

JUN 17 2013

PRINTED: 06/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/21/2013
NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST-ACUTE CARE-NEUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID, PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent a significant medication error by omitting to administer an anticoagulant medication ordered for 1 (Resident #117) of 3 residents whose medications were reviewed. Findings include:</p> <p>Resident #117 was admitted to the facility on 01/10/13 and readmitted on 05/07/13. Cumulative diagnoses included dementia, hypertension, atrial fibrillation and status post left hip fracture with left hip nailing on 05/04/13.</p> <p>Review of Resident #117's significant change Minimum Data Set (MDS) assessment, dated 05/14/13, revealed the resident was cognitively impaired, and required extensive assistance with activities of daily living (ADLs).</p> <p>Review of the admission nursing assessment, dated 05/07/13, did not reveal any swelling to the left leg.</p> <p>Per the manufacturer's information, Lovenox is an anticoagulant given to reduce the risk of developing deep vein blood clots</p> <p>Review of the physician's readmission orders for Resident #117 revealed an order for Lovenox 40 mg (milligrams) subq (subcutaneous) daily times</p>	F 333	<p>Submission of this Plan of Correction does not constitute admission of the under-signed that the deficiency was correctly cited or required correction.</p> <p>F: 333</p> <p>It is the intent of the facility to prevent significant medication errors by administering medications to our residents as ordered by their physicians.</p> <p>Resident #117's Lovenox was discontinued on 5/11/13.</p> <p>All other residents on Lovenox/ Coumadin are receiving these medications as MD ordered.</p> <p>On 5/13/13- 5/21/13 Licensed Nursing Staff was in-serviced on: "Emergency Medication Kit." per facility policy.</p> <p>Staff was counseled appropriately on 5/13/13 and 5/15/13.</p>		

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

*Betty Barnett*

TITLE

*Administrator (LNHA)*

(X5) DATE

*6/6/13*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 333	<p>Continued From page 1</p> <p>2 weeks. Further review did not indicate the resident was receiving medication for atrial fibrillation.</p> <p>Review of the discharge summary from the hospital, dated 05/07/13, hospital course section read in part: "We have continued to do daily 40 mg subq Lovenox for deep venous thrombosis prophylaxis." The discharge summary plan read in part: "She (Resident #117) should have Lovenox 40 mg subq daily two weeks postoperatively."</p> <p>Review of Resident #117's Medication Administration Record sheet, dated 05/07/13 to 05/31/13, revealed an order for Lovenox 40 mg subq daily times two weeks. Further review revealed the nurse initials circled on 05/08, 05/09, and 05/10 with a notation, dated 05/10/13, on the back of the MAR that read in part: "Lovenox not available will fax this to our pharmacy."</p> <p>The nurse, who cared for the resident on the 3-11 shift on 05/08, 05/09 and 05/10 and who would have been the nurse to administer the Lovenox, was unavailable for interview.</p> <p>A phone interview, on 05/21/13 at 5:09 PM, was conducted with Nurse #4, who confirmed she transcribed the initial orders with the assistance of a new nurse on the day the resident was readmitted. She stated an error occurred because the nurse faxing the orders failed to send both the written telephone orders and the MAR to the pharmacy. Nurse #4 reported she worked both as a charge nurse and supervisor while she was employed at the facility. She</p>	F 333	<p>On 5/24/13 a new Anticoagulant monitoring tool was for Levenox/Coumadin was developed.</p> <p>On 5/24/13 the facility began daily monitoring of residents on Levenox/Coumadin therapy.</p> <p>The Quality Improvement Nurse/ Designee will monitor the administration of Levenox/Coumadin daily.</p> <p>Any identified issues will be taken to the monthly Performance Improvement Committee for review.</p> <p>Identified issue will be corrected to maintain compliance.</p>	6/21/13

