STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	R-C 12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENDERSONVILLE	1510 HEBRON STREET HENDERSONVILLE, NC 28739

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{F 425} SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based upon observations, record review and staff interview the facility failed to accurately dispense medications as ordered for 2 of 11 residents reviewed (Residents #8 and #7) in 2 of 5 medication carts inspected. The findings included: 1. Resident #8 was admitted to the facility on 05/15/2009. According to the Minimum Data Set (MDS), quarterly review (completed on 12/25/2014) Resident #8 was cognitively intact and had diagnoses including: hypertension, anxiety disorder, depression, and unspecified	{F 425}	Preparation and / or execution of this plan of correction does not constitute admission or by agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by provisions of federal and state law. F 425 SS-D The Facility failed to accurately dispense medications as ordered for 2 of 11 residents reviewed (Residents # 8 and #7) in 2 of 5 medication carts inspected 1.) On 12/29/14 The Director of Nursing removed Resident #8's morning medication packet (opened containing (3) lamotrigine 25mg tablets) from the medication cart. The Director of Nursing also, removed the afternoon packet, which contained Trazadone 25mg, Hydroxyzine 25mg, and (3) Lamotrigine 25mg tablets. The Pharmacy was notified of no active order. The Pharmacy discontinued	1/2/2015 1/2/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 1/13/14

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 425}	Continued From page 1 sleep disturbance. According to the December 2014 Medication Administration Record (MAR), the current active orders for scheduled medications for Resident #8 were as follows: citalopram (a medication used to treat depression) 20 milligrams (mg) by mouth once daily at 8 AM, hydroxyzine (a medication used to treat anxiety) 25mg by mouth 2 times a day at 8 AM and 4 PM, metoprolol HCL (a medication used to treat hypertension) 12.5mg by mouth 2 times a day at 8 AM and 4 PM, and trazodone (a medication used to treat depression) 50mg by mouth 2 times a day at 8 AM and 8 PM. On 12/29/2014 at 3:20 PM an inspection of the East Wing medication cart (Cart C), revealed a medication packet labeled for Resident #8 for the 12/29/2014 morning medication pass. The packet was labeled to contain the following medications: citalopram 20mg (1 tablet), trazodone 50mg (1 tablet), and lamotrigine (a medication used to treat seizures and bipolar disorder) 25mg (3 tablets). This packet had been torn open and only the 3 lamotrigine 25mg tablets were in the remainder of the packet. A medication packet labeled for Resident #8 for the 12/29/2014 afternoon medication pass was also present in the medication cart, which was labeled to contain the following medications: trazodone 25mg (1 tablet), lamotrigine 25mg (3 tablets) and hydroxyzine HCL 25mg (1 tablet). The afternoon medication packet was unopened and contained the medications and quantities as labeled on the packet. A review of Resident #8's medical chart and electronic record of physician orders revealed no active medication order for lamotrigine. Resident	{F 425}	the dispensing of Lamotrigine and removed the order from the pharmacy's active orders. The Director of Nursing Re-dispensed the routine medications for 12/ 30/14. The re-dispensed packets were validated by the Director of Nursing to be correct. On 12/30/14 the Pharmacy was notified of medication administration times for Resident # 7 Tamsulosin 0.8mg by mouth daily at 08:30 am. Spironolactone 25 mg by mouth one time a day at 4pm. Duloxetine 60mg by mouth at 08:30am and 8:30 pm. The pharmacy corrected the times for the medications to be dispensed from the (ADU) Automated Dispensing Unit. The Director of Nursing validated the Medication dispensed correctly on 12/31/2014. 2.) The Nursing Management team completed a 100% Audit of all Residents medications, doses, and administration times compared to Medication Administration Record & avail. meds/ labels on12/31/14.	Cont.

