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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495139	A. BUILDING ______ B. WING ______	C 01/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 1/3/2017 through 1/4/17. A Complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 118 certified bed facility was 108 at the time of the survey. The survey sample consisted of 2 current Resident reviews (Residents 1 and 2) and 3 closed record reviews (Residents 3 through 5).	F 000		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to properly transcribe a medication for one of five residents in the survey sample, Resident #3. At the time of admission on 10/12/16, Resident #3's admission order for a medication to treat Parkinson's disease was transcribed by the facility staff incorrectly. Resident #3 was administered the incorrect dose of Carbidopa-Levodopa (1) through the time of discharge on	F 281	**F281** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 3 was identified in this practice. The resident was discharged from the facility on 10/18/2016. **F281** **Continued on Page 2**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn D. Kilpatrick
TITLE: Interim Executive Director
(X6) DATE: 1-25-2017

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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10/18/16.

The findings include:

Resident #3 was admitted to the facility on 10/12/16 with diagnoses that included; Parkinson's disease (a progress disorder of the nervous system affecting movement), hip fracture, cognitive communication deficit, atrial fibrillation (a dysrhythmia of the heart), chronic kidney disease and high blood pressure.

The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 10/18/16, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. Resident #3 was also coded as requiring limited to extensive assistance of one staff member with activities of daily living.

A review of Resident #3's clinical record revealed, in part a hospital discharge summary dated 10/18/16 with a "Daily medication list" which documented, in part; "Take these medications at their scheduled times. Carbidopa - Levodopa 25-500 mg (milligrams) Tabs (tablets). Commonly known as SINEMET. Take 1 Tab by mouth 3 times Daily." This medication list was reviewed and signed by ASM (administrative staff member) #1, the facility medical director, on 10/12/16. ASM #1 also noted beside the medication, "Parkinson's Dz (disease)."

Further review of Resident #3's clinical record revealed, in part, a POS (physician order summary) dated and signed by nursing on

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Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?

Residents that admitted and/or re-admitted to the facility have the potential to be affected by this practice. On 12/23/2016, a 100% audit was completed by the Nurse Unit Managers and DON to review all new admissions and re-admissions since 10/12/2016 to ensure all admission/re-admission orders were accurate.

Criterion #3 - What measures will be put in place or systematic changes made to ensure the practice will not reoccur.

Individual education about the transcribing physician's order process upon admission/re-admission was provided on 12/14/2016 by the Assistant Director

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10/12/16 with a date and signature of ASM #1 on 10/13/16. The POS revealed the following order; "Order date: 10/12/16. Type: Med (medication). Order: 10/12/16 carbidopa 25 mg (milligrams) - Levodopa 100 mg tablet Take 2 (two) tabs PO (by mouth) TID (three times daily). Parkinsons."

A review of Resident #3's progress notes revealed a discharge note dated 10/18/16 that documented, in part, the following; "Alert confused, pleasant and cooperative."

A review of Resident #3's discharge assessment summary dated 10/18/16 revealed, in part, the following; "Physical and mental functional status. Alert (abbreviation for with) confusion."

On 1/4/17 at 9:20 a.m. an interview was conducted with OSM (other staff member) #1, the pharmacist. OSM #1 was asked to describe the impact on a resident if he/she received double the dose of carbidopa - levodopa from what was originally ordered. OSM #1 stated, "It could take up to two weeks to get the full impact of the drug or to see any changes from the maximum effects of an increase in the drug. It really depends on the person and how well they were controlled on the lower dose. If there is too much carbidopa - levodopa in the system the side effects could be seen with stomach upset psychosis (impairment of thoughts and/or emotions) which could include an increase in confusion, hallucinations and agitation. The cognition could decrease. This takes time to build up, it is not immediate, and again it depends on the person. You would have to look at cognition at the time the drug was increased." OSM #1 was asked if he was familiar with Resident #3 and was he aware that his dose of carbidopa - levodopa was doubled when he

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Criterion # 3
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of Nursing (ADON) and Regional Director of Clinical Services (RDCS) to ASM # 2 and LPN # 2 identified in survey. The RN Staff Development Coordinator (SDC) also began the same education regarding the Transcription process with all Licensed Nurses on 12/14/2016. This education was completed on 01/25/2017.

On 01/06/2017, an education was completed with ADON and Nurse Unit Managers by the Regional Vice President (RVP) and Regional Director of Clinical Services (RDCS) regarding the Physician's orders and Month End Recap Process. An additional In-service was initiated by the Staff Development Coordinator (SDC) to all licensed nurses regarding the New Physician's Order process on 01/11/2017.

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entered the facility. OSM #1 stated that he was not familiar with the resident, that he (Resident #3) had left the facility prior to OSM #1 being at the facility to conduct his monthly medication review. OSM #1 was asked whether or not Resident #3 could have demonstrated any side effects previously mentioned within a six day period (10/12/16 - 10/18/16), OSM #1 stated, "I am not sure that you would see any changes in the resident in a 6 (six) day period, though you could potentially see stomach upset first accompanied by pain."

An interview was conducted with LPN (licensed practical nurse) on 1/4/17 at 10:15 a.m. LPN #1 was asked to describe the process when admitting a new resident into the facility. LPN #1 sated, "Admissions brings an admission package to the nursing staff which includes the discharge orders from the hospital. We give the discharge instructions to the physician as soon as we get them. He, the physician, reviews the orders and marks down any changes in the medication or the times to administer the medications. We fax the discharge medication list with the physicians' notations to (name of pharmacy) and we enter the information into the computer." LPN #1 was asked what the process was to ensure that the medications were entered correctly. LPN #1 stated, "After the first nurse enters the medication into the computer, a second nurse compares the medication list with the medications entered into the computer. Any transcription errors are then caught at that point."

