

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/CH			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and physician and staff interviews the facility failed to notify the physician of omitted and/or refused medication</p>	F 157	<p>F 157 Corrective action has been accomplished related to the alleged deficient practice in regards to Resident #2. Physician was notified on March 17, 2011 regarding omitted or refused medications. Clarification orders were received on March 17, 2011, to adjust medication times in order to receive medications on days of dialysis appointments. Director of Nursing (DON) discussed medication administration times with resident. Staff Development Coordinator (SDC) provided in service education to licensed nurses beginning March 17, 2011, regarding Policy and Procedure for notification of Physician for omitted or refused medications.</p> <p>Current residents have the potential to be affected by the alleged deficient practice. DON, Assistant Director of Nursing (ADON), RN Unit Managers conducted an audit of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for current residents to identify omitted medications beginning March 17, 2011. Physician was notified for any medications or treatments that were omitted or refused and new orders received as appropriate. SDC provided in service education beginning March 17, 2011 for licensed nurses regarding Policy & Procedure for</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	4-6-2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

ADMINISTRATOR

4-8-2011

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 closed, an approved plan of correction is requisite to continued program participation.

RECEIVED
APR 11 2011
BY: _____

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F 157 Continued From page 1
doses for one (1) of three (3) sampled residents. (Resident #2).

The findings are:

Resident #2 was admitted to the facility 01/25/2011 with diagnoses including End Stage Renal Disease on Dialysis, Diabetes Mellitus, Congestive Heart Failure, and Anemia. - Review of the admission Minimum Data Set (MDS), dated 02/01/11, Resident #2 was assessed as being cognitively intact for daily decision making.

Resident #2's March 2011 monthly "PHYSICIANS ORDER SHEET" (POS) and Medication Administration Record (MAR) revealed physician's orders, dated 01/23/2011, as follows:

- Norvir 100 milligram (mg) by mouth every other week twice daily
- Ziagen 300 mg by mouth twice daily
- Prezista 600 mg by mouth twice daily
- Isentress 400 mg by mouth twice daily

Resident #2's MAR from 03/01/2011 through 03/16/2011 revealed the following:

Norvir 100 mg - Ten (10) total doses were omitted including: Four 9:00 AM doses on 03/01/11, 03/03/11, 03/15/11, and 03/16/11. Six 5:00 PM doses on 03/01/11, 03/02/11, 03/04/11, 03/05/11, 03/15/11, and 03/16/11.

Ziagen 300 mg - Eight (8) total doses at 9:00 AM were omitted including: 03/01/11, 03/03/11, 03/07/11, 03/08/11, 03/10/11, 03/12/11, 03/15/11, and 03/16/11.

Prezista 600 mg - Eight (8) total doses at 9:00 AM

F 157

notification of Physician for omitted or refused medications.

Measures implemented to ensure that the alleged deficient practice does not recur include: SDC provided in service education for Licensed Nurses beginning March 17, 2011, regarding Policy and Procedure for notification of Physician regarding omitted or refused medications. DON, ADON, RN Unit Managers will review MAR's and TAR's daily for two weeks then three times a week ongoing to monitor for omitted or refused medications. Physician will be notified regarding omissions or refusals when identified. Medication Availability Log will be kept on each medication cart to identify medications are available as ordered. DON, ADON and RN Unit Managers will review Medication Availability Log daily to assure medications are available as ordered.

Director of Nursing to review and analyze data regarding notification of physician related to omitted or refused medications/treatments, identifying trends/patterns and report to Quality Assessment and Assurance Committee (QA&A) weekly for four weeks then monthly. The QA&A Committee will evaluate the effectiveness of the plan based on outcomes identified. The Committee will

