STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	1510 HEBRON STREET HENDERSONVILLE, NC 28739

(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 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, nurse practitioner, and physician interviews the facility failed to administer Ativan (sedative medication) as ordered for 1 of 4 residents reviewed for medication errors (Resident #4). Findings included: Resident #4 was admitted to the facility on 1/11/17 with diagnoses that included anxiety disorder, chronic obstructive pulmonary disease and dyspnea (shortness of breath). Review of the physician's orders for Resident #4 revealed an order dated 1/30/17 for Ativan 1 milligram (mg) 4 times a day related to anxiety disorder. Review of the Medication Administration Record (MAR) for February 2017 revealed Resident #4 was scheduled to receive 1 mg of Ativan at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM for anxiety. Review of the facility Medication Variance Report for February 2017 revealed a medication error for Resident #4 on 2/1/17. Review of the facility Incident Report dated 2/1/17 revealed Resident #4 received 2 mg of Ativan instead of the	F 281	Resident# 4's Physician and family were notified immediately upon notice of error. Pt was monitored and had no adverse effect from receiving one additional 1mg dose of Ativan. Pt # 4 medications were reviewed by the Director of Nursing on 2/2/2017 and no additional errors were identified. Nurse #1 was educated by the Director of Nursing immediately upon report of error on 2/2/2017 regarding facility procedure of medication administration. All residents receiving medications have the potential to be affected by this alleged deficient practice. On 2/25/ 2017, the Director of Nursing reviewed all medication carts to assure no discontinued medications were inside carts. No discontinued medications were located in medication carts and no other medication errors have been identified as a result of the audit. Licensed Nurses and Certified Medication Aides have been re-educated on the facility process for administering medications, to include the removal of	2/28/17

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

Electronically Signed | 02/27/2017

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F 281	Continued From page 1 scheduled dose of 1 mg administered by Nurse #1 on 2/1/17 at 8:00 PM. An interview conducted with the Adult Gerontology Nurse Practitioner (AGNP) on 2/14/17 at 10:45 AM confirmed she had been notified by Nurse #1 of the medication dosage error administered to Resident #4 on 2/1/17. She indicated they had recently increased Resident #4's Ativan in an effort to control her anxiety. The AGNP explained the normal side effects for receiving too much Ativan would be sedation and increased risk for falls. She added Resident #4 had displayed no adverse reactions due to the increased dose of Ativan and did not feel that it was a significant error due to the amount of Ativan she routinely takes as a result of her comorbidities (presence of two or more chronic diseases). A telephone interview conducted with Nurse #1 on 2/14/17 at 11:14 AM confirmed she had administered medications to Resident #4 on 2/1/17. Nurse #1 explained the order for Resident #4's Ativan had recently been changed from three times a day to four times a day. Nurse #1 indicated she had given Resident #4 1 mg of Ativan at 6:00 PM and had inadvertently looked at the discontinued order for Ativan on Resident #4's MAR when she had administered another dose of 1 mg of Ativan at 8:00 PM. Nurse #1 stated she had immediately informed the Director of Nursing (DON) and AGNP of the medication dosage error and had received no new orders. Nurse #1 added she had continued to monitor Resident #4's vitals throughout the remainder of her shift and Resident #4 had not displayed any change in condition or abnormal vitals after receiving the additional dose of Ativan.	F 281	discontinued medications from the medication cart and notifying the pharmacy regarding Physician's Orders received to discontinue medications. Licensed Nurses and Certified Medication Aides have also been re-educated regarding the review of the Medication Administration record prior to administration of all medications to differentiate between active Physician's Orders and Discontinued Physician's Orders. This education was completed by the Director of Nursing and Nurse Managers by 2/28/2017. The Director of Nursing or Nurse Manager will review Medication Carts 3 times per week for 12 weeks to validate removal of discontinued medications from the medication carts. The Director of Nursing or Nurse Manager will review 24 hour reports 3 times per week for 12 weeks to ensure medication errors are identified and addressed. Opportunities will be corrected as identified by the Director of Nursing or Nurse Managers. A QAPI will be performed by the Director of Nursing and results will be reported to the QAPI committee monthly for 3 months.	

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F 281	Continued From page 2 A telephone interview with the Medical Director (MD) on 2/14/17 at 12:02 PM revealed the normal side effects of being administered Ativan could be some sedation and slight respiratory depression. The MD explained a significant error from being administered too much Ativan would be an error that caused harm to the resident such as over-sedation. The MD explained the significance of a resident being administered 1 mg of Ativan and then receiving another 1 mg dose of Ativan 2 hours later would depend on the type of reaction the resident had. An interview was conducted with the DON on 2/14/17 at 1:10 PM who stated when a medication error was discovered she would expect for staff to notify her and the MD or AGNP. The DON confirmed she had been notified by Nurse #1 of the medication dosage error administered to Resident #4 on 2/1/17 and investigated the incident. The DON explained discontinued orders remained on the resident's computerized MAR for a period of 7 days with the word discontinued written on the order. The DON added the medication dosage error had occurred because Nurse #1 had looked at the wrong order prior to administering the medication.	F 281		