Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060098	A. BUILDING: _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOTT'S MANOR 2	10215 CONNELL ROAD CHARLOTTE, NC 28227

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 5/19/16.	C 000	We have set a new procedure in place to prevent this error from Reoccurrence. On all future Admissions & Readmissions All incoming paper work with Medication & treatment orders will not only be Reviewed by receiving staff but will also be double checked by 2nd Staff member on shift. We also had a meeting with staff members to go over the policy & Procedure to ensure that all Physician orders are Verified/Clairfied correctly upon Admission/Re-admission when orders are unclear, and upon receiving multiple forms upon Admission/Readmission.	5/24/16
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure contact with the resident's physician or prescribing practitioner for clarification of orders for medication, upon admission of the resident, that were not signed within 24 hours of re-admission to the facility for 1 of 3 sampled resident (Resident #3). The findings are: A. Review of Resident #3's record and current FL2 dated 4/17/16 revealed diagnoses including atrial fibrillation, hypothyroidism, anemia, mitral and tricuspid valve insufficiency, celiac disease, chronic airway obstruction, congestive heart failure, peripheral vascular disease, aortic	C 315		

Reviewed & Accepted 6-3-16

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C 315	Continued From page 1 stenosis, pulmonary hypertension, chronic kidney disease, non-ST elevation myocardial infarction, coronary artery disease, urinary tract infection and rectal bleeding. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 8/03/14. Further Review of the FL2 dated 4/17/16 revealed a Physician's order for hydromorphone 2mg Take 2mg twice daily. Take 1mg twice daily. Review of Resident #3's record revealed no clarification of hydromorphone within 24 hours of re-admission to the facility on 4/17/16. Review of Resident #3's record revealed: -The previous Physician's orders dated 4/05/16 were hydromorphone 2mg 1/2 tablet (1mg) twice daily and 1/2 tablet (1mg) every 4 hours as needed for pain. -Resident #3 was hospitalized from 4/14/16-4/17/16. The April 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for hydromorphone 2mg 1/2 tablet (1mg) twice daily at 8:00 am and 8:00 pm and documented as administered as ordered. -An entry for hydromorphone 2mg 1/2 tablet (1mg) every 4 hours as needed for pain with no documented administrations. Review of Resident #3's May 2016 eMAR revealed: -An entry for hydromorphone 2mg 1/2 tablet (1mg) twice daily and documented as administered at 8:00 am and 8:00 pm from 5/01-5/18 and at 8:00 am on 5/19/16.	C 315		

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C 315	Continued From page 2 -An entry for hydromorphone 2mg 1/2 tablet (1mg) every 4 hours as needed for pain with no documented administrations. Interview with a Supervisor-in-Charge/Medication Aide (MA) on 5/19/16 at 4:03 pm revealed: -She was not working the day the Resident #3 was re-admitted to the facility and did not remember who was working. -If there was an unclear order from an admission or re-admission from the hospital she would call the prescribing practitioner at the hospital. If she could not reach that practitioner she would call the resident's primary care physician for clarification. -After she obtained clarification she would call the Resident Care Director (RCD) and inform her of the clarification. Interview with the RCD on 5/19/16 at 3:15 pm revealed: -She was unaware that there was an unclear order, likely because it was a Sunday re-admission. -If she knew, she would have called Resident #3's primary care physician and sought clarification. -For a re-admission from the hospital the Supervisor/MA should request a signed FL2 or signed discharge summary with any new orders. -If there were any orders that were vague, unclear or incomplete the MA should call and have any and all orders clarified. -She would also expect the MA to call her and notify her of any re-admissions and any orders that required clarification. -She could not recall if a MA had called her to notify her about this re-admission. Interview with the Administrator on 5/19/16 at 3:42 pm revealed:	C 315		

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C 315	Continued From page 3 -The facility normally did not allow weekend admissions because it can be difficult to obtain new medications and have orders clarified if needed, but there were exceptions to this. -He could not recall when Resident #3 was re-admitted to the facility. -The MA was supposed to contact the physician for clarification of any unclear or incomplete orders. -The MA was also supposed to inform the RCC of any clarification. Interview with a Nurse from Resident #3's primary care physician's office revealed: -The current order that Resident #3's primary care physician intended Resident #3 to be administered was hydromorphone 2mg 1/2 tablet (1mg) twice daily and 1/2 tablet (1mg) every 4 hours as needed for pain. -She would be faxing an order clarification for the hydromorphone. Review of an order clarification faxed 5/19/16 at 2:50 pm from Resident #3's primary care physician's office revealed a physician's order for hydromorphone 2mg 1/2 tablet (1mg) twice daily and 1/2 tablet (1mg) every 4 hours as needed for pain. Based on attempted interview, it was determined Resident #3 was not interviewable. Observation of the medication on hand 5/19/16 at 3:00 pm revealed that there were 90 tablets of hydromorphone filled on 4/05/16.	C 315		