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 BY: *MH*

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F 157	<p>Continued From page 2</p> <p>were omitted including: 03/01/11, 03/03/11, 03/07/11, 03/08/11, 03/10/11, 03/12/11, 03/15/11, and 03/16/11.</p> <p>Isentress 400 mg - Eight (8) total doses at 9:00 AM were omitted including: 03/01/11, 03/03/11, 03/07/11, 03/08/11, 03/10/11, 03/12/11, 03/15/11, and 03/16/11.</p> <p>On 03/16/2011 at 3:45 PM and interview was completed with Licensed Nurse (LN) #3, assigned to Resident #2 on the day shift. During the interview LN #3 reviewed the March 2011 MAR and confirmed omitted documentation and circled initials in the dosage signature boxes indicated that Resident #2's medications were not administered as scheduled and ordered. LN #3 stated Resident #2 sometimes refused his medications prior to Dialysis on Tuesdays, Thursdays, and Saturdays. LN #3 stated she had not notified the physician that Resident #2 had refused and/or missed prescribed medications. No explanation was given for not contacting the resident's physician.</p> <p>On 03/16/2011 at 4:25 PM an interview was completed with LN #4, assigned to Resident #2 on the afternoon/evening shift. During the interview LN #4 reviewed the March 2011 MAR and confirmed if initials were not in the dose signature boxes it would indicate that medications were not administered. LN #4 stated to her knowledge the physician had not been notified regarding Resident #2's refused and/or omitted medications. No explanation was given for not contacting the resident's physician.</p> <p>On 03/16/2011 at 4:35 PM an interview was completed with the facility Director of Nursing</p>	F 157	<p>develop and implement additional interventions for negative trends to ensure continued compliance.</p> <p>“ Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.”</p>	

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F 157	Continued From page 3 (DON). During the interview the DON stated LN staff were responsible for notifying the physician when residents refused medications and/or when medications were not administered.	F 157			
F 281 SS=D	On 03/17/2011 an interview was completed with Resident #2's facility physician/Medical Director. During the interview the physician stated all medications should be administered as ordered and that he would not want Resident #2 or any other resident to miss their medications. The physician stated that he was available twenty four hours a day and should be notified of omitted and/or refused medications. The physician confirmed Resident #2's medications were not administered as ordered and prior to 03/16/2011 he had not been notified. The physician provided no further comment regarding concerns related to Resident #2's omitted/refused medications. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and physician and staff interviews the facility failed to accurately transcribe a physician's order resulting in medication not administered as ordered for one (1) of three (3) sampled residents. (Resident #2). The findings are: Resident #2 was admitted to the facility 01/25/2011 with diagnoses including End Stage Renal Disease on Dialysis, Diabetes Mellitus,	F 281			

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F 281	<p>Continued From page 4 Congestive Heart Failure, and Anemia.</p> <p>Review of Resident #2's medical record revealed a physician's admission order dated 01/25/2011 for Norvir 100 milligram (mg) to be administered by mouth twice daily.</p> <p>On Resident #2's February 2011 monthly "PHYSICIANS ORDER SHEET" (POS) and Medication Administration Record (MAR) the 01/25/2011 physician's order was transcribed as Norvir 100 mg to be administered by mouth "Every Other Week" BID (twice daily). The February POS and MAR revealed a checkmark by the Norvir order, the signature of Licensed Nurse (LN) #1, and the date (01/30/2011) indicating that the order was reviewed and accurate.</p> <p>On the February 2011 MAR Norvir 100 mg, ordered 01/25/2011, was scheduled to be administered to Resident #2 by mouth on 02/01/2011 and 02/15/2011 at 9:00 AM and 5:00 PM. All other days on the MAR during February were marked with "X" indicating that the medication was not scheduled to be administered. The transcription error of the 01/25/2011 order resulted in fifty two (52) doses of Norvir not being scheduled or administered to Resident #2.</p> <p>On Resident #2's March 2011 monthly POS and MAR for Resident #2 the 01/25/2011 physician's order included for Norvir 100 milligram (mg) to be administered by mouth "Every Other Week" BID (twice daily). The March POS revealed a checkmark by the Norvir order, the signature of LN #2, and the date (02/25/2011) indicating that the order was reviewed an accurate.</p>	F 281	<p>F 281 Corrective action has been accomplished related to the alleged deficient practice in regards to medication administered per physician orders. Director of Nursing (DON) notified physician regarding administration frequency of antiviral medication (Norvir). Orders were received to restart Norvir 100mg by mouth twice daily on 3/17/2011. Staff Development Nurse (SDC) began in service education on 3/17/11, for licensed nurses regarding Policy and Procedure for transcription and reconciliation of medications. In service education via Webinar on 3/15/2011 or licensed nurses regarding training for the use of the Care Central program to key in medications into the system to develop monthly Physician orders, Medication Administration Records (MAR's) and Treatment Administration Records (TAR's).</p> <p>Current and new admitted residents have the potential to be affected by the alleged deficient practice. DON, Assistant Director of Nursing (ADON), and RN Unit Managers conducted and audit beginning 3/17/11, of current resident charts comparing Physician orders to the MAR's and TAR's for accuracy of orders. DON, ADON, and RN unit managers notified Physician for any discrepancies that were identified. DON, ADON and RN unit managers began</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	4-6-2011

