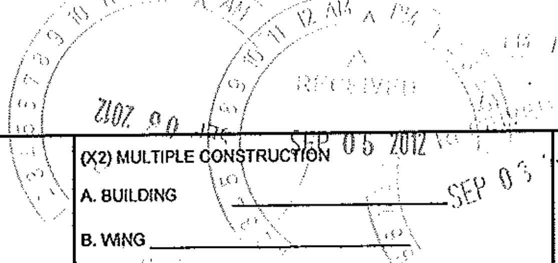
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING ______ B. WING ______	C 07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DR GREENSBORO, NC 27406

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F 000	INITIAL COMMENTS This complaint survey took place July 18-19, 2012. Partially extended survey took place July 31, 2012.	F 000	Greenhaven Healthcare and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Green haven's response to this Statement of Deficiencies does not demote agreement with the Statement of Deficiencies nor does it constitute an admission that the deficiency is accurate. Further, Greenhaven reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceedings.	
F 333 SS=J	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 resident and staff interviews, observations and a review of medical records the facility failed to administer oral and intravenous antibiotics, as ordered by the primary physician, to 1 of 8 sampled newly admitted residents, (Resident #2). The incident occurred on 6/29/12 and was identified and resolved on 7/2/12. The immediate jeopardy (IJ) for Resident #2 began on June 29, 2012 when the resident's antibiotics were not initiated. The administrator was notified of the immediate jeopardy (IJ) on July 31, 2012. The IJ was removed on July 18, 2012 when the facility completed inservicing all nursing staff. The facility was left out of compliance at no actual harm with the potential for more than minimal harm that is not IJ (D) to allow monitoring of the implementation of the corrective action. Findings: Resident #2 was admitted to the facility on 6/29/12 with diagnoses including Ostemyelitis and Insulin Dependent Diabetes. The Minimum Data Set (MDS) assessment dated 7/6/12 indicated	F 333		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindy Pittman	Administrator	8-27-12

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	F 333		

that the resident had no cognitive deficits and required extensive assistance with some activities of daily living. Care Plans dated 7/3/12 included interventions to address the resident ' s Ostemyelitis including the administration of antibiotics as ordered.

A hospital discharge summary dated 6/29/12 found in the resident ' s facility medical record indicated his hospital course included a right long finger partial amputation with incision and drainage of the right hand due to an infection on 6/26/12. The discharge instructions included that Resident #2 should continue his antibiotics Daptomycin administered through the PICC (Percutaneous Intravenous Central Catheter) line daily and Levaquin orally daily, both for 4 weeks with follow up with Infection Diseases physician.

A Discharge Med Reconciliation record, from the referring hospital, dated 6/29/12 indicated on page 3 of 4 pages that Resident #2 was to receive Daptomycin 720 milligrams (mg) intravenously daily times 4 weeks and Levaquin 750mg orally daily times 4 weeks.

A review of Resident #2 ' s Physician Orders dated 6/29/12 did not include the 2 antibiotics listed on the hospital ' s Med Reconciliation record. A review of the resident ' s Medication Administration Record (MAR)s for June 2012 and July 2012 revealed that the Levaquin was first administered on 7/2/12 and the Daptomycin was first administered on 7/3/12. All other medications were accurately reconciled and administered as ordered.

Resident #2 ' s History and Physical dated 7/3/12

1. Resident #2 was seen by Medical Director with no negative outcome. Lab orders were obtained, results reviewed by the physician with no new orders.
2. Physician Order reconciliation of identified resident. A 100% audit was completed on all new and re-admission Physician Orders with no negative findings.
3. In-servicing 1 on 1, on proper medication reconciliation, with the nurses involved. The DON/ Facility Consultant/ Pharmacy Educator in-serviced 100% of licensed nurses. All new hire nurses will receive proper reconciliation medication procedures during the orientation process.

