

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

PRINTED: 05/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/06/2018
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		
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F 756 SS=D	<p>Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)</p> <p>§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.</p>	F 756		5/4/18	

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

TITLE

(X6) DATE

Electronically Signed

04/25/2018

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 756	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and consultant pharmacist, pharmacy, physician and staff interviews, the consultant pharmacist failed to identify and report an irregularity related to the omission of an antiplatelet medication (a medication that decreases platelet aggregation and inhibits blood clot formation) upon admission for 1 of 3 residents (Resident #1) reviewed for unnecessary medications.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility from a hospital on 1/29/18. The resident ' s cumulative diagnoses included diabetes and a history of insertion of a drug-eluding stent into the right coronary artery due to coronary artery disease. A stent is a small mesh tube inserted into an artery to keep it open. A drug-eluding stent has a coating over the mesh that releases a drug over time to help keep the blockage from coming back.</p> <p>A review of the resident ' s hospital discharge medication list dated 1/29/18 included 19 medications. Each of the medications listed had a hand-written check mark next to it. The discharge medications included 10 milligrams (mg) prasugrel (an antiplatelet medication) to be given as one tablet by mouth once daily.</p> <p>A review of Resident #1 ' s electronic medical record revealed 18 of the 19 medications on the hospital discharge medication list were included in the facility ' s admission orders for this resident. However, prasugrel was not included in the listing of medications ordered for Resident #1 upon his</p>	F 756	<p>F756 Drug Regimen Review</p> <p>Resident #1 was assessed by UM #1 upon admission to the facility on 1/29/18. UM #1 inputted Resident #1's medication into the EMR. 18 of 19 transcribed over to the EMR. Director of Nursing noticed medication omission on 3/18/18 and notified the physician, pharmacy, and family of the medication error. The physician started Resident #1 back on the medication, since they were back at their baseline. Hospital notes were obtained that reflect there was no significant harm done to Resident #1.</p> <p>Corrective Action</p> <p>All medication review procedures have been examined by the Director of Pharmacy and the Director of Nursing. These procedures include reviewing all accessible documents such as MARs, discharge summaries, etc. All processes and procedures have been reviewed with the consultant pharmacist and will be executed thoroughly moving forward.</p> <p>Corrective Action for those having the potential to be affected</p> <p>All residents have the potential to be affected by this alleged deficient practice. All licensed staff have been in-serviced on the facility's medication input policy by the Assistant Director of Nursing (prn/weekend staff will be in-serviced</p>		

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F 756	<p>Continued From page 2 admission to the facility.</p> <p>Further review of Resident #1 ' s electronic medical record included the January 2018 Medication Administration Record (MAR). This MAR revealed prasugrel was not listed as an ordered medication.</p> <p>A review of Resident #1 ' s admission Minimum Data Set (MDS) assessment dated 2/5/18 indicated the resident had intact cognitive skills for daily decision making. The resident required limited assistance from staff for his Activities of Daily Living (ADLs), with the exception of requiring supervision for walking in room/corridor and locomotion on/off the unit. He was independent with eating.</p> <p>A review of the resident ' s medical record included the consultant pharmacist ' s medication regimen review dated 2/22/18. The pharmacist ' s note read: "Medication regimen reviewed for problems and/or irregularities."</p> <p>A review of Resident #1 ' s February 2018 electronic MAR revealed prasugrel was not listed as an ordered medication. The MAR did not include any documentation to indicate prasugrel was administered to the resident during the month.</p> <p>A review of the facility ' s Transfer/Discharge Report (dated 3/16/18) for Resident #1 included a listing of the resident ' s current medications. The list indicated 10 mg prasugrel was to be taken as one tablet by mouth one time a day for coronary artery disease with a start date of 1/30/18.</p> <p>Further review of Resident #1 ' s electronic</p>	F 756	<p>before working next shift) on 05-01-2018. Director of Nursing will in-service Director of Pharmacy on the facility's medication input policy on 05-01-2018. All resident's medications will be reviewed by pharmacist to ensure all residents medications are correctly being followed by the physician, and have been properly entered into the EMR by 05-04-2018.</p> <p>Systemic Changes</p> <p>The Assistant Director of Nursing will educate all licensed nurses, full-time and part-time, (prn/weekend staff will be in-serviced before working next shift) on the facility's medication input policy by 05 -01-2018.</p> <p>Monitoring</p> <p>The Director of Nurses, and/or her nurse managers, will perform five (5) audits each week for (3) three months, to ensure all admitting resident's medications are double-checked with the discharge summary from the discharging hospital with the transcribed EMR for accuracy. A pharmacy representative will audit 10% of the all admissions that the contracting pharmacist reviews (1) once monthly for (3) three months, to ensure all residents medications are correctly being followed by the physician, and have been properly entered into the EMR. Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.</p>		

