STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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, pharmacist, and physician interviews the facility failed to administer Hydrocodone-Acetaminophen (pain medication) as ordered for 1 of 3 residents reviewed for medication errors (Resident #1). Findings included: Resident #1 was admitted to the facility on 4/12/17 with diagnoses that included crushing injury of left hip, bronchopneumonia, and atrial fibrillation. Review of the physician orders for Resident #1 revealed an admission order dated 4/12/17 for Hydrocodone-Acetaminophen 5-325 milligrams (mg). Give one tablet every 4 hours as needed for moderate pain and give 2 tablets by mouth every 4 hours as needed for severe pain. A pharmacy delivery slip dated 4/13/17 revealed Oxycodone-Acetaminophen 5-325 mg, 60 tablets delivered to facility for Resident #1. Review of the Medication Administration Record for Resident #1 for April 2017 indicated Hydrocodone-Acetaminophen 5-325 mg was given on 4/14/17 at 9:24 PM by Nurse #1.	F 281	Criteria 1 The Nurse Supervisor completed a Medication Variance Report on 4/15/17 for the administration error of Oxycodone for Resident #1. The Physician was notified by the Charge Nurse as required by 4/15/17.The Pharmacy Manager completed an investigation of the occurrence by 5/17/17. Resident #1 was discharged to home on 4/20/17. Criteria 2 All residents receiving narcotic pain medications have the potential to be affected by this alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of narcotic medications currently stored in medication carts to validate medication are available according to the physicians order. This audit will be completed by 5/17/17. Opportunities were corrected as identified by the Director of Nursing and Nurse Managers. Criteria 3 The Director of Nursing, Nurse Manager or Area Staff Development Director will	5/17/17

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

Electronically Signed | 05/17/2017

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F 281	Continued From page 1 Review of the narcotic sheet for Resident #1 revealed Oxycodone-Acetaminophen 5-325 mg given on 4/14/17 at 9:30 PM and 4/15/17 at 3:00 AM by Nurse #1. Review of the facility Medication Variance Report for April 2017 revealed a medication error for Resident #1 on 4/14/17 at 9:30 PM and 4/15/17 at 3:00 AM. The report indicated Resident #1 received Oxycodone-Acetaminophen 5-325 mg given on 4/14/17 at 9:30 PM and 4/15/17 at 3:00 AM instead of the ordered dose of Hydrocodone-Acetaminophen 5-325 mg. An interview with the pharmacist on 4/27/17 at 12:49 PM revealed an order was written on 4/12/17 for Hydrocodone-Acetaminophen 5-325 mg and on 4/13/17 the pharmacy delivered Oxycodone-Acetaminophen 5-325 mg to the facility. The pharmacist confirmed the pharmacy made an error in sending the wrong medication. A telephone interview on 4/27/17 at 1:32 PM with the physician for Resident #1 revealed that when Nurse #2 called and informed him about the medication error he changed the order from Hydrocodone-Acetaminophen 5-325 mg to Oxycodone-Acetaminophen 5-325 mg because the resident tolerated the medication. The physician also indicated the resident had no detrimental effects from receiving Oxycodone-Acetaminophen 5-325 mg. The physician stated the medications were in the same medication class and were both mild narcotics. A telephone interview on 4/27/17 at 1:51 PM with Nurse #2 indicated she found a medication error	F 281	re-educate Licensed Nurses and Certified Medication Management with a focus on the 5 rights of Medication Administration to include reading the Physician's Order and validating the medication delivered from the pharmacy matches the medication ordered for administration . This education was completed by 5/17/17. The Director of Nursing or Nurse managers will randomly observe 5 Nurses or Certified Medication Aides completing a medication pass, weekly for 12 weeks to validate adherence to the 5 Rights of Medication Administration. Opportunities will be corrected daily as identified. Criteria 4 The Director of Nursing will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate effectiveness of the plan and make recommendations as required	

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F 281	Continued From page 2 for Resident #1 when he received Oxycodone-Acetaminophen 5-325 mg instead of the ordered dose of Hydrocodone-Acetaminophen 5-325 mg. Nurse #2 stated she called the pharmacy and it was confirmed that the pharmacy had delivered the wrong medication to the facility on 4/13/17. Nurse #2 also stated the resident did not have any adverse reactions from taking the Oxycodone-Acetaminophen 5-325 mg and the physician changed the order for Resident #1 to receive Oxycodone-Acetaminophen 5-325 mg. Nurse #1 (the nurse who administered the wrong medication) was not available for an interview at the time of the investigation. An interview conducted with the Director of Nursing (DON) on 4/27/17 at 4:53 PM revealed her expectations were for the nurses to read the physician order and the electronic medical record to ensure that the correct medication was given. The DON indicated if there was a question about the medication, the nurse was supposed to stop and verify the order or call the pharmacy prior to administering the medication.	F 281		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 425		5/17/17

