STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

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F 333 SS=E	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 medical record review and staff interview the facility failed to remove old Exelon patch as ordered with application of daily medication patch for 1 of 3 residents reviewed for medication patch administration (Resident #1). The findings are: Review of Exelon patch medication insert (undated) read in part: Dosage and Administration-Apply patch on intact skin for a 24 hour period; replace with a new patch every 24 hours. Adverse Reactions-Most commonly observed adverse reactions: Nausea, vomiting, and diarrhea. Resident #1 was admitted 12/27/12. Diagnoses included Parkinson's and dementia. Record review revealed admission physician order dated 12/27/12 for daily Exelon 4.6 mg (milligram)/24hr (hour) transdermal patch. Physician order dated 01/09/13 increased the dosage to Exelon 9.5 mg/24hr patch daily. Review of Medication Administration Record (MAR) included instruction to document site location, and to remove old patch before application of a new patch.	F 333	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 333 On 3/31/13, Resident #1 was found with two patches. The outdated patch was removed and the nurse responsible for placement on 3/31/13 was counseled by the Director of Nursing. On 4/01/13, the facility utilized a list from the pharmacy to conduct a 100% visual audit of all residents with medication patches. Staff education was provided by the nursing leadership team and included all aspects of patch use/documentation. All medication patches (not just Exelon) will be captured utilizing an updated form that will be included on the Medication Administration Record (MAR). The medication patch process will be incorporated into the New Employee Orientation program.	

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

Heidi Good, NHA | Nursing Home Administrator | 04/25/13

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.

DHSR NURSING HOME UNIT Received APR 26 2013 by: PAM

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F 333	Continued From page 1 Review of medication error reports and facility investigation revealed the following: On 01/20/13 Resident #1 was found with three Exelon patches in place dated 01/20/13, 01/16/13, and one patch with no date. Review of January 2013 MAR revealed Exelon 9.5mg was administered on 01/16/13 and 01/20/13. The dosage for the undated patch was undetermined. Nurses notes dated 01/20/13 at 5:45 PM revealed Resident #1 became unresponsive with blood pressure 77/41, pulse 58. Emergency medical staff arrived at 5:55 PM. Vital signs were monitored with blood pressure 104/62, pulse 78, respirations 20. The resident was sent out to the hospital for further evaluation. On 04/03/13 at 4:34 PM an interview was conducted with Nurse #1. Nurse #1 stated she worked day shift (7AM-3PM) on 01/20/13 with Resident #1. Nurse #1 stated she applied the Exelon patch dated 01/20/13 after removing the patch dated 01/19/13. Nurse #1 stated she documented the site location on the MAR and did not check for any additional medication patches. Nurse #1 stated at approximately 6:00 PM Resident #1's family alerted staff to the resident's room. Nurse #1 stated Resident #1 was unresponsive with a low blood pressure and pale appearance. Nurse #1 stated the physician and emergency medical services were contacted. The resident was transported to the hospital for further evaluation. Review of emergency department documentation dated 01/20/13 indicated Resident #1 had a history of syncope and orthostatic hypotension.	F 333	Pharmacy to provide the facility a current list of patches every Monday. Each Monday, Nurse Leaders will conduct total body audits on those residents with medication patches. Tuesday through Sunday, patch placement will be checked against the medication patch form to ensure appropriate placement. Results of the monitoring will be shared with the Administrator and/or Director of Nursing on a weekly basis and with the Quality Assurance Process Improvement (QAPI) Committee monthly for a period of 90 days at which time the frequency of monitoring will be determined by the QAPI Committee.	5/1/13

