STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

(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	483.20(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 record review, staff interviews, resident interview, and nephrology center staff interview, the facility failed to follow physician's orders prior to a surgical procedure for 1 of 3 sampled residents (resident #1). Findings include: Resident #1 was admitted to the facility on 2/17/04 with multiple diagnoses including end-stage renal disease (ESRD), hypertension, diabetes, and esophageal reflux. Review of the resident's MDS (minimum data set) dated 6/21/11 revealed the resident was cognitively intact. The MDS indicated the resident required assistance with all activities of daily living (ADL) except eating. The resident required setup help only with eating. Record review revealed instructions dated 6/27/11 from the nephrology center for the resident to return on 7/1/11 at 9AM for an angiogram. The instructions read in part "do not eat or drink after midnight the night before your procedure." Record review revealed a physician's order dated 6/27/11 which read "NPO (nothing by mouth) p (after) mid noc (midnight) on 6/30/11 for procedure on 7/1/11 at 9AM." Review of the resident's medication administration record (MAR) revealed a	F 281	F 281 1. Resident #1 has no current physician order for NPO (nothing by mouth). Nurse #1 is no longer employed at this facility. 2. Residents with physician orders for NPO have the potential to be affected by alleged deficient practice. A Review of current resident records revealed no current physician orders for NPO and therefore no other resident has been identified as having the potential to be affected by alleged deficient practice. 3. Systems/Training in place to ensure continued compliance are: • The staff development coordinator, Director of Nursing(DON), Assistant Director of Nursing (ADON) or unit manager have completed the following in-services to licensed nurses and certified nurse assistants (C.N.A).on 7-20-11 and 7-21-11 and to the facility dietary manager and dietary aides on 7/22/11.	8-23-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 8-5-11

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 281	Continued From page 1 handwritten entry which read "NPO p MN (midnight) 6/30/11." There was no date or signature on the entry. Review of the resident's Meal Consumption Record revealed she ate breakfast on 7/1/11, with 75% intake documented by her nursing assistant. In an interview on 7/20/11 at 3:01PM, the nursing assistant (NA#1) that regularly cared for resident #1 stated she had worked on 7/1/11 but didn't recall if the resident had breakfast that day. She stated the resident's intake would be charted in the ADL book. NA#1 stated if the resident was NPO, the nurse would have written NPO on the assignment sheet and posted it on the resident's door. She didn ' t remember if NPO had been posted that day for resident #1. In an interview on 7/20/11 at 3:20PM, nurse #1 (unit manager) stated the nephrology center called about 7:50AM on 7/1/11 and asked if the resident could come early for her procedure. Nurse #1 stated the resident received a tray about 7:50AM but did not eat a full meal. She indicated the intake was documented on the ADL sheet. Nurse #1 stated the dietary department did not receive the NPO order and did not know to hold the resident's tray. The NPO diet slip was supposed to be posted on the daily assignment sheet and at the nursing station. Nurse #1 stated "the procedure was not carried through that day," and the nurse on duty did not know about the NPO order. In an interview on 7/20/11 at 4:03PM, the nurse (nurse #3) that took the NPO order stated she was trained during orientation. She stated	F 281	"Facility policy and procedure for ensuring the implementation of a physicians order for NPO." The physicians order will be transcribed onto a diet order and sent to the dietary department. This order will be communicated to the dietary staff and posted on the dietary bulletin board. A copy of the order shall also be posted at the nurse's station and written on the 24 hour nursing report. The C.N.A. assignment sheet will reflect the order for NPO the day that it is implemented. The night before the order is to be initiated a sign indicating NPO status will be posted on the resident room door and removed as soon as the order has been carried out. • This procedure will be incorporated into the new employee orientation content.	7-23-11

