STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH CARE CENTER	1735 TODDVILLE RD CHARLOTTE, NC 28214

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure the correct dose of Ativan was administered to 1 of 3 residents reviewed for unnecessary medications. (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/20/13 with diagnoses which included brain	F 329	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the	3/17/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/14/2014

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F 329	Continued From page 1 tumor, cerebral edema, and stage IV melanoma. Review of Resident #1's most recent Admission Minimum Data Set (MDS) dated 11/27/13 assessed him as being cognitively intact. Review of progress notes written by the Nurse Practitioner (NP) dated 12/20/13 revealed Resident #1 continued to have a physical decline. Resident #1 had reported dizziness and inability to think clearly. NP was concerned over Resident #1's rapid decline and decreased ability to walk. The NP ordered stat labs, a chest X-ray, and a urinalysis with culture and sensitivity. Review of physician orders dated 12/27/13 revealed a new order for Decadron (a steroid drug used to reduce inflammation) 4 milligrams (mg) to be given three times per day. The previous order for Decadron 4 mg to be given twice per day was discontinued. Review of progress notes written by the NP dated 12/30/13 revealed Resident #1 continued to decline. NP spoke at length with resident's family member. Resident #1 also had insomnia and agitation. The NP ordered Ativan (an anti-anxiety medication) 0.5 milligrams (mg) every 8 hours as needed for agitation and Ambien (a hypnotic medication used for insomnia) 5 mg to be given at bedtime. Review of physician's orders dated 12/30/13 revealed an order for Ativan 0.5 mg to be given every 8 hours as needed for agitation. A physician order, dated 12/31/13, revealed to discontinue Ativan 0.5 mg 1 tab every 8 hours as needed and to begin Ativan 0.5 mg 2 tabs to be given every 8 hours as needed for agitation. These orders were electronically entered by the	F 329	following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F329 The facility understands that each resident□s drug regimen must be free from unnecessary drugs and with adequate monitoring. How the corrective action will be accomplished for the resident(s) affected. Resident #1, affected by the deficient practice, was sent to the hospital on 1/04/2014 with change in mental status, lethargy and was subsequently discharged from the hospital to another SNF. The nurse who made the transcription error was educated regarding 1) The 5 Rights associated with medication administration. 2) Conducting read back to confirm all verbal and telephone orders from the medical provider to ensure accuracy of order entry. 3) Final review of the electronic order entry prior to confirmation of the order. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit was completed by the Facility Medical Director and Nurse Practitioner on 2/20/2014 specific for Ativan use to	

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F 329	Continued From page 2 NP. Review of the December 2013 Medication Administration Record revealed the Ativan 0.5 mg was administered to Resident #1 on 12/30/13 at 9:57 AM and 12/31/13 at 9:18 PM. The Ambien had been administered as scheduled on 12/30/13 and 12/31/13 at bedtime. Review of the progress note written by the NP dated 12/31/14 revealed Resident #1 continued to be very confused and had a change in mental status. Ativan was increased to 1 mg every 8 hours as needed. Review of nurse's notes dated 01/01/14 at 8:29 AM read in part, Resident #1 was awake all night-kicking legs, trying to get up out of bed. PRN (as needed) Ativan was given with positive results. Review of the Medication Administration Record (MAR) for Resident #1 revealed he received Ativan 1 mg (as needed) on 01/01/14 at 3:56 AM, on 01/02/14 at 8:46 AM, on 01/03/14 at 1:58 AM and 9:18 AM. A progress note written on 01/02/14 by the NP revealed Resident #1 continued to decline rapidly. The recent workup which was done was negative. The NP had called Resident #1's family member to discuss advanced directives and the possibility of consulting palliative medicine. Resident #1 had a very poor prognosis. A nurse's note dated 01/02/14 at 4:47 PM read in part, Resident #1 continues to have signs of anxiety noted during the shift. He is unable to stand without assistance from staff.	F 329	ensure that orders were entered correctly. Charts were reviewed on the total number of residents in the facility; one hundred seven (107) to ensure that any resident prescribed Ativan matched the physician orders. Of the charts reviewed, zero (0) residents required corrections to ensure compliance with unnecessary medications and were found to be aligned with the physician order. Measures in place to ensure practice will not occur. A process for ordering and reviewing the medication entry process was systemically implemented at the facility. The following outlines the process that was revised and implemented on 3/1/2014 by the Director of Nursing. 1. If a nurse receives a telephone order, the nurse will read back the order for accuracy and document on the audit tool. 2. The nurses will print the alerts (orders) for their assigned residents at the end of each shift to compare with the telephone audit read- back tool to verify order entry accuracy. Any discrepancies will be clarified and corrected at that time. 3. The night shift nurses will complete the 24hr chart check nightly to review all new orders entered in the 24hr period for order accuracy upon comparison with the telephone order audit tool. Any discrepancies will be clarified and corrected at that time. 4. The Unit Managers will print the shift notes and alerts the following morning to	

