and MAR and confirmed Resident #288's systolic blood pressure was less than 110 mmHg on 11/17/11, 11/18/11, 11/22/11, 11/23/11, and 11/27/11 and Diltiazem 180 mg was administered. LN #3 stated she monitored Resident #288's blood pressure daily prior to administering medications but was unaware of specific directions to hold Diltiazem for systolic pressures less than 110 mmHg. During an interview, 12/01/11 at 6:00 PM, the Director of Nursing (DON) reviewed the 11/02/11 physician's order, vital sign and medical record, and November 2011 MAR and confirmed Resident #288 Diltiazem should have been held on 11/17/11, 11/18/11, 11/22/11, 11/23/11, and 11/27/11 when the systolic blood pressure was less than 110 mmHg. The DON stated LN staff were responsible for monitoring residents blood pressure and administering medications as ordered.	F 329			
F 371	483.35(j) FOOD PROCURE,	F 371			

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F 371 SS=D	<p>Continued From page 9</p> <p>STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to deliver meal trays in a sanitary manner by placing a partially consumed tray on the meal cart with a clean tray on one of six halls.</p> <p>The findings are:</p> <p>On 11/29/11 at 12:43 PM, the tray cart was delivered to 600 hall. At 1:20 PM NA # 1 removed a tray, with a partially consumed meal, from a resident's room and placed it on the same side of the meal cart with a clean tray that had not been delivered. At 1:22 PM, NA # 1 came back to the meal cart and removed the clean tray and delivered it to the resident.</p> <p>On 11/30/11 at 4:43 PM, NA # 1 was interviewed regarding putting dirty meal trays on the meal cart with clean meal trays. NA # 1 stated the dirty trays shouldn't be put on the same side of the cart as the clean trays. NA #1 was unable to explain why the dirty tray was placed on the same side of the meal cart as the clean tray.</p>	F 371 F371	<ol style="list-style-type: none"> All meal carts were tagged with signage that states dirty trays are not to be added to cart unless all clean trays have been served. Education to direct floor staff was implemented immediately. During meal times nursing administration assessed each hallway to assure that dirty meal trays were not being added to a cart that contained clean trays. This was done routinely until education was given to all floor staff. On-going education will be given for new hires and permanent signage has been ordered to replace laminated signs. During meal time Nursing Admin and or designee will assess and monitor tray pick-up to assure that no dirty are trays are added to a cart that has a clean tray. Monitoring will be done each shift for one meal 2 x week x 1 month. Discrepances will be corrected immediately and a report submitted at the next QA monthly meeting. 	December 29, 2011	

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F 371	Continued From page 10	F 371			
F 428 SS=D	<p>On 12/1/11 at 9:13 AM the Director of Nursing (DON) was interviewed about her expectations for placing dirty meal trays on the meal cart. The DON stated dirty trays should be placed on a separate side of the cart from the clean trays.</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility consulting Pharmacist failed to identify and report medication irregularities for two (2) of ten (10) residents sampled for medication review. Resident #288's medication was not withheld per indications and physician's order and Resident #33 was not administered pain medication as ordered during November 2011.</p> <p>The findings are:</p> <p>1. Resident #288 was admitted to the facility with diagnoses including Angina, Atrial Fibrillation, and Congestive Heart Failure. Review of the medical record and November 2011 Medication</p>	F 428	F428		
			<ol style="list-style-type: none"> 1. Consulting pharmacist made aware of medication irregularity for resident # 288 of Diltiazem 180mg. Pharmacist consulted with Director of Nursing and was made aware that attending physician was notified of medication being given when systolic blood pressure under 110mmHg. 2. All medications ordered with parameters will be reviewed by consultant pharmacist to assure that parameters are being followed correctly. 3. Each Month the consultant pharmacist will check all medications with parameters to assure that parameters were followed correctly. Any discrepancies will be reported to the Director of Nursing. 4. Each Month the consultant pharmacist will check all medications with parameters to assure that parameters were followed correctly. Written report will be given to the Director of Nursing each month x 3 then quarterly. Monthly reports will be submitted to the QA committee. 5. Dec. 29, 2011. 		

