| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345306 | A. BUILDING ______ B. WING ______ | 08/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| IREDELL MEMORIAL HOSPITAL INC | 557 BROOKDALE DRIVE STATESVILLE, NC 28677 |

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| E 000 | Initial Comments<br><br>An unannounced recertification surrey was conducted on 8/3/21 through 8/6/2021. The facility was found in compliance with the requirement CFR483.73, Emergency Preparedness. Event ID# V56U11. | E 000 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, staff interviews and nurse practitioner interview, the facility failed to follow the medication order for lisinopril (a medication that lowers blood pressure) and administered the lisinopril outside of the | F 757 | F757<br><br>Correction Action for resident affected by the alleged deficient practice: The provider for Resident #43 was notified on | 9/3/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/24/2021

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 757 | Continued From page 1<br>parameters specified in the physician order for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #43).<br><br>Findings included:<br><br>Resident #43 was admitted to the facility on 5/21/2021 with a diagnosis of hypertension.<br><br>The admission Minimum Data Set (MDS) dated 5/28/2021 showed Resident #43 was cognitively intact.<br><br>August 2021 physician orders revealed an order for lisinopril 5mg by mouth daily for Resident #43 showed a parameter for the order that stated to hold if systolic blood pressure was less than 100. The start date for this order was 6/23/2021.<br><br>Vital sign record revealed that on 8/3/2021 at 7:48 AM Resident #43's blood pressure was 92/60.<br><br>Medication Administration Record revealed lisinopril 5mg was administered on 8/3/2021 at 10:42 AM and there was not a recheck of the resident's blood pressure documented in their system prior to administration.<br><br>During an interview with Nurse #1 on 8/5/2021 at 12:00 PM, she stated that she had given Resident #43 the lisinopril 5mg at 10:42 AM on 8/3/2021 and had not rechecked the residents blood pressure prior to administration.<br><br>During an interview with the Nurse Aide (NA) on 8/5/2021 at 12:12 PM, she stated that the normal process for when vital signs were due in the morning was the NA wrote all their resident's vital signs on a piece of paper and then gave a copy to | F 757 | 8/03/2021 of the issue related to medication administration as well as the blood pressure parameters. No further orders were received. Nursing continued to monitor the resident's blood pressure and no ill effects were noted.<br><br>The nurse administering the medication outside of the order parameters was educated on 8/04/2021 regarding safe medication administration by the Director of Nursing<br><br>Corrective Action taken for those residents having the potential to be affected by the alleged deficient practice: All nursing staff was provided education in regards to safe medication administration with following physician parameter orders to be the priority. All nursing education will be completed by 8/30/2021.<br><br>Measure/Systemic changes put in place to assure the alleged deficient practice does not reoccur: All residents with medication order parameters have the potential to be affected. The Director of Nursing or designee will audit 5 resident medication administration records each week to ensure no parameters were overlooked during medication administration. These audits will begin on 8/30/2021 and they will continue until 11/26/2021 to ensure continued compliance. The Administrator or designee will also review the Director of Nursing audits weekly beginning on 9/03/2021 to ensure monitoring and compliance. The results of these audits | |

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| F 757 | Continued From page 2<br>the nurses. She further stated that the vital signs were then documented in the system by the NA.<br><br>During an interview with the Director of Nursing on 8/5/2021 at 12:20 PM, she stated due to Resident #43's blood pressure reading on 8/3/2021, the lisinopril should not have been administered due to the blood pressure parameter on the physician order.<br><br>During an interview with the Nurse Practitioner on 8/5/2021 at 12:24 PM, she stated that the parameters were in place for the use of the lisinopril and if Resident #43's blood pressure was 92/60 the medication should not have been administered. She further stated in a second interview on 8/6/2021 at 3:00 PM, that the resident could have become hypotensive (low blood pressure) due to administration of the lisinopril when blood pressure was already below the parameters given in the order. | F 757 | will be shared at the next QAPI meeting on 9/22/2021 and 12/22/2021 for final oversight.<br><br>All corrective actions will be monitored to ensure the alleged deficient practice does not reoccur. This will be monitored by the Director of Nursing or designee audits of 5 resident medication administration records each week to ensure no parameters were overlooked during medication administration beginning on 8/30/21. The Administrator or designee will audit the Director of Nursing audits weekly beginning on 9/03/21 to ensure monitoring and compliance. The results of these audits will be shared at the next QAPI meeting on 9/22/2021 and 12/22/2021 for final oversight. | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that--- | F 758 | | 9/3/21 |

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| F 758 | Continued From page 3<br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, staff interviews and pharmacy consultant interview, the facility failed to give a clinical indication for a scheduled antipsychotic medication and failed to ensure physician orders for as needed (PRN) | F 758 | F758<br><br>Corrective action for the resident affected by the alleged deficient practice: The prn medication for Resident #281 had not | |

