

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

PRINTED: 12/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/06/2012
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NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE RD CHARLOTTE, NC 28214
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F 000	<p>INITIAL COMMENTS</p> <p>The Division of Health Service Regulation, Nursing Home Licensure and Certification Section, conducted a complaint investigation on 11/19/12 and 12/05/12 - 12/06/12. Immediate Jeopardy began on 09/04/12 in 483.25 when the facility failed to obtain Dilantin blood levels for Residents #1 and #3 and began on 09/24/12 in 483.60 when the consultant pharmacist conducted a monthly drug review for Residents #1 and #3 and failed to report missing laboratory monitoring of Dilantin blood levels. The Administrator was notified of the immediate jeopardy on 12/05/12 at 3:45 PM. Immediate jeopardy was removed on 12/06/12 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level to ensure monitoring of systems put in place.</p>	F 000	<p>The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein.</p> <p>To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.</p>	
F 329 SS=J	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition</p>	F 329	<p>F329 The facility does understand that each resident's drug regimen must be free from unnecessary drugs and with adequate monitoring.</p>	1/3/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> MSBS, LONA	TITLE ADMINISTRATOR	(X6) DATE 12/13
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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 12-21-12 mh



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NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1736 TODDVILLE RD CHARLOTTE, NC 28214		
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F 329	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, hospital records and facility staff interviews, the facility failed to monitor Dilantin blood levels for 2 of 7 sampled residents receiving anticonvulsant therapy. (Resident #1 and #3).</p> <p>Immediate Jeopardy began 09/04/12 when the facility failed to obtain a Dilantin level on Resident #1 and the resident subsequently had a seizure which resulted hospitalization for status epilepticus and acute respiratory failure. Resident #1 was admitted to the intensive care unit of the hospital on a ventilator. In addition, the facility failed to obtain a Dilantin level on Resident #3 on 09/07/12 and the resident subsequently was admitted to the hospital with Dilantin toxicity. Immediate Jeopardy was removed on 12/06/12 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee training.</p>	F 329	<p>How the corrective action will be accomplished for the resident(s) affected.</p> <p>Resident #1, affected by the deficient practice, was sent to the hospital on 10/04/2012 with seizures and was subsequently discharged from the hospital on 10/17/12. The nurse who made the transcription error and the nurse who failed to execute a thorough 24-hour chart check were both counseled. The nurse was further educated and counseled that it is the responsibility of the nursing staff to complete the lab tracking form and requisition, not the unit supervisor.</p> <p>Resident #3, affected by the deficient practice, was sent to the hospital on 9/27/2012 and was evaluated in the emergency room for dizziness and subsequently readmitted to Charlotte Health Care Center on the same day.</p>	1/3/13	

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F 329	<p>Continued From page 2</p> <p>The findings are:</p> <p>1. Resident #1 was admitted to the facility on 08/29/12 with diagnoses that included seizure disorder. Review of hospital records prior to admission to the facility revealed Resident #1 had a Dilantin level on 08/27/12 of 12.1 microgram per milliliter (ug/ml) and on 08/28/12 of 10.3 ug/ml. Further review of hospital records revealed the resident was ordered three (3) capsules of Dilantin (an anti-seizure medication) 100 milligrams (mg) (totaling 300 mg) each night at bedtime.</p> <p>Review of physician orders dated 08/28/12 revealed an order for "Dilantin extended release 100 milligrams, 3 capsules by mouth every night, diagnosis epilepsy." This was an order written upon the resident's admission to the facility.</p> <p>Further review of physician orders dated 08/29/12 revealed an order for a Dilantin level in one week (09/04/12). On this same order two other labs were ordered to be drawn in one week, a complete blood count (CBC) and a basic metabolic panel (BMP).</p> <p>Review of Resident #1's care plan 08/30/12 revealed no plan of care for seizure disorder or monitoring of drug levels for Dilantin related to her seizure disorder.</p> <p>Further review of Resident #1's medical record revealed no result of the Dilantin level that was to be drawn on 09/04/12. Lab results indicated the two other labs that were to be drawn on 09/04/12, the CBC and BMP, had been drawn and the results were in the resident's medical record.</p>	F 329	<p>The nurse who made the transcription error and the nurse who failed to execute a thorough 24-hour chart check were both counseled. Resident #3's labs are currently being monitored by nursing as ordered by the physician, as presented during survey.</p> <p>How corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit was completed by the Unit Manager (UM) and a Licensed Practical Nurse (LPN) on 11/19/2012 for residents who are on Dilantin therapy to ensure that labs were completed as ordered. The total number of residents on Dilantin was four (4). The audit identified zero (0) residents requiring additional labs to obtain Dilantin levels. Licensed Practical Nurse, Unit Manager and Staff Development Coordinator conducted a 100%</p>	1/3/13	

