

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER WESTCHESTER MANOR AT PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE 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 329 SS=G	<p>483.25(I) 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 staff interviews and record review, the facility failed to identify a resident ' s low heart rate as a significant adverse consequence of the medication regimen for 1 of 3 sampled residents (Resident #3) reviewed for unnecessary medications.</p> <p>The findings included:</p>	F 329	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R.	5/2/14	

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

TITLE

(X6) DATE

Electronically Signed

04/22/2014

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 329	<p>Continued From page 1</p> <p>Resident #3 was admitted to the facility on 2/19/11. The resident was re-admitted to the facility from the hospital on 5/21/12. The resident ' s cumulative diagnoses included hypertension (high blood pressure) and a history of Irritable Bowel Syndrome (a disorder which affects the large intestine and commonly causes cramps, abdominal pain, bloating gas, diarrhea and constipation).</p> <p>A review of Resident #3 ' s medical record revealed that the following antihypertensive medications were reinitiated upon readmission to the facility on 5/21/12: 200 milligrams (mg) labetalol (a medication classified as a beta-adrenergic blocking agents or beta-blocker) given as one tablet by mouth twice daily; 50 mg atenolol (a medication classified as a beta-adrenergic blocking agents) given as one tablet by mouth twice daily; and 5 mg amlodipine (a medication classified as a calcium channel blocker) given as two tablets by mouth once daily.</p> <p>According to Lexi-Drug, a comprehensive drug database of Lexi-Comp, bradycardia (slowness of the heartbeat, usually a rate less than 60 beats per minute) may be observed more frequently in elderly patients (>65 years of age) receiving beta-adrenergic blocking agents (or beta-blockers); dosage reductions may be necessary.</p> <p>A review of the resident ' s Medication Administration Records (MARs) from June 2013 through October 2013 revealed the resident continued to receive the antihypertensive medication regimen initiated on 5/21/12, which included: 200 mg labetalol given as one tablet by mouth twice daily; 50 mg atenolol given as one</p>	F 329	<p>405.1907_____</p> <p>F329</p> <p>1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #3 was discharged to High Point Regional Hospital on February 22, 2013. Resident #3 was discharged from High Point Regional Hospital to another skilled nursing facility on February 26, 2014.</p> <p>2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p>An audit of resident medication regimens was conducted by the consultant pharmacist beginning April 13, 2014 and completed April 17, 2014. Consultant pharmacist began noting pulse readings on every resident in the facility, whether on cardiac medications or not, and will continue to monitor monthly going forward, and notify the physician for any pulses that are outside of the established vitals sign parameters as developed by the Medical Director on April 23, 2014. An audit of the monthly consultant pharmacist report will be completed by the Director of Nursing or Assistant Director of Nursing to ensure the ongoing monitoring of pulse readings by the consultant pharmacist as well as documentation by consultant pharmacist notifying the physician of readings outside of the established vitals</p>		

