STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation in this survey, event ID # NHOQ11.	F 000	F 333 Residents affected by the alleged deficient practice; the physician was notified on 1/25/12 regarding Resident #41. Resident #41 received Oxybutin ER 5mg and the physician order was Oxybutin 5mg. Physician was in facility and assessed resident on 1/25/12. Physician stated in his professional judgment no harm had been done. Physician order clarification was written for Oxybutin ER 5mg daily and transcribed onto the Medication Administration Record (MAR) by the licensed nurse on 1/25/12. Residents with the potential to be affected by the alleged deficient practice includes current facility residents receiving the medication Oxybutin. The Director of Nursing (DON) and Unit Manager conducted an audit to identify residents with orders for oxybutin. The audit was completed on 1/25/12 with no discrepancies identified. The Director of Nursing began in **" 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."**	2-13-12
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility administered the wrong formulation of oxybutinin chloride to one (1) or fifty-two (52) residents (Resident #41). The findings are: Resident #41 was admitted to the facility with paraplegia and neurogenic bladder with an indwelling catheter. The admission Minimum Data Set, dated 01/02/12, revealed the resident was cognitively intact and required extensive assistance with activities of daily living. A care plan, dated 12/30/11, addressed the resident's indwelling catheter with interventions which included administering meds as ordered. Further review of the resident's medical record revealed a physician order, dated 12/23/11, to administer oxybutinin chloride 5 mg by mouth twice daily for bladder spasms. On 01/25/12 at 9:28 AM, an observation was made of Licensed Nurse (LN) #1 as she administered medications to Resident #41. LN #1 dispensed one tablet from a blister pack labeled oxybutinin chloride extended release (ER) 5 mg, leaving two tablets in the blister pack out of an original total count of thirty. The blister pack indicated that the extended release oxybutinin	F 333		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X8) DATE

Administrator 2-17-12

Original Signature Date: 2-13-12

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F 333	Continued From page 1 was scheduled to be administered once daily. The blister pack also indicated it was dispensed to the facility by the pharmacy on 01/10/12. LN #1 administered the extended release 5 mg tablet of oxybutinin to Resident #41. A review of the Medication Administration Record (MAR) revealed the physician order, dated 12/23/11, for oxybutinin 5 mg twice daily. Initials of nursing staff indicated the medication had been administered twice daily since 12/23/11. On 01/25/12 at 2:05 PM the facility consultant pharmacist was interviewed. He stated oxybutinin chloride comes in a plain and an ER formulation. He stated that according to computer documentation, on 12/23/12 the pharmacy had made a therapeutic substitution of oxybutinin ER 5 mg once a day to replace the immediate release or plain oxybutinin 5 mg twice a day which had been ordered by the physician. The pharmacist stated that the ER formulation of oxybutinin 5 mg would have been sent to the facility on 12/23/11 with notification of the therapeutic interchange for nursing staff to inform the physician and change the order and the MAR. The pharmacy was able to provide printed computer documentation that indicated the pharmacy had sent a blister pack of the ER formulation of oxybutinin 5 mg and notification of the therapeutic interchange to the facility on 12/23/11 and a second blister pack of ER oxybutinin 5 mg on 01/10/12. The blister packs indicated the ER medication should be administered once daily. There was no record of the pharmacy ever sending plain oxybutinin 5mg for administration twice a day. The pharmacist stated the facility printed the MAR, not the pharmacy, so it was the facility responsibility to make the changes when notified of a therapeutic interchange by the pharmacy. He also stated that	F 333	service education for licensed nurses on 1/25/12 regarding "Policy and Procedure for Medication Administration, including procedure for implementing drug therapeutic interchange". The DON individually in-serviced the 3rd shift nurses regarding the process for implementing a therapeutic interchange order; the weekend RN supervisor will verify the interchange process for medication changes on the weekend. A MAR to card audit was completed on 2/8/12 by the Pharmacy technician on all medication carts. The Licensed nurse notified physician for order clarification for any discrepancies identified. Systemic Changes: The DON and Unit Managers began in service education for licensed nurses on 1/25/12 regarding "Policy and Procedure for Medication Administration, including procedure for implementing drug therapeutic interchange." In service education **" 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."**	

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F 333	Continued From page 2 according to the therapeutic interchange, the resident should have received only one dose of the oxybutinin ER 5 mg each day, not two doses. The pharmacist added, however, that the amount of extended release oxybutinin the resident may have received was still within the therapeutic range. On 01/25/12 at 2:54 PM, LN #2 was interviewed. She stated that the blister pack she used to dispense oxybutinin to Resident #41 contained ER oxybutinin, not immediate release as the physician order and MAR read. She stated she failed to notice that the blister pack read ER and one dose a day which differed from the order transcribed on the MAR. She stated if she had noticed the differences, she would have notified a supervisor to reconcile the discrepancy with the pharmacy. LN #2 stated the ER oxybutinin was the only formulation of oxybutinin dispensed by the pharmacy for Resident #41 in her medication cart. On 01/25/12 at 3:33 PM the Director of Nursing (DON) was interviewed. She stated that when the pharmacy sent notification of a therapeutic interchange along with medications, she expected the nurse who received the notification and the medications to make the changes in the orders and on the MAR, inform the physician, and provide a copy of the therapeutic interchange paperwork to the DON for review. She was unable to find new orders to reflect the therapeutic interchange and unable to find notification paperwork for the therapeutic interchange for this medication. The DON stated it appeared that the resident had been receiving the extended release formulation of the medication twice a day. She stated she expected nurses to make sure the medication they administered matched the transcribed order on the MAR, and if not to hold the medication until	F 333	will be completed by 2/13/12. The Interchange process includes: The Pharmacy will send an interchange request to the physician for approval. Once approval is obtained the Interchange request form will be wrapped around the medication and sent to the facility. The nurse that receives the medication will remove the interchange form, write the physician order, transcribe onto the MAR and make a copy of the interchange form to be given to the DON. The DON, Unit managers will review the interchange forms daily as received, beginning 1/26/12, to compare to the telephone order, MAR and medication card in the cart for accuracy. The DON and Unit Managers will conduct medication pass observations weekly for four weeks then bi weekly ongoing beginning 1/30/12, with focus on nursing comparing medication card to order written on the MAR for accuracy, if discrepancies are identified, the medication will not **" 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."**	