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F 329	Continued From page 3 Review of the Lab Tracking form with lab orders due to be drawn on 09/04/12 listed the CBC and the BMP to be drawn for Resident #1 and were initialed as being done. The Dilantin level was not listed on this form. Review of the Lab Requisition form dated 09/04/12 listed both the CBC and the BMP that were drawn on Resident #1. The Dilantin level was not listed on this form. Review of Medication Administration Records (MAR) indicated the Dilantin was signed as having been administered from 08/29/12 through 10/03/12. Review of nurses notes dated 10/04/12 at 10:13 PM read, "Resident sent out due to having multiple seizures 2-3 minutes non-stop." Review of hospital records dated 10/04/12 revealed the resident was admitted to the hospital with the diagnoses status epilepticus and acute respiratory failure. The hospital records stated Resident #1 had a tonic clonic seizure that lasted for greater than 30 minutes. Resident #1's Dilantin level, when she was admitted to the hospital, was less than 2.5 microgram per milliliter (ug/ml) (a therapeutic Dilantin level is 10 -20 ug/ml). The resident was intubated in the emergency department and was admitted to the intensive care unit of the hospital. Resident #1 continued to be on a ventilator until 10/05/12 when she was extubated and was able to breathe on her own. Resident #1 was discharged from the hospital on 10/17/12 to another long term care facility.	F 329	audit of all current lab orders on 12/5/2012. All lab discrepancies identified were obtained and corrected on nine (9) residents. Measures in place to ensure practice will not occur. A process for the ordering, monitoring, and reviewing of labs was systemically implemented at the facility. The following outlines the process that was revised and implemented on 11/28/2012 by the Director of Nursing. 1. A licensed nurse receiving a lab order will document the order on the current month's lab tracking form. The licensed nurse will then complete a lab requisition from the lab vendor.	1/3/13	

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F 329	Continued From page 4 An interview was conducted on 11/19/12 at 1:45 PM with the Director of Nursing (DON). The DON confirmed the Dilantin level that was to be drawn 09/04/12 on Resident #1 was not drawn. She stated it was a transcription error. She further explained the BMP and the CBC were completed but the Dilantin level was missed. She stated the nurse who received the order for the labs was responsible for entering the ordered labs on the Lab Requisition and the Lab Tracking forms. She stated the third shift nurse who had completed the chart check should also have made sure all three labs had been entered on the Lab Requisition form and the Lab Tracking form. During a later interview on 11/19/12 at 5:47 PM with the DON, she stated a chart check was completed and initialed and dated on 08/30/12 on Resident #1's physician order for the labs including the Dilantin level. She indicated the third shift nurse had initialed and dated as having checked the physician order for the labs indicating the order was transcribed correctly on the Lab Requisition and the Lab Tracking forms. The DON indicated it was her expectation that the labs that ordered were put on the Lab Requisition and Lab Tracking forms so they were drawn as ordered. A telephone interview was conducted on 11/21/12 at 4:21 PM with Nurse #2, the third shift nurse who had initialed and dated the physician order for the Dilantin level. She stated that by initialing the order she had made sure the labs had been transcribed in the lab book. She stated she did not remember this particular order as it had been so long ago. She stated she would have checked	F 329	<ol style="list-style-type: none"> If a routine lab test is not due during the current month the licensed nurse will document the appropriate information onto the Lab Tracking Log and complete a lab requisition, indicating the type of lab test ordered and the date to be completed. The 11-7 shift licensed nurse or supervisor will check the lab tracking form nightly for lab work to be drawn the following morning. The appropriate requisition will be pulled from the lab book (or completed if necessary) and placed in the facility's designated location for the lab technician. 	1/3/13	