An interview was conducted on 1/4/17 at 10:30 a.m. with ASM #2, the director of nursing. ASM #2 was asked if she was familiar with Resident #3. ASM #2 stated, "We (the facility staff) were

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Criterion #3
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This education was completed on 01/25/2017 and the same education will be included upon new hire orientation for nurses.

Beginning on 12/15/16, a review of all admission and re-admission orders will be completed by the DON or ADON and/or nurse unit managers (UM), daily Monday – Friday during clinical meeting for 3 months. This review will ensure that all physician orders were transcribed correctly. An audit tool will be completed for all records reviewed. Any issues identified and/or corrections necessary will be noted.

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made aware of the error with (name of Resident #3's) medications about two weeks ago. (Name of Resident #3's) daughter called us and told us what had happened. We immediately initiated a PI (performance improvement) plan. The process that we had in place failed, we did not catch the error in transcription."

An interview was conducted on 1/4/17 at 10:50 a.m. with RN (registered nurse) #1, a floor nurse. RN #1 was asked to describe the process when admitting a new resident to the facility. RN #1 stated, "Admissions brings us the discharge orders from the hospital. We give the orders to the physician and he makes any changes to the medication orders and gives them back to the nurses. The nursing staff faxes the orders with the physicians' notations to the pharmacy. The orders are input into the computer system and a second nurse then compares the written orders with the physician changes, and with the orders entered into the computer system. The night nurse also conducts a chart check for accuracy." RN #1 was then asked when the process she had described was put into place. RN #1 stated, "It has always been this way."

An interview was conducted on 1/4/17 at 11:00 a.m. with ASM #1, the facility medical director. ASM #1 was asked to describe the process when a resident was admitted to the facility from the hospital. ASM #1 stated that the nurses bring the hospital discharge summary with medications to him and he reviews them, and makes changes as necessary. ASM #1 was asked once the orders are entered into the system whether or not he reviewed the POS (physician order summary). ASM #1 stated, "The nurses print off the POS and give it to me for a signature. I only review the

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Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?

Results of admission and re-admission Physician's orders process audits will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON or ADON monthly for at least 3 months or until 100% compliant.

01/25/2017

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medications that I have changed to make sure that they were entered correctly. I really don't look at every single entry again." ASM #1 was asked if it was conceivable that if a transcription error occurred he may not catch it. ASM #1 stated that was true. ASM #1 was asked if he was familiar with Resident #3. ASM #1 stated that he was and that he was familiar with the error that was made with the carbidopa - levodopa. ASM #1 stated, "That is on me, I am ultimately responsible." ASM #1 was asked about the H & P (history and physical) when Resident #3 was discharged. ASM #1 printed off the H & P and stated, "The medications automatically download on the H & P and I really only look at the assessments and the meds (medications) associated with my assessment. I did not notice the error on the dosing of the Carbidopa - Levodopa."

An interview was conducted on 1/4/17 at 11:30 a.m. with LPN #2, a floor nurse. LPN #2 was asked to describe the process for a new admission from the hospital. LPN #2 stated Admissions gives us a packet that includes the discharge orders from the hospital. We give the orders to the physician and he looks them over and sometimes makes changes on the order sheet then gives back to the nurses. The nurse then inputs the orders into the computer and prints off a POS, a second nurse then verifies that everything is correct. Both nurses sign the POS then we print off the MARs (medication administration report)." LPN #2 was asked if this process was followed when Resident #3 was admitted to the facility on 10/12/16. LPN #2 stated, "I transcribed carbidopa - levodopa incorrectly. The second nurse missed the error." LPN #2 was asked if both the nurses signed the

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POS as being correct, LPN #2 stated "Yes." LPN #2 was asked how she became aware of the error. LPN #2 stated, "(Name of Resident #3's) daughter called and I (LPN #2) spoke with the daughter. She (Resident #3's daughter) told me that an error had been made. I wrote it up in the incident process."

On 1/4/17 at 11:40 a.m. ASM #2, the director of nursing, presented credible evidence that a four point plan of correction had been put into place for medication transcription through their PI (performance improvement) program. The credible evidence included the following:
1. All new admissions and readmissions from 10/12/16 were reviewed to ensure admission orders were correct.
2. All licensed nurses were to receive education on the order process.
3. Nursing leadership will review all new admissions and readmissions during the daily clinical meeting to ensure admission orders were transcribed correctly.
4. The director of nursing is to present all findings to PI (performance improvement) monthly.

As of 1/4/17, 59% of licensed nursing staff had received the education.

Planned Date of Correction: 1/12/17

The facility had not completed the corrective action plan at the time of the survey therefore this could not be cited as past non compliance.

During the survey, there were no concerns identified by observation or record review of any current concerns for the transcription of

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F 281	Continued From page 7 admission or physician orders. A review of the facility policy titled "Physician's Orders/Transcription" revealed, in part, the following documentation; "Standard. Proper channels of communication are used to ensure accurate delivery of medications and treatments to all residents. This is achieved by using the Order Sheet, Telephone Order Form, Medication Administration Record (MAR), and Treatment Record." There was no reference to orders received in an admission package. On 11/4/16 at 12:15 p.m. ASM #2 was asked what standard the nursing staff uses for medication transcription. ASM #2 stated, "We use our policy." No further information was provided prior to the end of the survey process. Complaint Deficiency (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601068.html	F 281		