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F 329	<p>Continued From page 2</p> <p>tablet by mouth twice daily; and 5 mg amlodipine given as two tablets by mouth once daily.</p> <p>A review of the resident ' s November 2013 MAR revealed the resident continued to receive the same antihypertensive medication regimen initiated on 5/21/12. Further review of the November 2013 MAR revealed the resident ' s vital signs were obtained and documented once a week. The vital signs included measurements of blood pressure (the normal blood pressure (BP) is 120/80) and pulse rate (a normal resting pulse or heart rate (HR) for adults may range from 60 to 100 beats per minute). Resident #3 ' s vital signs for November 2013 included:</p> <p>11/6/13 BP (lying) = 131/70; Pulse (radial or wrist) = 57 beats per minute (bpm)</p> <p>11/13/13 BP (lying) = 112/56; Pulse (radial or wrist) = 58 bpm</p> <p>11/20/13 BP (sitting) = 144/70; Pulse (radial or wrist) = 54 bpm</p> <p>11/27/13 BP (lying) = 166/84; Pulse (radial or wrist) = 64 bpm</p> <p>There was no documentation indicating a concern was identified regarding the resident ' s low heart rate (HR) or that the physician/Nurse Practitioner (NP) was notified of a low HR.</p> <p>A review of the resident ' s December 2013 MAR revealed the resident continued to receive the same antihypertensive medication regimen initiated on 5/21/12. Further review of the December 2013 MAR revealed the resident ' s vital signs were obtained and documented once a week. Resident #3 ' s vital signs for December 2013 included:</p> <p>12/4/13 BP (lying) = 150/84; Pulse (radial or wrist) = 62 bpm</p> <p>12/11/13 BP (lying) = 134/72; Pulse (radial</p>	F 329	<p>sign parameters. Any discrepancies will be reported to the pharmacy manager. The consultant pharmacist manager will audit the facility consultant pharmacist's monthly reviews to ensure documentation of pulses. If pulses are out of range per the facility protocol, the facility consultant pharmacist will note this in her nursing and physician notes to the facility, which the consultant pharmacist manager will also receive a copy of. Consultant pharmacy manager completed a medication usage report for residents on cardiac meds and had an additional pharmacist or pharmacists to review them all for therapeutic duplication as well on April 21, 2014. The consultant pharmacy manager completed a review of all residents medication list for therapeutic duplications, regardless of the duration of the therapy on April 21, 2014. Any clinically significant duplications were addressed on April 29, 2014 .</p> <p>3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:</p> <p>Licensed nursing staff (RN's and LPN's) were educated by the Director of Nursing or Assistant Director of Nursing on April 23, 2013 □ April 29, 2104 in regards to parameters for monitoring high and low pulse, blood pressure and blood glucose and the need to notify the physician of vitals outside of parameters. All licensed staff will review and sign the established vitals sign parameter policy which was developed on April 23, 2014 by</p>		

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F 329	<p>Continued From page 3</p> <p>or wrist) = 61 bpm 12/18/13 BP (lying) = 140/73; Pulse (radial or wrist) = 55 bpm 12/25/13 BP (lying) = 134/60; Pulse (radial or wrist) = 89 bpm There was no documentation indicating a concern was identified regarding the resident ' s low HR or that the physician/NP was notified of a low HR.</p> <p>A review of the resident ' s January 2014 MAR revealed the resident continued to receive the same antihypertensive medication regimen initiated on 5/21/12. Further review of the January 2014 MAR revealed the resident ' s vital signs were obtained and documented once a week. Resident #3 ' s vital signs for January 2014 included: 1/1/14 BP (lying) = 122/65; Pulse (radial or wrist) = 57 bpm 1/8/14 BP (lying) = 150/76; Pulse (radial or wrist) = 58 bpm 1/15/14 BP (lying) = 172/81; Pulse (radial or wrist) = 55 bpm 1/22/14 BP (lying) = 119/64; Pulse (radial or wrist) = 52 bpm 1/29/14 BP (lying) = 128/65; Pulse (radial or wrist) = 58 bpm There was no documentation indicating a concern was identified regarding the resident ' s low HR or that the physician/NP was notified of a low HR.</p> <p>A review of the resident ' s February 2014 MAR revealed the resident continued to receive the same antihypertensive medication regimen initiated on 5/21/12. Further review of the February 2014 MAR revealed the resident ' s vital signs were obtained and documented once a week. Resident #3 ' s vital signs for February 2014 included:</p>	F 329	<p>the facility Medical Director.</p> <p>4. Indicate how the facility will monitor its performance:</p> <p>Director of Nursing or Assistant Director of Nursing will review 10% of residents weekly for 12 weeks to ensure proper notification of physician for any resident vital signs that are outside of established parameters. Periodic audits will be conducted by the Director of Nursing or Assistant Director of Nursing on a quarterly basis.</p> <p>Results will be presented to the Quality Assurance team for recommendations and follow up for 12 months.</p>		

