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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING ______ B. WING ______	C 06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility medication error rate of was greater than 5% as evidenced by 3 medication errors out of 29 opportunities, resulting in a medication error rate of 10.3%, for 2 of 5 residents observed during medication pass. (Resident #3 and Resident #5) The findings included: 1. Resident #3 was admitted to the facility with cumulative diagnoses which included hypertension (high blood pressure). A review of the resident ' s June 2016 Physician ' s monthly orders included an order for furosemide 40 milligrams (mg) by mouth daily. On 6/16/16 at 7:37 am Nurse #2 was observed preparing and administering 8:00 am scheduled medications to Resident #3. These medications included furosemide 20 mg, one tablet. She then washed her hands, exited the room, initialed the medication administration record (MAR) to indicate that the medications had been given and began to return the blister packs to the Resident ' s drawer. At this point the surveyor brought her attention to the furosemide order, which was 40 mg by mouth daily, and the label on the blister pack, which was Furosemide 20 mg tablets. A	F 332	F 332 1. Resident # 3 receives medications as ordered by physician. A medication variance was completed for resident #3 and furosemide ordered clarified. A medication administration record to blister pack audit was performed by Omnicare on July 5th and 6th. Nurse # 2 received individualized re-education on 6 rights of medication administration and preventing medication errors. Nurse #2 received medication pass observation by Pharmacy Nurse Consultant on 6-24-16 and daily observations for two weeks by the Executive Director. Nurse #2 continues to have random medication pass observations. Follow up based on findings. Resident # 4 receives medications as ordered by physician. A medication variance was completed for resident #4. Oyster shell calcium 500mg with Vitamin D IU 200 was obtained and given to resident. Nurse # 3 resigned her position and no longer at the facility. A review was conducted of over the counter medications the facility has on hand to ensure over the counter medications ordered by the physician are available. Central Supply Clerk was	7/19/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/07/2016

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.

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F 332 Continued From page 1

review of the resident ' s June 2016 Physician ' s monthly orders included an order for furosemide 40 mg by mouth daily. The nurse went back and gave the missing furosemide 20 mg tablet to the resident.

During an interview with Nurse #2 on 6/16/16 at 7:45 am, she stated that she should have given two tablets of the furosemide instead of just one.

During an interview with the Administrator on 6/16/16 at 2:30 pm he stated that it was his expectation that all of the nurses follow the six rights of medication administration when giving medications; right resident, right drug, right dose, right route, right time and right documentation.

2. Resident #4 was admitted to the facility on 6/30/10 with cumulative diagnoses including osteoporosis (de-calcification of the bones).

A review of the Resident ' s June 2016 Physician ' s monthly orders included an order for Oyster Shell Calcium with Vitamin D 500 milligrams (mg)-200 IU one tablet by mouth twice daily.

On 6/16/16 at 7:59 am Nurse #3 was observed preparing and administering 9:00 am scheduled medications and one PRN medication (Tylenol) to resident #5. These medications included Oyster shell calcium 500 mg. A review of the resident ' s June 2016 Physician ' s monthly orders included an order for Oyster shell calcium with Vitamin D 500 mg-200 IU one tablet by mouth twice daily.

During an interview with Nurse #2 on 6/16/16 at 8:10 am the nurse stated that the Oyster shell calcium 500 mg did have Vitamin D in it and was the medication that was ordered.

F 332

educated on the process for ordering over the counter medications and maintaining par levels for over the counter medications on 7-1-16.

2. A physician order to medication cart audit was conducted to ensure each medication cart contained medications per physician order by 7-7-16. Nurses will be observed during medication pass utilizing medication pass worksheet to ensure accuracy with medication pass by 7-15-16. The Pharmacy Nurse Consultant completed medication pass observations on all current nurses on July 5th – 7th.

3. Licensed nursing staff will be re-educated on 6 rights of medication administration and preventing medication errors by 7-15-16. All licensed nursing staff will be re-educated on process for re-ordering medications to include process for obtaining over the counter medications by 7-15-16. The Director of Clinical Services or Supervisor will complete random medication pass observations of 3 nurses weekly for 12 weeks then monthly for 6 months utilizing the medication pass worksheet. The Director of Clinical Services will audit 10 residents' medications to physician orders to ensure the medication cart obtains the ordered medications for 12 weeks then monthly for 6 months.

4. The results of the medication pass observations and physician order to cart audits will be submitted to the QAPI Committee by the Director of Clinical Services for review by the IDT members each month for 6 months. The QAPI Committee will evaluate the effectiveness

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F 332	Continued From page 2 An interview with the Pharmacist for the facility on 6/16/16 at 8:30 am revealed that the medication that was given was not the same as the medication that was ordered and did not have Vitamin D as one of the ingredients. Inspection of the medication cart and medication storage room on 6/16/16 at 9:15 am revealed that there was no calcium with vitamin d in the facility. The Director of Nursing (DON) stated that the medication had been ordered and would be in the facility by the end of the day. During an interview with the Administrator on 6/16/16 at 2:30 pm he stated that it was his expectation that all of the nurses follow the six rights of medication administration when giving medications; right resident, right drug, right dose, right route, right time and right documentation.	F 332	and amend as needed.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		7/19/16

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F 520	Continued From page 3 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based On observation, record review and facility staff interviews, the facility ' s Quality Assessment and Assessment Committee failed to maintain procedures and monitor the interventions that the committee put into place in May 2016. This was for the recited deficiency which was originally cited on a complaint survey in May 2016 and on this follow-up and complaint survey. The deficiencies were in the area of a medication error rate of 5% or more. The continued failure of the facility during two surveys showed a pattern of the facility inability to sustain an effective Quality Assurance (QA) Program. The findings included: This tag was cross referenced to F 520. Based on observations, record review, and staff interviews, the facility medication error rate was greater than 5% as evidenced by 3 medication errors out of 29 opportunities, resulting in a medication error rate of 10.3%, for 2 of 5 residents observed during medication pass. (Resident #3 and Resident #5) F 520 was originally cited during the May 2016 a compliant survey. Based on observation, record review and staff interviews the facility failed to be free of a medication error rate of 5% or greater as	F 520	F 520 1. The Executive Director held a Quality Assurance Performance Improvement meeting on 6-30-16 with the Interdisciplinary Team including the Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities Director, Medical Records Director and Business Office Manager focusing on the citation of free of medication error rates of 5% or more. The ED will review Quality Assurance Performance Improvement Meeting with the Pharmacist with each monthly visit for 6 months. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance and maintaining error rate less than 5%. 2. During the Quality Assurance Performance Improvement on 6-30-16 the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of any identified deficiency to assure compliance and quality are maintained.	

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F 520	Continued From page 4 evidenced by 2 medication errors out of 34 opportunities resulting in a medication error rate of 5.88% for 2 of 3 residents observed during medication pass. An interview was conducted on 6/16/2016 at 11:00 am with the Administrator. The Administrator revealed his expectation of the Nurses was that each Nurse follow the 6 rights of medication administration for each resident. The administrator stated all the Nurses had been re-educated on medication administration. He also indicated that the Nurses were still being monitor and that " we have up to 16 weeks to monitor and audit our Nurses. " The Administrator indicated that he had and would continue to work on the Quality Assurance (QA) Program.	F 520	3. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be corrected as identified by the Executive Director and the Regional Director of Clinical Services. 4. The results of theses reviews will be submitted to the Quality Assurance Performance Committee by the Executive Director for review by Interdisciplinary members each month for 6 months. The Quality Assurance Performance Committee will evaluate the effectiveness and amend as needed.	