The Director of Nursing and the administrative nurses began using, on May 30, 2012, and will continue using the Greenhaven Medication Administration Record (MAR) Audit Tool Reconciliation of Physician Orders tool five times a week for eight weeks, then twice a week for four weeks. The administrator will review the audit tool weekly for twelve weeks. The Quality Improvement Executive Committee will meet quarterly and review the Greenhaven Medication Administration Record (MAR) Audit Tool Reconciliation of

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F 333	Continued From page 2 included " medication list reviewed. This is very complicated. Note, he has missed his antibiotics over the weekend. " On 7/18/12 at 1:40 pm Resident #2 was observed out of bed. His right arm was in a splint with dressings visible under the splint. There was erythmea (inflammation) and swelling of the right hand and forearm but the resident denied pain. He stated that he was admitted late on Friday (6/29/12) and that he hadn ' t received his intravenous antibiotics until Tuesday (7/3/12). He stated that he does have some pain at night up to a level of 7 on a scale of 1 to 10. He indicated that oral pain medication resolves the pain to a level of 0. The nurse who admitted Resident #2 (LPN #1) was interviewed on 7/19/12 at 8:40 am. She stated that Resident #2 was admitted late in the evening on 6/29/12. She stated that she did a head to toe assessment and saw the PICC line in the resident ' s left arm. She stated that she had written the physician orders before the resident arrived at the facility. She indicated that when she reported on duty on 6/29/12 at 3pm the Nurse Practitioner was reviewing the information on Resident #2 provided by the referring hospital. She stated she was given the Discharge Med Reconciliation record which she agreed were the same 4 pages provided to her during this interview. She then indicated that this type of discharge record was unfamiliar to her and that she missed the listing of Daptomycin and Levaquin included at the bottom of page 3. She stated that there was an emergency with another resident and that she failed to document the presence of the PICC Line on her admission	F 333	Physician Orders audits and make recommendations as appropriate. 4. After admission, within 24 hours, the Director of Nursing/Supervisor in charge will verify that two nurses have signed the admission physician's orders to assure proper transcription of physician orders. The Admission QI Audit tool will be completed by the Director of Nursing or administrative nurse for all new admissions. The Director of Nursing/Supervisor will sign off on the admission audit tool for every admission. Administrator will review the Admission QI audit tool results weekly for four weeks, and then bi-weekly for four weeks, then monthly for four months to assure QI Monitoring is functioning properly. The Quality Improvement Executive Committee will meet quarterly and review the Admission QI Audit tool information to make recommendations, take actions as appropriate, and monitor continued compliance in this area.	8-1-12

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F 333	Continued From page 3 assessment and failed to follow up on why a resident with a PICC line had no orders for intravenous medications. She stated that a second nurse had also reviewed the admission orders after she had transcribed them in accordance with facility policy. On 7/19/12 at 10:00 am the Nurse Practitioner (NP) who had reviewed Resident #2 ' s hospital information was interviewed. She indicated that she had read the resident discharge summary and reviewed the Discharge Med Reconciliation record. She indicated that she had made any necessary changes on this Med Reconciliation record pointing out the areas where she had crossed out medications she did not want continued. She stated that her expectation was that the Daptomycin and Levaquin would be administered once they were received from the pharmacy. She stated that she was notified on 7/2/12 of the error in not administering either of the antibiotics. She indicated that the Levaquin was started on 7/2/12 and that the Daptomycin was started on 7/3/12. She stated that the resident had no indications of sepsis that he had remained afebrile. She stated that there was no change in the resident ' s erythmea or swelling of the right hand and forearm from her initial assessment on 7/3/12 to present. The resident ' s Infectious Disease physician was interviewed on 7/19/12 at 10:30 am. He indicated that he was unaware of the medication errors and that the resident had told him he had received the antibiotics. He stated that there had been some improvement in the resident ' s right hand and forearm which he documented for his consultation on 7/10/12. He indicated that	F 333		

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F 333	Continued From page 4 Resident had a serious infection of the right hand and forearm due to a delay in the resident seeking medical evaluation prior to the hospitalization and that although this medication error was concerning it would not result in a change in the outcome for the resident. The 2nd nurse (RN#1) who reviewed the admission orders for Resident #2 was interviewed on 7/19/12 at 10:45 am. She stated that it was the facility ' s practice to have a 2nd nurse review the discharge information and compare it to the transcribed physician orders. She indicated that she had reviewed Resident #2 ' s discharge information and physician orders on the evening of 6/29/12. When supplied with the 4 page Discharge Med Reconciliation record for Resident #2 she indicated that she could not explain why the orders for antibiotics on page 3 had been missed. She stated that this form was unfamiliar to her and that might be the cause of the error. On 7/19/12 at 11:20 am the Director of Nursing (DON) on interview described the facility admission procedure. She stated that the discharge information provided by the referring hospital was reviewed by the admitting nurse. Any discrepancies were clarified with the referring hospital. The staff then calls the physician or NP and orders were verified. The physician orders and the MAR were then written, reviewed by a 2nd nurse and then faxed to the pharmacy. She stated that the medication error regarding Resident #2 ' s antibiotics was identified by the facility educator (SDC) and herself the morning of 7/2/12. The NP was notified and orders to resume the antibiotics were obtained. Incident reports were completed and the Administrator	F 333		

