

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345561	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/01/2015
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/FUQUAY-VARINA			STREET ADDRESS, CITY, STATE, ZIP CODE 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526		
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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 reviews and staff interviews, the facility failed to initiate the administration of an anticoagulant medication in accordance with the physician's orders for 1 of 3 sampled residents (Resident #3); and, failed to provide the correct dosage of an anti-Parkinson's medication for 1 of 3 sampled residents (Resident #3) reviewed for medication error(s).</p> <p>The findings included:</p> <p>1) Resident #3 was admitted from the community to the facility on 9/3/15. The resident's cumulative diagnoses included atrial fibrillation (a specific type of irregular heartbeat).</p> <p>A review of Resident #3's home medication list provided by his Primary Care Physician (PCP) included: 5 milligrams (mg) Coumadin (an oral anticoagulant) given as one tablet by mouth once daily. A hand-written notation was made in the margin of the first page which read, "PT/INR (Prothrombin Time and International Normalized Ratio, which are blood tests measuring the anticoagulation effects of Coumadin) 9/4/15." At the bottom of the second page of the home medication list, a signed, hand-written notation dated 9/3/15 read, "d/c (discontinue) Coumadin; Xarelto (an oral anticoagulant) 20 mg po (by mouth) q PM (every afternoon)."</p>	F 333	<p>1. Resident #3 was discharged on 9/26/2015</p> <p>2. Audit to be completed of 100% of physician order changes between 9/1/15 and 10/22/15 for in-house residents, and admissions orders for in-house residents admitted between 9/1/15 and 10/22/15. Any discrepancies in transcription will be addressed immediately upon discovery. Completion date: 10/22/15.</p> <p>3. -Nurse responsible for the errors will be disciplined and re-educated by 10/22/15. -All licensed nurses to be reeducated by 10/22/15 about properly transcribing new orders, and about follow-up audits to be done daily by the upcoming shift. No nurse will work after 10/22/15 until they have been inserviced. -Each time a medication order change is made, a second nurse will check behind the receiving charge nurse, to assure that transcription occurs correctly. Both nurses will initial the pink order sheet to indicate this has been accomplished. Beginning 10/22/15. -Night shift nurses will check all new orders and assure that transcription is</p>	10/20/15	

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

TITLE

(X6) DATE

Electronically Signed

10/20/2015

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>A review of the facility's printed September 2015 Physician Orders for Resident #3 included: 5 mg Coumadin given as one tablet by mouth daily. The medication order included a 9/4/15 Stop Date for the warfarin. Xarelto was not included on these orders.</p> <p>A review of Resident #3's September 2015 Medication Administration Record (MAR) revealed the resident received the 5 mg dose of warfarin one time only on 9/3/15. The MAR noted warfarin's Start Date was 9/3/15 with a Stop Date of 9/4/15. A line was drawn through the remainder of the row dedicated for documentation of warfarin administration on the MAR, with a hand-written notation which read, "d/c (discontinued) 9/7/15."</p> <p>A review of Resident #3's laboratory results included: INR = 2.78 on 9/4/15. The target INR for adequate anticoagulation in atrial fibrillation is typically 2 - 3.</p> <p>Further review of the resident's medical record revealed a Physician's Telephone Order was written on 9/7/15 which read, "Clarification: Xarelto 20 mg po q PM hypotension (low blood pressure); D/C (discontinue) Coumadin."</p> <p>Further review of Resident #3's September 2015 MAR indicated 20 mg Xarelto given once daily was initiated on 9/7/15.</p> <p>The resident's admission Minimum Data Set (MDS) dated 9/10/15 indicated the resident had moderately impaired cognitive skills for daily decision making. The assessment revealed he received an anticoagulant medication on 7 of 7 days during the look-back period. A review of</p>	F 333	<p>done correctly. Night nurse is also to initial <u>pink</u> order sheet to indicate this has been accomplished. Beginning 10/22/15.</p> <ul style="list-style-type: none"> -Each morning at clinical meeting, the physician medication order changes and subsequent MAR transcription will be reviewed by the DON or RN designee. Any discrepancies identified will be addressed immediately. Beginning 10/22/15. - Further incidents of improperly transcribed medication orders will be reviewed by the DON with disciplinary actions or remedial training provided as necessary. Beginning 10/22/15. - General fax cover sheets will no longer be acceptable tool for MD to document order changes or give feedback on. A specific communication form will be used by nurses, beginning 10/22/15 to request physician consideration of order changes and for verification of orders for new residents. In so doing, the line of communication between licensed nurses and the physicians will be improved, leaving smaller room for error between them. <p>4. Director of Nursing or RN designee to review medication orders for new admissions and other resident medication order changes as follows:</p> <ul style="list-style-type: none"> -Daily for 2 weeks beginning 10/23/2015. -2 times weekly for 2 weeks, beginning 11/6/15. -Once weekly for 2 months, beginning 11/20/15. <p>Present results to monthly QA & A (QAPI)</p>		