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F 428	<p>Continued From page 11</p> <p>Administration Record (MAR) revealed a physician's order, dated 11/02/11, for extended release Diltiazem (for treatment of Angina) 180 milligrams (mg) to be administered by mouth daily. The order included specific directions to hold (not give) the medication if systolic (top number) blood pressure (BP) was less than 110 millimeters of mercury (mmHg). Documentation and initials of Licensed Nursing (LN) staff on the MAR revealed Resident #288 received Diltiazem 180 mg daily at 9:00 AM from 11/03/11 through 11/30/11 without interruption.</p> <p>Review of the November 2011 "WEIGHT AND VITAL SIGNS RECORD" utilized by the facility for documenting residents' blood pressure, revealed Resident #288's systolic blood pressure was below 110 mmHg as follows: 11/17/11 - 101/63, 11/18/11 - 83/58, 11/22/11 - 98/67, 11/23/11 - 99/60, and 11/27/11 - 100/50. Review of medical records revealed no further blood pressures for Resident #288 on 11/17/11, 11/18/11, 11/22/11 11/23/11 and/or 11/27/11 prior to administration of Diltiazem.</p> <p>Review of the 11/30/11 "Consultant Pharmacist Drug Regimen Review" revealed no noted irregularities or recommendations regarding Resident #288's systolic blood pressure and/or administration of Diltiazem.</p> <p>During an interview on 12/01/11 at 3:15 PM LN #3, assigned to the resident, confirmed Resident #288's 11/02/11 physician's order for Diltiazem 180 mg daily included specific directions to hold the medication for systolic blood pressure under 110 mmHg. LN #3 reviewed the medical record and November 2011 vital sign record and MAR</p>	F 428			

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F 428	<p>Continued From page 12</p> <p>and confirmed Resident #288's systolic blood pressure was less than 110 mmHg on 11/17/11, 11/18/11, 11/22/11, 11/23/11, and 11/27/11 and Diltiazem 180 mg was administered. LN #3 stated she monitored Resident #288's blood pressure daily prior to administering medications but was unaware and did not recognize specific directions to hold Diltiazem for systolic pressures less than 110 mmHg.</p> <p>During a telephone interview, 12/01/11 at 5:45 PM, the facility consulting Pharmacists confirmed Resident #288's medications and physician's orders were reviewed 11/30/11 and no identified irregularities and recommendations were noted. The Pharmacist stated his practice was to review blood pressure monitoring when medications have prescribed parameters for administration. The Pharmacist stated he did not review blood pressure monitoring for Resident #288 and did not recognize that Diltiazem was administered outside prescribed parameters and physician's orders were not followed.</p> <p>During an interview, 12/01/11 at 6:00 PM, the Director of Nursing (DON) reviewed the 11/02/11 physician's order, vital sign and medical record, and November 2011 MAR and confirmed Resident #288's Diltiazem should have been held on 11/17/11, 11/18/11, 11/22/11, 11/23/11, and 11/27/11 when the systolic blood pressure was less than 110 mmHg. The DON stated the consulting Pharmacist was responsible for reviewing residents' records and identifying and reporting irregularities. The interview further revealed no irregularities or recommendations were reported regarding Resident #288's blood pressure and administration of Diltiazem.</p>	F 428		