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F 333	Continued From page 5 was notified. Inservice education was provided to the admitting nurse and the RN who reviewed the orders. The DON stated that it was her expectation that the nurse would have looked through all the pages of the Discharge Med Reconciliation record and if she had questions she should have gotten help. She indicated that the unfamiliar form was a contributing factor but that she expected medications to be administered as ordered. The DON indicated the nurses involved were inserviced on proper medication reconciliation policies for new admissions. She stated that the she, the facility educator or the MDS nurse reviewed the orders of all new admissions 5 days a week Monday through Friday. She stated that this review had been increased from Monday to Friday to seven days a week. The weekend supervisor was trained in this audit process. Documentation of admission audits was provided and found to be up to date and no further errors had been found. She stated that this incident and the corrective measures instituted had been reviewed in the Quality Assurance meeting on 7/3/12. On 7/19/12 at 12:00 pm Resident #2 ' s primary physician who was also the facility Medical Director stated during an interview that he had been made aware of this medication error. He indicated that it was a significant error but would have no " morbid " effect on the resident. He stated that he was present at the QA meeting on 7/3/12 when this was reviewed. On 7/19/12 at 2:00 pm the Medical Records clerk provided documentation which on review confirmed that the medication error and the implementation of the facility plan of correction	F 333		

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F 333	Continued From page 6 had been reviewed during the Quality Assurance Meeting on 7/3/12. The facility was notified of the immediate jeopardy on July 31, 2012. The facility provided an acceptable plan of correction August 1, 2012. When the resident was accepted to the facility the initial admission paperwork did not include the IV Daptomycin Antibiotic. When resident was admitted, at 9:27pm per Point Click Care documentation, on Friday evening, June 29, 2012, [Hospital Name] Discharge Med Reconciliation accompanied the resident that added New Medication Orders on page 3 of the orders which did include the IV Daptomycin 720 mg daily x 4 weeks order. During the Monday morning July 2, 2012 routine audit of the Friday evening June 29, 2012 admission paperwork, the Staff Facilitator identified the ABT IV Daptomycin was not on the MAR and had not been administered to Resident #1. The assigned RN assessed the resident and spoke to the nurse practitioner on July 2, 2012 who gave orders to start the antibiotics as ordered. The resident, who is his own RP, was notified. The resident received [oral antibiotic] medication at 5pm, July 2, 2012 and IV ABT Daptomycin at 9pm on July 2, 2012. On July 3, 2012 the medical director assessed the resident with no negative findings. July 3, 2012 the medication error was discussed at the QI committee meeting with the medical director and the consulting pharmacist present. July 4, 2012 labs were drawn and results reviewed by the physician with no new orders.	F 333		

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F 333	Continued From page 7 On July 2, 2012 a 100 percent audit was completed by the DON, Staff Facilitator, and MDS Nurse on all new and all re-admissions occurring over the weekend, of June 29 - July 1, 2012 to identify any missed orders with no negative findings. The Admission QI Tool lists resident name, admission date, MD orders verified, orders transcribed correctly, pharmacy faxed, meds available/given timely, admit summary done, 2nd check. July 2, 2012 Director of Nursing initiated use of the Admission QI Tool used to verify physician orders are transcribed correctly, orders faxed to pharmacy, medications are available and given timely. The DON and administrative nurses are using the QI tool to complete the audit. Validation of the facility ' s credible allegation was completed on 7/31/2012. During the investigation, the facility provided documentation of interventions put into place as a result of the incident of 6/29/12: Resident #2 ' s antibiotics were initiated; LPN #1 and RN#1 were inserviced on the reconciliation of admission orders 7/2/2012. Inservice records for the nursing staff were reviewed and nursing staff were interviewed demonstrating knowledge of the inservice on 7/18/2012. Documentation was provided for review that confirmed that the medication error identified on 7/2/12 was reviewed by the Quality Assurance Committee on 7/3/12. Members at the meeting included the Administrator, Medical Director and the DON. The facility has conducted daily audits of IV antibiotics since7/2/2012.	F 333		

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