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F 281	Continued From page 2 changes in diet orders were put on the 24 hour report, sent to the dietary department, and reported to the oncoming nurse at the change of shift. She stated the nursing staff relayed any diet changes verbally to the nursing assistants but the information was not posted anywhere for them. Nurse #3 stated she didn't remember if she had reported resident #1's NPO status to the dietary department or placed it on the 24 hour report. Nurse #3 stated she reported the order change to the next shift but didn't remember to whom. In an interview on 7/20/11 at 4:36PM, the dietary manager stated changes in diet orders were sent on a dietary communication slip from the nursing staff to the kitchen. The manager stated she posted the changes on the communication board in the kitchen for all cooks and assistants. She stated the cooks called the nursing station to verify all changes. The dietary manager checked the communication slips and stated she had not received any orders for resident #1 regarding her change to NPO status on 7/1/11. In an interview on 7/20/11 at 5:20PM, resident #1 indicated she had "blacked out" at the nephrology center on 7/1/11. The resident stated she was admitted to the hospital with low blood sugar and low blood pressure. The resident recalled eating most of her breakfast that morning. The resident was not aware she was to have nothing by mouth before her procedure. In an interview on 7/20/11 at 5:31PM, the Director of Nursing (DON) stated the staff was trained by the Staff Development Coordinator and unit managers during orientation, which included a	F 281	• Nursing and Dietary staff who fail to follow the policy will either re-in serviced and/or disciplined as indicated. 4. Monitoring in place to ensure continued compliance is: The DON/ADON/Unit Manager and/or Staff Development Nurse will monitor each new physician's order for NPO for 3 months. The DON will report trends or patterns of these findings to the monthly QA Committee for three (3) months. The Committee will adjust this plan based on those findings.	7-23-11

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F 281	Continued From page 3 review of the facility's policies and procedures. The DON stated for NPO orders, the order slip went to the dietary department, was posted at the nursing station, and "NPO" was placed on the resident's door. She stated NPO was also placed on the ADL assignment sheets for the nursing assistants. She stated the nurses have been inserviced and should know how to handle NPO orders. Her expectation was for the staff to read and follow the physicians' orders, to carry out new orders from beginning to end, and to include any order changes on the 24 hour report and MARS. In telephone interview on 7/22/11 at 9:45AM, the nurse (nurse #2) responsible for the resident's care on 7/1/11 stated it was his first day working on that hall. He stated the resident asked for her medications that morning. Nurse #2 indicated he gave the resident her oral medications, 5 units of insulin, and applied a clonidine patch as ordered on the MAR. The nurse stated there was no NPO order written on the MAR. He added the nurse on duty before him did not report the resident was NPO at change of shift. Nurse #2 stated the resident received a tray from dietary and ate breakfast but he wasn't sure how much. In a telephone interview on 7/29/11 at 9:54AM, the nurse (nurse #4) responsible for the resident's care at the nephrology center stated the resident arrived at 9:10AM on 7/1/11 for an angiogram. The nurse acknowledged orders had been sent on 6/27/11 instructing the nursing facility not to give the resident anything to eat or drink after midnight the night before the scheduled procedure. Nurse #4 stated the resident had received her usual medications at the nursing facility that morning as there was no order to hold	F 281		

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F 281	Continued From page 4 them. She stated this procedure did not require general anesthesia. The nurse stated NPO orders were given because the medications given prior to the procedure, Percocet (narcotic analgesic) and Valium (sedative/anxiolytic), caused nausea and vomiting in some patients. She added the patients also had to lie flat during the procedure. Nurse #4 stated the transport team told her resident #1 had eaten breakfast that morning. The resident also had crumbs around her mouth and on her clothing. The nurse stated the resident experienced a low blood sugar and hypotension prior to the procedure, and was sent to the emergency room for evaluation. The nurse indicated the resident had not received any Percocet or Valium. Record review revealed the resident was admitted to the hospital 7/1/11 with diagnoses of hypotension, hypoglycemia, and altered mental status. Record review revealed an angiogram was performed during the resident's hospitalization.	F 281		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	F329 1. Resident #1 is currently not receiving catapres or any other type of transdermal patches per physician's orders.	7-23-11

