

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

PRINTED: 10/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2011
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NAME OF PROVIDER OR SUPPLIER SUNRISE REHABILITATION & CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761
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F 329 SS=J	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, physician interviews and pharmacist interviews the facility failed to review changes in readmission physician orders to prevent a medication from being administered in an excessive dose for one (1) of seven (7) sampled residents. (Resident #3)</p>	F 329	<p>Without admitting or denying the validity or existence of the alleged deficiencies, Sunrise Rehab and Care Center provides the following plan of correction.</p> <p>F329</p> <ol style="list-style-type: none"> 1. Resident #3 was discharged from this facility on 9-28-11. 2. All new admissions and readmissions have the potential to be affected. All admissions/readmission in the last 30 days have been audited to ensure there are no discrepancies. A new process has been initiated. Reconciliation of medications on admission shall be done to ensure medication safety by accounting for the resident's medications and dosages upon admission or readmission to the facility. 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Whinnie J. Allison</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/02/11</i>
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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.

Original Signature Date: 10-28-11

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F 329	<p>Continued From page 1</p> <p>Immediate jeopardy began on 09/21/11 when Resident #3 was readmitted to the facility with physician's orders that increased his Dilantin dosage from four hundred (400) milligrams to eight hundred (800) milligrams each day and staff did not make attempts to clarify the rationale for this dosage increase. On 09/28/11 Resident #3 was admitted to the hospital and was diagnosed of Dilantin toxicity. Immediate jeopardy was removed on 10/12/11 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated deficient practice, no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place and completion of employee training.</p> <p>Then findings are:</p> <p>Review of the Manufacturer's "Dosage and Administration" information for Dilantin (an anti seizure medication) specified the following information: "General: Dosage should be individualized to provide maximum benefit. In some cases, serum blood level determinations may be necessary for optimal dosage adjustments- the clinically effective serum level is usually 10-20mcg/mL. With recommended dosage, a period of seven to ten days may be required to achieve steady-state blood levels with phenytoin and changes in dosage (increase or decrease) should not be carried out at intervals shorter than seven to ten days. Adult Dosage: Divided daily dosage: Patients who have received no previous treatment may be</p>	F 329	<p>Using a medications (MAR) form, staff will list all medications from the medication history, the discharge summary (if available), the previous MAR (if applicable), and the admitting orders. List the dose, route and frequency for all medications.</p> <p>If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy:</p> <p>A) Contact the nurse from referring facility.</p> <p>B) Contact the physician from the referring facility if possible.</p>		

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F 329	<p>Continued From page 2</p> <p>started on one 100-mg Dilantin (Phenytoin sodium) Extended Oral Capsule three times daily and the dosage then adjusted to suit individual requirements. For most adults, the satisfactory maintenance dosage will be one capsule three to four times a day. An increase up to two capsules three times a day may be made, if necessary."</p> <p>Resident #3 was readmitted to the facility from a hospital on 09/09/11 with diagnoses including; Seizure disorder and Deep vein thrombosis (DVT) of right lower extremity. Review of the resident's readmission orders revealed an order to receive one hundred (100) milligrams of Dilantin four times a day. Review of Resident #3's Medication Administration Record (MAR) from 09/10/11 to 09/16/11 revealed he received four hundred (400) milligrams of Dilantin each day as ordered. On 09/17/11 a physician's order was written for Resident #3 to be evaluated and treated for difficulty breathing at an Emergency Room.</p> <p>Review of Resident #3's hospital records revealed he was admitted to the hospital on 09/17/11. Review of Resident #3's hospital MAR revealed that during his hospitalization from 09/17/11 to 09/21/11 he received the following daily dosages of Dilantin:</p> <p>09/17/11: 100 milligrams 09/18/11: 400 milligrams 09/19/11: 400 milligrams 09/20/11: 400 milligrams 09/21/11: 200 milligrams</p> <p>Review of Resident #3's Hospital "Clinical Discharge Summary" of 09/21/11 revealed two</p>	F 329	<p>C) Contact the admitting and/or attending physician and Medical Director if Necessary.</p> <p>D) Document what was done and how it was resolved. If there is an increase of the medication, or a new medication, the medication is to be identified and reported to the physician. The physician should confirm the need for the increase or new medication for readmission and new admissions. A lab order should be obtained, if warranted by the physician within 72 hours.</p> <p>3. Nursing Staff has been in-serviced by the DON/ADON/Staff Development Nurse on the Reconciliation Process.</p>	