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F 333	Continued From page 2 Vitals signs were monitored and within normal limits. Diagnostic tests revealed no evidence of seizure activity. Electrocardiogram revealed normal heart rhythm. CT scan head revealed no evidence of acute intracranial abnormality. Laboratory data revealed no evidence of infectious process. Review of neurology consult dated 01/21/13 revealed Resident #1 was at significant risk for orthostatic hypotension due to his primary Parkinson's disease. The neurology consult indicated use of multiple doses of Exelon would also contribute to excessive orthostasis. Review of hospital discharge summary dated 01/22/13 indicated Resident #1 experienced a syncopal episode due to hypotension related to wearing three Exelon patches. Resident #1 returned to the facility 01/22/13 in stable condition with admission orders for daily Exelon 4.6mg/24hr patch with instruction to remove old patch before applying new patch. An interview was conducted on 04/03/13 at 2:54 PM with the facility Medical Director. The Medical Director stated Resident #1 had several medical diagnoses that may have contributed to the syncope episode. The Medical Director stated old medication patches should be removed before applying a new patch but reported he could not definitively state the medication patches caused the syncope episode. On 02/01/13 Resident #1 was found with two Exelon patches in place dated 02/01/13, and 01/26/13. Review of January-February 2013 MAR revealed Exelon 4.6mg was administered on	F 333		

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F 333	Continued From page 3 01/26/13 and 02/01/13. Nurses notes dated 02/01/13 revealed Resident #1 was found with two Exelon patches in place. The older patch was removed and the physician notified. Vital signs were monitored and within normal limits. No change in condition was identified. On 04/03/13 at 2:38 PM an interview was conducted with Nurse #2. Nurse #2 stated she worked day shift (7AM-3PM) on 02/01/13 with Resident #1. Nurse #2 stated she applied the Exelon patch dated 02/01/13 after removing the patch dated 01/31/13. Nurse #2 stated she did not check for any additional medication patches. Nurse #2 stated she did not identify any change in condition during the remainder of her shift. On 03/31/13 Resident #1 was found with two Exelon patches in place dated 03/31/13, and 03/30/13. Review of March 2013 MAR revealed Exelon 4.6mg was administered on 03/30/13, and 03/31/13. Nurses notes dated 03/31/13 revealed Resident #1 was found with two Exelon patches in place. The older patch was removed and the physician notified. Vital signs were monitored and within normal limits. No change in condition was identified. On 04/04/13 at 4:45 PM an interview was conducted with Nurse #3. Nurse #3 stated she worked the evening shift (3PM-11PM) on 02/01/13 with Resident #1. Nurse #3 stated the family reported two Exelon patches in place. Nurse #3 stated she removed the older patch,	F 333		

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F 333	Continued From page 4 notified the physician and monitored the resident's condition. Nurse #3 stated no change in condition was identified. Nurse #3 stated she also worked the evening shift (3PM-11PM) on 03/31/13 with Resident #1. Nurse #3 stated Resident #1 was on an outing with his family. Upon return to the facility the family reported they found two Exelon patches in place and stated Resident #1 experienced drooling and increased confusion. Nurse #3 stated she removed the older patch, notified the physician and monitored the resident's condition. Nurse #3 stated no change in condition was identified. On 04/03/13 at 10:50 AM an interview was conducted with the Director of Nursing (DON). The DON stated Nurse #4 worked day shift (7AM-3PM) on 03/31/13 with Resident #1. The DON stated Nurse #4 had not located and removed the patch from the previous day before applying the new medication patch. The DON stated Nurse #4 worked prn (as needed) and had not received re-education/training. Attempts to contact Nurse #4 were unsuccessful. On 04/03/13 at 12:24 PM an interview was conducted with the Pharmacy consultant. The Pharmacist indicated dosage in the Exelon patch was absorbed transdermally with minimal blood serum levels after the 24 hour time frame. Follow up interview was conducted on 04/04/13 at 8:30 AM with the DON. The DON stated she expected all nursing staff to maintain compliance with new systems implemented for accurate medication patch administration. The DON reported new measures were implemented 02/04/13 to document site location and document	F 333		

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F 333	Continued From page 5 removal of old medication patch with placement of new medication patch. The documentation tool was revised 04/01/13 with staff re-education/training in progress.	F 333		