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
	345174	A. BUILDING _____ B. WING _____	C 02/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE NURSING & REHABILITATION CENTER	91 VICTORIA RD ASHEVILLE, NC 28801

(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 medical record reviews and staff interviews the facility failed to be free from significant medication errors for 2 of 3 sampled residents reviewed for medication errors. A long acting medication (Morphine Sulfate) was crushed and administered to a gastrostomy tube fed resident and the correct dose of a seizure medication (Dilantin) was not administered as ordered. (Resident #1 and #2) The findings include: Resident #1 was admitted to the facility on 10/18/12. Resident #1's diagnoses included chronic pain syndrome, osteomyelitis, and stage IV pressure ulcer with colonized organisms, spinal cord injuries and care of percutaneous endoscopic gastrostomy (PEG) tube placement. Further review of the medical record revealed Resident #1 returned to the facility on 2/8/13 after PEG tube placement. The physician assessments and nursing notes for the month of January 2013 revealed that a PEG tube was needed due to concerns of severe weight loss and non compliance to food consumption. Resident #1 was able to swallow by mouth. A review of the physician orders for the month of February 2013 and the changed physician orders dated 2/8/13 included Morphine Sulfate 15 mg	F 333	1. • Resident #1 no longer resides at the facility • Resident #2 no longer resides at the facility 2. Any resident receiving crushed medication in the facility can be affected by this practice. Therefore, the MARS were audited by the DON and facility supervisor on 2-21-2013 to assure residents receiving crushed medication have no orders for medication that can not be crushed. Between 2-21-13 to 2-22-13 RN supervisor educated licensed nurses on common medications used in the facility that are not crushable and need for clarification orders for formulary changes as needed for residents who need their medications crushed . Beginning 3-01-2013 the MARS will be printed by the pharmacy and will no longer be done inside the building. From 2-26 to 2-28-2013 three nurses	3-11-13

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

Kamuina Badimu, Administrator. 3-13-13.

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.

Original signature 3-11-13 mh

Received
MAR 14 2013
By: MMH
BHSR LSC Black Mountain WRO

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F 333	Continued From page 1 extended release tablet three times daily scheduled at 8:00 AM 12:00 Noon and at 5:00 PM. A review of Medication Administration Records (MAR) for the month of February 2013 revealed three doses of Morphine Sulfate 15 mg extended release was administered on 2/9/13. Resident #1 was discharged to the hospital due to change in condition on 2/10/13. A Continued review of the nursing note of 2/10/13 written at 1:03 AM revealed that medications given at 5:00 PM the previous day were crushed and a review of the medication errors documented, revealed that a dose of Morphine Sulfate 15 mg extended release was also crushed with other medications for administration on 2/9/13 at 5:00 PM dose. The error review investigations revealed that the nurse who crushed the medications was disciplined and discharged. No further documentation was provided and was available for having in-serviced all other nurses related to this significant medication error. Interview with nurse #1 on 2/19/13 at 2:03 PM who administered the two doses on 2/9/13 during the morning shift revealed that she administered Morphine Sulfate 15 mg extended release tablet by mouth as indicated in the MAR. Nurse who administered 5:00 PM dose and who crushed the medications was not available for interview. An interview with the Director of Nursing on 2/19/13 at 2:42 PM revealed that she discussed the error made by the nurse as soon as she became aware of the issue but did not in-service	F 333	completed a 100% medical record audit of telephone orders and updated MARS received from pharmacy as appropriate. Triple check initiated 3-11-2013 requiring three nurses to review all telephone orders for accuracy of transcription to the MARS. On 3-11-13 a 100% audit of telephone orders received from 3-1-13 to 3-10-13 was conducted by 2 staff RN and DON. 3. In-services were conducted between 2-19-2013 through 3-10-2013 for licensed nurses by pharmacy and the DON which addressed the following areas: Crushed Medications, Medication errors, and transcription of Medication orders. Pharmacy completed a medication observation pass on 3-4-13. Beginning the week of 3-11-13 a medication observation pass will be conducted by pharmacy, nurse consultant, or RN from a sister	3-11-13

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F 333	Continued From page 2 all nurses related to this issue. She completed the medication error report and informed the physician. An interview with the medical director on 2/20/13 at 9:30 AM revealed that Resident #1 had on-going unresolved infection issues due to his stage IV pressure ulcer and had changes in status on 2/10/13 and was sent to the hospital for evaluations. He stated that the crushing of 15 mg extended release Morphine Sulfate might not have caused the change in condition as Resident #1 was tolerant to narcotics but agreed that it was an error to crush extended release medications. 2. Resident #2 was readmitted to the facility on 8/27/12 and was discharged on 1/7/13. Resident #2's diagnoses included recurrent seizures, bipolar disorder and head and neck cancer. A review of the admission physician orders dated 8/27/12 revealed Resident #2 had an order for Dilantin 200 mg in the suspension liquid form and it was administered via the Gastrostomy tube two times daily. Further review of the Medication Administration Records (MARs) for the month of August 2012 and September 2012 revealed that 10 ml of Dilantin suspension liquid amounting to 250 mg (Dilantin strength was 125 mg per 5 ml) was administered. The review revealed that the dose conversion was wrongly transcribed as 10 ml rather than 8 ml and thus causing a dosage error. Further Resident #2 received 10 ml of this Dilantin suspension liquid dose in error amounting to 250 mg instead of 200 mg as	F 333	facility weekly for 6 weeks. Any non compliance will result in redirection/ re-in-service 4. The DON, RN supervisor or Q.A. Nurse will conduct audits 3 times a week on new orders for 12 weeks to assure transcription and crushing of medication are correct beginning the week of 03-11-2013. Any nurse out of compliance with medication transcription or crushing of medications will be re-educated by the DON. Results of the audits will be reviewed at the Q.A.P.I meeting by the DON for 4 months. Any further process changes will be discussed at the QAPI by the DON.	3-11-13

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F 333	Continued From page 3 ordered two times daily. The review revealed that Resident #2 received this wrong dosage from August 27, 2012 to September 9, 2012 and a total of 27 doses of Dilantin 250 mg were given to Resident #2. Nurses who administered these doses of Dilantin suspension wrong dose were not available for interview at the time of this investigation. An interview with the Director of Nursing (DON) on 2/20/13 at 1:25 PM revealed that she was not aware of this error and stated that when Resident #2 went to the hospital for an evaluation on September 9, 2012 the Dilantin order was discontinued and was replaced. Further interview revealed that all physician orders and MAR's were printed by the facility and two nurses were responsible for checking for accuracy of all entries. The DON was not sure why this error was not detected at this accuracy checking point.	F 333		