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 _____	R-C 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE HEALTH AND REHABILITATION	104 COLLEGE DRIVE 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 000	INITIAL COMMENTS On March 13, 2014, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted a revisit. While the deficiencies cited on the recertification and complaint investigation on January 16, 2014 were corrected effective March 13, 2013 the facility remains out of compliance.	F 000		
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: Transmit FU/FC of 03/13/14. Facility remains out of compliance Based on record review, staff interview and physician interview, the facility failed to administer the antiplatelet agent clopidogrel for 13 days for 1 of 4 residents reviewed for medication administration (Resident #49). Findings included: Resident #49 was admitted to the facility on 12/16/13 with a history of coronary artery disease (CAD) and peripheral arterial disease with a right below-the-knee amputation. Review of his Minimum Data Set dated 02/02/14 revealed Resident #49 received anticoagulation medication for the 7 day assessment period. His care plan dated 2/21/14 included the problem of anticoagulation therapy with appropriate goals and interventions. Review of Resident #49's medical record revealed a computer-printed medication	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 3/22/14. Preparation and/or execution of this plan of correction do not constitute admission to or agreement with either the existence of, or scope and severity of any 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. The Physician was notified on 3/13/14 regarding the Plavix for resident #49. An order was obtained on 3/13/14 to restart Plavix 75mg and the resident is receiving the Plavix as ordered.	3/22/14

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

Electronically Signed

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F 333	Continued From page 1 administration record (MAR) for February, 2014 with clopidogrel, 75 milligrams (mg), take 1 tablet by mouth everyday for CAD at 9 AM, with an origination date of 12/17/13 and nurse-initialed date blocks documenting administration of this medication on all days in the month. Further review of Resident #49's medical record revealed computer-printed monthly routine order sheets for March, 2014, with page 1 containing an order for clopidogrel, 75 milligrams (mg), take 1 tablet by mouth everyday for CAD at 9 AM, with an origination date of 12/17/13, an illegible signature in a block labeled "meds reviewed by" dated 02/27/14 and an illegible signature in a block labeled "physician signature" dated 03/04/14. This order and all the orders on this routine order sheet were noted to have the word "VOID", appearing as crossed out with a single line, handwritten and superimposed across the computer-printed orders. The signature block labeled "complete entries checked" was empty on this page but this block on pages 3, 5 and 6 contained an illegible signature dated 02/28/13. Review of Resident #49's hand-printed MAR for March, 2014 revealed no transcribed order for clopidogrel. Review of the daily nursing schedule revealed nurse #1 assigned to Resident #49's hall on the 7:00 AM to 3:00 PM shifts on 02/28/14 and for the periods of 03/01/14 through 03/03/14 and 03/07/14 through 03/10/14. Nurse #2 was assigned to Resident #49's hall on the 7:00 AM to 3:00 PM shifts for the periods of 03/04/14 through 03/06/14 and 03/11/14 through 03/13/14. An interview on 03/13/14 at 5:00 PM with the assistant director of nursing (ADON) revealed	F 333	The nurse that hand wrote the Physician Order Sheet (POS), was in-serviced by the Director of Nursing on 3/14/14, regarding a second nurse is required to verify all new admission orders, monthly Medication Administration Records (MAR), Treatment Administration Records (TAR), Coumadin orders and any Medication Record which have to be rewritten by hand for any reason. Both licensed nurses must review the resident□s Medical Record for new and discontinued orders to ensure all current medications and treatments are transcribed accurately on the resident□s MARs and TARs. The licensed nurse was in-serviced regarding the proper method for discontinuing medications/treatments. A 100% chart to MAR/TAR audit was completed by the Administrative Nursing Staff on or before 3/19/14 to ensure the accuracy of the MARs/TARs. Any discrepancies were corrected during the audit. The licensed nurses were in-serviced by the Director of Nursing on or before 3/22/14 regarding a second nurse is required to verify all new admission orders, monthly Medication Administration Records (MAR), Treatment Administration Records (TAR), Coumadin orders and any Medication Records which have to be rewritten by hand for any reason. Both licensed nurses must review the resident□s Medical Record for new and discontinued orders to ensure all current medications and treatments are	

