

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

PRINTED: 05/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2017
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901		
(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=E	<p>483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>483.45(f) Medication Errors.</p> <p>The facility must ensure that its-</p> <p>(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review & staff interviews the facility failed to administer eye drops ordered to treat glaucoma per the physician's order for one of one resident reviewed for administration of medications (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 03/29/17 with diagnoses which included glaucoma. An admission Minimum Data Set assessment dated 04/05/17 indicated Resident #1 was cognitively intact for daily decision making and had no delirium, psychosis or rejection of care.</p> <p>The admission physician's orders dated 03/29/17 included an order for Dorzolamide ophthalmic (a liquid eye solution used to treat glaucoma) one drop to both eyes twice a day.</p> <p>Review of Resident #1's March 2017 Medication Administration Record (MAR) revealed Dorzolamide ophthalmic one drop both eyes twice a day was scheduled for administration at 6:00 AM and 6:00 PM. The dose scheduled for 03/30/17 at 6:00 AM was initialed and circled. A note on the back of the MAR dated 03/30/17 at 6:00 AM indicated the medication had not arrived</p>	F 333	<p>F333</p> <p>Resident #1 no longer at the facility.</p> <p>The Director of Clinical Services and/or Nursing Supervisor reviewed the last 30 days of administration of medication for availability of medications 4/21/17-4/27/17. Any further issues identified were addressed by the Nursing Supervisor.</p> <p>Licensed Nurses were re-serviced 4/21/2107-5/2/2017 on administering medications as ordered and notifying the pharmacy and Director of Clinical Services if medications are not available. The Director of Clinical Services and/or Nursing Supervisor will preform Quality Improvement Monitoring of Medication not available and/or not given and for delivery of new medications for five times a week for two months, three times a week for one month, then two times a week thereafter for one year.</p> <p>The Director of Clinical Services introduced the plane of correction to the Quality Assurance Performance</p>	5/3/17	

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

TITLE

(X6) DATE

Electronically Signed

05/02/2017

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>from the pharmacy. All the other doses scheduled for administration in March were initialed as given. Resident #1 missed one dose of Dorzolamide eye drops according to the March 2017 MAR.</p> <p>Review of the pharmacy's "Proof of Delivery" records revealed a bottle of Dorzolamide eye drops was delivered to the facility on 03/30/17 at 6:21 AM.</p> <p>Review of Resident #1's April 2017 MAR revealed Dorzolamide ophthalmic one drop to both eyes twice a day scheduled for administration at 10:00 AM and 10:00 PM. The April 2017 MAR had circled nurses initials for the 10:00 AM dose of Dorzolamide on 04/04, 04/05, 04/06, 04/07, 04/9 and 04/10 and for the 10:00 PM dose of Dorzolamide on 04/03, 04/04, 04/05 and 04/07 - 04/12/15. A note on the back of the April 2017 MAR dated 04/04/17 indicated that the Nurse #1 was unable to locate the Dorzolamide eye drops and the physician and resident's wife were notified. A note on the back of the April 2017 MAR dated 04/07/17 indicated all medications scheduled for administration between 10:00 AM and 12:00 PM were not administered because Resident #1 was out of the facility for a medical appointment.</p> <p>Review of the pharmacy's "Proof of Delivery" records revealed a second bottle of Dorzolamide eye drops was delivered to the facility on 04/05/17 at 1:16 AM.</p> <p>An interview on 04/20/17 at 11:05 AM with Resident #1's family member revealed Resident #1 was supposed to get 2 different medications to treat glaucoma and one of the medications that</p>	F 333	<p>Improvement Committee on 5/1/2017. The results of the Quality Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Service or designee in the absence of the Director of Clinical Services. the Quality Assurance Performance Improvement Committee consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager, Medical Director, Social Services, Activities Director, Maintenance Director, and MDS nurse and one direct care staff member.</p>		