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F 756	<p>Continued From page 3</p> <p>physician orders revealed 10 mg prasugrel was ordered for the resident on 3/18/18 with directions to give one tablet by mouth in the evening. The medication was documented as given once each day on 3/18/18 and 3/19/18. A review of the resident ' s March 2018 electronic MAR revealed prasugrel was not listed as an ordered medication and was not documented as having been administered to Resident #1 prior to 3/18/18.</p> <p>Resident #1 was discharged from the facility on 3/20/18 to go home with home health services.</p> <p>An interview was conducted on 4/5/18 at 2:39 PM with Unit Manager #1. Unit Manager #1 was identified as the nurse who input Resident #1 ' s admission medication orders into his electronic medical record. Upon inquiry, the Unit Manager described the process of receiving and transcribing admission orders for new residents. She reported the hospital discharge medication list was usually used when the physician was called for a resident ' s admission orders. She stated a check mark next to a medication on the hospital discharge med list indicated a physician ' s order was received to continue with that medication upon the resident ' s admission to the facility. After the physician ' s admission orders were received, the Unit Manager reported she would input the medications into the computer. She stated, "I would have thought I put it (prasugrel) in because it ' s checked (on the hospital discharge medication list). Why it ' s not there (on the MAR and the physician orders), I cannot tell you."</p> <p>A telephone interview was conducted on 4/5/18 at 3:20 PM with a representative from the facility ' s contracted pharmacy. Upon inquiry, the pharmacy</p>	F 756			

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F 756	<p>Continued From page 4</p> <p>reported 15 tablets of 10 mg prasugrel were dispensed for Resident #1 one time only on 1/29/18.</p> <p>An interview was conducted on 4/5/18 at 3:35 PM with the facility ' s Director of Nursing (DON). The DON recalled a question about Resident #1 ' s prasugrel was brought to Unit Manager #2 ' s attention a couple of days prior to his discharge from the facility. The DON reported the facility investigated the situation. She found out that although an electronically transmitted prescription for prasugrel was sent to the pharmacy after Resident #1 was admitted, prasugrel did not appear on the resident ' s electronic MAR or on the physician ' s orders listed in his medical record.</p> <p>A telephone interview was conducted on 4/5/18 at 4:30 PM with the facility ' s consultant pharmacist. During the interview, the omission of Resident #1 ' s prasugrel (from 1/29/18 to 3/17/18) as initially ordered by the physician was discussed. Upon inquiry, the pharmacist reported he tried to make sure the medication orders at the facility matched with the hospital discharge medication list when he reviewed the medical record of a new resident. The pharmacist reported he could see in his computer system where Resident #1 ' s prasugrel was filled by the pharmacy on 1/29/18. However, he stated no recommendations or concerns were noted during his 2/22/18 review of Resident #1 ' s medications. He stated, "If I didn ' t catch it (the omission of prasugrel), that ' s on me."</p> <p>A follow-up interview was conducted on 4/6/18 at 10:40 AM with Unit Manager #1. During the interview, the Unit Manager was asked where hospital discharge records were placed after the</p>	F 756			

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F 756	Continued From page 5 admission orders were entered into the computer system for a new resident. The Unit Manager stated she placed the hospital discharge records in the resident ' s paper chart until Medical Records scanned them into the computer system. Upon inquiry, Unit Manager #1 reported these records remained available for review at all times. A follow-up interview was conducted on 4/6/18 at 11:00 AM with the DON. During the interview, the DON was asked what her expectation was in regards to the consultant pharmacist ' s role in the omission of prasugrel for Resident #1. The DON stated, "He should have recognized there was a problem." A telephone interview was conducted on 4/6/18 at 11:19 AM with the physician who cared for Resident #1 during his stay at the facility. Upon inquiry, the physician stated he recalled Resident #1 and the medication error that occurred with the resident ' s prasugrel during his stay at the facility. The physician reported when the resident was started back on the prasugrel, he was back to his baseline. He stated no harm was done to the resident by the occurrence of this medication error. When asked how significant he felt this error was, the physician stated, "This type of thing should not occur in any case." The physician added, "He ' s lucky he didn ' t have an incident."	F 756			
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		5/4/18	