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F 281	Continued From page 5 On the March 2011 MAR the Norvir order was handwritten and scheduled to be administer at 9:00 AM and 5:00 PM daily from 03/01/11 through 03/05/11 stopping on 03/06/11 and resuming again on 03/13/11 and continuing through 03/19/11. Norvir was not scheduled to be administered from 03/06/11 through 03/12/11 as indicated by an "X" in the signature boxes on the MAR. The transcription error of the 01/25/2011 physician's order resulted in twenty eight (28) doses of Norvir not being scheduled or administered to Resident #2. On 03/17/2011 at 2:15 PM an interview was completed with the Director of Nursing (DON) regarding the Norvir transcription errors on the Physicians Order Sheets (POS) and MARs for February 2011 and March 2011. The DON confirmed transcription errors on the administration frequency of Norvir 100 mg, ordered 01/25/2011, occurred on the February and March 2011 POS and MAR and Norvir was not scheduled for administration as ordered. The DON stated, as a result of the transcription errors and medication scheduling, Resident #2 did not receive Norvir 100 mg twice daily as ordered on 01/25/11. The DON stated all monthly POS and MARs were generated, completed, and verified by facility staff. The DON stated Resident #2's 01/25/2011 order for Norvir 100 mg was incorrectly reflected on the February 2011 POS and MAR due to a computer keying error by Licensed Nurse (LN) #6. The DON stated LN #6 entered the order into the computer incorrectly and the error was not caught when the POS and MARs were generated and reviewed. The DON stated each month LN staff were responsible for reviewing the POS and MARs for accuracy and	F 281	comparing telephone orders to MAR's and TAR's daily to assure continued accuracy of transcription of medications as ordered. SDC began in service education on 3/17/11, for licensed nurses regarding Policy and Procedure for transcription of medications/treatments onto MAR's and TAR's. Measures implemented to ensure that the alleged deficient practice does not recur include: SDC to provide in service education for licensed nurses regarding Policy and Procedure for transcription of orders onto MAR's and TAR's. SDC will provide Care Central training update for staff responsible to key in information such as medications and treatments into the computer system and procedure for end of month reconciliation of Physician orders, which includes comparing orders to the prior month Physician orders. DON, ADON, and RN unit managers will review telephone orders daily and compare to MAR's and TAR's for accuracy. Physician will be notified regarding discrepancies identified. DON and ADON will conduct audits of ten charts per week, comparing Physician orders to previous months orders and MAR's and TAR's for transcription accuracy and end of month reconciliation accuracy, for four weeks then monthly for 3 months or until continued compliance has been achieved. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 281	<p>Continued From page 6</p> <p>making corrections as indicated. The interview further revealed the Norvir transcription error should have been recognized by LN #1 and LN #2 during the monthly review of the February and March 2011 POS and MARs.</p> <p>On 03/17/2011 at 2:55 PM an interview was completed with LN #2. During the interview LN #2 confirmed on 02/25/2011 she was responsible for reviewing and approving the March 2011 POS and MARs. LN #2 stated on the March POS and MAR Resident #2's Norvir 100 mg, ordered 01/25/2011, read Norvir 100 mg by mouth Every Other Week BID (twice daily)." LN #2 stated on the March MARs Norvir 100 mg was scheduled to be administered twice daily for one (1) day every other week (2 days monthly). LN #2 stated she interpreted the order differently and on 02/25/2011 rewrote and scheduled the Norvir to be administered at 9:00 AM and 5:00 PM starting 03/01/11 and continue daily through 03/05/11, stopping on 03/06/11, and resuming on 03/13/11 for seven (7) days. LN #2 stated she did not refer to the original order of 01/25/11 or clarify the Norvir order prior to rewriting the order and scheduling the medication. LN #2 confirmed the 01/25/2011 Norvir order on Resident #2's March 2011 POS and MAR were incorrect and Norvir 100 mg should have been to be administered twice daily by mouth, every day.</p> <p>On 03/17/2011 at 3:20 PM an interview was completed with LN #1. During the interview LN #1 stated Resident #2's, 01/25/2011, Norvir 100 mg was transcribed incorrectly to the February 2011 POS and MAR. LN #1 stated Resident #2 was ordered Norvir 100 mg to be administered by mouth twice daily, every day. During the interview LN #1 confirmed on 01/30/2011 she was</p>	F 281	<p>DON, ADON, RN Unit Managers to review and analyze data regarding transcription irregularities, identifying trends/patterns and report to Quality Assurance and Assessment (QAA) committee weekly for four weeks then monthly. The QAA committee will evaluate the effectiveness of the plan based on outcomes identified. The QAA committee will develop and implement additional interventions for negative trends to ensure continued compliance.</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>		