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F 329	<p>Continued From page 4</p> <p>2/5/14 BP (sitting) = 145/72; Pulse (radial or wrist) = 69 bpm</p> <p>2/12/14 BP (sitting) = 130/62; Pulse (radial or wrist) = 56 bpm</p> <p>2/19/14 BP (sitting) = 138/60; Pulse (radial or wrist) = 62 bpm</p> <p>There was no documentation indicating a concern was identified regarding the resident ' s low HR or that the physician/NP was notified of a low HR.</p> <p>A review of the Nursing Progress notes dated 2/22/14 at 3:45 PM revealed the resident ' s family member came into the facility and requested Resident #3 be sent to the Emergency Room (ER) due to complaints of abdominal pain during recent weeks. The nurse reported she contacted the on-call NP and received an order to send her to the ER. A second Nursing Progress note dated 2/22/14 indicated the resident ' s vital signs were taken at the facility prior to sending her out and included a report of BP 100/58 and HR 48 bpm. The Nursing Progress note also reported, " but when the EMS (Emergency Medical Service) got here P (pulse or heart rate was) 38 but resident was still alert and oriented propelling herself in her wheelchair without any difficulties noted. "</p> <p>A review of the hospital records revealed Resident #3 was transported by ambulance and arrived at the ER on 2/22/14 at 4:07 PM. The resident ' s chief complaints upon arrival to the ER were noted as: abdominal pain and bradycardia. The History and Physical dictated by the Medical Doctor (MD) at the ER read in part, " Per EMS report from nursing home, patient ' s heart rate usually runs in the 60 ' s ...Per EMS, upon arrival vitals were taken and HR was noted to be in the 30s and patient was pale</p>	F 329			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 5 and diaphoretic (perspiring profusely). " Additional notes from the 2/22/14 hospital admission records read, in part: " She goes on to say that she spent, ' the whole day telling the people at the nursing home to send me to the hospital, ' and eventually she called her son and at some point, it was realized that her heart rate was very low and so she was brought to the Emergency Department. In the ED, her vital signs have been stable, however. Her heart rate has been in the 30s all throughout her stay, between 33 and 38 beats per minute. On review of her medication, she is both on atenolol as well as labetalol and also on Aricept, all of which lead to bradycardia. "</p> <p>Further review of the hospital records dated 2/22/14 included the MD ' s Assessment and Plan which read, in part: " An 84-year-old female with a past medical history of mild dementia, mild diabetes mellitus, hypertension presenting with vague symptoms of feeling poorly and weak and found to have severe bradycardia. " 1. Symptomatic bradycardia: -- " I believe that we can attribute several of her symptoms to bradycardia. She has maintained an acceptable blood pressure throughout this stay. We would like, however, to administer glucagon (an intravenous medication which may be used to reverse beta-blocker-induced HR depression) and see if we can place her heart rate in at least the 40s. This may also improve her overall wellbeing. I am holding Aricept and we should monitor heart rate once it is re-introduced. " -- " Of note, the patient had been admitted in 2012 by [MD name] and during that admission,</p>	F 329			

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F 329	<p>Continued From page 6</p> <p>he discontinued the atenolol and mentioned that he was doing so because she was already on labetalol. Obviously, the patient was at some point placed back on both of them. "</p> <p>Resident #3 was discharged from the hospital on 2/26/14 to another nursing home facility. Hospital records indicated the resident ' s discharge diagnoses included, " 1. Symptomatic bradycardia secondary to medications. " The History of Present Illness and Hospital Course reported in the 2/26/14 discharge records read, in part: " The patient admitted with bradycardia with heart rate of between 33 and 38, the patient was found to be (on beta-) blockers (atenolol and labetalol). Both medications were discontinued. The patient ' s heart rate came up to the 60s-70s. Started atenolol at a low dose of 25 mg. " Discharge instructions from the hospital included discontinuation of labetalol and a decreased dose of atenolol (25 mg once daily) secondary to symptomatic bradycardia.</p> <p>An interview was conducted on 4/3/14 at 9:35 AM with Nurse #1. Nurse #1 worked on Resident #3 ' s hall during her stay at the facility. Upon inquiry, Nurse #1 indicated that routine vital signs were taken once a week for each resident and on an as needed basis. She stated that if the BP or HR was out of that resident ' s normal range, she would contact the physician. Nurse #1 was not aware of a facility policy which provided guidelines or parameters used to indicate when the resident ' s physician or NP would need to be alerted for a high or low reading.</p> <p>A telephone interview was conducted on 4/3/13 at</p>	F 329			