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F 329	Continued From page 5 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, resident interview, and nephrology center staff interview, the facility failed to properly administer a transdermal patch, resulting in an excessive dose of clonidine, for 1 of 3 sampled residents whose medications were reviewed (resident #1). Findings include: The Facility's policy "Transdermal Drug Delivery System (patch) Application Procedures," undated, read in part: "Purpose - to administer medication through the skin for continuous absorption while the patch is in place, through proper placement of the patch and care of the application site. Procedures - 3. Remove old patch from body. 4. Cleanse area of old patch with alcohol wipe. 5. Remove new patch from package and envelope. 6. Apply new patch 8. Document administration and placement site on MAR (medication administration record)." Resident #1 was admitted to the facility on	F 329	Nurse #1 is no longer employed at this facility. 2. Residents with physician orders for catapres and any other transdermal patch application have the potential to be affected by alleged deficient practice. Therefore residents with current orders for transdermal patches MAR and physician orders were reviewed by the facility Regional Clinical Nurse on 7-20-11 and no other residents were found to be affected by alleged deficient practice. On 7-20-11 the facility medication nurses observed every resident with current orders for transdermal patches to determine that the number of patches applied to the resident were correct and consistent with physician orders and are not affected by alleged deficient practice. 3. Systems/Training in place to ensure continued compliance are: • The staff development coordinator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or unit manager	7-23-11

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F 329	Continued From page 6 2/17/04 with multiple diagnoses including end-stage renal disease (ESRD), hypertension, coronary artery disease, history of cerebrovascular accident (CVA), and diabetes. Review of the resident's clinical record revealed physician orders dated 6/1/11 for Catapres (clonidine) (antihypertensive) 0.1mg (milligram) patch apply to skin every Friday, Cardura (antihypertensive) 10mg daily, Lisinopril (antihypertensive) 20mg daily, Lopressor 200mg (antihypertensive) twice daily, Norvasc (antihypertensive) 10mg twice daily, and Isordil (vasodilator) 20mg three times daily. Review of the MDS (minimum data set) dated 6/21/11 revealed the resident was cognitively intact. The MDS indicated no signs or symptoms of delirium, mental status changes, depressed mood, or behaviors. The MDS indicated the resident required assistance with all activities of daily living except eating. Lexicomp's Drug Information Handbook, 14th edition, read in part: "clonidine - Warnings/Precautions: use with caution in patients with severe coronary insufficiency, CVA, or chronic renal insufficiency. Elderly may be at greater risk for CNS (central nervous system) depressive effects. Adverse reactions - drowsiness, dizziness, hypotension, lethargy, and bradycardia. Overdosage/Toxicology - symptoms include bradycardia, CNS depression, respiratory depression. Monitoring parameters - blood pressure, mental status, heart rate." A study titled "Pharmacokinetics of transdermally delivered clonidine," in Clinical Pharmacology and Therapeutics, September 1985, included	F 329	have completed the following in-services to licensed nurses on 7-20-11 and 7-21-11. "Documentation requirements for the administration of transdermal patches to include checking for placement of previously administered patches and ensuring that the previous patch is removed before applying new patch. If the previously applied patch is not readily visible the nurse shall perform a full body assessment to ensure location and removal of patch." • These in-service topics will be incorporated into the new employee orientation content. • Licensed staff who fail to follow the policy will either re-in serviced and/or disciplined as indicated by the facility DON or administrator.	7-23-11

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F 329	Continued From page 7 information regarding clonidine patches left on for more than 7 days. The researchers projected a remaining reservoir in clonidine patches at 20-40% of the original concentration after 7 days of application. The study suggested if a second patch were applied while patients continued to wear the first patch beyond the recommended 7-day dosing interval, it could result in increased plasma concentrations of clonidine. Review of the resident's MAR revealed an entry, undated, which read "Catapres patch 0.1mg apply to skin q (every) Friday." The administration time was 9AM. According to the MAR, the patch was applied on 6/24/11 to the mid-chest, and on 7/1/11. The administration site was not charted for 7/1/11. Record review revealed the resident was scheduled for an angiogram at the nephrology center on 7/1/11 at 9AM. There was no order to hold the resident's medications. Review of the MAR revealed the resident received Cardura 10mg, Lisinopril 20mg, Norvasc 10mg, Lopressor 200mg, and Isordil 20mg the morning of 7/1/11. Record review revealed the resident's vital signs prior to departure to the nephrology center on 7/1/11 were: blood pressure 148/64, pulse 55, respirations 18, and oxygen saturation 99%. Record review of the Nursing care report from the nephrology center dated 7/1/11 revealed the resident was found to have a low blood sugar and then became hypotensive. Blood pressures of 83/53 and 82/50 were documented. The resident was given approximately 250cc (cubic centimeters) of normal saline and sent to the	F 329	• A new procedure for documenting the removal of transdermal patches on the MAR was instituted on 7-21-11. 4. Monitoring in place to ensure continued compliance is: The DON/ADON/Unit Manager and/or Staff Development Nurse will audit the documentation and application of transdermal patches of 5 residents weekly for one month and then monthly times three (3) months. The DON will report trends or patterns of these findings to the monthly QA Committee for three (3) months. The Committee will adjust this plan based on those findings.	7-23-11

