STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	C 02/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

(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 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and nurse practitioner and physician interviews, the facility failed to administer an oral antibiotic twice daily as ordered by the physician for 1 of 3 residents reviewed who were treated with an antibiotic medication (Resident #2); and, the facility failed to initiate the administration of an intravenous antibiotic without a delay of more than 24 hours after receipt of a physician ' s order for 1 of 2 residents reviewed who required treatment with an intravenous antibiotic medication (Resident #2). The findings included: 1) Resident #2 was admitted to the facility on 11/22/17 from a hospital. Her cumulative diagnoses included Alzheimer ' s disease, abnormal weight loss, anorexia, and a history of pneumonia. A review of Resident #2 ' s admission Minimum Data Set (MDS) assessment dated 11/29/17 revealed the resident had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance for bed mobility. A review of Resident #2 ' s medical record revealed she was seen on 1/10/18 by the Nurse	F 760	Resident #2 was discharged from the facility so no specific action was taken on him/her. Upon review, on 1/11/18, Nurse #1 made a transcription error when inputting the new order for Resident #2's Cefuroxime, leading to a schedule that included only one medication per day, when it should have been twice a day per the order from the NP. The "Time Code" that she chose in our eMAR system was for QD and not BID. The physician was notified (February 7th) at the time of the survey of the error. Upon review, on 1/15/18, Nurse #2 made a transcription error when ordering the new order for Resident #2's IV Cefuroxime, leading to the order not being filled by the pharmacy. The new IV medication was not ordered from the pharmacy due to an incorrect selection in our eMar system. The selection was "IV" and should have been "Medication". The physician was notified (February 7th) at the time of the survey of the error. As all residents have the potential to have been impacted by these errors, a 100% Medication review was completed on February 8th, on all 86 resident charts, going back 30 days by the Unit Manager and Director of Nursing using all orders received and all orders input into our eMar	3/7/18

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

Electronically Signed | 03/01/2018

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 760	Continued From page 1 Practitioner (NP) upon staff request due to a decreased appetite and level of comfort. The NP Assessment and Plan reported the resident had initially been treated on 1/3/18 with guaifenesin/dextromethorphan (a combination over-the-counter expectorant and cough suppressant) and ipratropium/albuterol nebulizer treatments (a combination inhaled medication used to relieve bronchospasms) for a cough and congestion with no improvement noted. The NP indicated a chest x-ray would be ordered to rule out pneumonia. A review of the resident ' s radiology report dated 1/10/18 at 5:44 PM revealed significant findings of the chest x-ray read, in part: "Atelectatic changes (incomplete expansion of the lung) / pneumonia at the right lower lobe. Clinical correlation is recommended." A review of Resident #2 ' s medical record revealed an order was received from the NP on 1/11/18 for 500 milligrams (mg) cefuroxime (an oral antibiotic) to be given as one tablet by mouth twice daily for 7 days. Resident #2 ' s electronic Nursing Notes dated 1/11/18 at 6:40 PM indicated the first dose of cefuroxime was pulled from the facility ' s Pyxis machine (an in-house, automated medication dispensing system) and administered to the resident. Further review of Resident #2 ' s electronic medical record included her January 2018 Medication Administration Record (MAR). The MAR indicated cefuroxime was ordered for the resident on 1/11/18 with directions to give one tablet (500 mg) by mouth twice daily for 7 days.	F 760	system for 100% of in-house residents using a monitoring tool. Additionally, 100% of nurses have completed inservice training on February 22nd, given by the Director of Nursing and the Unit Manager on how to accurately process any changes or new Physician orders. Any PRN or Agency nurses will receive this training before their first shift and newly hired nurses within the 1st week of orientation by the Director or Nursing or Unit Manager. A new system was put into place to promote accuracy of transcribing orders on February 8th. All new orders will be input into the eMAR system by the nurse who receives the order(s). The 2nd shift nurses will review all new orders as a 1st check and will initial the order confirming that it was entered into the eMar system correctly. If the order is received on the 2nd shift, a second nurse will complete this check. As a 2nd check, the Unit Manager will also audit 100% of all new orders the following workday (5x per week) and initial the order confirming that it was entered into the eMar system correctly. If there are any errors picked up during this audit, a medication error incident report will be completed with additional education or disciplinary action when warranted. This double check and audit will continue for at least 3 months and will end at the discretion of the QA committee. The Director of Nursing will review the audit sheets, confirm the double initials on new orders and bring this information to QA monthly for at least 3 months for	

