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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING ______ B. WING ______	C 05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET ST GRANITE FALLS, NC 28630

(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	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 observations, staff interview and record review, the facility failed to prevent a significant medication error by not administering 2 scheduled doses of anti-coagulant medication as ordered for 1 of 3 residents reviewed. (Resident #2). The findings included: Resident #2 was readmitted to the facility on 03/20/13 with diagnoses including hypertension, diabetes mellitus type 2 and chronic kidney disease. The most recent assessment was a quarterly Minimum Data Set (MDS) which was completed on 04/22/13. The MDS indicated Resident #2 was cognitively intact for daily decision making and did not have any memory deficits. The MDS indicated he received anticoagulant medication for 7 days of the observation period. A care plan which was updated on 04/16/13 addressed the risks associated with use of anticoagulant medication. Interventions included monitoring for abnormal bleeding and reporting any bruising. The care plan also indicated Resident #2 had a decline in health and was receiving Hospice services. Interventions included comfort measures as needed. A review of Resident #2's medical record revealed multiple physician's orders adjusting the dosage of Coumadin, an anti-coagulant	F 333	To correct the cited deficiency concerning order entry and the process of verifying accuracy of order entry being followed with the resultant medication errors identified for Resident #2 not receiving scheduled doses of anti-coagulant medication, the following corrective action was taken: 1. Resident #2's order was immediately corrected on the EMAR, plus order to read, "Coumadin 5 mg every day 2. The interval code was changed from every other day to every day per M.D. order. 3. A full audit of all residents on Coumadin was completed by the QI Nurse 4. Audits will be continued weekly x 4 then q monthly x 2 and then x 2 quarterly. Quarterly results of tracking, trending and interventions will be reported in the QAPI Committee by the Director of Nursing.	5/23/2013 5/23/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janet B. Eckard	RN	6/13/13

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 NH/LC Black Mountain WRO Received JUN 14 2013 by: PAM

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F 333	Continued From page 1 medication. The most recent order written on 05/20/13 indicated Resident #2 was to be given Coumadin 5 milligrams (mg) every day which was a decrease in dosage from the previous order. Further record review revealed lab reports of PT/INR tests (used to adjust dosage of Coumadin so the blood doesn't get too thin) which were done every 2 to 3 weeks. The most recent level was drawn on 05/17/13 with a PT of 32.9 and INR of 3.55. A review of Resident #2's Medication Administration Record (MAR) for May 2013 revealed an entry dated 05/20/13 which listed Coumadin 5mg every day. Under the date for 05/21, 05/23, 05/25, 05/27 05/29 and 05/31 the block for signing that the medication was administered was blocked out which indicated the medication was not to be given those days. The block for initialing under 05/20/13 was blank. An interview with the Assistant Director of Nursing (ADON) on 05/23/13 at 3:00 PM revealed the pharmacy dispensed a 7 day supply of Coumadin whenever the dosage was changed. The discontinued dosage was removed from the medication cart and returned to the pharmacy. Visual inspection with the ADON of the medication container for Resident #2's Coumadin revealed a dispensed date of 05/20/13. The dosages for 05/20/13 and 05/21/13 were still in the container. The ADON stated she would complete a medication error report for the 2 missed doses. She stated Resident #2 would not have received the other doses that were blocked out on the MAR if the surveyor had not brought	F 333	Nurses involved with medication errors for Resident #2 were given written disciplinary actions and re-educated on procedure for order entry and validating accuracy of order. Inservice for all nurses on order entry, lab log, Coumadin log and 5 step chart check by Staff Development Coordinator. Process for transcribing and verifying medication orders reviewed and policy revised. Nurses educated on revised policy of transcribing and verifying medication orders. **New Policy Process:** 1. New orders entered by Administrative Coordinator 2. New orders checked by charge nurse immediately following entry by Administrative Coordinator 3. New orders then checked by hall nurse prior to end of shift. 4. Fourth check of new orders by 7p-7a/11p-7a nurse. 5. Next AM, Director of Nursing and/or ADON will check all orders for accuracy in AM nursing meeting.	6/1/2013 6/14/2013 6/14/2013 6/14/2013 6/14/2013

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F 333	Continued From page 2 the error to her attention. She stated the medication would have been given every other day instead of every day as ordered. An interview with Nurse #1, who was working on 05/20/13 when Resident #2's Coumadin was scheduled to be given, revealed the Coumadin had not arrived from pharmacy prior to her leaving at 7:00 PM on 05/20/13. Nurse #1 stated she told the Medication Aide who relieved her that she would need to administer the Coumadin when it arrived from the pharmacy. Nurse #1 was also the nurse who was working on 05/21/13 when the Coumadin was scheduled to be given. When asked if she recalled giving the Coumadin, she stated she didn't recall giving the Coumadin on 05/21/13 at 5:00 PM. When Nurse #1 was informed that the medication was blocked out every other day beginning with 05/21/13 on the MAR, she stated it would not have lit up on the electronic MAR to be given so she would not have given it. When asked about the process for transcribing and verifying medication orders, Nurse #1 stated the charge nurse enters all new orders into the electronic MAR and the medication nurses are responsible for verifying they were transcribed correctly. She stated she couldn't recall if she was the nurse who verified the transcription on 05/20/13 when the new order was received. An interview on 05/23/13 at 4:50 PM with the ADON revealed the Coumadin dosage and instructions were entered correctly on the MAR but the interval code was not changed from "every other day" to "every day" so the computer blocked out every other day. The ADON stated the facilty's system for transcribing new orders is	F 333	6. Accuracy of new orders will be reported daily to the interdisciplinary team in morning meeting x 1 month, then weekly x 2 months, then monthly x 3 months. 7. Director of Nursing will review root cause of any inaccuracies and formulate a plan of correction immediately. 8. Report of findings and action will be reported quarterly to the QA/PI Committee.	

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F 333	Continued From page 3	F 333		

that one nurse enters the medication into the electronic MAR. A second nurse checks the entry to verify that it has been transcribed correctly. The order is checked a third time by the nurse who is working the 11:00 PM to 7:00 AM shift on the day the order was received. When the third nurse completes checking the orders, she signs the computer-generated list of new orders and gives it to the Director of Nursing.

An interview on 05/23/13 at 5:37 PM with the pharmacist revealed he delivered Resident #2's Coumadin to the facility at approximately 7:00 PM on 05/20/13 and left it in the medication storage room.

An interview on 05/23/13 at 5:40 PM with the Medication Aide who worked on 05/20/13 revealed that she did not administer Resident #2's Coumadin. She stated Nurse #1 told her the medication in the cart was the wrong dose and she didn't realize she needed to administer the Coumadin when the new dose arrived from the pharmacy.

An interview on 05/23/13 at 6:14 PM with Nurse #2, who worked the 11:00 PM to 7:00 AM shift on 05/20/13, revealed she printed a list of all new physician's orders that had been entered in the computer in the last 24 hours. She stated she compared the written order with the list to make sure the medication, dosage, frequency, time and resident all matched. She stated she did not look at the electronic MAR because she thought everything she needed to verify accuracy of the transcription was on the computer-generated print out.

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F 333	Continued From page 4 An interview on 05/23/13 at 6:20 PM with the ADON revealed her expectation of the second and third nurse who verified accuracy of the transcription was for them to compare the written order with the electronic MAR to verify accuracy of transcription.	F 333		