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F 329	<p>Continued From page 3</p> <p>(2) Dilantin orders, which would provide eight hundred (800) milligrams per day, were listed as medications to be taken after being discharged from the hospital. These Dilantin orders were as follows: Dilantin 100 milligrams four times a day and Dilantin 200 milligrams twice a day.</p> <p>Resident #3 was readmitted to the facility on 09/21/11 with diagnoses including; Left lower lobe pneumonia, Dysphagia, History of cerebrovascular accidents, Hypertension, Seizure disorder, Chronic Obstructive Pulmonary Disease exacerbation and Acute respiratory distress. Review of Resident #3's readmission orders revealed they contained two (2) physician's orders for the daily administration of Dilantin that if administered as ordered would provide a total of eight hundred milligrams each day. These readmission physician's orders were as follows; one hundred milligrams of Dilantin four times a day and two hundred milligrams of Dilantin twice a day. Seizure Disorder was the diagnosis noted for both of these orders. The readmission orders were signed by Licensed Nurse (LN) #1 on 09/21/11 and by the resident's physician on 09/22/11.</p> <p>A nurse's note written by LN #1 on 09/21/11 at 5:00 p.m. specified that copies of Resident #3's discharge summary and MARs were faxed to the resident's physician and the facility's dispensing pharmacy.</p> <p>Review of Resident #3's MAR for the dates of 09/21/11 to 09/28/11 revealed both of the Dilantin readmission orders were written on the MAR for daily administration. Further review of the MAR revealed staff documented that Resident #3</p>	F 329	<p>4. DON/ADON/Designee will audit admissions and readmissions for medication discrepancies daily times 4 weeks, weekly times one month, monthly times 3 months, then quarterly times 3 months. Results will be reported to the QA committee monthly. Daily audits of admissions/ readmissions since 10/12/11 have revealed no other discrepancies.</p>	10/28/11	