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F 281	Continued From page 7 responsible for reviewing and approving the February 2011 POS and MAR for Resident #2. LN #1 stated she did not compare the February POS and MAR to the original physician's orders as required therefore the transcription error was not recognized and corrected. The interview revealed Resident #2's Norvir order was entered incorrect by LN #6 and she (LN #1) would have caught the error had she referenced the original 01/25/2011 orders as required.	F 281		
F 428 SS=D	LN #6 was not available for interview regarding the transcription error. 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, staff interviews and the consultant pharmacist interview the pharmacist failed to bring a discrepancy related to dosing of a medication for one (1) of three (3) sampled residents. (Resident #2). The findings include: Resident #2 was admitted to the facility on 1/25/2011 with an admitting diagnoses including	F 428		

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F 428	<p>Continued From page 8</p> <p>History of End Stage Renal Disease (ESRD) on Hemodialysis and Diabetes Mellitus. A review of Resident #2's medication included four (4) combination medications for a treatment initiated prior to admission. All these medications were continued at the time of admission and were renewed each month. The medication treatment was a standard combination of drugs complementing each other to arrest the progress of the disease process. A review of the admission orders for these medications revealed that one of the combination medication Norvir (Ritonavir) 100mg one capsule was ordered to be given orally two times daily with other three medications. The review of the MAR revealed that this medication was to be administered at 9:00 AM and 5:00 PM.</p> <p>Further review of the February and March 2011 monthly "PHYSICIANS ORDER SHEET" (POS) and Medication Administration Record (MAR) for Resident #2 revealed the Norvir order was wrongly transcribed and administered. In the February 2011 POS and MAR's it was written to be administered as:</p> <ul style="list-style-type: none"> "Norvir 100mg Softgel Cap (Capsule) 1 Capsule by mouth (PO) Every Other Week BID" <p>The MAR indicated that for the whole month February 2011, Resident #2 received Norvir 100mg one dose on 2/1/2011 at 5:00 PM and on 2/15/2011 one dose at 9:00 AM and one dose at 5:00 PM. And all other days had the mark 'X' indicating not to be administered. The review revealed that Resident #2 missed 52 doses in February 2011.</p> <p>In the month of March 2011 POS and MAR's Norvir was wrongly written to be administered as:</p> <ul style="list-style-type: none"> "Norvir 100mg Softgel Cap (Capsule) 1 Capsule by mouth (PO) Every Other Week BID" 	F 428	<p>F 428</p> <p>Corrective action has been accomplished related to the alleged deficient practice in regards to Resident #2 receiving antiviral medication (Norvir) as ordered by Physician. Director of Nursing (DON) notified Physician on 3/17/11, regarding missed doses of Norvir, and new orders were received to restart medication as ordered, Norvir 100mg by mouth twice daily. Staff development nurse (SDC) provided in service education beginning 3/17/11, for licensed nurses regarding Policy and Procedure for transcribing medications, reconciliation of end of month orders and notification of physician regarding missed or refused medications. Pharmacy liaison reviewed Policy and Procedure with Omni Care Pharmacist regarding expectation of consulting Pharmacist to review charts monthly and report irregularities, including transcription errors and/or omitted or refused medications, to DON and Physician timely.</p> <p>Current residents and newly admitted residents have the potential to be affected by the alleged deficient practice. DON, Assistant Director of Nursing (ADON), RN unit managers conducted an audit beginning 3/17/11, comparing Physician orders to the Medication Administration Records (MAR's) and Treatment Administration Records (TAR's).</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	4-6-2011	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/CH			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	
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F 428	<p>Continued From page 9</p> <p>Review of the MAR from 03/01/11 through 03/05/11 revealed no documentation in the signature boxes for the 9:00 AM dose on 03/01/11 and 03/03/11 or the 5:00 PM dose on 03/01/11, 03/02/11, 03/04/11, and 03/05/11. Further review of the MAR from 03/14/11 through 03/17/11 revealed no documentation for the scheduled 5:00 PM dose on 03/13/11, 03/14/11, and 03/15/11. Documentation for the 9:00 AM dose on 03/15/11 and 3/16/11 included circled initials in the signature boxes. Review of documentation on the back of the MAR revealed a comment dated 03/15/11 that read "Resident refused some meds (medications) before Dialysis." The review revealed that Resident #2 missed 16 doses of Norvir 100mg in the month of March 2011. No other documentation was noted in the medical record of Resident #2 for these missed doses.</p> <p>A review of the monthly pharmacy progress notes by the consultant pharmacist revealed that Resident #2's medical chart was reviewed for medication monitoring on 2/3/2011 and on 3/3/2011. The review did not reveal any comments on the missed or inappropriate dose administration of Norvir 100mg doses.</p> <p>An interview with Assistant Director of Nursing (ADON) on 3/17/2011 at 12:55 PM revealed Licensed Nursing staff were responsible for reading administration directions on the pharmacy label as well as the monthly MAR when administering residents' medications. The ADON stated LN staff was responsible for contacting the physician for clarification of discrepancies on the medication label and the MAR and making corrections as indicated.</p>	F 428	<p>Physician was notified regarding discrepancies that were identified. SDC began in service education on 3/17/11, for the licensed nurses regarding Policy and Procedure for transcribing medications, reconciliation of end of month orders and notification of physician regarding missed or refused medications. Pharmacy liaison reviewed Policy and Procedure with Omni Care Pharmacist regarding expectation of consulting Pharmacist to review charts monthly and report irregularities, including transcription errors and/or omitted or refused medications, to DON and Physician timely.</p> <p>Measures implemented to ensure that the alleged deficient practice does not recur include: SDC began in service education on 3/17/11, for the licensed nurses regarding Policy and Procedure for transcribing medications, reconciliation of end of month orders and notification of physician regarding missed or refused medications. Pharmacy liaison reviewed Policy and Procedure with Omni Care Pharmacist regarding expectation of consulting Pharmacist to review charts monthly and report irregularities, including transcription errors and/or omitted or refused medications, to DON and Physician. DON, ADON, and RN Unit managers will compare telephone orders daily beginning</p> <p>" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	