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F 329	<p>Continued From page 7</p> <p>10:50 AM with the NP who had provided care for Resident #3. Upon inquiry, the NP did remember Resident #3. However, she did not have access to the facility ' s records at the time of the telephone interview so did not wish to comment on the specifics of Resident #3 ' s medication regimen. When asked in general terms whether having a resident on two beta-blockers was a typical or usual practice, she stated that the only time two beta blockers would be used was if one of them was an as needed (PRN) medication. Upon further inquiry, the NP reported she would expect to be contacted by nursing staff if a resident ' s HR was less than 60 or greater than 100 bpm. However, she added the some residents " run in the 50 ' s, " and in those cases, she would expect to be notified if the resident ' s HR was less than 50 bpm.</p> <p>A telephone interview was conducted with the facility ' s consultant pharmacist on 4/3/14 at 11:32 AM. Inquiry was made regarding Resident #3 ' s medication profile and inclusion of two beta-blockers to treat her blood pressure. The pharmacist stated she, " may have missed " this duplication. Upon further inquiry, the pharmacist stated that she typically would have contacted the prescriber when a therapeutic duplication was identified. During the interview, the pharmacist was asked if she had noted when the resident ' s heart rates were reported to be in the 50 ' s (bpm). The pharmacist stated, " I did not watch the HR as closely as the BP. "</p> <p>An interview was conducted on 4/3/13 at 12:15 PM with the Director of Nursing (DON). Upon review of the vital sign records for 12/13, 1/14, and 2/14, the DON stated, " I would have wanted to contact the physician and let him/her know the</p>	F 329			

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F 329	Continued From page 8 resident was having bradycardic episodes and ask does he need to do a medication review. "	F 329			
F 428 SS=G	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the pharmacist failed to identify and report bradycardia (low heart rate) as a clinically significant adverse consequence of duplicate medication therapy for 1 of 3 sampled residents (Resident #1) reviewed for unnecessary medications. The findings included: Resident #3 was admitted to the facility on 2/19/11. The resident was re-admitted to the facility from the hospital on 5/21/12. The resident ' s cumulative diagnoses included hypertension (high blood pressure) and a history of Irritable	F 428	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907 _____ F428 1. Corrective action will be accomplished	5/2/14	

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F 428	<p>Continued From page 9</p> <p>Bowel Syndrome (a disorder which affects the large intestine and commonly causes cramps, abdominal pain, bloating gas, diarrhea and constipation).</p> <p>A review of Resident #3 ' s medical record revealed that the following antihypertensive medications were reinitiated upon readmission to the facility on 5/21/12: 200 milligrams (mg) labetalol (a medication classified as a beta-adrenergic blocking agents or beta-blocker) given as one tablet by mouth twice daily; 50 mg atenolol (a medication classified as a beta-adrenergic blocking agents) given as one tablet by mouth twice daily; and 5 mg amlodipine (a medication classified as a calcium channel blocker) given as two tablets by mouth once daily.</p> <p>According to Lexi-Drug, a comprehensive drug database of Lexi-Comp, bradycardia may be observed more frequently in elderly patients (>65 years of age) receiving beta-adrenergic blocking agents (or beta-blockers); dosage reductions may be necessary.</p> <p>A review of the resident ' s Medication Administration Records (MARs) from June 2013 through October 2013 revealed the resident continued to receive the antihypertensive medication regimen initiated on 5/21/12, which included: 200 mg labetalol given as one tablet by mouth twice daily; 50 mg atenolol given as one tablet by mouth twice daily; and 5 mg amlodipine given as two tablets by mouth once daily.</p> <p>A review of the resident ' s November 2013 MAR revealed the resident continued to receive the same antihypertensive medication regimen initiated on 5/21/12. Further review of the</p>	F 428	<p>for those residents found to have been affected by the deficient practice:</p> <p>Resident #3 was discharged to High Point Regional Hospital on February 22, 2014. Resident #3 was discharged from High Point Regional Hospital to another skilled nursing facility on February 26, 2014.</p> <p>2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p>An audit of resident medication regimens was conducted by the consultant pharmacist beginning April 13, 2014 and completed April 17, 2014. Consultant pharmacist began noting pulse readings on every resident in the facility, whether on cardiac medications or not, and will continue to monitor monthly going forward, and notify the physician for any pulses that are outside of the established vitals sign parameters as developed by the Medical Director on April 23, 2014. An audit of the monthly consultant pharmacist report will be completed by the Director of Nursing or Assistant Director of Nursing to ensure the ongoing monitoring of pulse readings by the consultant pharmacist as well as documentation by consultant pharmacist notifying the physician of readings outside of the established vitals sign parameters. Any discrepancies will be reported to the pharmacy manager. The consultant pharmacist manager will audit the facility consultant pharmacist's monthly reviews to ensure documentation of pulses. If pulses are out of range per</p>		