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However, 500 mg cefuroxime was only scheduled to be administered once daily at 10:00 AM each morning (instead of 500 mg cefuroxime twice daily as ordered). The MAR did not include a scheduled dose of cefuroxime in the afternoon or evening. Documentation on the MAR indicated Resident #2 received one dose of 500 mg cefuroxime at 10:00 AM on 1/12/18, one dose at 10:00 AM on 1/13/18, and one dose at 10:00 AM on 1/14/18. A notation made on the MAR reported the resident refused her oral medication scheduled for 10:00 AM on 1/15/18. The oral cefuroxime was discontinued on 1/15/18 when a physician ' s order was received to initiate giving an alternative antibiotic intravenously.

An interview was conducted on 2/6/18 at 5:35 PM with the facility ' s Director of Nursing (DON). During the interview, the DON confirmed Resident #2 received the cefuroxime ordered on 1/11/18 only once daily (instead of twice daily as prescribed). The DON stated her expectation was, "To implement the order as directed."

A telephone interview was conducted on 2/7/18 at 8:45 AM with the resident ' s medical doctor (MD), who also served as the facility ' s Medical Director. During the interview, the administration of 500 mg cefuroxime given once daily (versus twice daily dosing, as ordered) was discussed. The MD stated if there was a transcription error between the actual order and what was input into the computer system, he would ask the question as to whether or not there was harm to the patient. Due to Resident #2 ' s age and debilitated state, the MD reported it would be hard to predict whether or not the reduction in the frequency of dosing for the antibiotic would have made a difference in outcome for this resident.

trends and recommendations for any modifications to the process.

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However, he noted this situation was still a concern as such a mistake needed to be audited and followed with a Performance Improvement Plan.

A telephone interview was conducted on 2/7/18 at 9:45 AM with the NP assigned to help care for Resident #2. Upon inquiry, the NP reported she expected Resident #2 to receive 500 mg cefuroxime twice daily as prescribed.

A telephone interview was conducted on 2/7/18 at 10:29 AM with a representative from the facility ' s contracted pharmacy. During the interview, the representative confirmed 14 tablets of 500 mg cefuroxime were dispensed from the pharmacy to fulfill the order dated 1/11/18; and, 10 tablets were returned to the pharmacy. Upon inquiry, the representative reported the directions on the dispensed medication were to give one tablet (500 mg) cefuroxime twice daily to Resident #2.

An interview was conducted on 2/7/18 at 11:12 AM with Nurse #1. Nurse #1 was identified as the nurse who received and transcribed the order for cefuroxime into the computer system on 1/11/18. Upon inquiry, Nurse #1 reported she was not sure why there was inconsistency between the written order and the dose frequency recorded on the resident ' s MAR.

Upon the nurse ' s request, a follow-up interview was conducted on 2/7/18 at 11:40 AM with Nurse #1. At that time, the nurse reported she reviewed the computer entry records for the cefuroxime ordered on 1/11/18 and determined she had entered the wrong "Time Code" in the computer during transcription. The nurse stated this mistake resulted in only one dose of cefuroxime

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being scheduled each day on Resident #2 ' s MAR (instead of two daily doses, as ordered). Nurse #1 stated, "It ' s an error."

2) Resident #2 was admitted to the facility on 11/22/17 from a hospital. Her cumulative diagnoses included Alzheimer ' s disease, abnormal weight loss, anorexia, and a history of pneumonia.

A review of Resident #2 ' s admission Minimum Data Set (MDS) assessment dated 11/29/17 revealed the resident had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance for bed mobility.