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F 329	<p>Continued From page 5</p> <p>the lab book to make sure the labs had been listed. She further stated that because this lab order was written toward the end of the month and due the following month, neither the Lab Requisition form nor the Lab Tracking forms would have been in the lab book yet. She stated it was the unit supervisor's job to take the labs that had been written in the lab book and transcribe them to the Lab Requisition form and the Lab Tracking forms. She stated that when she initialed and dated the physician's order, her initials indicated the three labs were listed in the lab book.</p> <p>2. Resident #3 was admitted to the facility on 06/23/2012 with diagnoses of seizure disorder. A quarterly Minimum Data Set (MDS) dated 09/13/12 recorded Resident #3 as cognitively intact. A plan of care dated 09/13/12 recorded Resident #3 at risk for injury related to seizure activity with an intervention to perform lab tests as ordered by the physician.</p> <p>A review of Resident # 3's laboratory report revealed a Dilantin lab result dated 06/28/12 with a Dilantin level of 9.6 micrograms per milliliter (ug/ml) and indicated the therapeutic Dilantin level range as 10.0-20.0 ug/ml.</p> <p>The medication administration record for June and July was reviewed. It revealed the resident had been on Dilantin therapy which was discontinued on 07/05/2012.</p> <p>A neurology consultation note dated 08/27/12 indicated a recommendation for Resident #3's Dilantin to be restarted at 200 milligrams (mg) twice daily and a Dilantin level to be drawn in 2</p>	F 329	<ol style="list-style-type: none"> 4. Upon completion of the lab draw a licensed nurse will document the date the specimen was drawn on the appropriate lab tracking form. 5. A licensed nurse will then notify the physician as soon as possible of any abnormal lab results. 6. Once the physician has been notified of the lab results, the nurse will document the date of notification and the method of notification on the Lab Tracking Log. 7. A licensed nurse will document any necessary information for follow up on the 24-hour Report. 	1/3/13	

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F 329	<p>Continued From page 6 weeks.</p> <p>A review of Resident #3's physician orders revealed an order dated 08/27/12 for Dilantin 200 mg twice daily and a Dilantin blood level to be drawn on 09/07/12.</p> <p>A review of the medication administration record (MAR) for August and September revealed Dilantin 200 mg was administered twice daily (total dose of 400mg per day) from 08/27/12 until 09/27/12.</p> <p>Further review of Resident #3's medical record revealed no documentation of a Dilantin blood level lab drawn on 09/07/12.</p> <p>A nurse's progress note dated 09/27/12 at 10:10 PM indicated Resident #3 requested to be sent out to hospital due to "feeling dizzy and drunk in the head". The physician was notified and an order was received to send the resident to the emergency department (ED) for evaluation. At 10:00 PM a call from the ED stated the resident had toxic Dilantin levels and would return to the facility later in the evening.</p> <p>A review of the ED summary dated 09/27/12 indicated Resident #3's condition included mild Dilantin toxicity with instructions to hold Dilantin tomorrow and contact the physician to adjust the Dilantin dose. Per the hospital records, the Dilantin level was 28 ug/ml.</p> <p>A physician's progress note dated 09/28/12 recorded an assessment and plan to hold the Dilantin and to check the Dilantin level on Monday.</p>	F 329	<p>8. Daily, during shift change, the licensed nursing staff for both shifts will review the status of current lab orders. To ensure practice will not recur, both nurses will sign, indicating completion and review of steps 1-8 above for twelve (12) weeks.</p> <p>9. At the end of each month, the unit manager or director of nursing will file the completed lab tracking and requisition forms and prepare the lab book for the new month; this process will include placing any recurring labs from the master lab log on the appropriate date's lab tracking form in the new month.</p>	1/3/13	

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F 329	Continued From page 7 A laboratory report dated 10/01/12 recorded Resident #3's Dilantin level was 18.8 ug/ml. Interview with the Director of Nursing (DON) on 11/19/12 at 1:46 PM revealed Dilantin levels were usually ordered by the physician and not scheduled unless the resident was remaining in the facility long term. The DON stated the nurse who received the order for a lab was responsible for entering the lab on a lab requisition sheet as well as a facility lab tracking form. She further explained the 3rd shift nurse was responsible to complete a 24 hour chart check, verify the lab ordered was placed on a lab requisition sheet for the next lab draw, and initial the order to indicate all steps had been completed. A follow-up interview with the DON on 11/19/12 at 5:46 PM confirmed the 09/07/12 Dilantin level was not drawn for Resident #3. The DON stated she could not identify the nurse who had initialed the order indicating a chart check and lab form had been completed. The DON stated she would have expected the nurse who initialed the order to have verified the lab was placed on the lab requisition and lab tracking sheet to ensure the Dilantin level would have been drawn on 09/07/12 as per physician order. An interview with the Nurse Practitioner (NP) 12/05/12 at 9:50 AM revealed Resident #3 was prone to have seizures and therefore she relied on the labs to monitor and evaluate Resident #3's need for changes in his Dilantin dose. Credible Allegation of Compliance for F-329	F 329	10. As an additional audit process, the licensed nurse on 11 p.m. to 7 a.m. shift will complete a 24-hour chart check on all in-house resident charts for new orders to ensure that orders are transcribed correctly. This process will be monitored by the Unit Manager. a. Licensed nurse will follow steps 1-8 above. b. Labs identified will be obtained and any discrepancies will be corrected as necessary. Upon completion of the chart check the nurse will complete the 24 hour chart check form.	1/3/13	