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F 333	Continued From page 3 clarified. The DON informed the physician of the error and the order and MAR were corrected. On 01/25/12 at 5:00 PM the resident's physician was interviewed. He stated he had examined the resident for any possible medication side effects and had found none. The physician stated the resident did not suffer any harm from the medication error.	F 333	be given, the physician will be notified, and the pharmacy will be notified for appropriate medication. The DON will call the pharmacy weekly, beginning 1/26/12, requesting a list of therapeutic interchanges that have been sent to the facility, to assure interchanges were received by the facility and physician orders were written and transcribed as ordered onto the MAR. The Pharmacy technician will perform MAR to card audits for each medication cart quarterly ongoing. QAA: The DON will review data obtained from audits and observations to determine continued compliance. Patterns/trends will be identified and analyzed and reported in QA&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to assure continued compliance.	
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 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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	F 431	**" 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."**	

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F 431	Continued From page 4 can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to remove expired medications from two (2) of five (5) medication carts. The findings are: 1. Observation of the 600 Hall Medication Cart on 01/26/12 at 11:05 AM revealed an Advair Diskus 250/50 mcg multiple dose inhaler, labeled for Resident #45, with a date dispensed of 11/06/11 and a date opened of 12/19/11. Interview with LN #1 at that time revealed she had administered the Advair that morning to Resident #45. A review of the January 2012 Medication Administration Record revealed the resident received Advair Diskus twice daily on a scheduled basis and last received the medication on 01/26/12 at 8:00 AM. Further review of Resident # 45's medical record revealed she was hospitalized from 12/26/11 through 01/01/12 and from 01/12/12 through 01/13/12. Manufacturer's guidelines stated: "The device should be discarded one (1) month after removal from the moisture-protective foil overwrap pouch or after all blisters have been used (when the dose indicator reads ' 0 '), whichever comes first." A review of the facility pharmacy guidelines revealed that Advair Diskus was good for one (1) month after removal from the foil pouch or after all blisters have been used, whichever comes	F 431	F 431 Residents affected by the alleged deficient practice; licensed nurse discarded expired Advair Discus on 1/25/12 and a new Advair discus was opened and dated when opened for Resident #45.Physician assessed resident on 1/25/12 and stated there was no harm done related to use of expired Advair discus. Licensed Nurse discarded Ferrous Gluconate on 1/26/12. Residents with the potential to be affected by the alleged deficient practice includes current facility residents. The Director of Nursing (DON) Unit Managers and Licensed nurses conducted an audit of each medication cart on 1/26/12 to identify expired medications. There were no other expired medications noted on medication carts. The DON and Unit Managers conducted an audit to identify residents with orders for Ferrous Gluconate. There were no residents with **" 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."**	2-13-12

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F 431	Continued From page 5 first. An interview with LN #1 on 01/26/12 at 2:18 PM about Resident # 45's Advair Diskus revealed the dose indicator read "20". LN # 1 stated there were doses left because Resident #45 had been in the hospital. LN #1 stated she did not know the Advair Diskus was only good for 30 days once opened. She noted there was an unopened Advair Diskus labeled for Resident # 45 available for use on the medication cart. The Director of Nursing (DON) was interviewed on 01/26/12 at 3:45 PM. She stated the nurse from the pharmacy checked medication carts and storage areas for expired medications monthly. The DON stated that facility nurses were also responsible to check and remove expired medications from the carts. She stated she expected nurses to label the medication when opened, monitor for expiration dates, and remove from the cart when expired. The DON stated she expected the nurse to discard the expired Advair. 2. Observation of the 100 Hall Medication Cart on 01/26/12 at 11:05 AM revealed one bottle of ferrous gluconate 240 mg tabs opened for use with a manufacturer's expiration date of 09/11. Interview with Licensed Nurse (LN) #2 revealed the bottle should have been discarded before the manufacturer's expiration date. LN #2 discarded the bottle. The Director of Nursing (DON) was interviewed on 01/26/12 at 3:45 PM. She stated the nurse from the pharmacy checked medication carts and storage areas for expired medications monthly. The DON stated that facility nurses were also responsible to check and remove expired medications from the carts. She stated	F 431	orders for Ferrous Gluconate. The DON began in service education on 1/25/12 for licensed nurses regarding "Policy and Procedure for dating and labeling medications and expiration dates for medications." In service education will be completed for licensed nurses on 2/13/12. Systemic Changes: The DON and unit managers will continue to in service licensed staff regarding "Policy and Procedure for dating and labeling medications and expiration dates for medications." In service education will be completed on 2/13/12. The DON and unit managers will audit medication carts three times a week for four weeks then weekly ongoing. The pharmacy technician will conduct cart audits monthly for 3 months, then at least quarterly there after. The results of audit will be reported to the DON for review. **" 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."**	

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F 431	Continued From page 6 she expected the nurse to discard the expired ferrous gluconate.	F 431	QAA: The DON will review data obtained during audits to determine continued compliance. Patterns/trends will be identified and analyzed and reported in QA&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to assure continued compliance. **" 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."**	