

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

PRINTED: 12/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345506	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2014
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NAME OF PROVIDER OR SUPPLIER WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407
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(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
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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 11/19/14. Event ID# UJJC11.	F 000		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and physician and staff interviews, the facility failed to draw and monitor ordered Dilantin labwork for 1	F 329	This plan of correction is submitted as required by State and Federal law. The provider maintains that the alleged	12/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/05/2014
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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 329	<p>Continued From page 1 of 1 resident (Resident #46) reviewed who was receiving Dilantin.</p> <p>Findings included:</p> <p>Resident #46 was originally admitted on 6/10/14 with diagnoses that included seizure disorder.</p> <p>The physician admission note dated 6/10/14 indicated the resident was admitted after being brought to the hospital on 5/24/14 with prolonged seizure activity, a history of seizures, and a low Dilantin level.</p> <p>The Minimum Data Set (MDS) dated 6/17/14 indicated Resident #46 was moderately cognitively impaired with no rejection of care and a history of seizure disorder.</p> <p>The Medication Administration Record (MAR) dated 7/22/14 revealed an order for Dilantin 100 milligrams (mg) by mouth twice a day for seizures.</p> <p>Record review revealed Resident #46 was admitted to the hospital from 8/5/14-8/7/14. His hospital discharge instructions indicated his Dilantin level checked in the hospital on 8/5/14 was low at 6.1 (normal range was 10.0-20.0) and should be rechecked "in about 3-4 days."</p> <p>The MAR dated 8/7/14 revealed a changed physician order to Dilantin 125 mg by mouth twice a day for seizures.</p> <p>The Physician readmission note dated 8/8/14 stated in part, "[Resident #46's] seizure medications were adjusted. Will check Dilantin level today."</p>	F 329	<p>deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit the providers' capacity to render adequate care.</p> <p>Tag F 329 483.25(l)</p> <ol style="list-style-type: none"> The correct labwork needed for the resident identified within the deficiency was completed as ordered. All other current residents on anti-seizure medications were audited for appropriate monitoring and any needed labwork was done and physician orders obtained for ongoing monitoring. New system will be developed by the Director of Nursing with detailed procedure for difficult blood draws including physician notification. Directed inservice training on drug monitoring, procedures for difficult blood draws and also physician notification will be done by our Staff Development Coordinator with the licensed nurses. Audit to be completed weekly and then monthly in conjunction with our Quality Assurance program by the Director of Nursing and/or RN Supervisor of all residents on medications requiring labwork for monitoring to ensure the labwork is done, done correctly and done timely. 		

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F 329	<p>Continued From page 2</p> <p>The Physician order dated 8/8/14 stated, "Dilantin level today." Record review revealed no Dilantin level results for Resident #46.</p> <p>Record review revealed Resident #46 had blood drawn on 8/8/14 for labwork but did not include a Dilantin level.</p> <p>The Physician order dated 8/11/14 stated, "Repeat Dilantin level." Record review revealed no Dilantin level results for Resident #46.</p> <p>Record review revealed Resident #46 had blood drawn on 8/11/14 for labwork but did not include a Dilantin level.</p> <p>Nurse's note dated 8/31/14 stated, "Resident suffered a seizure at 4:30 pm."</p> <p>Record review revealed Resident #46 was admitted to the hospital from 9/4/14-9/10/14. His discharge summary indicated neurology was consulted due to his epileptic episode. His Dilantin was increased. His Dilantin level checked in the hospital on 9/4/14 was normal at 10.7. His Dilantin level checked in the hospital on 9/8/14 was low at 8.8.</p> <p>The MAR dated 9/11/14 revealed a changed order to Dilantin 200 mg by mouth twice a day for seizures.</p> <p>The Physician order dated 11/11/14 stated, "Ok to check Dilantin and Keppra level. [Resident] sleeping too much in the evenings."</p> <p>Record review revealed Resident #46 had blood drawn on 11/11/14 for labwork but did not include</p>	F 329			

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F 329	<p>Continued From page 3 a Dilantin level.</p> <p>During an interview with the DON on 11/19/14 at 10:00 am she indicated that blood was drawn for other labwork for Resident #46 on 8/8/14, 8/11/14, and 11/11/14 at the facility, but an ordered Dilantin level that should have been included in the labwork was not drawn. Regarding an 8/8/14 Valproic Acid level result in the resident's chart she stated, "[Those labs] were the wrong labs. He has never been on Valproic Acid. They should have run a Dilantin level, not a Valproic level."</p> <p>During an interview with the Administrator on 11/19/14 at 10:05 am she indicated her expectation was for staff to follow physician orders and if staff could not obtain ordered bloodwork that the physician would be notified. The physician would then decide whether to send the resident to the local lab to have blood drawn. She further indicated if the resident or the family refused a blood draw, she expected there would be documentation of the refusal in the resident chart.</p> <p>During an interview with Physician #1 on 11/19/14 at 12:45 pm he indicated he ordered repeat Dilantin levels for Resident #46 after his dosage changes. He further indicated his expectations were that staff would have followed physician orders to draw the Dilantin level, would have communicated to him if they could not get the bloodwork, and then he would have decided what order to write - whether to cancel the blood draw or send the resident out of the facility for the blood draw.</p>	F 329			