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F 329	<p>Continued From page 8</p> <p>Resident #3, affected by the deficient practice, was sent to the hospital on 9/27/2012 and was evaluated in the emergency room for dizziness. The resident readmitted to Charlotte Health Care Center on 9/27/2012. Resident #3's labs are currently being monitored by nursing as ordered by the physician. Resident #1, affected by the deficient practice, was sent to the hospital on 10/04/2012 with seizures and subsequently did not return to the facility.</p> <p>An audit was completed by the Unit Manager (UM) and a Licensed Practical Nurse (LPN) on 11/19/2012 for residents who are on Dilantin therapy to ensure that labs were completed as ordered. The total number of residents on Dilantin was four (4). The audit identified zero (0) residents requiring additional labs to obtain Dilantin levels.</p> <p>Licensed Practical Nurse, Unit Manager and Staff Development Coordinator conducted a 100% audit of all current lab orders on 12/5/2012. All lab discrepancies identified were obtained and corrected on nine (9) residents.</p> <p>The following process for the ordering, monitoring, and reviewing of labs will be systemically implemented at the facility. The following process was revised and implemented on 11/28/2012 by the Director of Nursing.</p> <ol style="list-style-type: none"> 1. A licensed nurse receiving a lab order will document the order on the current month's lab tracking form. The licensed nurse will then complete a lab requisition from the lab vendor. 2. If a routine lab test is not due during the current month the licensed nurse will document the appropriate information onto the Lab Tracking 	F 329	<p>An in-service, which started on 11/28/2012, was conducted by the Director of Nursing (DON) for all licensed nurses currently working in the facility and was completed for all nurses on 12/06/2012, as presented during survey. The in-service included lab policy and the revised procedures as stated above. Any licensed nurse that is on Family Medical Leave Act (FMLA), Leave Of Absence (LOA), or vacation will be in-serviced before their next scheduled shift via phone or in person by the DON or UM.</p> <p>How the facility plans to monitor and to make sure solutions are sustained.</p> <p>The lab process for Dilantin will be monitored by a Nursing Manager by completing an additional 24 hour chart check on any resident receiving Dilantin for a period of: Daily (Monday – Friday) for four</p>	1/3/13

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F 329	Continued From page 9 Log and complete a lab requisition, indicating the type of lab test ordered and the date to be completed. 3. The 11-7 shift licensed nurse or supervisor will check the lab tracking form nightly for lab work to be drawn the following morning. The appropriate requisition will be pulled from the lab book (or completed if necessary) and placed in the facility ' s designated location for the lab technician. 4. Upon completion of the lab draw a licensed nurse will document the date the specimen was drawn on the appropriate lab tracking form. 5. A licensed nurse will then notify the physician as soon as possible of any abnormal lab results. 6. Once the physician has been notified of the lab results, the nurse will document the date of notification and the method of notification on the Lab Tracking Log. 7. A licensed nurse will document any necessary information for follow up on the 24 -hour Report. 8. Daily, during shift change, the licensed nursing staff for both shifts will sign, indicating completion and review of steps 1-8 above. 9. At the end of each month, the unit manager or director of nursing will file the completed lab tracking and requisition forms and prepare the lab book for the new month; this process will include placing any recurring labs from the master lab log on the appropriate date's lab tracking form in the new month. 10) As an additional audit process, the licensed nurse on 11 p.m. to 7 a.m. shift will complete a 24 -hour chart check on all in-house resident charts for new orders to ensure that orders are transcribed correctly. This process will be monitored by the Unit Manager.	F 329	weeks, Three times per week for four weeks, Then weekly for four weeks, Then quarterly x2. Completed audits are then to be given to be given to the Director of Nursing. To monitor Dilantin, the Unit Manager or House Supervisor will review all new orders for residents on Dilantin each weekday. Monitoring will also include auditing the charts of residents receiving Dilantin, lab book, lab tracking forms. Such monitoring will occur: Daily (Monday – Friday) for four weeks, Three times per week for four weeks, Then weekly for four weeks, Then quarterly x2. To monitor all labs, nursing management will review the nurses shift change check which includes checking the physician orders, lab tracking form, lab requisitions, lab tracking log, and results with any discrepancies corrected as necessary 5x per week for 12 weeks.	1/3/13	