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F 329	Continued From page 8 emergency room. The hospital History and Physical dated 7/1/11 revealed the resident was at the nephrology center, became combative with the staff, and was found to be hypoglycemic and hypotensive. The report read in part "upon arrival to the ED (emergency department) she was still not at her baseline and was found to have 2 Catapres patches on. Her last BP (blood pressure) was 70 sys (systolic)...She was also found to be bradycardic in the 50's." The ED physical exam revealed blood pressure of 104/41, pulse 53, temperature 97.7, respirations 16, and oxygen saturation level of 99%. The exam revealed the resident was cooperative and able to answer questions. The ED physician's Impression/Plan read in part: Hypotension - pt (patient) to be admitted for close cardiac monitoring...she had on 2 Catapres patches which is most likely contributing to her low BP...currently BP stable...AMS (altered mental status) - most likely secondary to hypotension and hypoglycemia. Review of the Hospital Discharge Summary dated 7/7/11 revealed discharge diagnoses which included hypotension. Review of the discharge summary revealed the resident's clonidine and cardura were discontinued. Record review revealed a facility Medication Error Report for clonidine was completed 7/7/11 for resident #1 by the Director of Nursing (DON). In an interview on 7/20/11 at 3:20PM, nurse #1	F 329		

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F 329	Continued From page 9 (unit manager) stated the resident's Catapres patch was ordered once weekly on Fridays and was scheduled to be applied 7/1/11. She indicated the policy was to remove the old patch before applying a new one and to change sites every week. Nurse #1 reviewed the MAR and acknowledged a patch was applied on 7/1/11, with no site documented, and on 6/24/11 to the resident's mid-chest area. In an interview on 7/20/11 at 5:20PM, resident #1 indicated she had "blacked out" at the nephrology center on 7/1/11. The resident stated she was admitted to the hospital with low blood sugar and low blood pressure. The resident did not recall getting her patch applied that morning. She did not recall removing the old patch herself or telling the nurse "I removed it." In an interview on 07/20/11 at 5:31PM, the DON stated the staff received training on proper medication administration during orientation by the Staff Development Coordinator and the unit managers. For transdermal medications, she stated the facility policy was to remove the old patch before applying a new one. She stated the nurse should have asked a second person to check for the old patch before placing a new one on resident #1. Her expectation was for staff to date the patches, chart where they were applied, and to thoroughly examine the residents to ensure the old patches were removed before applying new ones. In a telephone interview on 7/21/11 at 10AM, the nurse (nurse #2) who applied the Catapres patch on 7/1/11 stated he searched the resident's chest, shoulders, and arms and did not find the	F 329		

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F 329	Continued From page 10 old patch. Nurse#2 indicated the resident told him "I took it off." Nurse #2 stated he applied the new patch to the resident's left front chest area. He stated the resident was alert and oriented at that time with no signs of adverse effects to her medications. In a telephone interview on 7/29/11 at 9:54AM, the nurse (nurse #4) responsible for the resident's care at the nephrology center stated the resident arrived at 9:10AM on 7/1/11 for an angiogram. Nurse #4 stated the resident had received her usual medications at the nursing facility that morning as there was no order to hold them. She stated the resident was alert and talking upon arrival to the center. The resident's pulse was 60 and her blood pressure was 132/60. The nurse was monitoring the resident at her bedside prior to the angiogram and noted a change in her mental status. Nurse #4 stated the resident had not received her preparatory medications of Percocet (analgesic) and Valium (sedative). The resident was found to be hypoglycemic and then became hypotensive. The nurse indicated the resident's BP was 83/53. A repeat BP was 82/50. The physician was notified and instructed the staff to call 911. Nurse #4 stated she administered a 500cc normal saline solution bolus before EMS arrived and transported the resident to the hospital. Nurse #4 stated she had observed one patch on the resident but did not recall the location or whether it was dated or signed. The nurse who completed the initial ED assessment and discovered two clonidine patches on the resident no longer worked at the hospital and was unavailable for interview.	F 329		

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