

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

PRINTED: 02/24/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345529</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/21/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSAL HEALTH CARE/NORTH RALEIGH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616</b>		
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F 000	INITIAL COMMENTS  A complaint investigation was conducted 1/10/20 to 1/11/20. Additional information was obtained on 1/21/20. Therefore, the exit date was changed to 1/21/20. One of the three allegations was substantiated with a deficiency.	F 000			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F 622		2/7/20	

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

TITLE

(X6) DATE

Electronically Signed

01/29/2020

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 622	<p>Continued From page 1</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p>	F 622			

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F 622	<p>Continued From page 2</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, family, emergency medical services staff, and facility staff interviews the facility failed to provide emergency medical service staff with the correct medication administration record prior to transfer to the hospital for one (Resident #2) of three residents reviewed for conveyance of information upon discharge. Finding included:</p> <p>Resident #2 was admitted to the facility on 12/16/19 with cumulative diagnoses, some of which included hypertension, chronic kidney disease, diabetes mellitus, and cerebral infarction.</p> <p>Documentation in the nursing notes on 1/1/20 indicated that Resident #2 was noted to be lethargic and have a low heart rate at 1:15 AM. Documentation in the same nursing note revealed an order was obtained to send Resident #2 to the emergency room and family was notified of the resident's transfer.</p>	F 622	<p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident number 2 was readmitted to the facility on 1/6/2020. All medications were reviewed and verified by the MD on admission. A copy of the medical record including the medication administration record was given to the daughter on 1/2/2020 by the Administrator.</p> <p>Address how the facility will identify other residents having the potential to be affected;</p> <p>All residents who transfer to the hospital have the potential to be affected. An audit of acute transfers from 1/2/2020 to 1/28/2020 was conducted by the Administrator. No issues or concerns</p>		

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F 622	Continued From page 3  Documentation in the discharge summary from the hospital dated 1/6/20 revealed in the history of the present illness that Resident #2 presented in the emergency room with a low heart rate, a family member was notified in the early morning hours of his transfer to the hospital, and emergency medical services documentation was reviewed. The documentation further stated, "It is noted that there was a MAR (medication administration record) from the wrong patient from the rehab facility. This was apparently brought by EMS (emergency medical services) for the current patient. This MAR had shown Metoprolol as his home medication. After review of the MAR, it was found out that the MAR did not belong to the current patient and therefore at the time of the evaluation, medication list from the rehab facility is not available." The documentation from the history and physical written on 1/1/20 at 2:52 AM by the emergency room physician revealed the hospital electronic medical record was consulted to obtain past medical history information to include medications.  Nurse #1, who prepared the paperwork for Resident #2 for transport to the hospital on 1/1/20, was interviewed on 1/10/20 at 2:43 PM. Nurse #1 explained that Resident #2 was observed to be lethargic and with a low heart rate on 1/1/20. Nurse #1 indicated she called the physician and was given orders to send Resident #2 to the hospital. Nurse #1 revealed she printed off the face sheet, code status, MAR, and the most recent history/physical for Resident #2 from the electronic medical record. Nurse #1 also revealed she provided the documentation to the EMS staff who verified the paperwork with Nurse #1. Additionally, Nurse #1 indicated the EMS staff	F 622	were identified.  Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:  3. An Acute Care Discharge checklist was created by the DON to ensure accurate information is sent with the resident to the emergency room. The Acute Care Discharge Checklist contains a list of items to include in the packet sent with EMS:  a. Completed Resident Transfer From b. Face sheet c. Copy of current Medication administration record d. Copy of Advance Directives e. Copy of Living Will f. Original DNR form g. Copy of most recent history and physical h. Copy of most recent hospital discharge summary i. Copy of Bed Hold Policy And applicable Labs and x-ray report  The Acute Care Transfer Checklist will be reviewed with EMS by the nurse and each will sign the checklist acknowledging accurate information is included in the packet. Upon completion, the Acute Care Transfer Checklist will remain in the resident's chart.  All Licensed nurses educated on the use of the Acute Care Transfer Checklist by		

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F 622	<p>Continued From page 4</p> <p>verified with Resident #2 his name. Nurse #1 emphatically denied giving the EMS staff the wrong MAR.</p> <p>A family member for Resident #2 was interviewed on 1/10/20 at 3:01 PM. The family member recounted how she was contacted by the facility with notification of Resident #2 being sent to the emergency room on 1/10/20 at 1:30 AM. The family member maintained that when she arrived at the emergency room she was questioned about if Resident #2 was receiving dialysis services. The family member was at that point concerned the wrong medical information was sent with the resident to the hospital because Resident #2 was not on dialysis. The family member was disturbed to find out from the hospital staff that the wrong MAR was sent with Resident #2 from the facility.</p> <p>The Director of Nursing (DON) was interviewed on 1/11/20 at 12:50 PM. The DON revealed that human error was possible in the wrong MAR being sent to the ER with Resident #2 on 1/1/20. The DON insinuated that the wrong MAR could have been picked up by the EMS staff. The DON revealed that the nursing staff printed out all the MARs for all the residents on the hall for the physician's signature and approval at the beginning of the month. The DON didn't know if the MARs for the residents were in an area the EMS staff would have had access to. The DON insisted that the hospital did not call the facility to notify them the wrong MAR was sent with EMS.</p> <p>The EMS lead staff member who transported Resident #2 to the hospital on 1/1/20 was interviewed on 1/21/20 at 4:29 PM. The EMS staff member indicated that he reviewed the documentation for the call he received to go to</p>	F 622	<p>the DON and/or SDC and was completed on 1/31/2020.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>An audit of the Acute Care Transfer Checklist will be conducted by the DON or designee daily for 30 days, (for acute care transfer), then monthly for 3 months. If any identified concerns, the hospital and family will be notified. A QAPI meeting was held on 1/21/2020 and the Acute Care Transfer Checklist process was approved. Audit results will be presented at QAPI meeting February 18th 2020 and will determine if further action is needed.</p>		

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F 622	Continued From page 5 the facility to pick up Resident #2. He stated that he went to the resident's bedside and was handed paperwork from the facility nurse while his coworker assessed the resident. He related that he always looked for a medical history, a list of medications, and insurance information. The EMS staff member confirmed he did not go to the nursing desk to obtain additional documentation for Resident #2 but only took the paperwork that was handed to him by the nurse. He additionally added that about a half hour after he left Resident #2 at the hospital, the hospital called him letting him know that half of the packet for the resident was his while the other half, which included the MAR, was not the resident's medical information. The EMS staff member stated that the hospital had access to previous medical information regarding Resident #2 and the resident was not given any medications in the ambulance that would have interacted with his current medications used to treat his medical condition.	F 622			