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F 428	<p>Continued From page 13</p> <p>2. Resident #33 was admitted to the facility with diagnoses including Dementia, Cardiovascular Accident (CVA/Stroke), and Osteoarthritis. On the most recent Minimum Data Set (MDS), completed 10/31/11 for a significant change in condition, Resident #33 was assessed as having long and short term memory problems, severely impaired cognitive skills for daily decision making, limited range of motion in upper and lower extremities on one side, and as having frequent pain of moderate intensity with no scheduled pain medication.</p> <p>Review of the medical record revealed a 10/27/11 physician's order for routine Tylenol 650 milligram (mg) to be administered by mouth three times daily for Osteoarthritis pain.</p> <p>Review of the November 2011 Medication Administration Record (MAR) revealed the 10/27/11 physician's order for routine Tylenol 650 mg three times daily was not reflected on the MAR and Resident #33 did not receive Tylenol as ordered for pain during November 2011.</p> <p>Review of the 11/28/11 "Consultant Pharmacist Drug Regimen Review" revealed no noted irregularities or recommendations. Documentation revealed no recognition or report regarding the facilities failure to note and administer Resident #33's Tylenol as ordered 10/27/11 for pain.</p> <p>During an interview, 12/01/11 at 10:30 AM, the Assistant Director of Nursing (ADON) reviewed the November 2011 MAR and confirmed the 10/27/11 order for Tylenol was not reflected on</p>	F 428	<ol style="list-style-type: none"> For resident # 33, the pharmacist was notified of the Tylenol not being given for the month of Nov. 2011. Physician was made aware and new orders were written. An audit was conducted for all residents to assure that all orders written after print date of nov. medication administration record were transcribed to Dec. MAR's. Consultant Pharmacist and or his designee, will check all medication orders written after print date of Monthly MAR to assure that all orders are transcribed correctly to the new MAR. Any orders that are found by the pharmacist or their designee that were not transcribed to the new MAR will be reported to the Director of Nursing for immediate correction. All discrepancies will be reported to the QA committee monthly x3 and then quarterly. Dec. 29, 2011. 		

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F 428	Continued From page 14 the MAR and Resident #33 did not receive Tylenol for pain as ordered. During a telephone interview, 12/01/11 at 5:50 PM, the facility consulting Pharmacists confirmed Resident #33's medications and physician's orders were reviewed 11/28/11 and no identified irregularities and recommendations were noted. The Pharmacist stated during monthly pharmacy reviews original orders were reviewed to ensure orders were added to the MAR and medications were administered as ordered. The Pharmacists stated irregularity were not identified or reported regarding Resident #33's 10/27/11 order for Tylenol. The DON stated the consulting Pharmacist was responsible for reviewing residents' records and identifying and reporting irregularities. The interview further revealed no irregularities or recommendations were reported regarding the Resident #33's Tylenol order or the facilities failure to administer pain medications as ordered 10/27/11.	F 428			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	P431 1. Unit Manager was alerted by the surveyor which assured security of cart until nurse returned from emergency. Licensed Nurse for this hallway was disciplined and re-educated regarding the security of a medication cart. 2. All Licensed Staff were re-educated regarding the security of medication cart when unattended.		

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F 431	<p>Continued From page 15</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure one (1) of six (6) medication carts and three medications on top of the cart while unattended. (400 Hall medication cart).</p> <p>The findings are:</p> <p>Review of an undated Medication Storage Policy/Procedure, provided by the facility, read in part: "Medications must only be accessible to authorized staff, and locked when not under the</p>	F 431	<p>3. All Department heads have been instructed to assess security of med carts during their daily routine rounds if found unattended in the hallways. If found unlocked the Department Head is to remain at cart until the nurse returns. Nursing Management will then be notified. All licensed staff have been educated on securing their med carts when unattended.</p> <p>4. Unit Managers, Nursing Admin, and Department heads will routinely during rounds assess the security of unattended med carts on an on-going basis. Any non-compliance will be reported to Nursing Admin. To report also to QA committee monthly x 3.</p>	Dec. 29, 2011

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F 431	<p>Continued From page 16</p> <p>direct observation of authorized staff." "The medication cart should always be locked unless it is in direct view of the Unit Nurse." "No medications should be left unattended: On medication carts"</p> <p>On 12/01/11 from 4:42 to 4:45 PM the 400 Hall medication cart with three medications in a soufflé cup on top were observed unsecured and unattended between rooms 406 and 408. No residents or staff were observed in the immediate area at the time of the observation. At 4:45 PM the Unit Manager (UM) was called to the cart by the surveyor. The UM remained with the surveyor at the cart for approximately one minute at which time she (UM) asked Nursing Assistant (NA) staff to locate the Licensed Nurse (LN) assigned to the cart, LN #3. At 4:47 PM LN #3 exited from the closed door of room 402 and returned to the unsecured medications and cart, approximately thirty (30) feet away.</p> <p>During an interview, 12/01/11 at 4:47 PM, LN #3 stated she was in room 402, for a non-emergency, with the door closed for approximately three (3) to five (5) minutes while the medications and cart were unsecured and unattended. LN #3 stated medication carts should be secured at all times when unattended and medications should not be left on top. LN #3 identified the medications observed on top of the cart as Prilosec 40 milligram (mg) (for acid reflux), Reglan 10 mg (for heartburn), and Haldol 0.5 mg (antipsychotic for Schizophrenia).</p> <p>During an interview, 12/01/11 at 5:25 PM, the UM stated medication carts and medications should be secured at all times when unattended. The</p>	F 431			

