STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE HEALTH AND REHABILITATION	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 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 record review and staff interviews the facility failed to clearly identify a resident prior to administration of medications resulting in a significant medication error for one (1) of six (6) sampled residents (Resident #1). The findings are: Resident #1 was admitted to the facility on 03/08/12 with diagnoses of hypertension and right knee replacement. Review of the Minimum Data Set (MDS) dated 03/25/12 revealed Resident #1 was cognitively intact and was receiving physical and occupational therapy following knee replacement surgery. Review of a facility incident report revealed that on 03/26/12 Resident #1 was administered the following medications in error: Diltiaxem 360 milligrams (blood pressure medication), Lovenox 40 milligram injection (anti-coagulant), Colace 100 milligrams (stool softener), and Miralax powder 17 grams in liquid (laxative). Further review of the incident report revealed that the medications had been administered to Resident #1 by Nursing Student (NS) #1. Review of the physician progress notes revealed Resident #1 was seen by the Nurse Practitioner (NP) on 03/26/12 after the medication error had	F 333	*Hendersonville Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is April 23, 2012.* *Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.* 1. Licensed Nurse (LN) #1 and Student Nurse (SN) #1, immediately upon identification of medication error involving Resident #1, thoroughly assessed resident, notified the Family Nurse Practitioner, the residents daughter and the facility Director of Nursing. LN#1 and SN#1 were re-educated regarding the use of identifiers when administrating medications and the requirement that SN#1 be supervised at all times during her clinical experience.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-20-12

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 333	Continued From page 1 occurred. She wrote orders that read, "Monitor blood pressure and pulse every two (2) hours for twenty-four (24) hours." The order further specified to call the physician or NP for a pulse below 50. Review of nursing notes revealed that Resident #1 was monitored as ordered by the NP. At 5:30 PM Resident #1's pulse dropped to 46 beats per minute. The NP was notified and ordered the resident sent to the hospital for evaluation. Further review of the nursing notes revealed the resident returned to the facility that evening. An interview was conducted on 04/04/12 at 10:30 AM with Nursing Student (NS) #1. She reported that on 03/26/12 she pulled up Resident #7's medications under supervision of LN #1. LN #1 told NS #1 to go to the therapy gym and administer the medications to Resident #7. She reported she went to the gym and approached Resident #1 whom she thought was Resident #7. She addressed Resident #1 using Resident #7's name and he answered affirmatively. NS #1 administered the medications intended for Resident #7 to Resident #1. She reported she realized she had given the medications to the wrong resident later when she saw Resident #7 in his room. She stated she reported the error to LN #1 immediately. The medication error was then reported to the Nurse Practitioner who was in the facility at the time. She stated the Director of Nursing was notified of the medication error and an incident report was filled out. NS #1 stated she should have asked the resident to state his name rather than calling out a name. An interview was conducted on 04/04/12 at 11:36	F 333	2. All licensed nurses and facility Medication Aide were in-serviced regarding the use of a minimum of 2 of the 4 identifiers prior to medication administration. In-service training began 4/4/2012 and was completed by 4/9/2012. The four identifiers are: a photo of the resident with their MAR; asking the resident to state their name; checking the room number and bed letter and checking the resident's arm band. 3. Orientation of newly employed licensed nurses will include the use of the revised policy regarding the use of a minimum of 2 of the 4 identifiers prior to medication administration. On-going in-servicing will continue annually for all licensed nursing staff and Medication Aide. Colleges with nursing programs that contract with Hendersonville Health and Rehabilitation were reviewed. It was determined that those programs not providing a Nursing Instructor with their students will no longer be utilized. 4. The DON, ADON or designee will monitor the use of identifiers prior to medication administration for 10% of the population daily x1 month and weekly x 2 months and results reported in QA x 3 months.	

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F 333	Continued From page 2 with LN #1. LN #1 told NS #1 to go to the therapy gym and administer Resident #7's medications. She stated she had observed NS #1 administer Resident #7's medications before and thought the student knew him. She stated she should have gone with NS #1 to ensure she properly identified the resident prior to giving the medications. An interview was conducted on 04/04/12 at 1:17 PM with the Director of Nursing (DON). She stated she expected NS #1 to identify the resident by asking his name prior to administering the medications. An interview was conducted on 04/04/12 at 3:23 PM with the Nurse Practitioner. She stated that Resident #1 was not harmed by receiving the wrong medications. She reported she had sent him to the hospital so he could be monitored. She stated she had spoken with the emergency room physician who had ruled out any harm to the resident. She further reported Resident #1 did not receive any treatment while he was at the hospital other than being monitored. She reported he remained asymptomatic throughout the entire event.	F 333	Medication administration policy clarification stating, "A minimum of 2 of the 4 listed identifiers must be used to correctly identify each resident prior to the administration of any medication" was brought before QA Committee and approved 4/17/2012.	4/23/12