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F 329	<p>Continued From page 10</p> <p>a. Licensed nurse will follow steps 1-8 above.</p> <p>b. Labs identified will be obtained and any discrepancies will be corrected as necessary. Upon completion of the chart check the nurse will complete the 24 hour chart check form. This process will be monitored by the Unit Manager by completing an additional 24 hour chart check on any resident receiving Dilantin for a period of:</p> <ol style="list-style-type: none"> 1. Daily (Monday - Friday) for four weeks, 2. Three times per week for four weeks, 3. Then weekly for four weeks, 4. Then quarterly x2. 5. Completed audits to be given to be given to the Director of Nursing. <p>An in-service, which started on 11/28/2012, is being conducted by the Director of Nursing (DON) for all licensed nurses who are currently working in the facility and will be completed for all nurses by 12/06/2012. The in-service includes lab policy and including the revised procedures as stated above. Any licensed nurse that is on Family Medical Leave Act (FMLA), Leave Of Absence (LOA), or vacation will be in-serviced before their next scheduled shift via phone or in person by the DON or UM.</p> <p>To monitor the laboratory system, the Unit Manager or House Supervisor will review all new orders for residents on Dilantin each weekday. Monitoring will also include auditing the charts of residents receiving Dilantin, lab book, lab tracking forms. Such monitoring will occur:</p> <ol style="list-style-type: none"> a) Daily (Monday - Friday) for four weeks, b) Three times per week for four weeks, c) Then weekly for four weeks, d) Then quarterly x2. 	F 329	<p>Results from the Nursing Management audits will be given to the Director of Nursing for tracking and trending of concerns weekly for a period of 12 weeks and quarterly x2. Any deficient practice or concern will be addressed, at the time of the occurrence, including progressive disciplinary action if needed. The DON will report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed and continuation of audits as deemed necessary for further compliance.</p>	1/3/13	

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F 329	Continued From page 11 e) Results from the Unit Manager audits will be given to the Director of Nursing for tracking and trending of concerns weekly for a period of 12 weeks and quarterly x2. Any deficient practice or concern will be addressed, at the time of the occurrence, including progressive disciplinary action if needed. The DON will report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed and continuation of audits as deemed necessary for further compliance. The Immediate Jeopardy was lifted on 12/06/12 at 5:00 PM. The facility provided evidence of in-service training for all nursing staff. Interviews and observations of nursing staff implementing shift to shift report of all laboratory orders was completed. Nursing staff were observed using computer print out of all physician orders, specifically laboratory orders written that day, and comparing them to the labs listed on the Lab Requisition and Lab Tracking forms. Interview of nursing staff for all shifts was completed confirming they were trained on the procedure of obtaining and confirming that laboratory orders were carried out. Furthermore, interviews with third shift staff responsible for checking physician orders for labs and comparing them to the Lab Requisition and Lab Tracking forms for the 24 hour chart checks were completed and nursing staff assured an understanding of the procedure.	F 329			
F 428 SS=J	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	F 428	F428 The facility does understand that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist and that said pharmacist must report any irregularities to the attending physician and the director of nursing.	1/3/13	