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F 428	<p>Continued From page 10</p> <p>November 2013 MAR revealed the resident ' s vital signs were obtained and documented once a week. The vital signs included measurements of blood pressure (the normal blood pressure (BP) is 120/80) and pulse rate (a normal resting pulse or heart rate (HR) for adults may range from 60 to 100 beats per minute). Resident #3 ' s vital signs for November 2013 included:</p> <p>11/6/13 BP (lying) = 131/70; Pulse (radial or wrist) = 57 beats per minute (bpm)</p> <p>11/13/13 BP (lying) = 112/56; Pulse (radial or wrist) = 58 bpm</p> <p>11/20/13 BP (sitting) = 144/70; Pulse (radial or wrist) = 54 bpm</p> <p>11/27/13 BP (lying) = 166/84; Pulse (radial or wrist) = 64 bpm</p> <p>A review of the resident ' s December 2013 MAR revealed the resident continued to receive the same antihypertensive medication regimen initiated on 5/21/12. Further review of the December 2013 MAR revealed the resident ' s vital signs were obtained and documented once a week. Resident #3 ' s vital signs for December 2013 included:</p> <p>12/4/13 BP (lying) = 150/84; Pulse (radial or wrist) = 62 bpm</p> <p>12/11/13 BP (lying) = 134/72; Pulse (radial or wrist) = 61 bpm</p> <p>12/18/13 BP (lying) = 140/73; Pulse (radial or wrist) = 55 bpm</p> <p>12/25/13 BP (lying) = 134/60; Pulse (radial or wrist) = 89 bpm</p> <p>A review of the resident ' s January 2014 MAR revealed the resident continued to receive the same antihypertensive medication regimen initiated on 5/21/12. Further review of the January 2014 MAR revealed the resident ' s vital</p>	F 428	<p>the facility protocol, the facility consultant pharmacist will note this in her nursing and physician notes to the facility, which the consultant pharmacist manager will also receive a copy of. Consultant pharmacy manager completed a medication usage report for residents on cardiac meds, and had an additional pharmacist or pharmacists to review them all for therapeutic duplication as well on April 21, 2014. The consultant pharmacy manager completed a review of all residents medication list for therapeutic duplications, regardless of the duration of the therapy on April 21, 2014. Any clinically significant duplications were addressed on April 29, 2014.</p> <p>3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:</p> <p>Licensed nursing staff (RN□s and LPN□s) were educated by the Director of Nursing or Assistant Director of Nursing on April 23, 2013 □ April 29, 2104 in regards to parameters for monitoring high and low pulse, blood pressure and blood glucose and the need to notify the physician of vitals outside of parameters. All licensed staff will review and sign the established vitals sign parameter policy which was developed on April 23, 2014 by the facility Medical Director.</p> <p>The consultant pharmacist was educated by the Director of Nursing to the vital sign parameters as established by the facility Medical Director on April 23, 2014. The consultant pharmacy manager, Kimberly</p>		