A review of Resident #2 ' s medical record revealed she was seen on 1/10/18 by the Nurse Practitioner (NP) upon staff request due to a decreased appetite and level of comfort. The NP Assessment and Plan reported the resident had initially been treated on 1/3/18 with guaifenesin/dextromethorphan (a combination over-the-counter expectorant and cough suppressant) and ipratropium/albuterol nebulizer treatments (a combination inhaled medication used to relieve bronchospasms) for a cough and congestion with no improvement noted. The NP indicated a chest x-ray would be ordered to rule out pneumonia.

A review of the resident ' s radiology report dated 1/10/18 at 5:44 PM revealed significant findings of the chest x-ray read, in part: "Atelectatic changes (incomplete expansion of the lung)/pneumonia at the right lower lobe. Clinical

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correlation is recommended."

A review of Resident #2 ' s medical record revealed an order was received from the NP on 1/11/18 for 500 milligrams (mg) cefuroxime (an oral antibiotic) to be given as one tablet by mouth twice daily for 7 days.

Further review of Resident #2 ' s medical record revealed she was again seen by the NP on 1/15/18 upon staff request due to the resident not eating and refusing all medications, including the oral antibiotic for pneumonia. An order dated 1/15/18 (not timed) was received to discontinue the oral cefuroxime and to initiate the administration of a 2 gram (gm) vial of ceftazidime (an antibiotic) intravenously as one dose every 8 hours for 7 days due to the diagnosis of pneumonia.

A review of the electronic Nursing Notes included a notation dated 1/16/18 at 7:25 PM which read, in part: " ...she has an order for IV (intravenous) antibiotics to come tonight and be started ..."

A further review of Resident #2 ' s electronic medical record included her January 2018 Medication Administration Record (MAR). The MAR indicated a 2 gm vial of ceftazidime was ordered for the resident on 1/15/18 with a start date of 1/15/18. However, no doses of ceftazidime were documented on the MAR as having been given on either 1/15/18 or 1/16/18. Notations made on the MAR by Nurse #1 indicated the doses scheduled for 8:00 AM and 4:00 PM on 1/16/18 were refused by the resident. The MAR revealed Resident #2 received the first dose of ceftazidime on 1/17/18 at 12:00 AM.

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A telephone interview was conducted on 2/7/18 at 8:45 AM with the resident ' s medical doctor (MD), who also served as the facility ' s Medical Director. During the interview, the delay between when the ceftazidime was ordered and when it was first administered to Resident #2 was discussed. The MD stated he would have wanted to be notified if 12 hours or more had elapsed between when the antibiotic was ordered and when it was first administered, as this may have influenced further decisions. The MD stated he would have wanted to find out what antibiotic the pharmacy had available to "drop ship" or if there was an appropriate in-house substitute available to give the resident. Upon inquiry, the MD indicated it would be difficult to determine whether or not the delay in the administration of this intravenous antibiotic would have made a difference in outcome for Resident #2.

An interview was conducted on 2/7/18 at 9:29 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported the order for ceftazidime was entered into the computer system at the facility on 1/15/18 at 2:05 PM. The DON reported she had talked with the facility ' s contracted pharmacy and was told this order was not received and processed until 1/16/18 at 12:52 AM, which was after the cut off time for same-day delivery to the facility.

A telephone interview was conducted on 2/7/18 at 9:45 AM with the NP assigned to help care for the resident. Upon inquiry, the NP reported she did not recall being made aware of the delay in obtaining Resident #2 ' s intravenous antibiotic. The NP stated she would have wanted to know about this delay as that may have influenced whether or not the resident was sent out to the

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hospital. When asked, the NP reported she could not say whether or not the delay in administering the intravenous antibiotic would have made a difference in outcome for Resident #2.

An interview was conducted on 2/7/18 at 10:01 AM with the DON in the presence of the Regional Nurse Consultant and the Director of Clinical Operations. Upon inquiry, the Director of Clinical Operations indicated that assuming the pharmacy received the order for the medication, an intravenous antibiotic entered into the facility ' s computer system at 2:00 PM would be expected to be delivered that same evening around 12:00 AM.