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F 428	<p>Continued From page 12 pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and consultant pharmacist interview, the consultant pharmacist failed to report the missing laboratory monitoring of Dilantin blood levels for 2 of 7 sampled residents receiving anticonvulsant therapy. (Resident #1 and #3).</p> <p>Immediate Jeopardy began on 09/24/12 when the facility's pharmacist failed to identify and report missing Dilantin levels. Failure to identify and report the missing Dilantin blood levels resulted in Resident #1's hospitalization for status epilepticus and acute respiratory failure. Resident #1 was admitted to the intensive care unit of the hospital on a ventilator. In addition, failure to identify and report the missing Dilantin levels resulted in Resident #3 being admitted to the hospital with Dilantin toxicity. Immediate Jeopardy was lifted on 12/06/12 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are put into place.</p>	F 428	<p>How the corrective action will be accomplished for the resident(s) affected.</p> <p>Resident #1, affected by the deficient practice, was sent to the hospital on 10/04/2012 with seizures and was subsequently discharged from the hospital on 10/17/12. The nurse who made the transcription error and the nurse who failed to execute a thorough 24-hour chart check were both counseled. The nurse was further educated and counseled that it is the responsibility of the nursing staff to complete the lab tracking form and requisition, not the unit supervisor.</p> <p>Resident #3, affected by the deficient practice, was sent to the hospital on 9/27/2012 and was evaluated in the emergency room for dizziness and subsequently readmitted to</p>	1/3/13	

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F 428	<p>Continued From page 13</p> <p>The findings are:</p> <p>1. Resident #1 was admitted to the facility on 08/29/12 with diagnoses that included seizure disorder. Review of hospital records prior to admission to the facility revealed Resident #1 had a Dilantin level on 08/27/12 of 12.1 microgram per milliliter (ug/ml) and on 08/28/12 of 10.3 ug/ml. Further review of hospital records revealed the resident was ordered three (3) capsules of Dilantin 100 milligrams (mg) (totaling 300 mg) each night at bedtime.</p> <p>Review of Physician orders dated 08/28/12 revealed an order for a Dilantin blood level to be drawn in one week (09/04/12). On the same order two other labs were ordered to be drawn in one week, a complete blood count (CBC) and a basic metabolic panel (BMP).</p> <p>Review of physician orders dated 08/29/12 revealed an order for "Dilantin extended release 100 mg, 3 capsules by mouth every night, diagnosis epilepsy."</p> <p>Further review of Resident #1's medical record revealed no result of the Dilantin level that was to be drawn on 09/04/12. Lab results indicated the two other labs that were to be drawn on 09/04/12, the CBC and BMP, had been drawn and the results were in the resident's medical record.</p> <p>A review of Pharmacy notes dated 09/25/12 revealed the Pharmacist did not mention Dilantin, the need for monitoring a Dilantin level, or the missing results of the physician ordered Dilantin blood level.</p>	F 428	<p>Charlotte Health Care Center on the same day.</p> <p>The nurse who made the transcription error and the nurse who failed to execute a thorough 24-hour chart check were both counseled. Resident #3's labs are currently being monitored by nursing as ordered by the physician, as presented during survey.</p> <p>How corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit was completed by the Unit Manager (UM) and a Licensed Practical Nurse (LPN) on 11/19/2012 for residents who are on Dilantin therapy to ensure that labs were completed as ordered. The total number of residents on Dilantin was four (4). The audit identified zero (0) residents requiring additional labs to obtain Dilantin levels.</p>	1/3/13	

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F 428	<p>Continued From page 14</p> <p>Review of nurses notes dated 10/04/12 at 10:13 PM read, "Resident sent out due to having multiple seizures 2-3 minutes non-stop."</p> <p>Review of hospital records dated 10/04/12 revealed Resident #1 was admitted to the hospital with the diagnosis status epilepticus and acute respiratory failure. Resident #1 was noted to have a tonic clonic seizure for greater than 30 minutes. Resident #1's Dilantin level when she was admitted to the hospital was less than 2.5 microgram per milliliter (ug/ml) (a therapeutic Dilantin level is 10 -20 ug/ml). The resident was intubated on 10/04/12 and placed on a ventilator. The resident was admitted to the intensive care unit of the hospital.</p> <p>An interview on 11/19/12 at 1:45 PM was conducted with the Director of Nursing (DON). She confirmed the Dilantin level was not drawn for Resident #1 on 09/04/12.</p> <p>A telephone interview was conducted on 11/19/12 at 4:50 PM with the facility's pharmacist. He stated he usually looked at the physician orders that were written and that he must have missed the Dilantin level not being in the medical record. He further stated if a lab was not in the chart he did not look for it. He stated he would look for clinical presentation indicating there was a need for a Dilantin level.</p> <p>A later interview was conducted on 11/19/12 at 5:15 PM with the DON. The DON stated typically the pharmacist gave her a recommendation for a lab to be done if he did not see one in the medical record. She stated the pharmacist did not give her a recommendation indicating Resident #1</p>	F 428	<p>Licensed Practical Nurse, Unit Manager and Staff Development Coordinator conducted a 100% audit of all current lab orders on 12/5/2012. Any lab discrepancies identified were immediately corrected.</p> <p>An audit was completed on 100% of all in-house resident charts by the Pharmacy Consultant on 12/05/2012 through 12/06/2012 to ensure residents receiving Dilantin had the required labs as physician ordered. The audit identified zero (0) residents on Dilantin requiring additional labs. Pharmacy consultant also reviewed lab orders and medications that have recommendations for laboratory monitoring during his review.</p>	1/3/13	