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F 329	<p>Continued From page 4</p> <p>received the following daily amounts of Dilantin during this facility stay:</p> <p>09/21/11: 600 milligrams 09/22/11: 800 milligrams 09/23/11: 800 milligrams 09/24/11: 800 milligrams 09/25/11: 800 milligrams 09/26/11: 800 milligrams 09/27/11: 600 milligrams 09/28/11: 400 milligrams</p> <p>On 09/28/11 at 7:30 a.m. a nurse's note specified that Resident #3 was alert and verbal, in no apparent distress, but some of his words were "slurred and garbled."</p> <p>On 09/28/11 at 1:00 p.m. a nurse's note specified that Resident #3 had a decreased level of consciousness with a decreased oxygen saturation level of eighty-five percent while receiving one liter per minute of oxygen.</p> <p>On 09/28/11 at 1:30 p.m. a nurse's note specified that orders had been received for Resident #3 to be evaluated and treated at the hospital.</p> <p>Review of hospital laboratory results of 09/29/11 revealed Resident #3 had an elevated Phenytoin (Dilantin) level of 31.3 micrograms per milliliter (mcg/ml). The lab report specified the normal reference range for Phenytoin (Dilantin) was 10.0 to 20.0 mcg/ml.</p> <p>Review of Resident #3's 09/30/11 Hospital discharge summary of 09/30/11 revealed a diagnosis of "Dilantin Toxicity." The resident's discharge summary specified: "A Dilantin level</p>	F 329		
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F 329	<p>Continued From page 5</p> <p>was checked the morning after admission and noted to be elevated at 31. I reviewed the MAR from the prior nursing facility and it seems as if he was discharged on both Dilantin 200 mg twice daily and Dilantin 100 mg 4 times a day. He was receiving 800 mg of Dilantin a day. Review of his previous history and physicals seemed to indicate that he was only on 100 mg 4 times a day. This appears to be a medication error and his Dilantin has now been held. I am requesting a repeat Dilantin level to be checked on Sunday, and his Dilantin can be restarted once it falls below 20 at 100 mg 4 times daily."</p> <p>Interview with the facility's Administrator on 10/10/11 at 2:30 p.m. revealed the facility did not have a written policy which specified how staff was to process readmission physician orders. The Administrator stated that Licensed Nurse (LN) #1 was the facility's admissions nurse and was responsible for transcribing readmission orders and faxing the orders to the resident's physician.</p> <p>On 10/10/11 at 4:00 p.m. an interview was conducted with LN #1, who processed Resident #3's facility readmission orders of 09/21/11. LN #1 stated that when Resident #3 was readmitted on 09/21/11 she transcribed the physician readmission orders from the hospital's discharge summary onto a facility order sheet. LN #1 stated that while transcribing these orders she realized the resident had two orders for routine Dilantin, which would provide a daily dose of eight hundred (800) milligrams. LN #1 explained that she did not check the resident's prior Dilantin orders or MARs, so she was unaware that the readmission Dilantin orders were four hundred (400)</p>	F 329		
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F 329	<p>Continued From page 6</p> <p>milligrams more than what was previously prescribed for Resident #3. LN #1 stated that she did not contact the resident's physician and did not attempt to contact the hospital for clarification on any of the resident's 09/21/11 discharge instructions or physician's orders. LN #1 stated that on 09/21/11 she faxed a copy of Resident #3's readmission orders and MAR to the physician and to the facility's dispensing pharmacy. LN #1 stated that after she faxed this information she did not recall receiving any response from the physician or dispensing pharmacy regarding the resident's readmission orders. LN #1 stated that it was her understanding that when she processed a resident's readmission orders she was instructed that she only needed to transcribe the orders from the hospital's discharge summary onto a physician's order sheet and MAR and was to then fax this information to the resident's physician and the facility's dispensing pharmacy.</p> <p>On 10/10/11 at 4:15 p.m. an interview was conducted with Resident #3's physician. The physician stated that when a resident is readmitted to the facility nursing staff should review the resident's readmission orders and compare them to resident's previous orders to identify any changes. The physician explained that if the admitting nurse discovered the resident's new orders reflected changes in the resident's medications the nurse should then notify him of these changes. The physician stated that he did not recall facility staff notifying him of any concerns regarding Resident #3's readmission orders of 09/21/11. The physician explained that he would have expected the facility to notify him that Resident #3's readmission</p>	F 329			

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F 329	<p>Continued From page 7</p> <p>orders of 09/21/11 included a four hundred milligram per day increase in the resident's daily dose of Dilantin than previously prescribed. The physician stated that he was unsure why Resident #3 needed eight hundred (800) milligrams of Dilantin per day because his seizure disorder was being effectively managed with a daily dose of four hundred (400) milligrams.</p> <p>On 10/10/11 at 5:20 p.m. the facility's Director of Nurses (DON) was interviewed. The DON confirmed that Resident #3's daily dosage of Dilantin was increased from four hundred (400) milligrams to eight hundred (800) milligrams when he was readmitted on 09/21/11. The DON stated that the facility's Medical Director and Resident #3's physician had recently informed staff that they wanted the facility's admission nurses to only transcribe a resident's admission or readmission orders onto an order sheet and MAR and to then fax this information to them for approval. The DON stated that the physicians specified that they wanted to be responsible for reviewing a resident's admission and readmission orders, so they could review them and verify their accuracy.</p> <p>On 10/11/11 at 12:30 p.m. an interview was conducted with one of the facility's consulting pharmacists. The Pharmacist stated that no pharmacy review of Resident #3's medical record was performed during his readmission stay from 09/21/11 to 09/27/11. The pharmacist stated that to her knowledge the facility had not requested a pharmacist to review the resident's medications during this readmission stay. The pharmacist explained that if Resident #3's medications had been reviewed the increase in his daily dose of</p>	F 329			

