STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

(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 reviews and staff interviews the facility had significant medication errors for not using the discharge instructions from the hospital dated 03/17/2015 to obtain orders from the facility physician concerning Resident #11's medications upon admission to the facility for 1 of 1 residents reviewed for medication administration (Resident #11). Findings include: Resident #11 was admitted to the facility 03/17/15 from the hospital. Her diagnoses included severe sepsis and clostridium difficile infection. A review of medical records revealed that an undated history and physical discovered in Resident #11's chart had been used to obtain medication orders from the facility physician by the facility staff when Resident #11 was admitted to the facility on 03/17/15. A notation was made at the bottom of the list of medications which indicated the admitting nurse had read the medication list to the facility physician over the phone and he had approved them on 03/17/15. A review of Resident #11's medication administration record (MAR) dated 03/01/15 through 03/31/15 revealed that the following medications were ordered by the facility physician on 03/17/15 because the admitting nurse used an	F 333	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F333 1. How the corrective action will be accomplished for the resident(s) affected. Resident #11 orders were reviewed and corrective actions taken to ensure accuracy. 2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Current nurses will be in-serviced on transcribing admission medication orders and new orders for current residents. In□service to include how to accurately transcribe physician orders. In-services	4/17/15

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

Electronically Signed | 04/08/2015

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F 333	Continued From page 1 undated history and physical to obtain the admission orders instead of the hospital discharge instructions. The following medications were prescribed for Resident #11 upon admission to the facility using the undated history and physical: 1. Maalox Regular Strength 200-200-20 mg/5ml, give 30ml by mouth every six hours as needed for indigestion was administered one time on 03/17/15. 2. Vitamin D3 2000 units, give 2000 units by mouth one time a day for supplement was administered once on 03/18/15 and again on 03/19/15. 3. Zestril 20mg, give 20mg by mouth one time a day for hypertension was administered once on 03/18/15 and again on 03/19/15. 4. Zyprexa 10mg, give 10mg by mouth one time a day for anti-psychotic was administered once on 03/18/15 and again on 03/19/15. 5. Xanax 0.5mg, give 0.5mg by mouth two times a day was administered twice on 03/18/15 and once on 03/19/15. 6. Imodium 2mg by mouth three times a day before meals and as needed. Imodium A-D 2mg, give 2mg by mouth before meals for diarrhea was administered three times on 03/18/15 and twice on 03/19/15. 7. Aricept 10mg, give 10mg by mouth one time a day for dementia was administered once on 03/18/15 and again on 03/19/15. 8. Ditropan XL 5mg, give 5mg by mouth one time a day for neurogenic bladder was administered once on 03/18/15 and again on 03/19/15. 9. Lamictal 100mg, give 100mg by mouth one time a day for seizure disorder was administered once on 03/18/15 and again on 03/19/15.	F 333	will be completed on 4/17/15 by the Nurse Consultant/Designee. Current patients admitted or re-admitted from 3/1/15 forward have had admission orders reviewed for accuracy. 3. Measures in place to ensure practices will not recur. The Third shift nurse will complete an audit of new admissions or readmission orders daily for the past 24 hours. The third shift nurse will sign off on the MAR each night after the review of any new orders for accuracy is completed. Any inaccuracies noted will be corrected at that time. Unit Manager, DON or RN designee will audit new and re-admission physician orders to include completeness/accuracy 5 x week x 2 weeks, 3 x week x 1 week, 2 x week x 1 week, monthly x 2, then quarterly x 9 months. Newly hired nurses will be in-serviced on transcribing new admission orders/New orders for accuracy and completeness. Any current licensed staff who are unable to attend scheduled in-services will have the training prior to their next scheduled shift. Training will be incorporated into the orientation process by the SDC/Designee in her absence. 4. How the facility plans to monitor and ensure correction is achieved and sustained. Information obtained during audit will be reviewed during the QA&A (Quality Assessment and Assurance) Committee for compliance and revision if needed	

