

North Carolina Department of Health and Human Services Division of Health Service Regulation

Acute and Home Care Licensure and Certification Section

2712 Mail Service Center v Raleigh, North Carolina 27699-2712

Michael F. Easley, Governor Dempsey Benton, Secretary

http://facility-services.state.nc.us

Azzie Y. Conley, Chief

Phone: 919-855-4620 Fax: 919-715-3073

VIA FACSIMILE

September 18, 2007

Rob Turner, PhD, CEO Holly Hill Hospital 3019 Falstaff Road Raleigh, NC 27610

RE: Complaint investigation NC00039502

Dear Dr. Turner:

Thank you and your staff for the assistance provided to our team during the complaint investigation conducted at Holly Hill Hospital in Raleigh, NC on September 13-14 & 17, 2007. The purpose of conducting the complaint investigation survey was to evaluate the Hospital's compliance with the Conditions of Participation. The investigation resulted in identification of an Immediate Jeopardy (IJ) on September 17, 2007 at 1400, as a result of investigative findings beginning on April 17, 2007. Specifically, pursuant to Conditions of Participation 482.23 Nursing Services and 482.25 Pharmaceutical Services, the hospital failed to address medication errors to include: (a) the administration of medications to the wrong patients without physician notification of the medication error, (b) medication administration without a physician's order, (c) failure to administer medications according to a physician's order; and, (d) medication omissions.

As discussed during the survey, the information gathered during the survey was forwarded to the CMS Regional Office in Atlanta (Region IV). Our state agency is recommending 23 day termination due to noncompliance with the Conditions of Participation: 482.12 Governing Body, 482.13 Patients' Rights, 482.21 Quality Assessment and Performance Improvement, 482.23 Nursing Services and 482.25 Pharmaceutical Services. CMS Regional Office in Atlanta will make the determination of compliance or non-compliance and abatement or non-abatement of the immediate jeopardy. The CMS Regional Office will notify you of their findings and of any action to be taken. If you have questions regarding the status of the investigation, please contact the State Representative at CMS:

Ms. Janetta Booker
Division of Survey and Certification
CMS Atlanta Regional Office
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW Suite 4T-20
Atlanta, Georgia 30303-8909
(404) 562-7343

If you have any questions, please do not hesitate to contact this office at (919) 855-4620.

Sincerely,

Doug Stanton, RN, BSN Facility Survey Consultant

Acute and Home Care Licensure and Certification Section



RECEIVED SEP 2 8 2007

PRINTED: 09/20/2007 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HOLLY HILL MENTAL HEALTH SERVICES SUMMARY STATEMENT OF DEPICIENCES STREET ADDRESS, CITY, STATE, ZIP CODE 3019 FALSTAFE RD RALEIGH, NC 27510 CAN JD SPREY SUMMARY STATEMENT OF DEPICIENCES PART PART	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER HOLLY HILL MENTAL HEALTH SERVICES SUMMARY STATEMENT OF DEFICIENCIES PREPAY REGISTRATE RD				A. BUILDING			
HOLLY HILL MENTAL HEALTH SERVICES MAJIO SUMMARY STATEMENT OF DEPICIENCIES CRACK DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISCIDENTHYMIC INFORMATION) THE PRETEX TAG PRETEX TAG			344014	B. WING		09/17	/2007
A 000 INITIAL COMMENTS A complaint investigation was conducted at the hospital on September 13, 2007. As a result of investigative findings beginning on April 17, 2007, an Immediate Jeopardy (IJ) was identified on September 17, 2007 at 1400 in regards to the facility failed to address medication errors, resulting in a potential or immediate threat to the health and safety of patients served. The immediate jeopardy was not abated. Nursing staff administered the wrong medication or a patient (a seven year-old), and did not notify the physician or guardian of the medication error. The physician was administered another patients medication and the physician was not notified of the medications given which were not ordered by the physician (#2, 12, 10, 411). Nursing staff failed to monitor for identification of a side effect (low blood pressure) of a medication administered to a five year-old by failing to ensure vital signs were obtained as ordered by the physician (#3, 12, 210, 411). Nursing staff failed to monitor for identification of a side effect (low blood pressure) of a medication administered to a five year-old by failing to ensure vital signs were obtained as ordered by the physician (#4, 12, 210, 411). A summary of the action plan submitted and implemented by the hospital on 9-17-2007 included:			ERVICES	30	19 FALSTAFF RD		
A complaint investigation was conducted at the hospital on September 13-14 & 17, 2007. As a result of investigative findings beginning on April 17, 2007, an Immediate Jeopardy (IJ) was identified on September 17, 2007 at 1400 in regards to the facility failed to address medication errors, resulting in a potential or immediate threat to the health and safety of patients served. The immediate jeopardy was not abated. Nursing staff administered the wrong medication to a patient (a seven year-old), and did not notify the physician altered the patients medication regimen based on current assessment, but without knowledge of the medication error (#8). Patient #11 was administered another patient's medication and the physician was not notified of the medication error. A total of 4 of 17 patients sampled had medications (#16). Six of 17 patients sampled had medications (#16). Six of 17 patients sampled had medications were not administered to a five year-old by failing to ensure vital signs were obtained as ordered by the physician was not notified the patient refused or missed the dose of medication (#7, #20, #6, #4, #13, #12). A summary of the action plan submitted and implemented by the hospital on 9-17-2007 included:	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		A complaint investig hospital on Septembresult of investigative 17, 2007, an Immedidentified on Septembregards to the facility errors, resulting in a to the health and saimmediate jeopardy. Nursing staff adminition a patient (a sever the physician or guated The physician altereregimen based on a without knowledge of Patient #11 was admedication and the the medication error sampled had medication arrors sampled had medication arrors sampled had medication arrors sampled had medication errors sampled had medication staff failed the a side effect (low bloadministered to a fix vital signs were obtained by the physician (#16). Signedications not documentation in the medications were not the physician. The patient refused or modification (#7, #20, #6, #4, #1). A summary of the a implemented by the included: 1. All medication training the summary of the and implemented by the included:	ation was conducted at the per 13-14 & 17, 2007. As a se findings beginning on April iate Jeopardy (IJ) was aber 17, 2007 at 1400 in y failed to address medication potential or immediate threat fety of patients served. The was not abated. Stered the wrong medication and year-old), and did not notify ardian of the medication error. In the patient's medication error (#8), and the patient's medication error (#8), and the patient's medication error (#8), and the patient's physician was not notified of the A total of 4 of 17 patients ations given which were not ician (#8, #12, #10, #11). To monitor for identification of the od pressure) of a medication we year-old by failing to ensure a sined as ordered by the continuous of the continuous end and the physician was not notified the physician was not	RE	The facility has ensured that no potential or immediate the health and safety of patiserved, by taking the steps of this Plan of Correction. Implementation of corrective began during the survey and continued ongoing.	areat of ents outlined in ve actions d has	(X6) DATE • Z 6 • 2

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.

Event ID: JZWI11

Facility ID: 953222

PRINTED: 09/20/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 344014 09/17/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3019 FALSTAFF RD HOLLY HILL MENTAL HEALTH SERVICES RALEIGH, NC 27610 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 000 A 000 Continued From page 1 was halted as of 1515 on 9-17-2007 pending education of current nursing staff and supervisor staff in the building at that time. 2. Training nursing staff and supervisor staff on subsequent shifts would be provided until 100% of staff trained. 3. Unit Secretaries no longer transcribing medication orders. 4. Education provided to nursing staff through an education packet, including: a. Transcription of medication orders only by licensed nursing staff and co-signed by licensed nursing staff. 100% of medication order transcription to be monitored by management

meetings.

order.

staff for 30 days for compliance.

b. All medication passes for 30 days will be monitored by supervisor staff and documented. Recommendations and findings will be discussed at the Monday through Friday management

c. Policy "Medication Administration: General Guidelines" to be reviewed, specifically, no medications will be given without a physician

d. Medications Clonidine and Tenex added to the "High Risk Medications" policy. Physician education provided to 100% of physician staff by the physician Medical Director on 9-17-2007. Physician staff will order blood pressure

parameters. Blood pressures and pulse rates for these medications will be documented on the medication administration record (MAR). All