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F 329	Continued From page 3 Review of Physician's orders dated 01/03/14 revealed an order to discontinue Ativan 1 mg every 8 hours as need and a new order for Ativan 1 mg to be given every 4 hours (12:00AM, 4:00AM, 8:00AM, 12:00PM, 4:00PM and 8:00PM) for anxiety. This was documented as a verbal order given by the NP and entered by Nurse #1. Further review of the January MAR revealed Resident #1 received Ativan 1 mg (scheduled) on 01/03/14 at 4:00 PM and 8:00 PM and on 01/04/14 at 12:00AM, 4:00 AM, 8:00 AM, 12:00 PM and 4:00 PM. A nurse's note dated 01/03/14 at 4:32 PM read in part: Urine culture results no growth in 48 hours. Resident #1 very agitated. Ativan given x1, order changed from 1 mg every 8 hours as needed to 1 mg every 4 hours as needed. A nurse's note dated 01/03/14 at 10:48 PM read in part, Resident currently resting in the chair outside of the nurses' station in order to keep eyes on him and keep him safe. He would not stay in the bed and was very restless. His family member was in this shift and stated that he spoke with the resident's neurologist, who stated that the Dexamethasone increase was causing the restlessness. Family member stated the neurologist plans to decrease this medication in about a week. Resident #1 was alert with confusion. A nurse's note dated 01/04/14 at 10:28 PM read in part: Severe change in mental status and agitation ... resident was very confused. Called on-call (doctor) and also called the family member. Before writer was able to give report to	F 329	check physician orders and notes for accuracy by auditing the telephone order audit tool against the alerts. Any discrepancies will clarified and corrected and coaching for staff nurses involved as necessary. 5. To ensure practice will not recur, nurses will sign the alerts indicating completion and review of steps 1-3 above for twelve (12) weeks. 6. At the end of week, the Unit Manager or Director of Nursing will file the completed audit tools. An in-service, which started on 2/26/2014 was conducted by the Director of Nursing (DON) for all licensed nurses currently working in the facility and was completed for all nurses on 03/17/14. The in-service included the policy on order entry and the revised procedures as stated above. Any licensed nurse that is on Family Medical Leave Act (FMLA), Leave Of Absence (LOA), or vacation will be in-serviced before their next scheduled shift via phone or in person by the DON or UM. How the facility plans to monitor and to make sure solutions are sustained. The pharmacy consultant and the Director of Nursing, or her designee, will monitor through record review, monthly for 3 months, then at least quarterly, to assure resident□s medication regimens are free of unnecessary drugs with an emphasis	

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F 329	Continued From page 4 on-call, the family member wanted the resident sent to the hospital for evaluation. The patient was sent out. Review of Hospital Records revealed Resident #1's discharge summary from the hospital dated 01/10/14 recorded diagnoses of acute mental status secondary to metabolic encephalopathy and polypharmacy. The discharge summary explained Resident #1's hospital course as: Patient is an 84 year old male admitted for confusion. His symptoms were related to polypharmacy. He has been seen by the neurologist ...Ativan is to be avoided. He has had an EEG (electroencephalography), which showed findings of toxic metabolic encephalopathy. His mental status has improved. An interview was conducted on 02/20/14 at 2:05 PM with the Nurse Practitioner (NP). The NP stated she saw Resident #1 very often. She stated the resident had lost his ability to walk while at the facility even though he had physical therapy. She stated she had ordered Ativan for Resident #1's agitation. She stated it did help. She started with 0.5 mg which worked at first. She stated she increased the Ativan on 01/31/13 to 1 mg as needed. She stated she did not give the order for Ativan 1 mg every 4 hours scheduled. She stated the order was to be prn (as needed). The NP stated she would not do this unless the resident was terminal and on palliative care. She further stated she would not have done this for a resident unless she had talked to the family and they were on the same page about what the resident needed to receive. She stated the resident was receiving Decadron to shrink the brain tumor and it could have been what was causing the agitation. The Ativan would have	F 329	on the accuracy of entering verbal/telephone orders. The audits will be reviewed in the QA meetings. The quality assurance committee will make suggestions for compliance maintenance and/or revisions to system changes as needed to ensure sustained compliance with unnecessary medication.	

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calmed the agitation. The resident was alert but he would be very confused. The NP stated the resident had no quality of life but she could not get the family to agree to palliative care.

An interview was conducted on 02/20/14 at 2:23 PM with Nurse #1. Nurse #1 stated she did take the telephone order for the Ativan for Resident #1. She stated she did not think the NP would have ordered the Ativan 1 mg every 4 hours scheduled unless the resident had been on palliative care. She stated she put the order into the computer wrong and it was a medication error on her part. She stated the boxes that are checked for every 4 hours scheduled and every 4 hrs prn (as needed) are right next to each other. She stated she must have clicked the wrong line.

An interview was conducted on 02/20/14 at 3:27 PM with the Director of Nursing (DON). The DON stated her expectation was for the nurse taking the order to have read it back to the NP to make sure it was accurate. She would also expect every shift to print off the shift notes to see if there were any new orders and verify accuracy. The DON further stated the nurse should have gone back and checked the order.