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F 329	<p>Continued From page 8</p> <p>Dilantin from four hundred milligrams to eight hundred milligrams per day would have been identified as an irregularity and the resident's physician would have been asked why this increased dosage was necessary.</p> <p>On 10/12/11 at 8:45 a.m. an interview was conducted with the facility's Medical Director regarding resident admission and readmission orders. The Medical Director stated that nursing staff should review resident orders when a resident is readmitted to the facility. If during this review the nursing staff identify any changes or concerns they should then contact the hospital to get clarification of the orders and notify the resident's physician.</p> <p>On 10/12/11 at 3:20 p.m. an interview was conducted with a pharmacist at the facility's dispensing pharmacy. This interview revealed that on 09/21/11 the pharmacy received Resident #3's readmission orders which contained two Dilantin orders. The pharmacist explained that it was at the pharmacist's discretion to inform the facility of any concerns that are identified when filling resident prescriptions. The pharmacist stated that from the information available he did not see where the pharmacist, who processed Resident #3's readmission orders of 09/21/11, had informed the facility or physician of any concerns or irregularities.</p> <p>The Administrator was notified of the Immediate Jeopardy on 10/11/11 at 3:00 p.m. The facility provided a credible allegation of compliance on 10/12/11 at 6:40 p.m. The following interventions were put into place by the facility to remove the Jeopardy:</p>	F 329			

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F 329	<p>Continued From page 9</p> <p>Resident #3 was identified during survey with readmission physician's orders of 09/21/11 which included; 100 milligrams of Dilantin four times a day and 200 milligrams of Dilantin twice a day. So, upon Resident #3's readmission to the facility on 09/21/11 he had orders to receive a total of 800 milligrams of Dilantin per day which was 400 milligrams more than previously ordered for this resident. Resident #3 was discharged from the facility on 09/28/11.</p> <p>On 10/11/11 an audit was performed by the Assistant Director of Nurses (ADON) and Director of Nurses (DON) on all residents receiving Dilantin to check their current ordered dosage and method of administration, their last lab level and when drawn to ensure that no other residents are at risk. As a result of this audit no problems were identified. On 10/11/11 and 10/12/11 an audit of all resident admissions within the past thirty (30) days was conducted by facility licensed nursing staff as overseen by the Administrator. Any Discrepancy identified from this audit required minor adjustments to resident physician orders and physician notification.</p> <p>Upon a resident's admission or readmission to the facility each resident's physician orders, including medication orders, will be reviewed by the facility's admission nurse or a Licensed Nurse. If this is a readmission to the facility the nurse will review the physician orders that were in place prior to the resident's discharge from the facility and compare them to the resident's readmission orders. As part of this review the nurse will compare the resident's previous Medication Administration Record (MAR) to the</p>	F 329			

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F 329	<p>Continued From page 10</p> <p>resident's new readmission medication orders. If the admissions nurse or Licensed Nurse identify changes in the resident's drug regime they will communicate these changes by calling the resident's physician. A second licensed nurse will also review resident admission and readmission physician orders and sign the orders as reviewed.</p> <p>On 10/12/11 a new policy was developed by the Administrator and Director of Nurses (DON) describing the new process for reviewing physician's orders upon a resident's admission or readmission to the facility.</p> <p>The Director of Nurses (DON) and Assistant Director of Nurses (ADON) will in-service all facility nurses on the facility's admission process regarding the review of resident admission and readmission orders by 11:59 P.M. on 10/11/11. The two nurses who were unable to receive this inservice information will be inserviced prior to being allowed to return to work.</p> <p>The Director of Nurses, Assistant Director of Nurses and Treatment Nurse will audit all resident admission and re-admission physician orders including; medications that require therapeutic lab levels daily x 4 weeks; Weekly x 1 month; monthly x 3 months and then quarterly x 3 months. Results will be reported to Quality Assurance Committee monthly.</p> <p>Immediate Jeopardy was removed on 10/12/11 at 7:40 p.m. based on review of the facility's new policy for processing admission and readmission orders. Staff interviews with licensed nursing staff on all three shifts revealed that facility staff</p>	F 329			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2011
NAME OF PROVIDER OR SUPPLIER SUNRISE REHABILITATION & CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761		
(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 329	Continued From page 11 received inservice training on the facility's new process on admission and readmission orders and on the staff's responsibilities to clarify orders with a resident's physician. Resident interviews regarding the facility's medication administration procedures.	F 329			