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F 333	Continued From page 2 nurse #3's signature in the "meds reviewed by" block on Resident #49's monthly routine order sheet for March, 2014. She stated she could not understand why the word "VOID" was handwritten on the computer-printed monthly routine order sheet then crossed off. She stated if a discontinued medication card remained in the medication cart drawer in March for Resident #49 she would expect nurses to question why it remained in the absence of an order on the MAR. An interview on 03/13/14 at 5:10 PM with nurse #2, assigned at that time to Resident #49, was conducted in the presence of the ADON at nurse #2's medication cart. Upon inspection of Resident #49's medications in the medication cart, a medication card containing clopidogrel tablets, 75 mg dose, was observed with one pill dispensed as evidenced by a 1 broken pill location on the card and 14 remaining tablets. Nurse #2 stated she thought Resident #49 received clopidogrel but when the March 2014 MAR was reviewed and the medication was not noted, she stated she did not know anything about it. Nurse #2 stated whenever she dispensed a medication she verified the medication against the MAR to confirm the correct dosage and time. An interview on 03/13/14 at 5:49 PM with the physician revealed his direction to continue an order for clopidogrel. He stated as Resident #49 had also been receiving warfarin, Resident #49 was therapeutic for anticoagulant needs and when on clopidogrel had double coverage. He stated although no harm resulted due to the oversight he would have expected the clopidogrel order to be carried over to the March, 2014 MAR. He stated he would resume clopidogrel for	F 333	transcribed accurately on the resident□s MARs and TARs. The licensed nurses were inserviced regarding the proper method for discontinuing medications/treatments. The DON and/or Designee will perform Weekly Audits of five charts from each hallway (30 charts) for three months for accuracy of the residents□ POS, MARs, and TARs. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for review and recommendations.	

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F 333	Continued From page 3	F 333		

desired anticoagulant double coverage with the warfarin.

A phone interview on 03/13/14 at 6:15 PM with nurse #3, with the director of nursing (DON) present, revealed she normally would write " DC" for discontinuing a medication or the word "DUPLICATE" on the routine order sheet but never the word "VOID" and she did not recall handwriting a MAR. Further interview on 03/13/14 at 6:40 PM with nurse #3, now in person and with the DON present, revealed she did not write the word "VOID" on Resident #49's routine order sheet and did not know who would have written this. She stated she did remember checking the routine order sheet against a MAR but the MAR was not handwritten. Nurse #3 stated after she checked the orders against the MAR she would place them in a stack for a second nurse to check. The DON stated the signature at the bottom of Resident #49's handwritten March, 2014 MAR was made by nurse #4.

An interview on 03/13/14 at 6:34 PM with nurse #2 revealed she could not recall giving Resident #49 clopidogrel.

A phone interview on 03/13/14 at 6:50 PM with nurse #4 (whose signature was noted by the DON at the bottom of Resident #49's handwritten March, 2014 MAR) was attempted with a voice message left but no return call was made by nurse #4.

A phone interview on 03/13/14 at 7:00 PM with nurse #1 revealed she was familiar with Resident #49 but could not recall if she gave him clopidogrel. She stated if a medication was not

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F 333	Continued From page 4	F 333		

listed on the MAR then she did not give it. She stated if she saw a medication card in the medication cart for a resident but did not see it on the MAR, she would normally check to see why it was not on the MAR, but she could not comment on the clopidogrel.

An interview on 03/13/14 at 7:04 PM with nurse #5, with the director of nursing (DON) present, revealed her signature in the block labeled "complete entries checked" and dated 02/28/13 on pages 3, 5 and 6 of Resident #49's monthly routine order sheets for March, 2014. She stated the handwritten word "VOID" on page 1 of his sheets was not in her handwriting, she signed off treatment orders and at that time she did not see any orders with the handwritten word "VOID." The DON stated nurse #4 normally worked another hallway than the one where Resident #49 resided so she was not sure why she would have hand written a MAR for him. Nurse #5 stated the hand written word "VOID" would have been a red flag.

During interviews with the DON on 03/13/14 starting at 7:23 PM and concluding at 7:45 PM, she revealed that upon review of an attendance roster for a recent nurse in-service training regarding the completion of MARs at the end of the calendar month, nurse #5 did not attend the in-service. She stated nurse #5 had worked as an as-needed (PRN) nurse and had communicated her resignation effective with her last scheduled work day as 03/24/14. The DON stated a review of the daily nursing schedule for 02/28/14 revealed nurse #5 assigned to Resident #49's hallway, further stating nurse #5 must have been nurse to check off the orders from the monthly routine order sheets for March, 2014,

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F 333	Continued From page 5 hand write the MAR and not transcribe the order for clopidogrel.	F 333		