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F 428	<p>Continued From page 15 needed a Dilantin level.</p> <p>2. Resident #3 was admitted to the facility on 06/23/12. The Resident's diagnoses included seizure disorder. A quarterly Minimum Data Set (MDS) dated 09/13/12 recorded Resident #3 as cognitively intact. A plan of care dated 09/13/12 recorded Resident #3 at risk for injury related to seizure activity with an intervention to perform lab test as ordered by the physician.</p> <p>The medication administration record for June and July was reviewed. It revealed the resident had been on Dilantin therapy which was discontinued on 07/05/2012.</p> <p>A neurology consult dated 08/27/12 recommended restarting Dilantin at 200 mg (milligrams)twice daily and to recheck Dilantin blood levels in 2 weeks.</p> <p>A physician order dated 08/27/12 included to administer 200 mg of Dilantin twice a day (total dose of 400 mg per day) scheduled at 8:00 AM and 8:00 PM and to obtain a Dilantin blood level on 09/07/12.</p> <p>Further review of the Medication Administration Records (MARs) for August 2012 revealed that this dose change was appropriately made and Resident #3 received 400 mg Dilantin every day from August 27th 2012 until September 27th 2012.</p> <p>Review of Resident # 3's laboratory reports revealed no labs were drawn on 09/07/12.</p>	F 428	<p>Measures in place to ensure practice will not occur.</p> <p>Administrator met with Pharmacy Consultant on 12/05/2012 at 8 p.m. The Administrator educated Pharmacy Consultant on:</p> <ol style="list-style-type: none"> 1) Expectation of Consultant Pharmacist to review lab orders and medications that have recommendations for laboratory monitoring during his monthly facility reviews. 2) Pharmacist is to recommend laboratory monitoring to the physician as outlined in the suggested laboratory monitoring parameters for selected medications in the Omnicare Pharmacy Reference. 	1/3/13

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F 428	<p>Continued From page 16</p> <p>Review of the monthly pharmacy progress notes revealed that Resident #3's chart was reviewed by the consultant pharmacist on 09/24/12. There was no mention about the missing Dilantin level in the review and no recommendations were forwarded to the physician or Director of Nursing by the consultant pharmacist.</p> <p>Further review of the medical record revealed a nurse's progress note dated 09/27/12 at 10:10 PM indicated Resident #3 requested to be sent out to hospital due to "feeling dizzy and drunk in the head." The physician was notified and an order was received to send the resident to the emergency department (ED) for evaluation. At 10:00 PM a call from the ED stated the resident had toxic Dilantin levels and would return to the facility later in the evening.</p> <p>A review of the ED summary dated 09/27/12 indicated Resident #3's condition included mild Dilantin toxicity with instruction to hold Dilantin tomorrow and contact the physician to adjust Dilantin dose due to a Dilantin level of 28 ug/ml (therapeutic range 10 -20 ug/ml).</p> <p>A telephone interview was conducted on 11/19/12 at 4:50 PM with the facility's pharmacist. He stated he usually looked at the physician orders that were written and that he must have missed the Dilantin level not being in the medical record. He further stated if a lab was not in the chart he did not look for it. He stated he would look for clinical presentation indicating there was a need for a Dilantin level.</p> <p>An interview with the DON on 11/19/12 at 5:46 PM confirmed that the facility had missed the</p>	F 428	<p>3) Expectation of Consultant Pharmacist that, if an order is on the chart for a laboratory test to be conducted, he is to verify the lab results are in the medical record and that this is to be completed with each monthly review. If the results are not available on the medical record, then he is to identify the concern each month with his consultant review report.</p> <p>The Pharmacy Consultant will continue to audit patients receiving Dilantin. This audit will include ensuring that required or ordered labs are present. If the results are not available on the medical record, then he is to identify the concern each month with his consultant review report. The Director of Nursing, or in their</p>	1/3/13	