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F 760	<p>Continued From page 6</p> <p>Based on record reviews and consultant pharmacist, pharmacy, physician and staff interviews, the facility failed to administer an antiplatelet medication (a medication that decreases platelet aggregation and inhibits blood clot formation) in accordance with the physician ' s admission orders for 1 of 3 residents (Resident #1) reviewed for unnecessary medications.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility from a hospital on 1/29/18. The resident ' s cumulative diagnoses included diabetes and a history of insertion of a drug-eluding stent into the right coronary artery due to coronary artery disease. A stent is a small mesh tube inserted into an artery to keep it open. A drug-eluding stent has a coating over the mesh that releases a drug over time to help keep the blockage from coming back.</p> <p>A review of the resident ' s hospital discharge medication list dated 1/29/18 included 19 medications. Each of the medications listed had a hand-written check mark next to it. The discharge medications included 10 milligrams (mg) prasugrel (an antiplatelet medication) to be given as one tablet by mouth once daily.</p> <p>A review of Resident #1 ' s electronic medical record revealed 18 of the 19 medications on the hospital discharge medication list were included in the facility ' s admission orders for this resident. However, prasugrel was not included in the listing of medications ordered for Resident #1 upon his admission to the facility.</p> <p>Further review of Resident #1 ' s electronic</p>	F 760	<p>F760 Residents are Free of Significant Med Errors.</p> <p>Resident #1 was assessed by UM #1 upon admission to the facility on 1/29/18. UM #1 inputted Resident #1 ' s medication into the EMR. 18 of 19 medications transcribed over to the EMR. Director of Nursing noticed medication omission on 3/18/18 and notified the physician, pharmacy, and family of the medication error. The physician started Resident #1 back on the medication, since they were back at their baseline. Hospital notes were obtained that reflect there was no significant harm done to Resident #1.</p> <p>Corrective Action</p> <p>All medication review procedures have been examined by the Director of Nursing, Assistant Director of Nursing, MDS Coordinator and Unit Managers. These procedures include reviewing all accessible documents such as MARs, discharge summaries, etc. All processes and procedures have been reviewed with the nursing Staff to ensure all medications are administered properly. Medication reviews will be thoroughly examined moving forward.</p> <p>Corrective Action for those having the potential to be affected</p> <p>All residents have the potential to be affected by this alleged deficient practice. All licensed staff have been in-serviced on the facility's medication input policy. All</p>		

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F 760	<p>Continued From page 7</p> <p>medical record included the January 2018 Medication Administration Record (MAR). This MAR revealed prasugrel was not listed as an ordered medication.</p> <p>A review of Resident #1 ' s admission Minimum Data Set (MDS) assessment dated 2/5/18 indicated the resident had intact cognitive skills for daily decision making. The resident required limited assistance from staff for his Activities of Daily Living (ADLs), with the exception of requiring supervision for walking in room/corridor and locomotion on/off the unit. He was independent with eating.</p> <p>A review of Resident #1 ' s February 2018 electronic MAR revealed prasugrel was not listed as an ordered medication. The MAR did not include any documentation to indicate prasugrel was administered to the resident during the month.</p> <p>A review of the facility ' s Transfer/Discharge Report (dated 3/16/18) for Resident #1 included a listing of the resident ' s current medications. The list indicated 10 mg prasugrel was to be taken as one tablet by mouth one time a day for coronary artery disease with a start date of 1/30/18.</p> <p>Further review of Resident #1 ' s electronic physician orders revealed 10 mg prasugrel was ordered for the resident on 3/18/18 with directions to give one tablet by mouth in the evening. The medication was documented as given once each day on 3/18/18 and 3/19/18. A review of the resident ' s March 2018 electronic MAR revealed prasugrel was not listed as an ordered medication and was not documented as having been administered to Resident #1 prior to 3/18/18.</p>	F 760	<p>resident's medications on MAR have been double-checked with the medical record by the administrative nurses to ensure accuracy by 05/03/2018.</p> <p>Systemic Changes</p> <p>The Assistant Director of Nursing will educate all licensed nurses, full-time and part-time, on the facility's medication admission policy (prn/weekend staff will be in-serviced before working next shift) on 05-01-2018.</p> <p>Monitoring</p> <p>The Director of Nurses, and/or her nurse managers, will perform five (5) audits each week for (3) three months, to ensure all admitting resident's medications are double-checked with the discharge summary from the discharging hospital with the transcribed EMR for accuracy. Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.</p>		

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F 760	<p>Continued From page 8</p> <p>Resident #1 was discharged from the facility on 3/20/18 to go home with home health services.</p> <p>An interview was conducted on 4/5/18 at 2:39 PM with Unit Manager #1. Unit Manager #1 was identified as the nurse who input Resident #1 ' s admission medication orders into his electronic medical record. Upon inquiry, the Unit Manager described the process of receiving and transcribing admission orders for new residents. She reported the hospital discharge medication list was usually used when the physician was called for a resident ' s admission orders. She stated a check mark next to a medication on the hospital discharge med list indicated a physician ' s order was received to continue with that medication upon the resident ' s admission to the facility. After the physician ' s admission orders were received, the Unit Manager reported she would input the medications into the computer. She stated, "I would have thought I put it (prasugrel) in because it ' s checked (on the hospital discharge medication list). Why it ' s not there (on the MAR and the physician orders), I cannot tell you."</p> <p>An interview was conducted on 4/5/18 at 3:04 PM with Unit Manager #2. Unit Manager #2 reported that when she was getting ready to discharge Resident #1 from the facility, she printed a discharge summary with a list of his current medications. When she saw the prasugrel, she called the pharmacy and asked why it printed out on the medication list but not on the monthly MAR during his stay at the facility. The Unit Manager reported the pharmacy did not give her a clear answer as to how this had happened. She stated she called the physician and informed him the</p>	F 760			