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F 425	Continued From page 3 (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on record review, and staff, pharmacist, and physician interviews the pharmacy failed to dispense Hydrocodone-Acetaminophen 5-325 milligrams (mg) (pain medication) as ordered for 1 of 3 residents reviewed for medication errors (Resident #1). Findings included: Resident #1 was admitted to the facility on 4/12/17 with diagnoses that included crushing injury of left hip, bronchopneumonia, and atrial fibrillation. Review of the physician orders for Resident #1 revealed an admission order dated 4/12/17 for Hydrocodone-Acetaminophen 5-325 mg. Give one tablet every 4 hours as needed for moderate pain and give 2 tablets by mouth every 4 hours as needed for severe pain. Review of a script faxed to the pharmacy at 4/12/17 at 10:20 PM indicated Lorcet 5-325 mg (generic for Hydrocodone-Acetaminophen) one tablet every 4 hours as needed for mild pain and 2 tablets every four hours as needed for moderate and severe pain. A pharmacy delivery slip dated 4/13/17 revealed Oxycodone-Acetaminophen 5-325 mg, 60 tablets was delivered to facility for Resident #1. Review of the narcotic sheet for Resident #1 revealed Oxycodone-Acetaminophen 5-325 mg	F 425	1. The RN Supervisor completed a Medication Variance Report by 4/15/17 for the administration error of Oxycodone for Resident #1. The Physician was notified by the Charge nurse as required by 4/15/17. The Pharmacy Manager completed an investigation of the occurrence by 5/17/17. Resident #1 was Discharged to home on 4/20/17. 2. Residents receiving narcotic pain medication's have the potential to be affected by this alleged deficient practice. The Pharmacy Manager completed an audit of the retroactive report for active Physician's orders for Percocet and Lorcet orders to validate accurate dispensing. This audit was completed by 5/17/17. Opportunities were corrected by the Pharmacy Manager as identified. 3. Order Entry Staff and Pharmacists have been re-educated by the Pharmacy Manager on the importance of verifying all illegible orders stamped "void" prior to dispensing, to call the Facility or Physician to clarify if there is doubt or concern. When the Pharmacist speaks with the prescriber or nurse to clarify the order, the full name of the person along with the date and time stamp will be documented in the pharmacy's electronic health record. This education was completed by 5/17/17. The Pharmacy Manager will randomly	

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F 425	Continued From page 4 given on 4/14/17 at 9:30 PM and 4/15/17 at 3:00 AM by Nurse #1. Review of the Medication Administration Record for Resident #1 for April 2017 indicated Hydrocodone-Acetaminophen 5-325 mg was given on 4/14/17 at 9:24 PM by Nurse #1. Review of the facility Medication Variance Report for April 2017 revealed a medication error for Resident #1 on 4/14/17 at 9:30 PM and 4/15/17 at 3:00 AM. The report indicated Resident #1 received Oxycodone-Acetaminophen 5-325mg given on 4/14/17 at 9:30 PM and 4/15/17 at 3:00 AM instead of the ordered dose of Hydrocodone-Acetaminophen 5-325mg. An interview with the pharmacist on 4/27/17 at 12:49 PM revealed an order was written on 4/12/17 for Hydrocodone-Acetaminophen 5-325 mg and on 4/13/17 the pharmacy delivered Oxycodone-Acetaminophen 5-325 mg to the facility. The pharmacist confirmed the pharmacy made an error in sending the wrong medication. The pharmacist went on to say Nurse #2 called and reported the error to the pharmacy. The pharmacist also indicated that after the medication error was reported for Resident #1, the physician changed the order from Hydrocodone-Acetaminophen 5-325 mg to Oxycodone-Acetaminophen 5-325 mg. The pharmacist further indicated that education was performed at the pharmacy to prevent the error from happening again. A telephone interview on 4/27/17 at 1:32 PM with the physician for Resident #1 revealed that when Nurse #2 called and informed him about the medication error he changed the order from	F 425	review 5 residents receiving narcotic pain medications to validate accurate dispensing according to the Physician's Orders. This monitoring will occur weekly for 4 weeks then monthly for 2 months. Opportunities will be corrected as identified by the Pharmacy Manager. 4. The Director of Nursing will report the results of these observations to the QAPI committee monthly for 3 months. The committee will evaluate the effectiveness of the plan and make recommendations as required.	

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F 425	Continued From page 5	F 425		

Hydrocodone-Acetaminophen 5-325 mg to Oxycodone-Acetaminophen 5-325 mg because the resident tolerated the medication. The physician also indicated the resident had no detrimental effects from receiving Oxycodone-Acetaminophen 5-325 mg. The physician stated the medications were in the same medication class and were both mild narcotics.

A telephone interview on 4/27/17 at 1:51 PM with Nurse #2 indicated she found a medication error for Resident #1 when he received Oxycodone-Acetaminophen 5-325 mg instead of the ordered dose of Hydrocodone-Acetaminophen 5-325 mg. Nurse #2 stated she called the pharmacy and it was confirmed that the pharmacy had delivered the wrong medication to the facility on 4/13/17. Nurse #2 also stated the resident did not have any adverse reactions from taking the Oxycodone-Acetaminophen 5-325 mg and the physician changed the order for Resident #1 to receive Oxycodone-Acetaminophen 5-325 mg.

Nurse #1 (the nurse who administered the incorrect medication) was not available for an interview at the time of the investigation.

An interview conducted with the Director of Nursing (DON) on 4/27/17 at 4:53 PM revealed her expectations were for the nurses to read the physician order and the electronic medical record to ensure that the correct medication was given. The DON indicated if there was a question about the medication, the nurse was supposed to stop and verify the order or call the pharmacy prior to administering the medication.