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 000	monitoring nurse for MARs by the manage 100% compliance. e. Education to nursimedication errors to administering nurse or recognized after the	dications will be called to the verification. Monitoring of ement staff for 30 days for any staff regarding calling all the physician by the property of the management staff if administration period.	A	000			
	Monday-Friday mana ensure appropriate for g. Medication error d and type of errors) at monthly, and quarter	ata collected daily (number nd aggregated weekly, ly with graphical gated data to be reviewed by t, medical executive			•		
	each day Monday the on Saturdays and Su	lementation of an electronic					
A 043	signed by the physic medical staff educate 482.12 GOVERNING The hospital must ha	BODY ave an effective governing	A	043			
	body legally respons hospital as an institu have an organized g legally responsible for	ible for the conduct of the tion. If a hospital does not overning body, the persons or the conduct of the hospital inctions specified in this part			See next page		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			JRVEY TED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUI	A. BUILDING				
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A 043	Continued From page	e 3			A 043: The hospital now ens		9/18/07	
	that pertain to the go	verning body.			effective Governing Body and		ongoing	
	that pertain to the governing body.				leadership responsible for the			
					of the hospital as an institution	n. In		
		not met as evidenced by:	*		order to effectively guide the			
		policy and procedures, open			responsibilities of nursing ser			
		ecords, medication error			and pharmaceutical services,		; ;	
		facility meeting minutes,			following actions have been to			
	quality assessment a	bservations during tour and	•The Governing Body has a				İ	
	staff intention the fa	cility's leadership staff failed			additional meetings to its 200			
	to provide an organiz				quarter and 2008 1st quarter m			
		ice by failing to: ensure		1	to review items in this action Review of the corrective action			
		ministered only under the						
		for 4 of 17 sampled patients		1	this action plan will be an one	gomg,		
	(#8, #12, #10, #11);	administer medications as			standing agenda, along with evaluation of outcomes with a	2777	İ	
	ordered by the physi	cian for 6 of 17 patients			necessary recommendations.		1	
	sampled (#7, #20, #6	5, #4, #18, #12); reassess for	l		corporate Divisional Presiden		:	
	the effect of medicat	ion being administered and	1		participate in this review and	IL WILL		
	reassess vital signs	per physicians's order for 7 of			oversight. At a minimum, the	agenda		
	17 sampled patients	(#16, #5, #2, #11, #3, #17,			will consist of an outcomes re			
	#9); and, notity a priy	ysician of a medication error ampled (#8, #11). The			this corrective action plan as			
	for 2 of 17 patients s	taff failed to promote the		į	report from the CEO on nursi			
		by failing to notify the			services and pharmaceutical s			
	i guardian of wrong m	edications being given to		1	•A daily weekday meeting co			
	their children for 2 of	7 unemancipated patients			to analyze medication errors			
		(#8, #10). The facility's			overall medication manageme			
	leadership staff failed	d to incorporate and maintain			the previous 24 hours (The M			
	data related to medic	cation errors, and regarding			meeting will include a review		1	
		ceutical services, into its			medication errors from the w			
	quality assessment a				period). This analysis also inc	cludes		
	improvement activities	2 8.			results from the medication			
					monitoring on medication pas	sses.		
	Findings include:				Actions are identified from the			
	· · · A) The facility of least	lership staff failed to provide			analysis for implementation v			
	A) The facility's lead	g staff by failing to ensure			nursing and pharmaceutical s			
	medications were ac	Iministered only under the					1	
		for 4 of 17 sampled patients			Continued on next page			

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		344014			09/17/2007
	ROVIDER OR SUPPLIER LL MENTAL HEALTH SE	RVICES	301	ET ADDRESS, CITY, STATE, ZIP CODE 19 FALSTAFF RD ILEIGH, NC 27610	
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
A 043	(#8, #12, #10, #11). cross refer to 482.2 Tag A0404 B) The facility's leader an organized nursing medications as order 17 patients sampled cross refer to 482.2 Tag A0404 C) The facility's leader an organized nursing for the effect of medicand reassess vital signature of 17 sampled patients, #9); cross refer to 482.3 Care- Tag A0395 D) The facility's leader an organized nursing physician of a medicing patients sampled (#8) cross refer to 482.3 Care- Tag A0395 E) The facility's leader an organized pharmanotify a physician of	ership staff failed to provide staff by failing to administer ed by the physician for 6 of (#7, #20, #6, #4, #18, #12); 23(c) Administration of Drugs ership staff failed to provide staff by failing to reassess cation being administered gns per physicians's order for ents (#16, #5, #2, #11, #3, 23(b)(3) RN Supervision of ership staff failed to provide g service by failing to notify a ation error for 2 of 17 8, #11); 23(b)(3) RN Supervision of ership staff failed to provide action error for 2 of 17 ership staff failed to provide acceutical service by failing to a medication error for 2 of 17	A 043	Continued from page 4: A043: These Governing Body member receive updates on the following action plan items, and take action ensure that: All medications given have a phorder Effectiveness of medications is reassessed along with the reasses vital signs as needed Physician notification occurs wimedication errors Pharmacy Services notifies physiall medication errors Guardians are informed of all merrors that involve minors Data from medication errors relinursing and pharmacy services at aggregated and analyzed into performance improvement. Pharmacy services is tracking all medication errors through it own for cross-reference to nursing set Monitoring: Actions are identified through this review for prompt for and are recorded on the Medicativariance Reports and morning management meeting notes as appropriate. Any instances of noncompliance will be reviewed Governing Body will ensure that necessary related resources, educand/or corrective actions are taked daily weekday meeting will conticonvene for a minimum of four a months to ensure safe administra medications. After such period, in the following production of the promotes of the morning will conticonvene for a minimum of four a months to ensure safe administra medications. After such period, in the following production of the promotes and morning will conticonvene for a minimum of four a months to ensure safe administra medications. After such period, in the following production of the p	key as to sysician sment of th all sicians of edication ated to re Il system rvices. Ed bllow-up on and the any cation en. This inue to additional tion of eporting
	patients sampled (#8 ~ cross refer to 482. Complications - Tag	25(b)(6) Reporting		of medication errors from Pharm Nursing will be a standing agend at the daily weekday morning management meeting. Persons Responsible: CEO, DON Pharmacy Director, and Medical	la items

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER	A. BUILDIN	IG		c
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	the rights of its patier guardian of wrong metheir children for 2 of under the age of 18 (cross refer to 482.1 Informed Consent - 1 G) The facility's lead incorporate and main medication errors, and pharmaceutical services assessment and perfectivities. cross refer to 482.1 Responsibilities - Tall H) The facility's lead pharmacy services asystem to analyze at cross refer to 482.1 Responsibilities - Tall 482.13 PATIENT RIAL A hospital must proteach patient.	ership staff failed to promote hts by failing to notify the edications being given to 7 unemancipated patients (#8, #10). 13(b)(2) Patients' Rights - Fag A0131 ership staff failed to nation data related to not regarding nursing and idea, into its quality formance improvement 21(e)(1) QAPI Executive g A0311 ership failed to ensure developed and maintained a not track medication errors. 25(a)(1) Pharmacist ng A0492 GHTS ect and promote the rights of	A 04	Medication Error Reporting ("Medication Variance Reporting to include the clear notification of: -Family/Guardian -Name and relationship -Date and time Implementation: Previously forms were removed and rewith revised form. Monitoring: All medication will be reviewed during the management meeting with of the Governing Body presincluding DON, CEO, and Director, as well as Pharma Director. The DON, CEO, Medical Director are resporthis review and ensure that medication errors without a to family or guardian will be promptly corrected to proven the control order to ensure that 100% of is maintained. Medication remain in the daily review and pharmacy supervisory standing agenda item to the morning management mee monthly reviews in Safety Committee, Pharmacy and Therapeutics Committee, a	used placed errors morning members sent, Medical cy and asible for any notification se ide proper inue in compliance errors will of nursing staff as a e weekday ting, with	9/18/07
	Based on review of and closed medical reports, and staff int	s not met as evidenced by: policy and procedures, open records, medication variance rerview, the facility's dot to promote the rights of its		Medical Executive Comming Persons Responsible: CEC and Medical Director.		