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F 333	<p>Continued From page 2</p> <p>Resident #3's Care Plan dated 9/18/15 included a problem/need related to the use of an anticoagulant medication (Xarelto).</p> <p>An interview was conducted with Nurse #1 on 9/30/15 at 3:25 PM. During the interview, Nurse #1 reviewed the process of medication reconciliation and receipt of physician orders upon a resident's admission to the facility. The nurse reported that when a resident was admitted from the community, the medication list from his/her PCP would be faxed to the physician and verbal orders obtained. She indicated nurses would normally write notes alongside the medication list, noting the facility physician's orders. The nurse would then input the orders into the computer. Upon review of Resident #3's home medication list and computer records, Nurse #1 acknowledged she herself had made notations in the margins of the medication list, confirming the orders. These orders included the 5 mg Coumadin to be given once daily and the PT/INR scheduled for 9/4/15. However, Nurse #1 indicated the hand-written notation made on the second page of the medication list was written by the physician. Nurse #1 stated, "That is not where an order should be written." She stated additional orders needed to be written as a Physician's Telephone Order and placed on the chart.</p> <p>An interview was conducted with Resident #3's physician at the facility on 10/1/15 at 2:45 PM. Upon review of the resident ' s medical record, the physician indicated the Xarelto should have been started on 9/4/15 (not 9/7/15). She noted the laboratory INR from 9/4/15 revealed the resident was adequately anti-coagulated on 9/4/15 and probably on 9/5/15 as well. She</p>	F 333	meeting x 3 months, then quarterly thereafter. Plan will be adjusted as deemed necessary by the committee.		

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F 333	<p>Continued From page 3</p> <p>indicated she was less certain as to whether or not the resident would have been adequately anti-coagulated on 9/6/15 or 9/7/15 prior to administration of the Xarelto.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/1/15 at 3:47 PM. During the interview, the DON acknowledged the order dated 9/3/15 for Resident #3's Xarelto had been missed. She indicated the Xarelto order should have been written on a Physician's Telephone Order instead of having been written on the bottom of the home medication list. The DON reported the physician had noted the omission of Xarelto and called into the facility on 9/7/15 with an order clarification to initiate this medication for Resident #3.</p> <p>2) Resident #3 was admitted from the community to the facility on 9/3/15. The resident's cumulative diagnoses included Parkinson's disease.</p> <p>A review of Resident #3's home medication list provided by his Primary Care Physician included: 25/100 milligrams (mg) Sinemet (a combination medication used in the management of Parkinson's disease) given as one and one-half (1 and ½) tablets by mouth three times daily.</p> <p>A review of the facility's printed September 2015 Physician Orders for Resident #3 included: 25/100 mg Sinemet given as one (1) tablet by mouth three times daily.</p> <p>A review of Resident #3's September 2015 Medication Administration Record (MAR) revealed the resident received 25/100 mg Sinemet given as one (1) tablet by mouth three</p>	F 333			

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F 333	<p>Continued From page 4</p> <p>times daily beginning on 9/3/15 and throughout the remainder of his stay in September 2015.</p> <p>The resident's admission Minimum Data Set (MDS) dated 9/10/15 indicated the resident had moderately impaired cognitive skills for daily decision making. His active diagnoses included Parkinson's disease. A review of Resident #3's Care Plan dated 9/18/15 included a problem/need related to the diagnosis of Parkinson's disease. The approaches included: "Medications will be administered as ordered."</p> <p>An interview was conducted with Nurse #1 on 9/30/15 at 3:25 PM. During the interview, Nurse #1 reviewed the process of medication reconciliation and receipt of physician orders upon a resident's admission to the facility. The nurse reported that when a resident was admitted from the community, the medication list from his/her PCP would be faxed to the physician and verbal orders obtained. She indicated nurses would normally write notes alongside the medication list, noting the physician's orders. The nurse would then input the orders into the computer. Upon review of Resident #3's home medication list and computer records, Nurse #1 acknowledged she had input the order for Sinemet into the computer for one tablet (versus 1 and ½ tablets) of 25/100 mg Sinemet to be given three times daily. When asked if there was a discrepancy between the order written and what was put into the computer, the nurse stated, "Yes."</p> <p>An interview was conducted with Resident #3's physician at the facility on 10/1/15 at 2:45 PM. Upon review of the resident's medical record, the physician indicated the dose of Sinemet given to</p>	F 333			

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

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F 333	Continued From page 5 resident #3 during his stay at the facility was an error. She stated she did not order a dose change for the Sinemet. An interview was conducted with the Director of Nursing (DON) on 10/1/15 at 3:47 PM. During the interview, the DON acknowledged a transcription error had been made when Resident #3's usual medications had been reviewed and his admission medication orders entered into the computer. The DON indicated she would have expected the correct dosage of a medication to be transcribed; and, if an error had occurred, for that error to have been caught during the facility's new admission audit.	F 333			