A telephone interview was conducted on 2/7/18 at 10:29 AM with a representative from the facility ' s contracted pharmacy. During the interview, the representative confirmed Resident #2 ' s order for ceftazidime (dated 1/15/18) "hit our computer system a little after midnight on the 16th (1/16/18)." She stated it was unclear as to why there was a delay between the time the facility input the order for the ceftazidime and the pharmacy received it. When asked, the pharmacy representative stated, "We can always provide a STAT (immediate) delivery upon request." She reported a medication could be delivered to the facility in approximately 1-2 hours if a STAT delivery request was made. Upon checking the pharmacy records, she reported there were no notes of such a request being made by the facility.

An interview was conducted on 2/7/18 at 10:50 AM with Nurse #2. The nurse recalled caring for Resident #2 the morning of 1/15/18 when she refused to take her oral antibiotic. Nurse #2

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F 760	Continued From page 8 reported she informed the NP on 1/15/18 that the resident was refusing her oral medication. At that time, the NP asked Nurse #2 to call and see if the pharmacy had ceftazidime on hand. The nurse reported the pharmacy told her they did have the medication, she relayed this information to the NP, and the order for ceftazidime was written. An interview was conducted on 2/7/18 at 11:12 AM with Nurse #1. Nurse #1 had made notations on Resident #2 ' s January MAR which indicated the resident refused the 8:00 AM and 4:00 PM doses of ceftazidime (to be given intravenously) on 1/16/18. During the interview, Nurse #1 speculated she may have made an incorrect selection from a drop down box on the electronic MAR when she was asked to indicate why this medication was not administered as ordered. Upon inquiry, Nurse #1 reported the facility did not have the intravenous antibiotic (ceftazidime) for Resident #2 during her shift on 1/16/18.	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and nurse practitioner and physician interviews, the facility failed to obtain a laboratory test as ordered	F 770	Resident #2 was discharged from the facility so no specific action was taken on him/her. Upon review, on 01/12/2018, the	3/7/18

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F 770	Continued From page 9 by the physician for 1 of 3 residents reviewed who had been treated with an antibiotic medication (Resident #2). The findings included: Resident #2 was admitted to the facility on 11/22/17 from a hospital. Her cumulative diagnoses included Alzheimer ' s disease, abnormal weight loss, anorexia, and a history of pneumonia. A review of Resident #2 ' s admission Minimum Data Set (MDS) assessment dated 11/29/17 revealed the resident had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance for bed mobility. A review of Resident #2 ' s medical record revealed she was seen on 1/10/18 by the Nurse Practitioner (NP) upon staff request due to a decreased appetite and level of comfort. The NP Assessment and Plan reported the resident had initially been treated on 1/3/18 with guaifenesin/dextromethorphan (a combination over-the-counter expectorant and cough suppressant) and ipratropium/albuterol nebulizer treatments (a combination inhaled medication used to relieve bronchospasms) for a cough and congestion with no improvement noted. The NP indicated a chest x-ray would be ordered to rule out pneumonia. A review of the resident ' s radiology report dated 1/10/18 at 5:44 PM revealed significant findings of the chest x-ray read, in part: "Atelectatic	F 770	order to repeat BMP was not put into the lab book and ordered. The Physician was notified (February 7th) at the time of the survey of the error. As all residents have the potential to have been impacted by this error, a 100% lab order review was completed on February 8th on all 86 resident charts, going back 30 days by the Unit Manager and Director of Nursing using all lab orders received and all lab orders input into our lab book using a monitoring tool. Additionally, 100% of nurses have completed inservice training on February 22nd, given by the Director of Nursing and the Unit Manager on how to accurately process any changes or new Physician orders for laboratory services, including entering the lab into E-lab, writing the lab in the Lab book and the date the lab is due to be drawn. Any PRN or Agency nurses will receive this training before their first shift and newly hired nurses within the 1st week of orientation by the Director or Nursing or Unit Manager. A new system was put into place on February 8th to promote accuracy of transcribing orders for laboratory services. The 2nd shift nurses will review 100% of all new orders and, as a 1st check, will initial the order confirming that it was entered into the eMar system and/or lab book correctly. If the order is received on the 2nd shift, a second nurse will complete this check. As a 2nd check, the Unit Manager will also audit 100% of all new orders the following workday (5 times per week) and initial the order confirming that it was entered into the eMar system	