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 09/20/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	COMPLET	
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A 131	medications being gunemancipated pat #10). Findings include: ~ cross refer to 482 Informed Consent -482.13(b)(2) PATIE CONSENT The patient or his callowed under Statinformed decisions The patient's rights or her health status planning and treatror refuse treatment construed as a me provision of treatment medically unneces This STANDARD Based on review cand closed medical	o notify the guardian of wrong given to their children for 2 of 7 ients under the age of 18 (#8, 2.13(b)(2) Patients' Rights -	A 115	A 131 Plan of Correction 1. Medication Error Repo (entitled "Medication Var Report") was revised to it clear notification of familiand physician. Previously were removed and replac revised form. Training of was initiated on 9/20/07 v planned completion date September 27, 2007 from competency sessions. Training content includes *Use of revised Medication Reporting Form *Proper completion of the an emphasis on notificati *Proper documentation of errors and medication add in the medical record. Any nursing staff not pre all-staff competency sess required to complete train working. *Person Responsible: Dire Nursing	orting Form riance include the lay/guardian rused forms ed with new forms with a of n all-staff s: on Error e form with ons f medication ministration esent at the lain grior to	Initiated 9/18/07 Target Completion 9/27/07
	notify the guardiar given to their child	of wrong medications being ren for 2 of 7 unemancipated age of 18 (#8, #10).		Continued on next page		

Facility ID: 953222

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				- CIVID INC	7. 0330-0331
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	ED
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HOLL! HI	LE MENTAL MEALM O			RALEIGH, NC 27610			
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TAG	REGULATORY OR Continued From page Findings include: Review of policy "Parevealed "5. The prinformation from his/illness, course of tree (including unanticipareview revealed "At of facility) must have the person who may make decisions regard the patient." 1. Closed record review 12 year old male add 8-12-2007 for bipolar physician's orders on "Tegretol 200mg PC (at bedtime). Review (name of unit secret revealed "8/13/07 not purther review revealed "RN note of the order (name of RN #2)". Closed record review review review revealed "RN #2)".	tient Rights" revised 12-2003 atient has the right to receive her physician about his/her atment, outcome of care ted outcomes)" Further Time of Admission6. (name all patient rights available to have legal responsibility to arding medical care on behalf tiew for Patient #7 revealed a mitted to the facility on r disorder. Review of n 8-13-2007 at 1350 revealed or m (in the morning) and hs w revealed "noted 8/13/7 ary)". Further review oted 1405 (name of RN)". aled documented below the r at 1405 "8/13/07 noted w for Patient #8 revealed a		131	A 131 Continued from previous Monitoring: 1. All medication errors will be reviewed during the morning management meeting by the ODON, ADON, Pharmacy Director for the assurance that all notification completed. Any errors without notification to family or guard be promptly corrected to proving proper notice. In addition, nursupervisory staff will provide education, coaching and/or coaction to nursing staff as need related to the medication error audit will continue to ensure compliance is maintained. 2. All medication passes are monitored by supervisory staff order to assess medication administration and check for medication errors. All errors evaluated for completeness as actions will be taken to ensure proper notifications are complany additional staff training,	ous page be CEO, ector, s are at dian will vide rsing corrective ded or. This 100% ff in any will be and e that all eleted.	
	seven year-old male 8-08-2007 for attent disorder and bipolar revealed "Tegregol	e admitted to the facility on ion deficit hyperactivity disorder. Review of the MAR (a medication to control			coaching and/or corrective ac will also be provided as need enhanced monitoring will cor until such time as there is evi	ed. This ntinue dence of	
•	seizures or to stabili po am (in the mornin 8/13/7T (transcrib noting Tegretol orde (nurse initials) (initial off Patient #7 record	ze a mood disorder) 200mg ng) & hs (at bedtime) - order er) (initials of unit secretary er off Patient #7 record), NI als of RN noting order at 1405 d). Further review of the MAR			ongoing safe and appropriate medication administration. A period, random monitoring of medication passes will be cor to ensure ongoing compliance Training and/or corrective actions.	fter such f nducted e.	
	revealed on 8-13-20 nurse who administ	007 at 2000 initials of the ered Tegretol 200mg po to the			will also be ongoing as neede	ed.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	RVICES		30	EET ADDRESS, CITY, STATE, ZIP CODE 19 FALSTAFF RD ALEIGH, NC 27610		
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A 131	written beside the Te Review of the physic order for Tegretol 20 Record review of the failed to reveal docur being given or of the notified of the medica physician progress n "Pt sleepy during day	e 8 ew of the MAR revealed gretol "wrong pt's MAR". ian orders failed to reveal an Omg po by the physician. nursing progress notes mentation of the medication physician or guardian being ation being given. Review of otes on 8-14-2007 revealed /time - unable to assess as pt change Clonidine 0.05mg po	A	131			
	1500 revealed the ur for the Tegretol 200n orders for Patient #7 accidentally transcrib MAR for Patient #8. noted the order on P	secretary on 9-14-2007 at nit secretary took the ordering po off the physician's on 8-13-2007 at 1350, but bed the medication onto the Interview revealed a RN latient #7's record at 1405 scribed medication on the					
	9-14-2007 at 1530 re aware of the Tegreto Interview revealed the Clonidine dose for P assessment that the difficult to arouse. In knowledge of the me would not have mod regimen. Interview of drowsiness.	lysician for Patient #8 on evealed the physician was not be being given to her patient. he physician changed the atient #8 based on the patient was drowsy and herview revealed with edication error, the physician ified Patient #8's medication revealed Tegretol can cause				`	
	dated 8-13-2007 rev	igative report of the incident realed "Notifications: Doctor:" ner review revealed nily" was not checked "yes"				·	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '	TIPLE CONSTRUCTION	(X3) DÅTE SUI COMPLET	
			A. BUILD	JING	-	С
		344014	B. WING		09/1	7/2007
	ROVIDER OR SUPPLIER	ERVICES		STREET ADDRESS, CITY, STATE, ZI 3019 FALSTAFF RD RALEIGH, NC 27610	P CODE	
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A 131	Continued From pag	ge 9 he form revealed review by a	A 1	31		
	9-14-2007 at 1605 vinvestigation of the revealed the staff might whether the guardia revealed the investigation whether the guardia revealed either the reconsultation with the expected to notify the error. Interview falls physician or guardia medication error. In	management staff on who completed an medication error event ember was unaware as to n was notified. Interview gation did not document n was notified. Interview hursing staff, after e physician, would be the guardian of any medication ed to reveal documentation of an notification of the aterview confirmed staff did licy on notifying the guardian				
	9-14-2007 at 1635 in medication error be Interview revealed the first week of employ revealed it has been an increase in the facility related to awareness of report revealed there is a and analysis of medical information there has identified to address with nursing staff. I staff did not follow the physician or guestimeters.	ng administrative staff on revealed no knowledge of the tween Patient #7 and #8. The error occurred within the rement at the facility. Interview in recognized that there has medication error reporting at increased nursing ting errors. Interview further plan for better aggregation dication errors at the facility. Without the aggregated ave been no current priorities is specific medication errors interview confirmed nursing acility policy in not notifying ardian of the medication error.				
	2. Closed record re a 45 year old admit	eview for patient #13 revealed ted to the facility on 7/23/2007				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	COVIDER OR SUPPLIER	RVICES		301	ET ADDRESS, CITY, STATE, ZIP CODE 19 FALSTAFF RD LEIGH, NC 27610		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 131	Disorder. Review of 7/23/2007 at 1600 re (anti-depressant drug mouth) daily start 1st revealed "noted (nam 7/23/2007 at 1620." "noted (name of nurs 36 year old admitted Dependence and Big The patient was discrevealed "Cymbalta (milligrams) po (by rotranscribed (written) Administration Recorevealed "Order 7/2 Date/Reorder) 8/22, secretary noting Cymrecord), NI (nurse in review of the MAR reinitials of the nurse was 30mg po to patient #reveal a physician's daily, 1st dose now I review of nursing prodocumentation of the	ence and Major Depressive physician's orders on vealed "Cymbalta g) 30 mg (milligrams) po (by dose today." Review ne of unit secretary) Further review revealed e) 7/23/2007 1700." of patient #11 revealed a on 7/23/2007 for Alcohol polar (psychiatric) Disorder. The property of the prop	A	131			
	#11 on 9/14/2007 at was not aware of the patient. Interview re placed on Lexapro (would not have place because that would	tending physician for patient 1245 revealed the physician c Cymbalta being given to the vealed "This patient was antidepressant drug), so I ed them on Cymbalta be two drugs for depression." infirmed that the physician did					

PRINTED: 09/20/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 344014 09/17/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3019 FALSTAFF RD HOLLY HILL MENTAL HEALTH SERVICES RALEIGH, NC 27610 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 131 A 131 Continued From page 11 not write an order in the physician orders for Cymbalta. Further interview revealed "I expect the nursing staff to inform me immediately when a medication error has occurred." Further interview revealed no notification of the parents or guardians of the patient regarding the medication error by the physician. Further interview confirmed the physician was not notified of the medication error and did not notified the parents or guardians. Interview with nursing management staff on 9/14/2007 at 1610 failed to reveal available documentation of a physician's order or of physician or guardian notification of the administration of Cymbalta to patient #11. Interview confirmed nursing staff did not follow facility policy in not notifying the physician or guardian of the medication error. 9/26/07 A 263 Plan of Correction: A 263 A 263 482.21 QAPI The hospital ensures that an effective, ongoing, comprehensive data-driven The hospital must develop, implement and performance improvement program is maintain an effective, ongoing, hospital-wide, in place. Performance improvement data-driven quality assessment and performance

FORM CMS-2567(02-99) Previous Versions Obsolete

improvement program.