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F 428	<p>Continued From page 17</p> <p>09/07/12 lab draw for Resident #3 after a dose change in Dilantin. The DON also explained she would have expected the consultant pharmacist to have caught the error on his monthly visit and made her aware of the missed lab.</p> <p>Credible Allegation of Compliance F428</p> <p>Resident #3, affected by the deficient practice, was sent to the hospital on 9/27/2012 and was evaluated in the emergency room for dizziness. The resident readmitted to Charlotte Health Care Center on 9/27/2012. Resident #3 's labs are currently being monitored. Resident #1, affected by the deficient practice, was sent to the hospital on 10/04/2012 for seizures and subsequently did not return to the facility.</p> <p>Administrator met with Pharmacy Consultant on 12/05/2012 at 8 p.m. The Administrator educated Pharmacy Consultant on:</p> <ol style="list-style-type: none"> 1) Expectation of Consultant Pharmacist to review lab orders and medications that have recommendations for laboratory monitoring during his monthly facility reviews. 2) Pharmacist is to recommend laboratory monitoring to the physician as outlined in the suggested laboratory monitoring parameters for selected medications in the Omnicare Pharmacy Reference. 3) Expectation of Consultant Pharmacist that, if an order is on the chart for a laboratory test to be conducted, he is to verify the lab results are in the medical record and that this is to be completed with each monthly review. If the results are not available on the medical record, then he is to identify the concern each month with his consultant review report. 	F 428	<p>absence the Unit Manager or Registered Nurse Supervisor, will review recommendations with the Pharmacy Consultant during his monthly facility visit and compare those recommendations to the list of patients on Dilantin and ordered labs to ensure recommendations are addressed and any discrepancies are corrected as needed.</p> <p>The pharmacy consultant is also to review medications that have recommendations for laboratory monitoring, and review lab orders for results as outlined in steps 1-3 above.</p> <p>How the facility plans to monitor and to make sure solutions are sustained. Monthly, the Director of Nursing will review the completed Pharmacy recommendations. The Consultant Pharmacist or Director of Nursing will report</p>	11/3/13	

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F 428	Continued From page 18 An audit was completed by the Unit Manager (UM) and a Licensed Practical Nurse (LPN) on 11/19/2012 for residents who are on Dilantin therapy to ensure that labs were completed as ordered. The total number of residents on Dilantin was four (4). The audit identified zero (0) residents requiring additional labs to obtain Dilantin levels. Licensed Practical Nurse, Unit Manager and Staff Development Coordinator conducted a 100% audit of all current lab orders on 12/5/2012. All lab discrepancies identified and corrected. An audit was completed on 100% of all in-house resident charts by the Pharmacy Consultant on 12/05/2012 through 12/06/2012 to ensure residents receiving Dilantin had the required labs as physician ordered. The audit identified zero (0) residents on Dilantin requiring additional labs. The Pharmacy Consultant will continue to audit patients receiving Dilantin. This audit will include ensuring that required or ordered labs are present. If the results are not available on the medical record, then he is to identify the concern each month with his consultant review report. The Director of Nursing, or in their absence the Unit Manager or Registered Nurse Supervisor, will review recommendations with the Pharmacy Consultant during his monthly facility visit and compare those recommendations to the list of patients on Dilantin and ordered labs to ensure recommendations are addressed and any discrepancies are corrected as needed. Monthly, the Director of Nursing will review the	F 428	findings of Pharmacy recommendations and any missing Dilantin or other laboratory recommendations to the Quality Assurance and Assessment Committee quarterly x3 for continued compliance and revision of monitoring as needed and directed by the committee.	1/3/13	

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F 428	Continued From page 19 completed Pharmacy recommendations. The Consultant Pharmacist or Director of Nursing will report findings of Pharmacy recommendations and any missing Dilantin recommendations to the Quality Assurance and Assessment Committee quarterly x3 for continued compliance and revision of monitoring as needed and directed by the committee. Immediate Jeopardy was lifted on 12/06/12 at 5:00 PM. The facility's Unit Manager and DON completed a 100% audit of all medical records. The pharmacist was in-serviced on his responsibility to complete a review of all facility residents' medical records monthly and indicate in his monthly reports any need for further laboratory testing. The Pharmacist specifically reviewed all residents on Dilantin and their physician orders and found none of these residents required additional testing.	F 428		1/3/13	