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F 770	Continued From page 10 changes (incomplete expansion of the lung)/pneumonia at the right lower lobe. Clinical correlation is recommended." A review of Resident #2 ' s medical record revealed a physician ' s order was written on 1/11/18 for a Basal Metabolic Panel (BMP). A BMP is a laboratory blood test that measures a patient ' s glucose (sugar) level, electrolyte and fluid balance, and kidney function. Resident #2 ' s blood was collected for the BMP lab test on 1/12/18 at 11:35 AM. The laboratory results included a sodium level of 173 (normal range = 135-146), which was identified as a critically high level. A notation made on the laboratory report indicated a nurse at the facility was called by the lab and notified of this result on 1/12/18 at 4:11 PM. A review of the resident ' s medical record included a physician ' s order dated 1/12/18 for the following: "Normal Saline IV (intravenously) at 75 ml/hr (milliliters per hour) x 2 L (times 2 liters); repeat BMP on 1/15/18." The indication/diagnosis for this order was noted as: "Elevated sodium level." A further review of Resident #2 ' s electronic and paper medical records revealed there was no documentation of a repeat BMP having been completed on 1/15/18. An interview was conducted on 2/6/18 at 4:49 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported the 1/15/18 BMP lab test for Resident #2 was entered in to the facility ' s electronic laboratory system to be completed as ordered. However, she also	F 770	and lab book correctly. There will be one lab book, located at the main nurse's station, which will be the single place that lab orders and results are entered. The nurse who received the order will initiate an entry in the lab book. After the lab is drawn, the Unit Manager will highlight the lab in yellow, indicating that the draw is complete and waiting on results. When the results are received, the Unit Manager the following day (5 times per week) will highlight in pink, signifying that it is completed. (making the highlight orange). This audit will continue for at least 3 months and will end at the discretion of the QA committee. The Director of Nursing will review the order audit and the lab book, confirm the double initials on new orders and highlighted labs and bring this information to QA monthly for at least 3 months for trends and recommendations for any modifications to the process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	C 02/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 770	Continued From page 11	F 770		

stated this order appeared to be crossed out in the system. The DON reported she needed to investigate the situation further.

A telephone interview was conducted on 2/7/18 at 8:45 AM with the resident ' s medical doctor (MD), who also served as the facility ' s Medical Director. During the interview, Resident #2 ' s sodium level from the 1/12/18 BMP and the missing lab results for a repeat BMP on 1/15/18 were discussed. Upon inquiry, the MD reported he would have wanted to have a repeat BMP drawn due to the resident ' s high sodium level and the intravenous hydration being given. Given the overall situation, he indicated it would be hard to predict how much of an impact obtaining a repeat BMP may have had for Resident #2. However, he stated the issues raised were a concern regarding the internal systems and processes in place at the facility.

A follow-up interview was conducted on 2/7/18 at 9:29 AM with the DON. The DON reported she was unable to identify who was responsible for crossing out (deleting) the lab order to complete a repeat BMP for Resident #2. The DON confirmed the BMP had not been done as ordered for the resident on 1/15/18.

A telephone interview was conducted on 2/7/18 at 9:45 AM with the NP assigned to help care for the resident. During the interview, Resident #2 ' s sodium level from the 1/12/18 BMP and the failure to obtain repeat BMP results on 1/15/18 were discussed. When asked if she would have wanted to have a repeat BMP completed for Resident #2 on 1/15/18, the NP stated, "definitely."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 770	Continued From page 12 A follow-up interview was conducted on 2/7/18 at 1:31 PM with the facility ' s DON. Upon inquiry, the DON stated her expectation would be, "for the lab to be drawn as ordered."	F 770		