The hospital's governing body must ensure that

hospital's organization and services; involves all

to improved health outcomes and the prevention

hospital departments and services (including

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

those services furnished under contract or arrangement); and focuses on indicators related

and reduction of medical errors.

the program reflects the complexity of the

Event ID: JZWI11

Facility ID: 953222

activities and planning will include

all aspects of care throughout the

various hospital departments. As

these activities relate to pharmacy

actions have been executed:

Continued on next page

and nursing services, the following

If continuation sheet Page 12 of 63

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 263	This CONDITION is Based on review of preeting minutes, quiperformance improve interview, the facility incorporate and main medication errors, and pharmaceutical services assessment and perfactivities. Findings include: A) The facility's leads a system to analyze a cross refer to 482. Responsibilities - Ta B) The facility's leads an organized nursing medications were accorder of a physician (#8, #12, #10, #11). Cross refer to 482 Tag A0404 C) The facility's leads an organized nursing medications as order order of a physician (#8, #12, #10, #11).	not met as evidenced by: policy and procedures, ality assessment and ement data, and staff as leadership staff failed to entain data related to end regarding nursing and eices, into its quality formance improvement ership staff failed to develop and track medication errors. 21(e)(1) QAPI Executive	A	263	A 263 Continued from previous particles. A) The system for data collection aggregation, and analysis for perfimprovement functions was reengall hospital departments. In particle enhanced system to analyze and the medication errors is in place through a revised medication error report form. Monday-Friday review of all meterrors by members of the Governing Body and Pharmacy Director for analysis and prompt intervention medication errors for the next 4 manalysis and prompt intervention medication errors for the next 4 manalysis. By the Pharmacy of the daily weekends, supervisory and will be reported to the daily weekends, supervisory nursing an pharmacy staff will review and rethe Monday morning management meeting. Data is aggregated for demonthly and quarterly analysis. By C) All medication errors are redaily to ensure proper follow-up. medication errors, including medication errors, including medication given without a physician order a medications given that do not foll physician's order, receive prompt up and physician notification as not Medication errors are tracked dail aggregated for review in Pharmac Therapeutics meeting, Medical Ex Committee, and Safety Committee.	commance gaged for ular, an rack agh: ting dication ing tracking, of nonths. Is will be armacy a staff weekday in the ad port on a taily, wiewed All acations and ow a follow-eeded. It is and a secutive in the secutive in t	

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	- Tag A0404 D) The facility's lead an organized nursing for the effect of med and reassess vital si 7 of 17 sampled pati #17, #9); - cross refer to 482. Care- Tag A0395 E) The facility's lead an organized nursing physician of a medic patients sampled (#1 - cross refer to 482. Care- Tag A0395 F) The facility's lead an organized pharm notify a physician of patients sampled (#1 - cross refer to 482. Complications - Tag IG) The facility's lead the rights of its patie guardian of wrong medical the rights of its patie guardian of wrong medica	ership staff failed to provide g staff by failing to reassess ication being administered gns per physicians's order for ents (#16, #5, #2, #11, #3, 23(b)(3) RN Supervision of ership staff failed to provide g service by failing to notify a cation error for 2 of 17 3, #11); 23(b)(3) RN Supervision of ership staff failed to provide acation error for 2 of 17 3, #11); 25(b)(6) Reporting A0508 dership staff failed to promote ints by failing to notify the nedications being given to f 7 unemancipated patients (#8, #10).	A 263	A 263 Continued from previous D) All vital signs used for assumed reassessing the effects of medications per physician or be obtained and documented medical record and vital signs Monitoring: The obtainment, response to, and documentativital signs will be monitored ensure 100% compliance is maintained. Person responsible: Director Nursing. E, G) All medication errors will be documented on the Medication variance Reports with notific indicated of the date and time Monitoring: Medication Variance Reports will be audited to ensure 100% compliance. Person responsible: Director Assistant Directors of Nursing F) All medication errors will promptly called to physicians pharmacy staff. Medication ewill be documented on the Medication Variance Reports motification indicated of the ditime. Monitoring: Medication Variance Reports notification indicated of the ditime. Monitoring: Medication Variance Reports will be audited to ensure the modification indicated of the ditime. Monitoring: Medication Variance Reports will be audited to ensure the modification indicated of the ditime. Monitoring: Medication Variance Reports will be audited to ensure the modification indicated of the ditime. Monitoring: Medication Variance Reports will be audited to ensure the modification responsible: Pharmacy Director.	der will in the is sheet. on of to of will be is and to staff. on cations c. ance sure and g. l be is by irrors is with late and ance sure
				See next page	

STATEMENT OF DE	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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A 311 Cor The gro authose officiens safe is defined in the second	ntinued From page hospital's governoup or individual wathority and responsipital), medical straining that an ongoety, including the defined, implement defined, implement data, as sility's leadership stem to analyze andings include: Eview of facility portions of system to analyze and analysis of system to analyze andings include: Eview of facility fulfills not analysis of system to analyze and analysis of system to analyze and analysis of system to analyze and analysis of system to analysis of system	e 14 ning body (or organized tho assumes full legal sibility for operations of the aff, and administrative ible and accountable for loing program for patient reduction of medical errors, atted and maintained. I not met as evidenced by: facility meeting minutes, and performance and staff interview, the staff failed to develop a nd track medication errors. Ilicy "Improving Organizational and 8-06 revealed "Philosophyties responsibilitiesthrough the matic monitor, aggregation, em and process outcomes"	 -	311	A 311 Plan of Correction: A) The system for data aggregation, and analy performance improved was reengaged for all I departments. In particular enhanced system to an medication errors is in A revised medication form. Monday-Friday review months of all medication embers of the Gover (CEO, DON, Medical Pharmacy Director for analysis and prompt in medication errors. Data for daily, monthly and analysis. After such period of 4 medication errors will daily by pharmacy and supervisory staff to en and will remain as a stitem on the weekday in management meeting, and analysis will be comonthly reporting to the Committee, Pharmacy Therapeutics, and Medication. Persons Responsible: Pharmacy Director, and Responsible: Pharmacy Director, and Persons Responsible: Phar	a collection, risis for ment functions hospital alar, an alyze and track place through: error reporting w for the next 4 on errors by ming Body Director) and tracking, attervention of a is aggregated quarterly a months, be reviewed a nursing sure follow-up anding agenda norning Data trending ompleted for the Safety and dical Executive ling and standing werning Board CEO, DON,	9/19/07