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F 333	<p>Continued From page 2</p> <p>indicated during the time frame and while she was the supervisor, the nurse in charge of the resident did not ever notify her that the medication was not available. Nurse #4 reported she first became aware of the missed medication when she saw the resident was going to be sent for a Doppler, inquired about the reason and learned of the medication error.</p> <p>Review of the progress notes for Resident #117, dated 05/11/13, revealed Nurse #3 observed the resident's left leg to be swollen.</p> <p>An interview, on 05/21/13 at 5:15 PM, was conducted with Nurse #3. Nurse #3 stated during medication administration on 05/11/13, which she indicated was a Saturday, she noted the Lovenox was not given on 05/08, 05/09, and 05/10. She indicated she did not want to give the Lovenox since it had not been given for the three days; so, she called the resident's physician for clarification. Nurse #3 reported the physician gave her an order to hold the Lovenox, to start Aspirin 325 mg and to check with the surgeon on Monday regarding the Lovenox. The nurse indicated she administered the Aspirin as order and assessed the surgical site as she did when she was assigned the hall and the resident had the usual swelling that occurs post operatively but no other swelling. Nurse #3 continued on 05/12/13, one of the resident's family members wanted to look at the resident's incision site and when she lowered the pant leg to view the incisional area, she noted more swelling down the leg. She indicated she removed the pant leg and noticed excessive swelling from the knee to the ankle, she reported the resident did not complain of pain in the leg and denied pain when asked.</p>	F 333	<p>Addendum to POC dated 6/6/13.</p> <p>F tag: 333</p> <p>A directed in-service training by a well-established center for geriatric health services education has been arranged by "Eastern AHEC Department of Nursing Education."</p> <p>In-services are scheduled for the following: 6/21/13, at various times</p> <p>Nursing Continuing Education CEU's will be awarded to License Nursing Staff.</p> <p>All licensed nursing staff are mandated to attend.</p> <p>The Medication Error Problem was reviewed by the facility Medical Director Dr. Wright Shields MD.</p>	6/21/13
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F 333	<p>Continued From page 3</p> <p>Nurse #3 stated she notified the physician of the swelling, received orders from the physician to begin Xarelto 15 mg twice a day and to send the resident for a Doppler study in the AM</p> <p>Per the manufacturer's information, one of the uses for Xarelto is to reduce the risk of forming a blood clot in the legs and lungs of people who have just had knee or hip replacement surgery. Review of the emergency room report, dated 05/12/13, indicated the resident had symptoms of a deep vein thrombosis of the left leg; that she was to continue the Xarelto 15 mg twice a day; to follow up with the resident's physician; and, to return to the emergency room if symptoms worsen. The resident was discharged back to the nursing home. Per the report, there was no order for the Lovenox to be restarted.</p> <p>Review of a note, dated 05/13/13, by the physician and faxed to the facility read in part: "Have reviewed Doppler report. No need for Xarelto as blood clot in superficial system. DC (discontinue) (the) Xarelto. Moist heat PRN (whenever necessary) (for) comfort. Elevation for swelling."</p> <p>An observation and interview, on 05/21/13 at 3:25 PM, was conducted with Nurse #1. Accompanied by Nurse #1, an observation of the emergency kit (E-kit) for the 100-200 hall medication room was made. The observation revealed six single injectable doses of Lovenox 30 mg was in the E-kit. Nurse #1 stated when a medication is not on the medication cart, the nurse would check the E kit to see if it was in the kit. She continued that if the medication was not in the E-kit, then staff would call the pharmacy and/or they could get it from the back up pharmacy. Nurse #1 confirmed</p>	F 333			

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F 333	<p>Continued From page 4</p> <p>medication should be given when ordered.</p> <p>An observation, on 05/21/13 at 3:45 PM, was made accompanied by the Quality Improvement Nurse of the E kit for the 300-400 halls medication room. The observation revealed six single injectable doses of Lovenox 30 mg was in the E-kit.</p> <p>An interview, on 05/21/13 at 3:50 PM, was conducted with Nurse #2. She indicated that if the medication to be given was not in the medication cart that the nurse should check the E-kit in the medication room. Nurse #2 went on to explain if the medication was not in E kit the pharmacy should be called. She continued that the staff could also call the back-up pharmacy which was located across the street from the facility to obtain the medication.</p> <p>An interview, on 05/21/13 at 4:45 PM, was conducted with the Director of Health Services (DHS). The DHS stated the facility policy was that the staff should use the E kit for medication they have not received or make contact with the pharmacy on the day it is first noted. She indicated there was an error in the transcription and the pharmacy had not received the initial order. The DHS indicated when the error was noted the physician was called and new orders received.</p> <p>An interview, on 05/21/13 at 7:30 PM, was conducted with the Administrator. The Administrator indicated the staff identified the error, assessed the resident when the left leg was swollen, notified the physician, began new medication and sent the resident to for the</p>	F 333		

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F 333	Continued From page 5 Doppler as ordered. She continued that the clot the resident had was a superficial clot and not a deep vein thrombosis (DVT).  A phone interview, on 05/22/13 at 11:00 AM, was conducted with the resident's Primary Care Physician (PCP). The PCP indicated he was notified regarding the Lovenox, began the Xarelto, ordered a Doppler and after all the information had been received, the results were that the resident had a superficial blood clot and not a DVT. He continued that because the resident's clot was superficial it did not pose the same dangers that a DVT would. The PCP indicated Resident #117 returned to the facility ambulating and it would be difficult to connect that not receiving the Lovenox caused the superficial clot.	F 333			