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F 333	Continued From page 2 10. Lasix 20mg, give 20mg by mouth one time a day was administered once on 03/18/15 and again on 03/19/15. 11. Mevacor 20mg, give 20mg by mouth in the afternoon was administered once on 03/18/15 and again on 03/19/15. 12. HCTZ 12.5mg, give 12.5mg by mouth one time a day for diuretic was administered once on 03/18/15 and again on 03/19/15. 13. Norvasc 5mg, give 5mg by mouth one time a day for hypertension was administered once on 03/18/15 and again on 03/19/15. 14. Prilosec 20mg, give 20mg by mouth one time a day for reflux was administered once on 03/18/15 and again on 03/19/15. 15. Milk of Magnesia 30ml by mouth every 12 hours as needed for constipation-not administered between 03/17/15 and 03/19/15. 16. Norco 10/325mg, 1 tablet by mouth every 6 hours as needed for pain-not administered between 03/17/15 and 03/19/15. 17. Nystop Powder 10,000 units/gram, apply to affected area every six hours as needed for pain-not administered between 03/17/15 and 03/19/15. 18. Robitussin Chest Congestion Syrup 100mg/5ml, give 10ml by mouth every 6 hours as needed for cough/congestion-not administered between 03/17/15 and 03/19/15. 19. Tylenol Extra Strength 500mg, give 500mg by mouth every 6 hours as needed for pain-not administered between 03/17/15 and 03/19/15. 20. Ultram Tablet 50mg, give 50mg by mouth every 6 hours as needed for pain-not administered between 03/17/15 and 03/19/15. 21. Xanax 0.5mg, give 0.5mg by mouth every 24 hours as needed for anxiety-not administered between 03/17/15 and 03/19/15. 22. Benadryl 25mg, give 25mg by mouth every 4	F 333	quarterly x 4. 5. Date of Completion: 4/17/15	

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hours as needed for itching-not administered between 03/17/15 and 03/19/15.
23. Hydrocortisone Cream 0.5%, apply to affected area topically every 24 hours as needed for rash-not administered between 03/17/15 and 03/19/15.
24. Imodium 2mg, give 2mg by mouth every 2 hours as needed for diarrhea after each loose stool-not administered between 03/17/15 and 03/19/15.

A comparison of the medications ordered by the hospital physician specified on the discharge instructions dated 03/17/15 with the list of medications on the undated history and physical and Resident #11's MAR dated 03/01/15 through 03/31/15 determined the following medications were ordered in error:
1. Benadryl 25mg every 4 hours by mouth as needed,
2. Lasix 20mg by mouth every day,
3. Maalox by mouth as needed four times a day,
4. Microzide 12.5mg by mouth every day,
5. Norco 10/325mg by mouth every 6 hours as needed,
6. Norvasc 5mg by mouth every day,
7. Nystop 10,000 units/gram apply topically four times a day as needed,
8. Prilosec 20mg by mouth every day,
9. Robitussin 100mg/5ml by mouth every 6 hours as needed,
10. Ultram 50mg by mouth every 6 hours as needed,
11. Vitamin D3 2000 units by mouth every day and
12. Zestril 20mg by mouth every day.

A review of Resident #11's medical records revealed that hospital discharge instructions

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dated 03/17/2015 listed the following medications as prescribed to Resident #11 by the hospital physician.
1. Tylenol 500mg (milligrams) one tablet by mouth every six hours as needed.
2. Xanax 0.25mg one tablet by mouth twice a day.
3. Aricept 10mg one tablet by mouth with supper.
4. Lamictal 100mg one tablet by mouth daily.
5. Mevacor 20mg one tablet by mouth daily.
6. Zyprexa 10mg one tablet by mouth daily.
7. Vancomycin 125mg/5ml (milliliters) by mouth four times a day.

A staff interview and record review was conducted with the facility administrator and Director of Nursing (DON) on 03/19/15 at 3:25 PM. The facility administrator verbalized that it is her expectation that when a resident is admitted from the hospital the current hospital discharge instructions be used to obtain medication orders from the facility physician. The Administrator further verbalized that it is her expectation that the orders for residents admitted to the facility be second checked by a third shift nurse the night following their admission. The Administrator reported that she was not sure if there was a policy concerning charts being second checked by a third shift nurse. The DON reviewed Resident #11's MAR verifying that second checks were not performed on Resident #11's orders following her admission on 03/17/15.

A staff interview and record review was conducted with the facilities physician. The Physician reviewed the undated history and physical affirming that it was the wrong document for a nurse to use to obtain telephone orders from

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F 333	Continued From page 5 a physician. He verbalized that it is his expectation that a residents current discharge instructions be used to obtain telephone orders when a resident is being admitted to the facility from the hospital. The Physician further verbalized that he did not think Resident #11 had been harmed by the medication errors which resulted from the wrong list of medications being used to obtain admission medication orders on 03/17/15.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		4/17/15