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
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A 311	Continued From page	e 15	A	311			
	revised 10-2004 reve medication error data	policy "Medication Errors" aled "Procedure:CThe will be reviewed by the peutics committeelooking on causes."					·
	revised 11-03 revealed Medication Error Form forwarded to the Direct pharmacist, who will needed, take any immindicated, and incorp	ctor of Nursing and review, investigate as nediate corrective actions					-
	Review of minutes from Executive Committee report of medication of June 2006.	om the Medical Staff (MEC) revealed the last errors to the MEC was in					
	Therapeutics Commi	om the Pharmacy and ttee From January 2007 to al trending of medication auses.					
	of Nursing on 9-13-20 has been a recognize and analysis of media revealed re-education reporting was accoms ummer of 2007, while error reporting. Interbeen no formalized a medication errors sin	plished during the early ch increased medication view revealed there has aggregation and analysis of ce March 2007. Interview ommon causes or trends or					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
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	Interview with the pattern Chief Exect 1415 revealed the accomplished at the Performance Impressible to reveal repathe MEC from July 482.23 NURSING The hospital must service that provid The nursing service supervised by a result of the procedures, open review, observation medication variance (HR) files facility's leadership organized nursing medications were order of a physicia (#8, #12, #10, #11 ordered by the physicial procedures of the physic	chysician Medical Director and utive Officer on 9-17-2007 at medication error reporting is the MEC meetings through the overnent summary. Interview orting of medication errors at 2006 to current. SERVICES have an organized nursing es 24-hour nursing services. The services are must be furnished or gistered nurse. is not met as evidenced by: of facility policies and and closed medical record and closed medical record and staff interview, the obstaff failed to provide an service by failing to: ensure administered only under the an for 4 of 17 sampled patients by administer medications as ysician for 6 of 17 patients	A 311	A 385 Plan of Correction: 1. All nursing staff training wa on 9/18/07 and included: "Only medications ordered by will be given. "Use of high risk medications (and Tenex) with vital sign pare "Medication error notification requirements and documentation." "Use of pre-printed Medication Administration Records (MAR Telephone orders by physician (See attached training packet of "Holly Hill Hospital Medication Administration: Registered and Nurse Training"): Monitoring: All medication en notifications, use of the pre-printed Medication and Tenex with vita reviewed daily by the CEO, Depharmacy Director, and Medication ensure follow-up. This daily review will continue for 4 add months and will then be review by the pharmacy and nursing staff. The review of medication will remain a standing agenda weekday morning management in addition, nursing supervisor provide education, coaching a	physicians (Clonidine ameters. 9) on. (Con. (C	nitiated /18/07 arget ompletion 0/10/07
· <u>.</u>	sampled (#7, #20, the effect of medic reassess vital sign 17 sampled patier #9); notify a physic	#6, #4, #18, #12); reassess for cation being administered and as per physicians's order for 7 of ats (#16, #5, #2, #11, #3, #17, cian of a medication error for 2 appled (#8, #11); report a critical		corrective action to nursing st needed related to the medicati Persons Responsible: CEO, D Medical Director and Pharma Continued next page.	on error.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
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A 385	Continued From page	e 17	A	385	A 385 Continued from previo	ous page	
	lab value to the phys	ician per facility policy for 1 of		ļ	2. Critical Lab Tests and Tre	atment	
	18 patients sampled	(#5); update 2 of 1 sampled		1	Plans: All nursing staff reedu	cation	
	patients treatment pla	ans (#16, #2); and, ensure	ŀ		was conducted on 9/27/07 to		İ
	current certification w	as maintained in CPR			 Reporting of critical lab val 	ues to	
	(Cardiopulmonary Re	esuscitation) for 3 of 5 files			physicians		
		ees requiring current CPR by			 Updates to patient treatment 	t plans	
	the job description (#	·2, #3, #4).			Monitoring:	_	
	Findings include:				 Critical Lab testing and con 		
	Findings include:	•			of treatment plans will be au		
	A) The facility's nurs	ing staff failed to ensure		1	ensure that 100% compliance		
	medications were ad	ministered only under the			maintained. All variances of		
	order of a physician f	for 4 of 17 sampled patients	-		lab test reporting will be foll		
	(#8, #12, #10, #11).	•			daily and promptly by nursir	ıg	
					supervisory staff. Persons Responsible: Direct	or and	
	~ cross refer to 482.2 - Tag A0404	23(c) Administration of Drugs			Assistant Directors of Nursin		
	B) The facility's nursi	ing staff failed to administer			3. CPR Certifications: Staff		
	medications as order	red by the physician for 6 of			for those who require certific		
	17 patients sampled	(#7, #20, #6, #4, #18, #12);			and recertification in CPR,	will be	
	! !	and the state of t			conducted on:		
		23(c) Administration of Drugs			•9/28/07		
	- Tag A0404				•9/29/07		
	C) The facility's gure	ing staff failed to reassess for			•10/1/07 •10/2/07		-
	the effect of medicat	ion being administered and			•10/2/07	thia	į
	reassess vital signs	per physicians's order for 7 of			Any staff who cannot attend mandatory training will be r		
	17 sampled patients	(#16, #5, #2, #11, #3, #17,			obtain certification or recert		į
	#9);				by 10/10/07 in order to be el		ļ
					work. Records of this certifi		i
	•	23(b)(3) RN Supervision of			will be made available for it		
	Care- Tag A0395				Persons Responsible:	ispositori.	
`.,	: - D) The factor to	ing stoff foiled to potify a			Director and Assistant Director	ctors of	
		ing staff failed to notify a cation error for 2 of 17			Nursing; Director of Human		į
	pnysician of a medic patients sampled (#8				Resources	•	ļ
	pauerits sampled (#0	2, # + 1/h			20000000		!
	~ cross refer to 482.	23(b)(3) RN Supervision of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES					0.0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE SUF	
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	critical lab value to the for 1 of 17 patients is a cross refer to 482. Care- Tag A0395 F) The facility's nurs 17 sampled patients cross refer to 482. Tag A0395 G) The facility's nurs current certification of (Cardiopulmonary Reviewed for employ the job description (Cardiopulmonary Reviewed for employ the job description (Cardiopulmonary Reviewed for employ the job description (Cardiopulmonary Reviewed for employ the job description (Cardiopulmonary Reviewed for employ the job description (Cardiopulmonary Reviewed for employ the job description (Cardiopulmonary Reviewed for employ the job description (Cardiopulmonary Reviewed for employ the job description (Cardiopulmonary Reviewed for employed f	ing staff failed to report a ne physician per facility policy ampled (#5); 23(b)(3) RN Supervision of ing staff failed to update 2 of treatment plans (#16, #2); 23(b)(4) Nursing Care Plan - sing staff failed to ensure was maintained in CPR tesuscitation) for 3 of 5 files rees requiring current CPR by #2, #3, #4). 23(b)(2) Licensure of Nursing SURE OF NURSING STAFF must have a procedure in hospital nursing personnel rensure is required have a		385	A 394: Plan of Correction: Implementation: Staff trainin require certification and recertification in CPR will be conducted on: 9/28/07 9/29/07 10/1/07 10/2/07 Any staff who cannot attend mandatory training will be reobtain certification or recertiby 10/10/07 in order to be eliwork. Records of this certific will be made available for in Future scheduling and auditiupcoming needs of CPR certand recertification will be coby the Director of Human Repersons Responsible: Director and Assistant Director of director and recertification.	this equired to fication igible to cation spection. If the cation is a cation inducted esources.	Initated 9/28/07 Target Completion 10/10/07
	ensure current certi	fication was maintained in nary Resuscitation) for 3 of 5			Nursing; Director of Human Resources		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		CONSTRUCTION	(X3) DATE S COMPLI		
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A 394	files reviewed for em CPR by the job describing include: 1. Review of job describes include: 1. Review of job describes include: 1. Review of job describes include: (6-11-07) revealed "CPR". Review of HR file for Youth Services Assi (ADON) revealed a recommended recermenth and 14 days Review of the file far certification. Interview with human 9-14-2007 at 1400 many includes included the certification. Interview was no documentatic certification. Interview of Job describes included inc	cription (#2, #3, #4). cription on 9-14-2007 for four four forms of Nursing - Youth Services. Maintain certification to teach restart Director of Nursing CPR card with a stification date of 7-2007 (one since the end of July 2007). Ited to reveal a current CPR on resources staff on evealed by job description the phave up to date CPR ew confirmed the CPR card bired. Interview revealed there ion available of current CPR ew revealed the ADON was d in CPR. scription on 9-14-2007 for (4-16-07) revealed	A:	394				

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F C C C V C C C V C	RN is required to have certification. Interview copy on file was expirited as a copy on file was expirited as not currently certification. Interview was not currently certification. B. Review of job describility of the certification". Review of HR file for staff Mental Health Technology of the file for staff Mental Health Technology of the certification".	resources staff on wealed by job description the e up to date CPR v confirmed the CPR card red. Interview revealed there in available of current CPR v revealed the staff RN #3 iffed in CPR. ription on 9-14-2007 for incian" (6-11-07) revealed	A 39	94	
A 395 4	nterview with human 9-14-2007 at 1400 re MHT is required to hat certification. Interview was no documentation certification. Interview was not currently certification. Interview was not currently certification. RN SUFCARE	resources staff on vealed by job description the ave up to date CPR w confirmed the CPR card red. Interview revealed there in available of current CPR w revealed the staff MHT #4 tified in CPR. PERVISION OF NURSING ust supervise and evaluate	A 38	95 See next page	

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A 395	Based on review of fa procedures, open and review, review of med staff interview, the fact. A) reassess for the eladministered and real physicians's order for (#16, #5, #2, #11, #3) B) notify a physician 17 patients sampled. C) report a critical lab facility policy for 1 of Findings include: A) The facility's nursi the effect of medicati reassess vital signs pof 17 sampled patient #17). Review of facility policy for 1 of performed at least danotify physicians of solution Vital signs will be record9. Nursing stagnificant variances concerns." Review of facility policy facility policy physicians of solutions. The RN will record of the RN will rec	not met as evidenced by: acility policies and d closed medical record dication variance reports and cility's nursing staff failed to: ffect of medication being assess vital signs per 7 of 17 sampled patients , #17, #9); of a medication error for 2 of (#8, #11); and, 0 value to the physician per 17 patients sampled (#5). Ing staff failed to reassess for on being administered and per physicians's's order for 7 ts (#16, #5, #2, #11, #3, #9, Incy "Vital Signs / Weight" alled "1. Vital signs will be aily5. Nursing staff shall ignificant abnormalities6. Forded in the medical aff will alert M.D. of and/or treatment related and of the provised of Medication revised 02-2004 revealed abservationsin the daily	A	395	A 395: Plan of Correction: All nursing staff training on mediadministration was initiated on 9/with reeducation on 9/27/07. Focinclude: 1. The assessment and reassessment the effectiveness of medications are lates to vital signs. 2. The assessment and reassessment and reassessing and reassessing of critical lab results one hour of notification. Monitoring: 1. All vital signs for assessing and reassessing the effects of medicate be obtained and documented in the medical record and vital signs should an economic and vital signs will monitored to ensure 100% complimated. 2. The effectiveness of medication for pain will be assessed and reasses within one hour. An audit of will conducted on this procedure to ensure 100% compliance is maintained. 3. All medication errors will be pecalled to physicians by nursing st Medication Variance Reports will audited to ensure 100% compliance is maintained. 4. Critical Lab testing will be audensure 100% compliance is maintained. 4. Critical Lab testing will be audensure 100% compliance is maintained. All variances of critical lab test rewill be followed up daily by nursing supervisory staff. Persons Responsible: Director an Assistant Directors of Nursing	ent of as it ent of as it ent of as it ent of as it ent of as it ent of as it ent of as it ent on en	Initiated 9/17/07 Target Completion 9/27/07
	nursing assessment.	ecorded in the medical			. Dolouin Dioonio of Ituishig		