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F 428	<p>Continued From page 10</p> <p>Further a follow up interview was completed on 03/17/2011 at 2:15 PM with the Director of Nursing (DON) regarding the Norvir transcription errors on the Physicians Order Sheets (POS) and MARs for February 2011 and March 2011. The DON was unaware of the February and March transcription errors and the pharmacist reviewing the POS and MAR's had not brought this discrepancy to her attention.</p> <p>An interview with the consultant pharmacist on 3/17/2011 at 5:07 PM revealed that it was his usual practice to review all POS and MAR's for all residents to find any discrepancy in dosing or administration frequency of medications. The interview revealed that for Resident #2 the pharmacist did not notice the transcription errors related to Norvir 100mg and had missed the improper dosing or the errors in Norvir 100mg dosing. The interview revealed that he was aware that the correct dose of Norvir 100mg was two times daily with other medications.</p> <p>LN #6 who transcribed the physician orders was not available for interview during the survey.</p>	F 428	<p>3/17/11 to MAR's and TAR's for accuracy of transcription. Physician will be notified for any discrepancies identified. DON or designee will review Pharmacy consultant notes/recommendations within 72 hours of receipt and follow up as indicated. DON and ADON will conduct audits of ten charts per week, comparing Physician orders to previous months orders and MAR's and TAR's for transcription accuracy and end of month reconciliation accuracy, for four weeks then monthly for 3 months or until continued compliance has been achieved.</p> <p>DON and ADON to review and analyze data regarding Pharmacist recommendations and audits performed for transcription accuracy, identifying trends/patterns and report to Quality Assurance and Assessment (QAA) committee weekly for four weeks then monthly. The QAA committee will evaluate the effectiveness of the plan based on outcomes identified. The QAA committee will develop and implement additional interventions for negative trends to ensure continued compliance.</p> <p>" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	