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| F 758 | Continued From page 4<br>antipsychotic medication was time limited in duration for 1 of 5 residents (Resident #281) reviewed for unnecessary medications.<br><br>Findings included:<br><br>Resident #281 was admitted to the facility on 7/31/2021 with a diagnosis of encephalopathy, generalized weakness and recent history of Covid-19. There was no psychiatric diagnosis listed in Resident #281's medical record. No Minimum Data Set assessment was available due to Resident #281 was a new admission.<br><br>During an observation and interview with Resident #281 on 8/3/2021 at 2:18 PM, resident was amicable and there were no observations of behaviors.<br><br>a. Physician orders reviewed for Resident #281 revealed an order for Quetiapine (antipsychotic) 2 tabs to equal 50mg by mouth every night that had a start date of 7/31/2021.<br><br>The Pharmacy Consultant's drug regimen review dated 8/3/2021 included a notation for clarification of a diagnosis for the use of the Quetiapine. The response from the physician stated that there was no indication for the use of Quetiapine found in Resident #281's documentation.<br><br>The Medication Administration Record (MAR) was reviewed and revealed that Resident #281 received Quetiapine 50mg each night from 7/31/2021 through 8/5/2021.<br><br>b. Physician orders reviewed for Resident #281 revealed an order for Haloperidol (antipsychotic) 3mg- 0.6mL intravenous push every 4 hours PRN | F 758 | been administered and was discontinued immediately on 8/06/2021.<br><br>All current mediation orders for all residents at the time of survey were audited by the Director of Nursing on 8/06/2021 to identify any unnecessary use of antipsychotic medication to include appropriate stop dates and to ensure that a supporting diagnosis was present for these medications.<br><br>Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: The Medical Director and Nurse Practitioner were re-educated on 8/09/2021 regarding appropriate use of antipsychotic medication to include time limitation of the drug and appropriate usage of the drug with a supporting diagnosis. Both verbalized understanding and signed the education that was provided by the Director of Nursing on 8/09/2021.<br><br>Measures/Systemic changes put in place to assure the alleged deficient practice does not reoccur: All residents have the potential to be affected. Residents who are admitted to the facility will have their medications reviewed for antipsychotic medications, appropriate stop dates and supporting diagnosis at time of admission by Director of Nursing or designee. The antipsychotic listing will be obtained weekly and reviewed with providers on a weekly basis. These audits will begin on 8/30/2021 and will continue until 11/26/2021. The result of these audits will | |

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| F 758 | Continued From page 5<br>for agitation that also had a start date of 7/31/2021. There was no stop date on the order for Haloperidol for Resident #281.<br><br>Pharmacy Consultant's drug regimen review dated 8/4/2021 included a recommendation to the physician to review the risk benefit in geriatric resident for the use of Haloperidol PRN. There was no response from the physician in the drug regimen review for use of Haloperidol PRN as of 8/6/2021.<br><br>MAR review revealed the Haloperidol PRN order had not been administered to Resident #281 since resident was admitted to facility on 7/31/2021.<br><br>During an interview with Nurse #2 on 8/6/2021 at 11:30 AM, he stated that he was not sure why Resident #281 was on the Quetiapine. He further stated that he did not see a stop date on the Haloperidol in Resident #281's MAR or physician orders and stated that these orders had come over from the hospital.<br><br>During an interview with the Nurse Practitioner on 8/6/2021 at 3:00 PM, she stated that there was no diagnosis to support the use of the Quetiapine and further stated that for PRN antipsychotics, she usually went into the system and discontinued them if they were not being used.<br><br>During a phone interview with the Pharmacy Consultant on 8/6/2021 at 3:51 PM, he stated that PRN antipsychotics should have a stop date. He further stated that Resident #281 did not have a diagnosis to support the use of the Quetiapine.<br><br>An interview with the Director of Nursing (DON) | F 758 | be shared at the next QAPI meeting on 9/22/2021 and 12/22/2021 for regulatory compliance and final oversight.<br><br>Corrective actions will be monitored to ensure the alleged deficient practice will not occur. Residents who are admitted to the facility will have their medications reviewed for antipsychotic medications, appropriate stop dates and supporting diagnosis at time of admission by Director of Nursing or designee. The antipsychotic listing will be obtained weekly and reviewed with providers on a weekly basis. These audits will begin on 8/30/2021 and will continue until 11/26/2021. The result of these audits will be shared at the next QAPI meeting on 9/22/2021 and 12/22/2021 for regulatory compliance and final oversight. | |

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| F 758 | Continued From page 6 on 8/6/2021 at 4:08 PM revealed that the order for Haloperidol should not have been on Resident #281's physician orders and further stated that it should have had a stop date. The DON also stated that the Quetiapine should not have been administered to Resident #281 without a diagnosis to support the use of the medication. | F 758 | | |