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A 395	Continued From page	22	A 3	395			
		patient's perception of					
	7-2005 revealed "10.	ral Guidelines" revised The nurse should know the is given to a patient and the					
	#16 revealed a five yet facility on 9-04-2007 disorder. Record rev written by the physici (checked) Daily". Re examination of the parevealed "r/o (rule ou	w on 9-17-2007 for Patient ear-old male admitted to the for psychosis and mood iew of the admitting orders an revealed Vital Signs: cord review of a physician's attient on 9-05-2007 at 1300 t) arrhythmia" and "r/o Rt es". Review of physician's					
	orders on 9-05-2007 pt (patient) to the ER abnormal EKG (elect electrical activity of the ischemia? psychosis "Scheduled Medication	at 1730 revealed "Transfer (Emergency Room) - rocardiogram - test to map he heart) & possible brain ". Review of the form hons" revealed "Clonidine by morning) and q noon				•	
	(every evening) Hold pressure) < (less than number of blood pressure) < Record review of doc Signs" flowsheet for spressure 86 (systolic parameter)/38 (diaster parameter), on 9-07-(five points below parameter), or 84 (six points below parameter), or below parameter).	if SBP (top number of blood n) 90 or DBP (bottom ssure) < (less than) 50" cumentation on the "Vital 9-06-2007 revealed a blood - four points below the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SUF COMPLET		
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A 395	Continued From page	23	A 3	395				
	Medications" revealed was administered each through 9-11-2007. If notes failed to reveal	d the medication Clonidine ch day from 9-06-2007 Review of nursing progress documentation that the dof the low blood pressures						
	administration of the failed to reveal why the medications outside of	Clonidine. Record review ne nurse gave the						
	ordered daily vital sig as well as the irregula	vealed the patient was ns because of the Clonidine ar EKG found during the essment. Interview revealed						
	emergency departme evaluation of the brace possible brain ischement the brain) since the p	nt on 9-05-2007 for dycardic rhythm and for nia (decreased blood flow to						
	same day for negativ revealed the physicia to call prior to admini vital signs had been o	n would expect nursing staff stering the Clonidine if no obtained and if the blood						
	diastolic. Interview re not notified on 9-06-2 or 9-09-2007 of the lo	an 90 systolic or less than 50 evealed the physician was 2007, 9-07-2007, 9-08-2007 ow blood pressures prior to				`		
	revealed the physicia	Clonidine. Interview further in was not notified vital signs 9-10-2007 and 9-11-2007 ation of the Clonidine.						
	9-17-2007 at 1200 re collected regularly sin	g management staff on vealed vital signs are nce medications such as osychiatric medications can						

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	IULTIPL LDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	1
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A 395	effect the blood press revealed when "no vit mental health technic vital signs because the Interview confirmed to 9-07-2007, 9-08-2007 document the physicial blood pressures (blood systolic and less than 9-10-2007 and 9-11-2 document the vital sign physician. Interview documentation by nurvere not obtained. In documentation the pholow blood pressures obtain vital signs as of to administration of the confirmed staff did not facility policy of obtain 2. Closed record revisto year old admitted Dependence, Malignating blood pressure), potassium). The patie 9/3/2007. Record revitelephone order writte nurse "2. Check Blif DBP (diastolic blood 100 at 3 PM (evening (for blood pressure) times per day) (9, 3, revealed a red line drinoted 8/27/07 2015 nurse #2)." Review on 8/27/2007 at 1700 (check mark)s hourly	sure. Interview further tals" is documented, the sian was unable to obtain the sian was unable to obtain the sian was unable to obtain the sian was unable to obtain the se child was not cooperative. The cooperative of the cooperative of the low obtained of the low obtained of the low obtained of the low obtained of the low obtained of the staff failed to go as ordered by the failed to reveal rising as to why vital signs of the cooperative failed to reveal rising as to why vital signs of the cooperation of the low ordered by the physician prior of the Clonidine. Interview of the cooperation of the low of the low of the low of the low of the low of the low of the low of the low of the low of the low of the low of the low of the low of the low of low	A	395			
	revealed no documer	ntation of blood pressures on		ĺ			