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F 428	<p>Continued From page 11</p> <p>signs were obtained and documented once a week. Resident #3 's vital signs for January 2014 included:</p> <p>1/1/14 BP (lying) = 122/65; Pulse (radial or wrist) = 57 bpm 1/8/14 BP (lying) = 150/76; Pulse (radial or wrist) = 58 bpm 1/15/14 BP (lying) = 172/81; Pulse (radial or wrist) = 55 bpm 1/22/14 BP (lying) = 119/64; Pulse (radial or wrist) = 52 bpm 1/29/14 BP (lying) = 128/65; Pulse (radial or wrist) = 58 bpm</p> <p>A review of the resident 's February 2014 MAR revealed the resident continued to receive the same antihypertensive medication regimen initiated on 5/21/12. Further review of the February 2014 MAR revealed the resident 's vital signs were obtained and documented once a week. Resident #3 's vital signs for February 2014 included:</p> <p>2/5/14 BP (sitting) = 145/72; Pulse (radial or wrist) = 69 bpm 2/12/14 BP (sitting) = 130/62; Pulse (radial or wrist) = 56 bpm 2/19/14 BP (sitting) = 138/60; Pulse (radial or wrist) = 62 bpm</p> <p>A review was completed of the consultant pharmacist 's monthly progress notes from June 2013 through February 2014. No concerns were documented in regards to the use of two beta-blockers or the low HR recorded for Resident #3.</p> <p>A review of the Nursing Progress notes dated 2/22/14 at 3:45 PM revealed the resident 's family member came into the facility and</p>	F 428	<p>Ward, Pharm D, Senior Consultant Pharmacist educated the facility consultant pharmacist on April 23, 2014 regarding the identification of potential clinically significant adverse consequences of duplicate medication therapy and proper reporting.</p> <p>4. Indicate how the facility will monitor its performance:</p> <p>Director of Nursing or Assistant Director of Nursing will review 10% of residents weekly for 12 weeks to ensure proper notification of physician for any resident vital signs that are outside of established parameters. Periodic audits will be conducted by the Director of Nursing or Assistant Director of Nursing on a quarterly basis. Results will be presented to the Quality Assurance team for recommendations and follow up for 12 months.</p> <p>The facility monthly pharmacy review will be sent to the consultant pharmacy manager monthly for 6 months. The consultant pharmacy manager will conduct an audit of the monthly pharmacy review as completed by the consultant pharmacist for 6 months to ensure the identification and reporting of potential clinically significant adverse consequences of duplicate medication therapy. The consultant pharmacy manager will take a sample of 35 residents to ensure that pulse rates were documented, and were in range per the facility protocol, for a 6 month period.</p>		

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F 428	<p>Continued From page 12</p> <p>requested Resident #3 be sent to the Emergency Room (ER) due to complaints of abdominal pain during recent weeks. The nurse reported she contacted the on-call NP and received an order to send her to the ER. A second Nursing Progress note dated 2/22/14 indicated the resident ' s vital signs were taken at the facility prior to sending her out and included a report of BP 100/58 and heart rate 48 bpm. The Nursing Progress note also reported, " but when the EMS (Emergency Medical Service) got here P (pulse or heart rate was) 38 but resident was still alert and oriented propelling herself in her wheelchair without any difficulties noted. "</p> <p>A review of the hospital records revealed Resident #3 was transported by ambulance and arrived at the ER on 2/22/14 at 4:07 PM. The resident ' s chief complaints upon arrival to the ER were noted as: abdominal pain and bradycardia. The History and Physical dictated by the Medical Doctor (MD) at the ER read in part, " Per EMS report from nursing home, patient ' s heart rate usually runs in the 60 ' s ...Per EMS, upon arrival vitals were taken and HR was noted to be in the 30s and patient was pale and diaphoretic (perspiring profusely). "</p> <p>Additional notes from the 2/22/14 hospital admission records read, in part: " She goes on to say that she spent, ' the whole day telling the people at the nursing home to send me to the hospital, ' and eventually she called her son and at some point, it was realized that her heart rate was very low and so she was brought to the Emergency Department. In the ED, her vital signs have been stable, however. Her heart rate has been in the 30s all throughout her stay, between 33 and 38 beats per minute. On review of her medication, she is both on atenolol as well</p>	F 428	Results will be presented to the Quality Assurance team for recommendations and follow up for 6 months.		