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{F 425}	Continued From page 2 #8 had previously been prescribed lamotrigine 75mg by mouth 2 times a day, but this order was discontinued per a physician's order dated 05/28/2014 at 2:24 PM. On 12/29/2014 at 4:40 PM an interview with Nurse #1 involved a discussion of the finding of the lamotrigine labeled for Resident #8 and the lack of an active medication order for lamotrigine for Resident #8. Nurse #1 reviewed Resident #8's medical chart and electronic record of physician orders and was unable to locate an active order for lamotrigine for Resident #8. Nurse #1 was unable to provide an explanation as to why the lamotrigine was included in the medication packets. Nurse #1 was asked about the frequency of occurrence of this type of error. Nurse #1 was also asked about what actions are taken when this type of error is detected. Nurse #1 stated that this type of error was sporadic (no specific frequency stated) and that when discovered the unnecessary/non-ordered medications were discarded in the waste container on the medication cart and that the dispensing pharmacy was notified about the discrepancy, usually via telephone. On 12/29/2014 at 5:30 PM an interview with the Director of Nursing (DON) involved the discussion of the dispensing of lamotrigine to Resident #8 in the absence of an active order for lamotrigine and discussion of medications being dispensed in incorrect medication administration time packets. The DON reviewed Resident #8's chart and electronic record of physician orders and was unable to locate an active medication order for lamotrigine for Resident #8. The DON was unable to provide an explanation as to why the lamotrigine was being dispensed by the facility's	{F 425}	The pharmacy was notified of results and corrections made. The corrections were validated by the Director of Nursing. On 12/30/2014 The Automated Dispensing Unit (ADU) Default times for routine medications was synchronized with the Default times used in PCC (The software program the Medication Administration Record is formatted in). 3.)The Director of Nursing and/ or designee will audit all medications, and labeling on packets dispensed by the ADU and compare to active administration times, dose, and Meds on the Med Administration Record. daily x 1week, Then 5 times a week x 2 weeks. Then 2 times a week x 2weeks. Then ongoing as determined by the Executive Director or designee. Audit results will be discussed in the monthly Quality Assurance Performance Improvement committee meeting x 3months, and ongoing as determined by the	Cont. 1/2/2015

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(F 425)	Continued From page 3 automated dispensing system (ADU). The DON checked the batch of medications dispensed for 12/30/2014 (which had already been generated by the ADU for the next day's 24 hour supply of medications) and discovered that the lamotrigine had been dispensed for Resident #8 with the rest of Resident #8's medications for 12/30/2014. The DON removed the lamotrigine from the rest of Resident #8's medications for 12/30/2014. The DON stated that Nurse #1 had informed the DON of the dispensing error when discovered earlier that day and stated that the dispensing pharmacy was notified of the dispensing error. The DON stated that the pharmacy had removed the lamotrigine order and that lamotrigine was no longer on the profile of active medication orders for Resident #8. The DON stated that the ADU had already processed medications for 12/30/2014 prior to notifying the pharmacy about the dispensing error. The DON then re-dispensed (via the ADU) Resident #8's medication 24 hour supply for 12/30/2014 and no lamotrigine was dispensed for Resident #8. On 12/30/2014 at 4 PM an interview with Pharmacist #1 (via telephone), involved discussion of the medication dispensing error discovered for Resident #8. Pharmacist #1 was aware of the dispensing issue and traced back the dispensing history of lamotrigine for Resident #8. The dispensing history for Resident #8 revealed that several refill requests for lamotrigine were received and processed since the original lamotrigine start date of 11/18/2013. There was a refill request and dispensing of lamotrigine for Resident #8 as late as 06/01/2014, but the discontinuation order for lamotrigine written on 05/08/2014 was not located in the pharmacy computer system. When questioned	(F 425)	committee. Any discrepancies revealed in the audit will be corrected immediately and medication packets re-dispensed correctly before being placed on the Med carts. All discrepancies revealed are communicated with Alixa Pharmacy to perform Root Cause Analysis and make necessary corrections to re-dispense medications correctly. At the time the audit is performed. The Director of Nursing or Designee will validate corrections have been made at the time medication is re-dispensed from the ADU correctly. 4.)The Director of Nursing and/or designee will audit compliance of new orders, discontinued orders, and order changes, with medication sent or dispensed from pharmacy. Corrections will be made at time of audit if indicated. Audit will be performed 5 times a week for 2 weeks then 3 times a week	Cont. 1/2/2015