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A 395	Continued From pag	e 25	A	395			
	the vital signs record after the 1700 entry	, nursing progress notes or on the MAR for 8/27/2007.					
	9/14/2007 at 1500 fadocumentation of blue the physician. Furth	g management staff on iled to reveal any available bood pressures as ordered by er interview confirmed that but to reassess the patient's					
	blood pressure per p	hysician order. Further the nursing staff did not follow					
	revealed a 19 year of a diagnosis of Bipola psychotic features. sustained an injury t	cord review of patient #2 ald admitted on 8/5/2007 with ar Disorder, manic, with While hospitalized the patient to the right ankle on					
	fracture (break) of the (ankle bone). The part 8/13/2007. Review nurse on 8/10/2007	diagnosed with an avulsion le right lateral malleolous latient was discharged on of the progress notes by a lat 2230 revealed "Pt. (patient)					
	ankle during gym to discomfort" Furthe on 8/13/2007 at 114	ave twisted her (R) (right) day causing current er review of a physician note 0 revealed "pt's ankle still nts d/c (discharge to have					
	orthopedist examine splint" Further revi	e and possible apply a new of a social worker note on nevealed "Pt. said she was in number wanted to be d/c to go					
	to the hospital." Resheet revealed a tel 8/10/2007 at 1750 b (R) ankle PRN (as repain) 600 mg (millig	view of a physician's order ephone order written on by a nurse for "Apply Ice to leeded) swelling, Motrin (for learns) po (by mouth) q6hr RN pain" Review of a					
	medication administ	ration record (MAR) revealed					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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A 395	Continued From page	e 26	A	395				
		ion) Date 9/9/07, Tran	i					
	(transcribed) [initials	of nurse #1 who wrote the	}					
		RN (registered nurse) Init						
		rse #2]." Further review						
	royoolod documental	tion by a nurse on 8/11 at						
	1700 ico applied "Re	ason: 10 (pain), Pain Scale:						
	1700 ice applied ice	De (decreased)." Further					İ	
	rovious foiled to reves	al a reassessment time,						
	documentation of a F	F/U pain level (scale 1/10),	Ì					
	and the implementati	on of additional pain control						
	measures Further re	eview revealed on 8/12/07 at						
	2100 ice applied (28	hours after 1st application)						
	"Reason: 10 Pain So	cale: 8/10, F/U (follow up):						
	De." Further review	failed to reveal a			•			
	reassessment time	documentation of a F/U pain						
•	level (scale 1/10), an	d the implementation of						
	additional pain contro	ol measures. Further review						
	failed to reveal the a	polication of ice on						
	8/13/2007 Further r	eview revealed an "Motrin						
	600mg po g6hr. Ord	er 8/10/07, Exp Date 9/9/07,					Ĺ	
	Tran (initials of nurse	#1 who wrote the order onto				*		
	the MAR) RN Init (in	nitials of nurse #2)." Further						
	review revealed doc	umentation of administration						
	by a nurse on 8/10 a	t 1915 "Reason: 10, Pain						
	Scale: 8/10 F/U: De	." Further review failed to						
	reveal a reassessme	ent time, documentation of a						
	F/U pain level (scale	1/10), and the	`					
	implementation of ac	ditional pain control	1					
	measures. Further	review revealed						
	documentation of ad	ministration by a nurse on						
	8/11 at 1320 (18 hou	ırs after first dose), "Reason:						
	7, Pain Scale: 8/10,	F/U: De." Further review						
	failed to reveal a rea	ssessment time,						
	documentation of a l	F/U pain level (scale 1/10),						
	and the implementat	ion of additional pain control						
	measures. Further r	eview revealed						
	documentation of ad	ministration by a nurse on						
	8/12 at 0930 (21 hou	ırs after second dose),						
	"Reason: 10, Pain S	cale: 7, F/U: De." Further						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED	
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A 395	documentation of a F and the implementation measures. Further redocumentation of a Maria 1730 (8 hours 10, Pain Scale: 7/10, review failed to reveat documentation of a F and the implementation measures. Further readministration of any Further review failed a Comprehensive Par RN when the patient pain on 8/10/2007. F pain reassessment different individualized treatment individualized treatment addressed pain. Furth documentation of phy injured ankle and resigning pain manage modified treatment plant preveal documentation notified for additional the RN. Interview with nursing	I a reassessment time, //U pain level (scale 1/10), on of additional pain control eview revealed ininistration by a nurse on after third dose), "Reason: F/U: Al (alleviated)." Further I a reassessment time, //U pain level (scale 1/10), on of additional pain control eview failed to reveal the	A3	95			
	MAR, Let's just say the say the say the leging, but, it is obviously baving pain." Further nurses should have runge in medication Interview revealed the	nat the patient's pain was a o a 7 or 8, the Motrin was ous the patient was still r interview revealed "The notified the physician for a a, for something stronger." at "It does not look like the he patient's response to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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A 395	Continued From pa	age 28	A 395				
	confirmed the nurs	progress notes." Interview ing staff failed to reassess for e master treatment plan to ospital policy CLS091A.					
	4. Closed record ra 36 year old admir Dependence and E The patient was dis of a physician's order written by a rate for "Phenergan 25 hours" PRN Nause documentation on "Phenergan (for (intramuscular) x1 Further review reve"c/o (complains of a MAR revealed the (one per day) of Pl 7/24, and 7/25 and	eview of patient #11 revealed ted on 7/23/2007 for Alcohol Bipolar (psychiatric) Disorder. Scharged on 8/4/2007. Review der sheet revealed a telephone durse on 7/23/07 (not timed) mg IM or PO q4hr (every four alvomiting." Review of nursing 7/23/07 at 2000 revealed durausea and vomiting) IM (times one) for nausea" ealed on 7/24/07 at 0700 of) nausea" Further review of the patient received 3 dosages denergan 25 mg IM on 7/23, dd 1 dosage of Phenergan 25mg					
	PO on 7/24/2007. failed to reveal doc reassessment for the for 3 out of 4 doses revealed a nurses migraine (headach order sheet revealed a nurse on 7/24/07 650mg po q4hrs preview revealed a and "noted (name (name of RN)." Re"Tylenol 650mg po (expiration date/re(transcribed) [left blank]." Further researces	Review of the progress notes cumentation of a nursing the effectiveness of Phenergan is administered. Further review note on 7/24/07 at 1730 "c/o i.e)" Review of a physician's ed a telephone order written by at 1100 for "Tylenol (for pain) orn HA (headache)." Further red line drawn under the order unit secretary) 7/24/07 at 1245/view of a MAR revealed of 4hr, Order (left blank), E/R order) [left blank], Tolank], NI (nurses initial) [left eview failed to reveal the tylenol to the patient as ordered					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI		CONSTRUCTION	COMPLETED	
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A 395	Interview with nursing 9/14/2007 at 1500 re reassess the patient medication." Further available documental reassessments. Intestaff failed to follow hereassessment after timedication. 5. Closed record revipalization of the facility on 8-14 commitment related Review of physician's 8-14-2007 at 1135 re (checked) twice daily failed to reveal documental obtained twice per dorders on 8-18-2007 (telephone order) Se (emergency medical (symbol for increase (symbol for decreass saturation), hx (histor Record review reveat transferred to another admission on 8-21-2 Interview with nursing 9-14-2007 at 1530 cordered vital signs to	g management staff on vealed, "The nurse should after administration of a interview revealed no tion of nursing project of the administration of a sew of Patient #3 on a 15 year old male admitted 1-2007 as an involuntary to an attempted suicide. It is admission orders on evealed "Vital Signs: The Review of the record mentation of vital signs being an at 0150 revealed "T.O. and pt (patient) to E.R. tt (facility name) via EMS services)Rationale The patient was a ser facility for evaluation and 1007. The g management staff on confirmed the patient was wice per day. Interview	AS	395			
	record of vital signs	no documentation on the having been obtained twice firmed staff did not follow					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 344014	A. BUI	LDING	CONSTRUCTION	(X3) DATE SI COMPLE	
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A 395	obtaining vital signs of the control	twice daily or facility policy of at least daily. w of Patient #17 on a fifteen year old male y on 9-05-2007 for Review of physician's 9-06-2007 at 1320 revealed ed) Daily". Review of e MAR revealed "Eskalith CR c depression) 450mg PO d being administered as documentation on the "Vital ealed on 9-15-2007 was gns recorded. Review of les on 9-15-2007 failed to n of why the vital signs were notifying the physician that	A	395			
	9-17-2007 at 1200 rd collected regularly signanti-depressants car Interview revealed the vital signs as ordere failed to reveal documentified that the staff signs as ordered by confirmed staff did in facility policy of obtain 17. Open record revieweled an eight ye facility on 9-06-2007 oppositional defiant	g management staff on evealed vital signs are ince medications such as a effect the blood pressure. The staff failed to document the doby the physician. Interview mentation by nursing as to were not obtained. Interview mentation the physician was a were unable to obtain vital the physician. Interview of follow physician's orders or ining vital signs at least daily. The work of Patient #9 on 9-17-2007 are old male admitted to the for Cyclothymia and disorder. Review of on orders on 9-06-2007 at					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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•	ROVIDER OR SUPPLIER	SERVICES		REET ADDRESS, CITY, STATE, ZIF 3019 FALSTAFF RD RALEIGH, NC 27610	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
A 395	1320 revealed "Vita Review of documer Review of documer flowsheet revealed Review of nursing pailed to reveal documented to the munable to obtain the was not cooperative 9-10-2007 the staff signs as ordered by failed to reveal documented that the stagings as ordered by confirmed staff did	ge 31 I Signs: (checked) Daily". Itation on the MAR revealed Itation on the "Vital Signs" on 9-10-2007 "No vitals". Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to document the vital Interview confirmed that on failed to obtained. Interview furnentation the physician was ff were unable to obtain vital Interview Interview confirmed that on failed to document the vital Interview confirmed that on fail	A 399	5			
	physician of a med patients sampled (#Review of facility prevised 11-2003 re the medical record error made, b. notification: Geographic Grand Properties of the medical record error made, b. notification: Geographic Grand G	olicy "Medication Errors" vealed "3. Documentation on shall include the following: a. ication of physician"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SUI COMPLET	ED
		344014	B. WING		i i	C 7/2007
	ROVIDER OR SUPPLIER	ERVICES	3019	T ADDRESS, CITY, STATE, ZIP CODE 9 FALSTAFF RD LEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		(X5) COMPLETION DATE
A 395	right amount, the right the right time, the right time, the right the right the right are documented on Record immediately 1. Closed record revelow 12 year old male additional sold male additional	the 32 Introduction, the right patient, the medicine, the medications the Medication Administration after they are given" Item for Patient #7 revealed a mitted to the facility on redisorder. Review of the 8-13-2007 at 1350 revealed am (in the morning) and his way revealed "noted 8/13/7 ary)". Further review the 1405 (name of RN)". Item for the morning of the state of the st	A 395			