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F 333	<p>Continued From page 2</p> <p>he should have gotten every night wasn't given while he was in the facility. The family member stated she provided one bottle of Dorzolamide eye drops for the facility to use but was told the eye drops were lost. The family member stated she was also told two additional times by nurses that the Dorzolamide eye drops had been lost. The family member stated she was very concerned because Resident #1 was not able to see as well when he missed the eye drops.</p> <p>An interview on 04/20/17 at 2:49 PM with Nurse #1 revealed she was unable to locate the Dorzolamide eye drops that were scheduled for administration on 04/04/17 at 10:00 AM and notified the pharmacy. Nurse #1 stated the pharmacy had already dispensed the eye drops and she had to complete a request stating the facility would pay for the drops to be replaced. Nurse #1 stated she completed the form and sent it to the pharmacy. Nurse #1 stated if a medication wasn't given the nurse was expected to circle their initials on the front of the MAR for the dose that was missed and put an explanation on the back of the MAR and notify the physician. Nurse #1 stated she thought the pharmacy sent another bottle of eye drops. Nurse #1 checked the medication cart and was unable to locate the Dorzolamide eye drops.</p> <p>An interview on 04/20/17 at 2:49 PM with Nurse #2 revealed she returned all of Resident #1's oral medications to the pharmacy but she did not return any eye drops to the pharmacy after his discharge on 04/12/17.</p> <p>An interview on 04/20/17 at 2:49 with the Director of Nursing (DON) revealed she expected the nurses to make a note of explanation on the back</p>	F 333			

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F 333	<p>Continued From page 3</p> <p>of the MAR for any circled doses of medication because a circled dose indicated the medication wasn't given.</p> <p>An interview on 04/20/17 at 5:29 PM with Resident #1's physician revealed he wasn't aware of the missed doses of Dorzolamide eye drops. The physician stated it was clinically significant that Resident #1 missed the eye drops used to treat glaucoma because it would have caused his vision to be blurred and could have caused agitation and confusion as well as increased pain in his eyes.</p> <p>An interview on 04/21/17 at 2:46 PM with Nurse #3, who circled the 10:00 PM dose of Dorzolamide eye drops on 04/04/17 and 04/10/17, revealed she didn't administer the eye drops because they weren't in the medication cart. Nurse #3 stated she didn't notify the pharmacy or physician but should have called the pharmacy and physician.</p> <p>An interview on 04/21/17 at 2:58 PM with Nurse #4, who circled the 10:00 AM dose of Dorzolamide eye drops on 04/10/17, revealed she didn't administer the eye drops because they weren't in the medication cart. Nurse #4 stated she sent a refill request to the pharmacy and was told they had sent the eye drops and it wasn't refillable. Nurse #4 stated she looked everywhere for the eye drops including the refrigerator and couldn't locate them. She stated Resident #1's family member was informed that she couldn't locate the eye drops and she also notified Resident #1's physician via fax message.</p> <p>An attempt was made on 04/21/17 at 3:09 PM to call Nurse #6, who initialed and circled the doses</p>	F 333			

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F 333	<p>Continued From page 4</p> <p>of Dorzolamide eye drops that were scheduled for administration at 10:00 AM on 04/05/17 and 04/09/17, but number had been disconnected.</p> <p>An interview on 04/21/17 at 5:04 PM with Nurse #5, who circled the 10:00 PM doses of Dorzolamide eye drops on 04/07/17, 04/08/17 and 04/09/17, revealed she didn't administer the eye drops because they weren't in the medication cart. Nurse #5 stated she looked for the eye drops but couldn't find them. She stated she couldn't recall if she notified the pharmacy or Resident #3's physician.</p> <p>A message was left requesting a return call on 04/21/17 at 5:07 PM from Nurse #7, who initialed and circled the dose of Dorzolamide eye drops that was scheduled for administration on 04/06/17 at 10:00 AM. Nurse #7 did not return the call.</p> <p>A message requesting a return call was left on 04/21/17 at 5:10 PM for Nurse #8, who initialed and circled the dose of Dorzolamide eye drops that was scheduled for administration on 04/11/17 at 10:00 PM. Nurse #8 did not return the call.</p> <p>An interview on 04/21/17 at 5:15 PM with the DON revealed she was unable to explain what happened to the bottles of eye drops that were dispensed for Resident #1. The DON stated she expected medications to be administered as ordered and for the nurse to notify the pharmacy if a medication wasn't available for administration. The DON also stated the resident's physician should be notified of all missed medications.</p>	F 333			