

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2017
NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262	
(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	<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, resident, staff and physician interviews, that facility failed to provide the long term medication Aubagio (a medication used to treat a neurological disorder) for 1 of 3 residents sampled (Resident # 3), resulting in a significant medication error.</p> <p>The findings included: Resident # 3 was admitted to the facility on 6/17/17 from the hospital. Diagnoses included: Neurological Disorder.</p> <p>A review of the most recent Quarterly Minimum Data Set (MDS) dated 9/15/17 revealed the resident was cognitively intact, had no behaviors and did not refuse care. The resident required extensive assistance of two people for bed mobility, required a mechanical lift for transfers, did not ambulate, was totally dependent on staff for bathing, fed self after set up. Resident # 3 was out of bed to a wheelchair and could not propel herself. Review of section M of the MDS revealed the resident did not have pressure ulcers.</p> <p>A review of the Physician's Orders for June, July, August and September 2017 revealed an order for Aubagio 14 milligrams by mouth daily.</p> <p>A review of the Medication Administration Record</p>	F 333	<p>Resident #3 has received the prescribed medication since September 1, 2017.</p> <p>Other residents who have the potential to be affected were identified by review of their electronic medication administration record (eMar) for any documented missed doses of prescribed medication from August 2017 to present by the Unit Managers.</p> <p>Licensed nurses, including week end and part time, were reeducated on the procedure on how to handle situation when a medication is not available and the procedure on reordering medications in time to be received before current supply is exhausted by the Nurse Educator on 10/11/17. The Unit Managers and Assistant Center Nurse Executive will audit the (eMar) 5 days a week , including one week end day for one month, 2 times a week, including one week end day for one month, then weekly for one month.</p> <p>The Center Nurse Executive will review the results of the audit and present to the QAPI monthly for 3 months.</p>	10/11/17

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

TITLE

(X6) DATE

Electronically Signed

10/10/2017

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>for June-August revealed that Resident # 3 did not receive the prescribed Aubagio for the months of July and August, 2017. Further review revealed documentation of "unavailable", "not in stock", "on order", "on hold" and "waiting on pharmacy" as reasons for the missed doses.</p> <p>A phone interview with Resident # 3's family member on 9/27/17 at 3:30 PM revealed that the resident was receiving insurance benefits through a private insurance and she had been getting the medication shipped to her home and she was taking it to the facility. She took the last 28 day supply to the facility sometime in May, 2017; she could not recall the exact date, and that the prescription had expired. She revealed Resident #3 began receiving Medicaid benefits in June and required a new prescription.</p> <p>An interview with Nurse #1 on 9/28/17 at approximately 1:00 PM revealed the procedure for obtaining missing medications was to check the overstock, the pyxis (an automated medication dispensing system), notifying the pharmacy and the physician that the resident needed a new prescription. She revealed she contacted the pharmacy and was informed the medication would have to be received from a specialty pharmacy. She revealed she placed a call to the specialty pharmacy and left a message and that she also called the neurologists office and left a message. She further revealed she informed the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) of the missing medication.</p> <p>A follow-up record review revealed no entries that indicated the pharmacy or the physician were notified of missing medication.</p>	F 333			

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

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F 333	Continued From page 2 An interview with the unit supervisor on 9/28/17 at 1:30 PM revealed the process for obtaining missing medications was for the charge nurse to call the pharmacy if the medication wasn't in the pyxis, notify administration (herself, ADON or DON) and notify the physician. She further revealed she was unaware that Resident # 3 was out of her Aubagio and that a new prescription was required. A phone interview with the neurologist on 9/27/17 at 5:30 PM revealed that her Nurse Practitioner had been the one seeing Resident # 3 in the office and that she was under the impression that Resident #3 wasn't receiving her medication since June because of the change from private insurance to Medicaid. The neurologist didn't believe the resident had any adverse effects at this time as there were no symptoms of relapse, but she could not say whether the resident would be affected in the long term due to not taking the medication continuously. A follow-up phone interview with the neurologist's office on 9/28/17 at 3:30 PM revealed that they were unaware that the facility required a new prescription, but, that since Resident #3 was an established patient and was already prescribed the Aubagio, they (the facility) could have called neurologist's office and had a prescription faxed. An interview with the DON on 9/28/17 at 4:00 PM revealed that most of the nurses knew the procedure for obtaining medications, but since this was a specialty medication, it was a different process. She revealed she had started in-servicing staff members today. She further revealed she would expect the nurse responsible	F 333			

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F 333	Continued From page 3 for taking care of the patient to follow-up with providers and pharmacy to ensure medications were received timely.	F 333			