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F 441	Continued From page 6 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews facility staff failed to implement contact precautions while providing care for a resident diagnosed with a clostridium difficile infection (CDI) for 1 of 3 residents (Resident #12). Findings included: 1.The facilities infection control policies and procedures regarding transmission prevention of CDI directed staff to perform vigilant hand hygiene using soap, water and friction for no less than 15-20 seconds and to don gloves and gown when entering room and during patient care activities. The facilities infection control policy also directed staff to place residents diagnosed with known or suspected CDI associated diarrhea on contact precautions. Review of lab results in the medical record of Resident #12 noted a positive culture for CDI dated 02/17/15. A review of a nurse's note dated 02/18/15 revealed that Resident #12 was placed on	F 441	F441 1. How the corrective action will be accomplished for the resident(s) affected. CNA # 1 has been re-educated 1:1 on isolation practices, incontinence care and resident #12 isolation practices and incontinence care. There are no isolation rooms in the facility at this time. 2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Nurses and Nurse Assistants will be re-educated on Infection Control Policy 403 Isolation Precautions □ General Practice and incontinence care as outlined in Mosby's Textbook for Nursing Assistants, 6th edition with focus on Standard Precautions as outlined on page 192-193 Box 15-4 Standard Precautions which covers (Hand Hygiene, Personal Protective Equipment, Gloves, Gowns, Mouth, Nose and Eye Protection, Respiratory Hygiene/Cough Etiquette, Care of Environment, Textiles and Laundry). Re-education will be completed	

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F 441	Continued From page 7 contact precautions related to a diagnosis of CDI by facility staff as directed in the facilities infection control policy on 02/18/15. The nurse's note written on 02/18/15 indicated the facilities physician had been informed that Resident #12 had tested positive for CDI and had been placed on contact precautions. The nurse's note informed that Vancomycin was started on 02/18/15. The duration of the Vancomycin order written by the facilities physician on 02/19/15 and continued through 05/15/15. A staff interview was conducted on 03/17/15 at 4:00 PM with the Director of Nursing (DON). The DON verbalized that Resident #12 should be on contact precautions until her course of Vancomycin was completed. An observation of resident care was conducted on 03/17/15 at 10:50 AM. Nursing Assistant #1 entered Resident #12's room without donning the required PPE. NA #1 put gloves on but did not wear a gown while assisting Resident #12 to the toilet and providing peri-anal care following Resident #12 having a bowel movement. NA #1 placed a feces stained towel used to provide peri-anal care for Resident #12 on the countertop by the sink in the toilet in Resident #12's room. NA #1 removed her contaminated gloves which were worn while providing peri-anal care for Resident #12 and placed them on the sink countertop beside the contaminated towel. NA #1 washed her hands, put on clean gloves and placed the contaminated gloves in the plastic bag lined trash can. NA #1 carried the feces stained towel and the plastic bag containing the contaminated gloves and the feces stained protective undergarment	F 441	by 4/17/15 by the Nurse Consultant/ Designee. 3. Measures in place to ensure practices will not recur. DON/Unit Manager will audit isolation rooms daily Monday-Friday x 2 weeks, Monday, Wednesday and Friday x 2 weeks, Monday x 2 months, then quarterly x 3. Incontinence care with focus on linen handling will be audited randomly on 10% of residents in-house weekly x 4, bi-weekly x 2, then quarterly x 3. Any breaches noted will be addressed at that time with re-education/ discipline as needed. Newly hired staff nurses and nurse assistants will be in-serviced on Isolation procedures and proper incontinence care during orientation by the SDC/ Designee in her absence. Any current staff who are unable to attend scheduled in-services will have the training prior to their next scheduled shift. 4. How the facility plans to monitor and ensure correction is achieved and sustained. Information obtained during audits will be reviewed during the QA&A (Quality Assessment and Assurance) Committee for compliance and revision if needed quarterly x 4. 5. 4/17/2015	

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into the hallway outside of Resident #12's room and disposed of them then discarded the gloves she was wearing.
NA #1 did not wash her hands following disposal of the contaminated items before continuing to provide care for Resident #12.

An interview was conducted with NA #1 on 03/17/15 at 11:49 AM. NA #1 verbalized that appropriate PPE and infection control procedures should have been practiced including wearing a gown when entering Resident #12's room and disposing of the contaminated, feces soiled towel in the bio-hazard receptacle located in Resident #12's room. NA #1 verbalized that she should have washed her hands prior to returning to resident care following disposal of the feces soiled towel and the plastic bag containing contaminated gloves and a feces stained protective undergarment. NA #1 verbalized that she forgot about a gown being part of the PPE required for providing care for residents on contact precautions.