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F 431	Continued From page 17 UM stated LN #3 should have secured the cart and medications before leaving the immediate area.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441 F441	<ol style="list-style-type: none"> 1. Nursing Assistant #2, immediately upon events reported was counseled and re-educated by A.D.O.N. and unit manager. Regarding proper handling of soiled linens and appropriate use of gloves and hand-washing. 2. All direct care staff were in-serviced on this unit immediately and the remaining staff in-serviced Dec. 2nd. Within 72 hours all staff had been in-serviced on infection control, proper handling of soiled linens and hand-washing. 3. On new employee orientation of direct care staff includes proper handling of soiled lines, appropriate use of gloves and hand-washing. On-going in-serving will continue annually. 4. Nursing Admin. And or designees will monitor the handling of soiled linens, glove usage and proper hand-washing Direct observation will be monitored 3x week x 3 months and reported to QA committee monthly x 3 	Dec. 29, 2011

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F 441	<p>Continued From page 18</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, facility staff failed to remove gloves after handling soiled linens in one (1) of two (2) sampled residents observed during incontinence care. (Resident # 293).</p> <p>The findings are:</p> <p>A facility policy/procedure dated August 2008 and titled "Standard Precautions" stated in part to change gloves between tasks and procedures after contact with material that may contain microorganisms. Remove gloves promptly after use, before touching non-contaminated items and surfaces, and wash hands as soon as possible after glove removal. Staff should handle contaminated laundry as little as possible with a minimum of agitation and place soiled linen in plastic laundry bags.</p> <p>During an observation on 11/30/11 at 9:57 AM Nursing Assistant (NA) #2 provided incontinence care to Resident #293 who was soiled with stool. During the incontinence care NA #2 used three (3) towels to clean the stool from Resident #293's buttocks and tossed each soiled towel, one at a time, across the bed into a trash can on the opposite side of the bed. NA #2 removed her gloves, washed her hands and put on clean gloves. NA #2 walked over to the trash can and with her gloved hands, picked up a handful of</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>soiled towels and placed them into a second trash can. She returned to the first trash can and picked up the remainder of the soiled towels and deposited them on top of the other soiled towels in the second trash can. Without removing her gloves, NA #2 moved the resident in her chair, pushed the privacy curtain back against the wall, turned the light switch off, touched the door handle, opened the door then proceeded to removed her gloves.</p> <p>During an interview on 11/30/11 at 1:35 PM with NA #2 she stated she had placed the trash can for the soiled linen on the opposite side of the resident's bed so she wouldn't trip over it. She explained she separated the linen from one trash can to another because she realized she had put soiled linens on top of trash in the trash can and it had to be separated before she took it to the soiled holding room. She also confirmed she did not remove her gloves after handling the soiled linen and stated she should not have touched the resident's chair, the privacy curtain, the trash can in the resident's bathroom, the light switch or the door handle to the resident's room before she removed her soiled gloves.</p> <p>During an interview on 11/30/11 at 3:25 PM the Assistant Director of Nurses (ADON) stated during orientation Nursing Assistants (NA's) received education regarding infection control and handwashing. She explained NA's were also assigned to work with a preceptor who taught them about infection control, wearing gloves and handwashing.</p> <p>During an interview on 11/30/11 at 4:36 PM with the Director of Nurses (DON) she stated she</p>	F 441			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345493	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2011
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE COLLEGE DRIVE AND SOUTH ALLEN ROAD FLAT ROCK, NC 28731		
(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 441	Continued From page 20 expected nursing staff to remove their gloves and wash their hands after they provided incontinence care or handled soiled linen. She stated staff should not touch any clean items in the resident's room with their soiled gloves. The DON further stated she expected nursing staff to place the trash can or a plastic bag for soiled linen on the same side of the bed next to them and they should not toss the linen across a resident's bed.	F 441			