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F 760	<p>Continued From page 9</p> <p>resident had not received the prasugrel thus far during his stay at the facility. Unit Manager #2 reported the physician told her to assess the resident and to initiate the prasugrel. She stated a medication error report was completed. She also noted that when she assessed the resident, he did not have any evident effects from the medication error.</p> <p>A telephone interview was conducted on 4/5/18 at 3:20 PM with a representative from the facility ' s contracted pharmacy. Upon inquiry, the pharmacy reported 15 tablets of 10 mg prasugrel were dispensed for Resident #1 one time only on 1/29/18. There was no record of how many tablets were returned to the pharmacy upon his discharge from the facility.</p> <p>An interview was conducted on 4/5/18 at 3:35 PM with the facility ' s Director of Nursing (DON). The DON recalled a question about Resident #1 ' s prasugrel was brought to Unit Manager #2 ' s attention a couple of days prior to his discharge from the facility. She stated the Unit Manager contacted the physician and initiated the medication in accordance with the physician ' s order. The DON stated that basically the facility had a card with medication (prasugrel) for Resident #1 without the medication showing up on the electronic MAR. The DON reported the facility investigated the situation. She found out that an electronically transmitted prescription for prasugrel was sent to the pharmacy after Resident #1 was admitted. However, it was not clear why prasugrel did not appear on the resident ' s electronic MAR or on the physician ' s orders listed in his medical record. The DON stated she talked with the pharmacy again today and called the software company to see if they</p>	F 760			

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F 760	<p>Continued From page 10</p> <p>could provide any insight as to why this had occurred. The DON reported she has done in-service education with the nursing staff instructing nurses to question any medication received from the pharmacy without a corresponding order or listing on the MAR. When the DON was asked if a Quality Assessment and Assurance (QAA) activity or monitoring had been implemented to ensure this did not reoccur, she stated, "I haven ' t as far as an actual audit tool, did not do that." The DON reported the facility double checked new residents ' admission orders during their clinical meetings. Upon further inquiry, the DON confirmed this "double check" was already in place at the time Resident #1 was admitted to the facility. This second check on admission orders did not identify the omission of prasugrel ordered for Resident #1.</p> <p>A telephone interview was conducted on 4/5/18 at 4:30 PM with the facility ' s consultant pharmacist. During the interview, the omission of Resident #1 ' s prasugrel (from 1/29/18 to 3/17/18) as initially ordered by the physician was discussed. The pharmacist stated, "If they got the card (containing the medication), they should have questioned, ' why do I have this card? ' " When asked how significant he would consider the omission of an antiplatelet medication such as prasugrel from Resident #1 ' s admission medications, the pharmacist stated, "Well, very."</p> <p>A follow-up interview was conducted on 4/6/18 at 8:15 AM with the DON. During the interview, the DON confirmed 10 of the 15 prasugrel tablets dispensed by the pharmacy for Resident #1 on 1/29/18 were left on the medication card when the resident was discharged from the facility on 3/20/18. According to the electronic MAR</p>	F 760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/06/2018
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		
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F 760	<p>Continued From page 11</p> <p>records, one tablet of the prasugrel was administered to Resident #1 on 3/18/18 and one tablet was administered on 3/19/18. The DON acknowledged three tablets of prasugrel had not been accounted for on the electronic MARs.</p> <p>A second follow-up interview was conducted on 4/6/18 at 11:00 AM with the DON. During the interview, the DON was asked what her expectation was in regards to the prasugrel ordered for Resident #1 upon admission. The DON stated her expectation was, "If there is a card of meds and they 're (the nurses are) unsure about it and it 's not on the eMAR (electronic MAR), they would call the supervisor and notify her there 's a problem." The DON also reported she would expect the nurse to try to fix the problem.</p> <p>A telephone interview was conducted on 4/6/18 at 11:19 AM with the physician who cared for Resident #1 during his stay at the facility. Upon inquiry, the physician stated he recalled Resident #1 and the medication error that occurred with the resident 's prasugrel during his stay at the facility. The physician reported when the resident was started back on the prasugrel, he was back to his baseline. He stated no harm was done to the resident by the occurrence of this medication error. When asked how significant he felt this error was, the physician stated, "This type of thing should not occur in any case." The physician added, "He 's lucky he didn 't have an incident."</p>	F 760			