

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/16/2014
NAME OF PROVIDER OR SUPPLIER TRIAD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262		
(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 10/16/2014. Event ID#LYVZ11. NC00097401, NC00098022 & NC00097603 .	F 000			
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 and staff interview the facility failed to transcribe, administer or give a substitute medication for a requested and as needed medication (Xanax) for 1 of 1 resident (Resident #238). Findings Included: Resident #238 was admitted to the facility on 5/14/2014 at 3:15 PM. An Interdisciplinary Progress Note dated 5/14/2014 revealed Resident #238 was admitted from the hospital and was alert and oriented to person, place, and time. A record review of Resident #238 ' s Discharge Summary dated 5/14/2014 included: (in Part) Discharge Diagnosis: 2) Anxiety Disorder and Discharge Medications: 12) Xanax (antianxiety) 0.5mg every eight hours as needed. A record review of Resident #238 ' s discharge medication reconciliation list signed and dated by the physician on 5/14/2014 included Xanax 0.5	F 281	1.) Resident #238 did not receive an alternate PRN medication as she left the facility AMA. 2.) All other residents receiving PRN antipsychotics will be reviewed for medication availability. 3.) The Licensed Nurses will be in serviced on admissions/readmissions verification of orders by NPE/Unit Manager by 11/8/14. The 11-7 nurses will check the Admissions/Readmissions orders against hospital discharge summary and discharge medication list for accuracy. The nurse will initial on the Discharge Medication list after verifying. 4.) The DNS or designee will review the new consolidated orders upon admissions, readmission, quarterly assessments and change of condition. Any finding from the review will be brought to the PI meeting each month for the next	11/13/14	

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

TITLE

(X6) DATE

Electronically Signed

11/07/2014

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.

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

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0391

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F 281	<p>Continued From page 1 mg (milligrams) every 8 hours as needed.</p> <p>A record review of Resident #238 ' s hospital active order report revealed the last dose of Xanax was given to Resident #238 on 5/14/2014 at 11:05 AM.</p> <p>A record review of Resident #238 ' s medical record included a hard copy prescription for Xanax 0.5 mg every eight hours as needed.</p> <p>A record review of Resident #238 ' s nurse note dated 5/14/2014 at 9:25 PM revealed Resident #238 ' s family asked for her medications. The nurse reported there was no order in the book or computer.</p> <p>A record review of Resident #238 ' s nurse note dated 5/14/2014 revealed a late entry by Nurse #1 that stated an order was given from the Nurse Practitioner (however never transcribed to the MAR) to administer the as needed antianxiety medication.</p> <p>A record review of Resident #238 ' s Medication Administration Record (MAR) dated 5/14/2014 included three medications: Calcium Carbonate (supplement), Geri-Lanta (antacid), and Ipratropium Bromide (bronchodilator). All three medications were scheduled as needed and were signed by Nurse #1 as given with a start date of 5/15/2014 at 5:30 PM. Xanax was not listed on Resident #238 ' s MAR.</p> <p>A record review of the Pharmacy shipment summary included an order for Resident #238 ' s Xanax, dated received on 5/15/2014 at 4:18 AM.</p> <p>An interview on 10/16/2014 at 3:50 PM with</p>	F 281	three months.		

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F 281	<p>Continued From page 2</p> <p>resident #238 's admission nurse and unit manager (Nurse #1) revealed Resident #238 was agitated and wanted something for her nerves. Nurse #1 recalled receiving an order for Xanax but did not recall if the medication was given or why it was not transcribed onto the MAR.</p> <p>An interview on 10/16/2014 at 2:46 PM with the Director of Nursing (DON) revealed the resident was upset on 5/14/2014 and asked about her medications; specifically her antianxiety medication. Resident #238 was informed by a staff nurse that her medications were not at the facility.</p> <p>An interview on 10/16/2014 at 4:55 PM with the DON revealed her expectation was for all staff nurses to request a substitution anxiety medication order from the Nurse Practitioner for a medication that was ordered for a resident but was not stocked at the facility until the Pharmacy could deliver the resident medications or get the hard copy prescription filled at a local third party Pharmacy.</p>	F 281			