	Closed record review seven year-old male 8-08-2007 for attention disorder and bipolar revealed "Tegregol (seizures or to stability po am (in the morning 8/13/7T (transcriber noting Tegretol order (nurse initials) (initiated off Patient #7 record revealed on 8-13-20 nurse who administed patient. Further review ritten beside the Tegretol 20 Record review of the failed to reveal docubeing given or of the notified of the medical	or for Patient #8 revealed a admitted to the facility on on deficit hyperactivity disorder. Review of the MAR a medication to control ze a mood disorder) 200mg and a hard series of the market of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		344014	B. WIN	3			C 7/2007	
	OVIDER OR SUPPLIER	ERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3019 FALSTAFF RD RALEIGH, NC 27610			DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
A-395	refuses to wake up am" Interview with a unit	rtime - unable to assess as pt change Clonidine 0.05mg po secretary on 9-14-2007 at	A :	395				
	facility since June 20 revealed the unit sec three-day orientation assigned to shadow patient assignment a another, who also ha Interview revealed the	it secretary had been at the 07. Further interview retary received the general to the facility then was a nurse one day, who had a nd to shadow a MHT d a patient assignment. at since the staff members septors were not functioning						
	as a unit secretary, be responsibility for pating for many questions of duties of the role of underseased "you just have learn the rest as you revealed the unit second regretol 200mg poor Patient #7 on 8-13-2	nut had a primary ent care, there was not time or for observation of the unit secretary. Interview eve to learn what you can and go along I guess." Interview eretary took the order for the ff the physician's orders for 1350, but accidentally						
<u>-</u>	Patient #8. Interview order on Patient #7's	cation onto the MAR for revealed a RN noted the record at 1405 and initialed cation on the MAR for Patient						
	9-14-2007 at 1530 re aware of the Tegreto Interview revealed the Clonidine dose for Plassessment that the difficult to arouse. In knowledge of the me would not have modi	ysician for Patient #8 on evealed the physician was not be being given to her patient. he physician changed the atient #8 based on the patient was drowsy and herview revealed with edication error, the physician fied Patient #8's medication evealed Tegretol can cause						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		344014	B. WING		09/	17/2007
di.	ROVIDER OR SUPPLIER	SERVICES	3019	T ADDRESS, CITY, STATE, ZIP CODE FALSTAFF RD LEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 395	Continued From particular drowsiness.	ge 34	A 395			
	9-14-2007 at 1605 of investigation of the revealed the staff my whether the physici revealed the investigation of any failed to reveal door notification of the my confirmed staff did notifying the physici Interview with nursige-14-2007 at 1635 medication error be Interview revealed first week of employ revealed it has been an increase in the facility related to awareness of repor revealed there is a and analysis of medication there hidentified to address with nursing staff, staff did not follow the physician of the cocaine Depen Disorder. Review of the staff of the cocaine Depen Disorder. Review of the staff of the cocaine Depen Disorder. Review of the color of the cocaine Depen Disorder. Review of the cocaine Depen Disorder. Review of the cocaine of the cocaine Depen Disorder. Review of the cocaine of the cocaine Depen Disorder. Review of the cocaine of the cocaine Depen Disorder. Review of the cocaine of t	medication error event member was unaware as to an was notified. Interview gation did not document an was notified. Interview aff would be expected to notify medication error. Interview umentation of physician edication error. Interview not follow facility policy on ian of a medication error. In administrative staff on revealed no knowledge of the tween Patient #7 and #8. The error occurred within the medication error reporting at medication error reporting at medication errors. Interview further plan for better aggregation dication errors at the facility without the aggregated ave been no current priorities as specific medication errors Interview confirmed nursing facility policy in not notifying				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344014	B. WIN	G		1	7/ 2007
	COVIDER OR SUPPLIER	ERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3019 FALSTAFF RD RALEIGH, NC 27610				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 395	(anti-depressant drug mouth) daily start 1st revealed "noted (nan	g) 30 mg (milligrams) po (by dose today." Review ne of unit secretary) Further review revealed	A	395			
	36 year old admitted Dependence and Big The patient was disc revealed "Cymbalta (milligrams) po (by m transcribed (written) Administration Recorrevealed "Order 7/2"	d (MAR). Further review					
·	secretary noting Cynrecord), NI (nurse initreview of the MAR reinitials of the nurse via 30mg po to patient # reveal a physician's daily, 1st dose now breview of nursing prodocumentation of the	tial left blank)." Further evealed on 7/23 at 1800, who administered Cymbalta 11. Record review failed to order for Cymbalta 30mg po by the physician. Record pagress notes failed to reveal a medication being given or ag notified of the medication					
	#11 on 9/14/2007 at was not aware of the patient. Interview re placed on Lexapro (would not have place because that would Further interview conot write an order in Cymbalta. Further i	tending physician for patient 1245 revealed the physician c Cymbalta being given to her evealed "This patient was antidepressant drug), so I ed them on Cymbalta be two drugs for depression." infirmed that the physician did the physician orders for interview revealed "I expect inform me immediately when a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		344014	B. WIN	G			C 7/2007	
	OVIDER OR SUPPLIER	RVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3019 FALSTAFF RD RALEIGH, NC 27610					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
A 395	medication error has confirmed the physici medication error. Interview with nursing 9/14/2007 at 1610 fai documentation of a physician notification	e 36 coccurred." Further interview an was not notified of the management staff on led to reveal no available hysician's order for or of of the administration of 11. Further interview	Α	395				
	confirmed that the nu hospital policies. C) The facility's nursi	rsing staff did not following staff failed to report a ephysician per facility policy				·		
	Results, original date 01/07 revealed "Polic name) to notify the plantical test resultsP laboratory tests are dordered STAT runs. defined as lab results lab name) panic limits and those called in by having panic limits man physician within one	efined as tests that are All critical lab values are that have identified (private sAll critical lab test results y (private lab name) as ust be reported to the nour of receiving the result.		And the state of t				
	the lab are document Lab formThe attend paged"	sults that are phoned in by ed using the STAT/Critical ling physician is immediately of patient #5 revealed a 36						
	year old admitted on Dependence, Maligna high blood pressure), (low potassium name	8/27/2007 for Alcohol ant Hypertension (constant History of hypokalemia						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUI	LDING			С
		344014	B. WIN	IG			7/2007
	OVIDER OR SUPPLIER	RVICES		30	EET ADDRESS, CITY, STATE, ZIP CODE 19 FALSTAFF RD ALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 395	called to (nurse name (Eastern Standard Tir STAT/Critical Lab Ph at 0145 revealed "F Notified: (nurse name 8/29/2007, Doctor Pa Time/Date Notified: 0 minutes after initial nureturned call @ (at): review revealed a lainame). Further review 9/01/2007 0645, : (re Printed 9/1/2007 112 result verified" Fur reveal additional doc physician notification 8/29/2007. Further recompletion of a STA or immediate physician results on 9/1/2007 b. Interview with nursing 9/14/2007 at 1500 recalled immediately to time of day." Further nursing staff did not a hours and 45 minutes critical lab value to the	from (private lab #1). ed "Potassium, Serum e) on 8/29/2007 at 0141 EST me)." Review of a one Report dated 8/29/2007 Potassium2.5Nurse e) Time/Date Notified: 0145 ged: (doctor name) 630 8/29/2007 [4 hours 45 otification of nurse], Doctor 0620" Further record or report from (private lab #2 w revealed "Coll: (collected) eceived) 9/1/2007 1036, 7Potassium2.5Critical ther record review failed to umentation of immediate of the critical lab results on ecord review failed to reveal T/Critical Lab Phone Report an notification of critical lab	A	395			
A 396	documentation of a S Report for a lab repo Interview confirmed t follow hospital policie	STAT/Critical Lab Phone rt dated 9/1/2007 @ 1124. hat the nursing staff did not es.	A	396			
	The hospital must en develops, and keeps	sure that the nursing staff current, a nursing care plan					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		344014	344014 B. WING			C 09/17/2007		
NAME OF PROVIDER OR SUPPLIER HOLLY HILL MENTAL HEALTH SERVICES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 3019 FALSTAFF RD RALEIGH, NC 27610 ID PROVIDER'S PLAN OF CORRECTION (X5)				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
A 396	This STANDARD is Based on policy and open and closed receptacility's nursing staff sampled patients treed. Review of facility po Treatment Plan", review of facility po Treatment Plan", review of facility po Treatment Plan of care includes measures of the plan is determined the plan is determined the plan is determined the patient and is reviewed to the patient and is reviewed to the patient and is reviewed to the patient and is reviewed to the patient and is reviewed to the patient and is reviewed to the patient and is reviewed to the patient and is reviewed to the patient and is reviewed to the patient and is reviewed to the patient and is remarked to the patient and is r	not met as evidenced by: procedure review, review of ords, and staff interviews, the f failed to update 2 of 17 atment plans (#16, #2). licy CLS053 - "Master vised 07/05 revealed r Treatment Plan will set e and consistent with theThe Master Treatment Plan hat will restore, maintain and ent's well beingThe scope of ed by the anticipated needs of viewed and revised as the change" Further review e: I. Master Treatment dical: The RN (registered th medical problem that is ed. The RN initiates a Sheet for each problemII. lursing will always initiate eets"	A	396	A 396 Plan of Correction: Mandatory All-Nursing Train initiated on 9/27/07. All nursinot in attendance will be requirective training prior to their scheduled shift. Content of trainclude: "Completion of a master treat plan for all patients with a foothe completion of medical prosheets. "Pain assessment, pain reasse and appropriate follow-up in treatment of pain. "Completion of the comprehe pain assessment for patients whave pain. Monitoring: An audit on mast reatment plans, pain assessment and completion of the comprepain assessment will be condensure 100% compliance is maintained. Persons Responsible: Director Assistant Directors of Nursin	ng staff ired to next aining to ment cus on oblem ssment, the nsive who ter eents, ehensive ucted to	9/27/07	
*.a.,	#16 revealed a five facility on 9-04-2007 disorder. Record re examination of the p	ew on 9-17-2007 for Patient year-old male admitted to the ' for psychosis and mood view of a physician's patient on 9-05-2007 at 1300 ut) arrhythmia" and "r/o Rt						