

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345561	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2016
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/FUQUAY-VARINA			STREET ADDRESS, CITY, STATE, ZIP CODE 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526		
(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>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interviews the facility failed to have medication passes that were free of significant medication errors in relation to one (Resident # 1) of five sampled residents. The findings included: Record review revealed Resident # 1 resided at the facility from 11/18/15 until her discharge on 12/24/15. The resident had diagnoses of Parkinson ' s disease and vascular dementia. Review of Resident # 1 ' s hospital discharge summary, dated 11/18/15, revealed a list of medications the resident was to receive upon admission to the facility on 11/18/15. A bracket was drawn around the medications on the list and a nurse had noted by the bracket the medications had been verified. One of the medications on the list was for management of the resident ' s Parkinson ' s disease. This medication was listed as Carbidopa-Levodopa-Entacapone 25-100-200 mg (milligrams) to be administered twice per day. There was a notation on the medication list that this combination was commonly known as the drug Stalevo 100. Record review revealed the Entacapone component of the three combination drug was not transcribed as an ordered medication when the resident was admitted to the facility on 11/18/15 and therefore was not administered during the resident ' s residency. The Parkinson ' s medication appeared as a two drug combination, Carbidopa-Levodopa 25-100, on both the</p>	F 333	<p>1. The resident was transferred to the hospital on 12/24/15 and has not returned.</p> <p>2. A. Resident medications will be audited by the DON or RN designee for every resident admitted from 2/1/16 through 2/19/16. Any errors identified will be called in to attending MD, and immediate correction will follow. Audit to be completed by 2/20/16. B. Medications for newly admitted residents will be audited by an RN within 24 hours to determine accuracy. Any errors identified will be called in to attending MD, and immediate correction will follow. C. Transcription of medications changed on a day to day basis will be checked by a second nurse at the time the order is transcribed. Any discrepancies will be immediately corrected. Ongoing, beginning 2/12/16.</p> <p>3. Licensed nurses will be inserviced on: A. Accurate medication transcription. B. What to do when they identify a medication that is not available in the AHT software, i.e., call the pharmacist and get clarification on how to enter the medication correctly.</p>	2/20/16	

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

TITLE

(X6) DATE

Electronically Signed

02/12/2016

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	Continued From page 1 resident ' s physician orders and MARs (medication administration records) for the months of November and December 2015. Review of pharmacy records revealed the medication was dispensed and received into the facility on 11/19/15 at 3:30 AM as Carbidopa-Levodopa. There was no record Entacapone was dispensed. The DON (Director of Nursing) was interviewed on 2/8/16 at 11:10 AM regarding the facility ' s process of transcribing new orders when residents are initially admitted. The DON stated a nurse routinely sends the hospital discharge summary to the physician who is scheduled to care for the resident while the resident resides at the facility. The DON stated the physician verifies the discharge summary medications as the medications to be given at the facility, and then the nurse enters the medications into the computer system. The DON stated she would review the record to determine why Resident # 1 ' s Parkinson ' s medication had not been entered correctly on 11/18/15. The administrator, DON (Director of Nursing), and nurse consultant were interviewed on 2/8/16 at 1:15 PM. During this time a phone interview was also conducted with a facility pharmacist. The facility pharmacist stated the pharmacy had filled the medication as Carbidopa-Levodopa based on the transcription by the facility. The pharmacist stated they had not reviewed the discharge summary and therefore the error had not been detected by them. The administrator and DON stated the nurse who had entered the resident ' s medications on 11/18/15 was not available for interview. They stated they had researched how the error could have occurred and in doing so they found the following. When entering medications into the computer system a	F 333	C. Need for 2nd nurse to check new medication transcriptions for accuracy, at the time of the transcription. D. Contact MD for further clarification if a medication is ordered that is not available in the strength, frequency, complexity, etc. that it has been ordered. All licensed nurses will be trained by SDC and/or DON by 2/20/16. 4. New medication order transcription will be audited monthly by the DON for 10 residents in March, April, and May 2016. Results will be reported to the QA Committee monthly, and the need for further audits will be determined at that time.		

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

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F 333	Continued From page 2 nurse is routinely provided a " drop down " box of choices for a specific drug. They stated when an attempt is made to enter the three drug combination of Carbidopa-Levodopa-Entacapone, the computer " drop down " box only reflects the two drug combination of Carbidopa and Levodopa as an entry choice, and if the brand name drug of Stalevo is entered it is unclear which one to choose. The DON stated there was no record the nurse called and discussed with the physician before entering the medication as Carbidopa-Levodopa, and it would have been her expectation that the nurse should have called and discussed the medication entry problem with the pharmacy on 11/18/15. An interview with the resident ' s responsible party on 2/8/16 at 11:30 AM revealed the responsible party routinely accompanied Resident # 1 to her neurology appointments where she was seen in relation to Parkinson ' s disease management. The responsible party stated the neurologist ' s specific recommendation for Resident # 1 was that she be on the three medication combination used in Stalevo (Carbidopa; Levodopa; and Entacapone.)	F 333			