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{F 425}	Continued From page 4 as to why the lamotrigine discontinuation order on 05/08/2014 was not in the pharmacy computer profile, Pharmacist #1 indicated that it either had not been faxed to the pharmacy or was missed and not processed by the pharmacy. Pharmacist #1 was asked why the lamotrigine for Resident #8 was still being dispensed by the ADU as of 12/29/2014, when neither the facility's computer system nor the pharmacy's computer system contained an active order for lamotrigine. Pharmacist #1 could not provide a definitive answer and indicated that it could possibly be due to some unusual computer processing malfunction. 2. Resident #7 was readmitted to the facility on 11/03/2014. According to the MDS dated 11/07/2014, Resident #7's cognition was intact and diagnoses included: hypopotassemia, unspecified essential hypertension, and neurogenic bladder. According to the December 2014 MAR for Resident #7, current active medication orders and medication administration times included: Spironolactone (a medication used to treat hypertension and hypokalemia) 25mg by mouth one time a day at 4 PM, duloxetine 60mg by mouth 2 times a day (8:30 AM and 8:30 PM), and tamsulosin (a medication used to treat enlarged prostate and to help relieve symptoms of urinary urgency) 0.8mg by mouth once daily at 8:30 AM. On 12/30/2014 at 9:35 AM Inspection of the West Wing medication cart (Cart B) revealed medications packaged and labeled for Resident #7. One medication packet labeled for the 12/30/2014 afternoon medication administration contained the following medications: tamsulosin	{F 425}	for 2 weeks, then 1 time a week for 2 weeks, then ongoing as determined by the Executive Director or designee. Results of the audit will be reported immediately to the Executive Director or designee. Audit results will be discussed in the monthly Quality Assurance Performance Improvement committee meeting x 3months, and ongoing as determined by the committee.	cont. 1/2/2015

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{F 425}	Continued From page 5	{F 425}		

0.4mg capsules (2 capsules), duloxetine 60mg capsule (1 capsule) and spironolactone 25mg tablet (1 tablet). The packet had been torn open and contained only 1 spironolactone 25mg tablet and 1 duloxetine 60mg capsule in the remainder of the packet. Review of the electronic MAR revealed that the 2 tamsulosin 0.4mg capsules were administered to Resident #7 on 12/29/2014 at 8:30 AM.

On 12/30/2014 at 1:30 PM an interview with Medication Technician (Med. Tech.) #1 involved a discussion of medication discovered in the incorrect medication administration time packet. Med. Tech #1 acknowledged this finding. Med. Tech #1 acknowledged that this type of packaging could increase the risk for medication administration errors.

On 12/30/2014 at 2:50 PM an interview with the DON involved a discussion of the discovery of medication dispensed in the incorrect medication administration time packet. The DON acknowledged this finding. The DON stated that on 12/29/2014 it was discovered that the facility's computer default times for medication administration did not match the dispensing pharmacy's computer default times for medication administration. For example, the facility's default time for once daily administration defaulted to an administration time of 8 AM, but the pharmacy's computer default time for once daily administration defaulted to an administration time of 4 PM. The DON indicated that this discovery was made during a telephone communication with Pharmacist #1. The DON further stated that the facility and dispensing pharmacy were in the process of reviewing all default medication administration times in both

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{F 425}	Continued From page 6 computer systems and changing the default medication administration times to be congruent within the two systems. On 12/30/2014 at 4 PM an interview with Pharmacist #1 (via telephone) involved discussion of the discovery of medication dispensed in the incorrect medication administration time packet. Pharmacist #1 acknowledged awareness of this problem. Pharmacist #1 confirmed the recent discovery of the facility's computer system default medication administration times not matching the pharmacy's computer default medication administration times. Pharmacist #1 also stated that the pharmacy and the facility were comparing the two different sets of default medication administration times and that the two systems were being changed to match to the same default medication administration times.	{F 425}		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	Refer to F425 for compliance, monitoring, auditing and QAPI process for residents #7 and #8. The Dir. of Clinical Education has re-educated the QAPI committee and reviewed Golden Living's QAPI policies on identifying issues, systems and root cause analysis, and the implementation of the plan of correction. The regional nurse consultant will audit all QAPI meetings for one year.	1-2-2015

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F 520	Continued From page 7 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place in November 2014. This was for the one re-cited deficiency that was originally cited on a follow up survey in November 2014 and on a follow up survey on December 30, 2014. The deficiency was in the area of medication dispensing. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F425: Pharmaceutical Services: Based on observations, record review and staff interviews the facility failed to accurately dispense medications as ordered for 2 of 11 residents whose medications were reviewed. During the first follow up survey of November 2014, the facility was cited for F425 for failing to	F 520		

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F 520	Continued From page 8 dispense medications as they were ordered. On the survey of December 30, 2014 the facility was again cited for failing to dispense medications accurately in accordance with current physician's orders. During an interview on 12/30/14 at 6:34 PM the Administrator stated she thought the facility's plan of correction failed because they relied on comparing the orders in the facility's electronic record with the pharmacy's electronic record and because they matched they didn't look at the medication packages that were dispensed and the medications in the packages. The Administrator stated they discovered during the December 30, 2014 survey that the medication default times in the facility's system for the electronic Medication Administration Record (MAR) didn't match the default times in the Automatic Dispensing Unit for medications that were scheduled for administration once a day and those scheduled for administration twice a day.	F 520		