STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345101	A. BUILDING _____ B. WING _____	C 02/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD OAKS NURSING AND REHABILITATION CENTER	208 CARY ST ENFIELD, NC 27823

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F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to administer a cardiac (heart) medication in accordance with the physician's orders for 1 of 3 sampled residents (Resident #6) reviewed for medication errors. The findings included: Resident #6 was admitted to the facility on 1/18/13. The resident's cumulative diagnoses included atrial fibrillation (a specific type of irregular heartbeat), congestive heart failure, a history of cerebrovascular accident (CVA or stroke), and a history of pulmonary embolism (blockage of an artery in the lung). The most recent quarterly Minimum Data Set (MDS) dated 12/6/13 indicated the resident had moderately impaired cognitive skills for daily decision making. A review of Resident #6's December 2013 Physician's Orders revealed his medication regimen included 0.25 milligrams (mg) digoxin (an antiarrhythmic medication used to control the heart rate in atrial fibrillation and/or used in the treatment of congestive heart failure) given as one tablet by mouth daily with an initial order date of 5/14/13. A review of Resident #6 ' s December 2013 Medication Administration Record (MAR) revealed that he received digoxin once daily as ordered from 12/1/13 through 12/29/13.	F 333	1. Resident number 6 MAR was corrected to include digoxin .25 a stat lab was obtained to ensure levels were in therapeutic range. MD and RP was notified of medication error 2. A digoxin list will be obtained by pharmacy to ensure all residents on digoxin are receiving the recommended dose by 3/14/14. All March MARs will be verified for accuracy by an administrative nurse by Monday 3/14/14. 3. The DON will in-service all licensed nurses on verifying orders at month end change over, ensuring all medications are carried over. This will be completed by 3/14/14. The facility will implement administrative MAR checks in conjunction with the floor nurses completing the 2nd MAR check starting in the month of March. 4. The DON will audit at least 10 charts a month ensuring all medications have been carried over. Any issues will be address 1:1 with the nurses. The audits will be brought to the monthly QI meeting. 5. 3/14/14	3/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/14/2014

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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A review of the medical records for Resident #6 revealed the resident was sent out to the hospital on 12/29/13. Resident #6 returned to the facility on 1/24/14. Discharge medications from the hospital and subsequent admission orders to the facility dated 1/24/14 included 0.25 mg digoxin given as one tablet by mouth daily.

A review of the January 2014 MAR revealed that Resident #6 received 0.25 mg digoxin once daily as ordered by the physician from 1/25/14 through 1/31/14.

A review of the handwritten February 2014 Monthly Physician's Orders revealed digoxin was not listed as one of the prescribed medications for Resident #6. Further review of the medication orders for this resident revealed there were no physician ' s orders on his chart to indicate the digoxin had been discontinued. Review of the February 2014 MAR revealed digoxin was not listed as an ordered medication to be administered to the resident. There was no documentation on the February 2014 MAR to indicate that Resident #6 received digoxin as a scheduled medication from 2/1/14 through the date of the record review (2/19/14).

An interview was conducted with the facility's Director of Nursing (DON) on 2/19/14 at 11:10 AM. During this interview, inquiry was made as to why digoxin had been discontinued for Resident #6. The DON indicated he would review the resident's medical record to determine what had transpired.

An interview was conducted with Nurse #1 and the facility's Nurse Consultant on 2/19/14 at 11:35 AM. During this interview, the nurse and Nurse

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F 333	Continued From page 2 Consultant indicated that Resident #6 ' s medical record had been reviewed to determine why he no longer received digoxin. They indicated that apparently the digoxin had been left off of the February 2014 Monthly Physician Orders and February 2014 MAR. The Nurse Consultant reported that the facility would notify Resident #6 ' s physician of the omission of digoxin during the month of February 2014 (to date) and would request an order for a STAT (immediate) digoxin level (a laboratory blood test) to be drawn. Additionally, she stated that the residentss vital signs would be checked, the resident's Responsible Party (RP) would be notified of the medication omission, and a medication error report would be completed. An interview was conducted with the DON on 2/19/14 at 11:39 AM. Upon inquiry, the DON reviewed the facility's process for ensuring the accuracy of the Monthly Physician's Orders and MARs during the transition from one month to the next. The DON reported that the process of month-end changeover began around the 23rd of each month and continued through the 30th. During this period of time, the new month's MARs were reviewed and physician's orders were checked to see if any changes had been made to the resident's medication regimen. Once the initial review was completed by a nurse, it was initialed. The DON reported that a second check was also completed for each new month's MAR. The second check was completed and initialed by a second nurse. When asked what his expectations were in regards to completion of the month-end changeover for the MARs, the DON stated, "I expect that to be done correctly every month."	F 333		

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An interview was conducted with Nurse #2 on 2/19/14 at 11:56 AM regarding the facility's process for ensuring the accuracy of the Monthly Physician ' s Orders and MARs during the month-end changeover. Nurse #2 was the nurse identified as having completed the second check for Resident #6's February 2014 MAR during the month-end changeover. Upon inquiry, Nurse #2 reported that the new month's MARs typically came into the facility around the 23rd of each month. The nurse stated that when the new MARs came in, the first nurse would take the MARs and compare them with the actual physician's orders from the resident's medical record. She noted the nurse reviewed all of the physician's orders to see if any new orders had been written. If there were new orders written, the nurse would check to be sure these orders were on the new month's MAR. If the new orders were not already on the new MAR, they would be added to it. Nurse #2 indicated that after the first nurse checked (and initialed) the new MAR for accuracy, a second nurse would repeat the process to check (and initial) the MAR for accuracy. When asked why Resident #6's digoxin was not on the February 2014 MAR, Nurse #2 stated, " The (digoxin) may have been overlooked. "

A review of Resident #6's electronic medical record revealed a Progress Note dated 2/19/14 at 12:25 PM which read: "Call made to MD (Medical Doctor) office and made aware that resident had missed dosages of Digoxin for the entire month of February. Informed that resident was (discharged) from hospital on 1/24/14 and that was initially started on Digoxin. Informed that resident showed no adverse reactions to missed dosages, resident arousable to name. VS (Vital

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F 333	Continued From page 4 Signs) 150/78 (blood pressure), 76 (pulse), 16 (respiration rate), 96.9 (temperature). MD and RP notified of medication omission."	F 333		