

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/14/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - CHARLOTTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2616 EAST 5TH STREET</b> <b>CHARLOTTE, NC 28204</b>	
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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 observations, record review and staff interviews the facility failed to administer a narcotic pain medication per physician's order for 1 of 4 sample residents (Resident #30). Not removing a medication patch before applying a new can result in the resident receiving more than the prescribed dose of medication that has been ordered.</p> <p>Findings included:</p> <p>A review of the manufacturer's information on Fentanyl transdermal patches recommended monitoring of patients and adjusting the dose as necessary. For use in the geriatric population, the manufacturer recommended to use the Fentanyl transdermal system (topical patch) with caution, and reduced dosages in elderly patients.</p> <p>The facility policy was reviewed for the specific medication administration procedure for transdermal drug delivery system (patch) application dated 05/2012 which stated, "The purpose is to administer medication through the skin through proper placement of the patch. The patch must be placed firmly on the skin to ensure transdermal administration of the medication. The old/used patch is removed prior to the placement of the new patch. The new patch is labeled with date and nurse's initials. The placement of the patch is documented on the MAR (Medication</p>	F 333	<p>Preparation on and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. This plan of correction is submitted as the facility's credible allegations of compliance</p> <p>1)On 10/14/15 the patch dated 10/10/15 was immediately removed from Resident #67. Two RNs witnessed the destruction of the patch by flushing it. RP and Nurse Practitioner were notified. No new orders were given.</p> <p>2)On 10/14/15 an immediate audit was completed of 100% of all Fentanyl patches to ensure that no other resident had 2 fentanyl patches in place.</p> <p>3)Directed in-service on medication administration to be conducted on November 12th and 13th. In-service will be conducted by an independent consultant pharmacist. Director of Clinical education or designee will re-educate nurses on fentanyl patch application and</p>	11/17/15

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

TITLE

(X6) DATE

Electronically Signed

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 Administration Record)."</p> <p>On 4/2/2015 the physician ordered a Fentanyl patch for Resident #30. Staff was ordered to apply one 50 microgram per hour transdermal patch every three days related to generalized pain. The patch was ordered to be removed per schedule. On 4/27/2015 a new order instructed staff to check placement of the Fentanyl patch every shift.</p> <p>A review of the electronic Medication Administration Record (eMar) dated 10/1/2015 through 10/31/2015 revealed the location of the Fentanyl patch application. On 10/10/2015 at 9:06 PM nurse documentation indicated the location of the patch on the left front shoulder. The next entry on 10/13/2015 at 9:52 PM further documentation indicated the patch was applied on the resident's chest.</p> <p>Based on an observation at 3:26 PM on 10/14/2015 Nurse #1 located a Fentanyl patch on Resident #30. The patch was dated 10/10/2015 and was located on the resident's left shoulder area. The eMar was reviewed on 10/14/2015 at 3:30 PM with the unit manager. It revealed a Fentanyl patch was applied on 10/10/2015 at 9:06 PM. An additional Fentanyl patch had been applied on 10/13/2015 at 9:20 PM to the chest. On 10/14/2015 at 3:49 PM, Resident #30 was observed with the Fentanyl patch on her right clavicle area dated 10/13/2015. The unit manager removed the patch dated 10/10/2015 before applying the patch dated 10/13/2015.</p> <p>On 10/14/2015 at 3:49 PM the unit manager said the policy stated nurses should remove the used patch with another nurse as a witness and</p>	F 333	<p>removal. Education will include that the nurse must ensure that the old fentanyl patch is removed then wasted with two nurses each time a new patch is applied. Education will also include how to document the removal by 2 nurse signatures. Audits will be completed following each scheduled fentanyl patch change x 4 weeks. The audit will then be completed weekly x 4 weeks then monthly for 3 months. Should other residents receive an order for a fentanyl patch they will be added to the audit process.</p> <p>4)The Director of Nursing Services or nursing designee will bring findings of audits to QAPI x 3 months.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	<p>Continued From page 2</p> <p>destroy it, cut it into small pieces and put it in the sharps container. His expectation was for the nurse passing the medication to remove the old/used patch before applying a new one. If the old/used patch was not found on the resident, then the nurse was to report this to the unit manager and document in the progress notes that it was not on the resident to be removed. Resident #30 was observed with a Fentanyl patch on her right clavicle area to her left shoulder area dated 10/10/2015 and a Fentanyl patch on her right clavicle area dated 10/13/2015. The nurse unit manager removed the patch dated 10/10/2015 from the resident's left shoulder area. Nurse #2 had failed to remove the Fentanyl patch dated 10/10/2015 before applying the patch dated 10/13/2015.</p> <p>A review of Resident #30's medical record revealed the resident had diagnoses that included rapidly progressing Alzheimer's disease, pressure ulcer stage 4 right buttock, anemia, major depressive disorder, obstructive hydrocephalus, primary generalized arthritis, and seborrheic dermatosis. The progress note dated 10/12/2015 indicated pain management was in place. The resident was receiving Hospice care.</p> <p>A review of the care plan indicated end of life issues, advance directives, falls, comprised short and long term care memory. Resident #30 had no recall due to progressive Alzheimer's. The resident was at risk for falls, decreased physical functioning and needed assistance with activities of daily living, alteration of skin breakdown Stage IV pressure to right ischium, and was at risk for further breakdown related to assistance required for bed mobility. The resident had contractures of all extremities, dependent on staff for turning,</p>	F 333			

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F 333	<p>Continued From page 3</p> <p>repositioning, incontinence care, and that the resident had a terminal diagnosis.</p> <p>On 10/14/2015 at 4:28 PM the Director of Nursing (DON) stated we expect 2 nurses to dispose of the prior Fentanyl patch when it was removed and before a new Fentanyl patch was placed. A nurse should never apply a new Fentanyl patch before removing the old one. The DON stated two Fentanyl patches on at the same time for this resident would do this resident harm because of her as needed (PRN) morphine, other pain medications and other comorbidities. "I saw this resident this morning and she was at baseline. A nurse is currently assessing her for her general assessment so that the physician can be notified of the significant medication error."</p> <p>On 10/14/2015 at 4:30 PM, Nurse #2 stated she worked the 3-11 PM shift on 10/13/2015. She stated she applied the Fentanyl patch to the right chest of Resident #30 about 9:30 PM and she could not locate the previous patch. She said Resident #30 was lying in bed and was able to be turned and repositioned. A complete assessment was performed and the previously placed patch was not observed on Resident #30. Nurse #2 then said she placed the patch dated 10/13/2015 to the right chest. She said she did not observe or assess any changes in Resident #30's level of consciousness or neurological status. She stated there were no concerns in pain control that would indicate any need for notifying the physician or the family. The resident was "restful and comfortable for the remainder of the shift."</p> <p>On 10/14/2015 at 4:53 PM, the Nurse practitioner (NP) stated the Fentanyl patch was a 72 hour</p>	F 333			

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F 333	Continued From page 4 time released patch and all the medicine should have been released "however, it is a medication error." She stated she would have preferred that this did not occur. The NP stated she did not think there would be any negative impact to the resident since it was her regular medication regime to have the Fentanyl patch and she also received morphine prn for pain which she received at 7:30 AM this morning. She was notified by staff and spoke with the unit manager about the error. She requested monitoring of the resident including vital signs and instructed him to notify her of any changes in status.	F 333		