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F 428	<p>Continued From page 13 as labetalol and also on Aricept, all of which lead to bradycardia. "</p> <p>Further review of the hospital records dated 2/22/14 included the MD ' s Assessment and Plan which read, in part: " An 84-year-old female with a past medical history of mild dementia, mild diabetes mellitus, hypertension presenting with vague symptoms of feeling poorly and weak and found to have severe bradycardia. "</p> <p>1. Symptomatic bradycardia: -- " I believe that we can attribute several of her symptoms to bradycardia. She has maintained an acceptable blood pressure throughout this stay. We would like, however, to administer glucagon (an intravenous medication which may be used to reverse beta-blocker-induced HR depression) and see if we can place her heart rate in at least the 40s. This may also improve her overall wellbeing. I am holding Aricept and we should monitor heart rate once it is re-introduced. "</p> <p>-- " Of note, the patient had been admitted in 2012 by [MD name] and during that admission, he discontinued the atenolol and mentioned that he was doing so because she was already on labetalol. Obviously, the patient was at some point placed back on both of them. "</p> <p>Resident #3 was discharged from the hospital on 2/26/14 to another nursing home facility. Hospital records indicated the resident ' s discharge diagnoses included, " 1. Symptomatic bradycardia secondary to medications. " The History of Present Illness and Hospital Course</p>	F 428			

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F 428	<p>Continued From page 14</p> <p>reported in the 2/26/14 discharge records read, in part: " The patient admitted with bradycardia with heart rate of between 33 and 38, the patient was found to be (on beta-) blockers (atenolol and labetalol). Both medications were discontinued. The patient ' s heart rate came up to the 60s-70s. Started atenolol at a low dose of 25 mg. " Discharge instructions from the hospital included discontinuation of labetalol and a decreased dose of atenolol (25 mg once daily) secondary to symptomatic bradycardia.</p> <p>Resident #3 was discharged from the hospital on 2/26/14 to another nursing home facility. Hospital records indicated the resident ' s primary discharge diagnosis was symptomatic bradycardia secondary to medications. The History of Present Illness and Hospital Course included in the 2/26/14 discharge records read, in part: " The patient admitted with bradycardia with heart rate of between 33 and 38, the patient was found to be (on beta-) blockers (atenolol and labetalol). Both medications were discontinued. The patient ' s heart rate came up to the 60s-70s. Started atenolol at a low dose of 25 mg. "</p> <p>A telephone interview was conducted with the facility ' s consultant pharmacist on 4/3/14 at 11:32 AM. Inquiry was made regarding Resident #3 ' s medication profile and inclusion of two beta-blockers to treat her blood pressure. The pharmacist stated she, " may have missed " this duplication. Upon further inquiry, the pharmacist stated that she typically would have contacted the prescriber when a therapeutic duplication was identified. During the interview, the pharmacist was asked if she had noted when the resident ' s heart rates were reported to be in the 50 ' s</p>	F 428			

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F 428	<p>Continued From page 15</p> <p>(bpm). The pharmacist stated, " I did not watch the HR as closely as the BP. " Upon review of her records, the pharmacist indicated she did not see where a concern or written recommendation was made to Resident #3 ' s physician/NP in regards to the therapeutic duplication of the beta-blockers prescribed or the low heart rates recorded.</p> <p>An interview was conducted on 4/3/13 at 12:15 PM with the Director of Nursing (DON). Upon review of the vital sign records for 12/13, 1/14, and 2/14, the DON stated, " I would have wanted to contact the physician and let him/her know the resident was having bradycardic episodes and ask does he need to do a medication review. " When asked about the therapeutic duplication and use of two beta-blockers for Resident #3, the DON also stated, " I would have thought the pharmacist would have picked up on that. "</p>	F 428			