Utah Department of Health
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APR 0_ 2004

DEPARTMENT OF HEALTH AND HU... N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 3/25/2004
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465084	Bureau of Medicare/Medicaid Program Certification and Resident Assessment A. BUILDING ______ B. WING ______	C 3/17/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASIN CARE AND REHABILITATION CENTER	187 WEST LAGOON STREET ROOSEVELT, UT 84066

COMPLAINT NUMBER. UT00001872

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333 S=G	483.25(m)(2) QUALITY OF CARE The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that 1 sampled resident was free from any significant medication errors. Specifically, the resident received Dilantin (a medication used to prevent seizures) instead of Diltiazem (a medication used to prevent high blood pressure and tachycardia). (Resident identifier:1) Findings included: Resident 1 was admitted to the facility on 12/18/03 with diagnoses including atrial fibrillation, hypertension, senile dementia, constipation and insomnia. Review of Resident 1's medical record was completed on 3/17/04. Review of resident 1's admission physician's orders from Uintah Basin Medical Center for Skilled Nursing Care, dated 12/18/03, documented medications to include "Diltiazem ER (extended release) 90 mg (milligrams) PO (by mouth) QD (daily)". Diltiazem is used to control hypertension and atrial fibrillation. Resident 1 was diagnosed with hypertension and atrial fibrillation. . Review of the facility's computer generated physician's order sheet, dated 12/18/03, documented "Dilantin 90 mg PO QD" was to be given, instead of Diltiazem ER. Dilantin is a medication used to prevent and/or treat seizure disorders. Resident 1 was not diagnosed with a	F 333 acceptable POC 4/8/04 Sylenda RN Completion date 5/3/04	For resident # 1 and all residents of this facility the Director of Nursing will review the accuracy of all admitting medication and treatment orders signed by the physician, before the medical record clerk inputs them into the computer. Once the orders have been input into the computer and printed, the Director of Nursing/Assistant Director of Nursing and one other nurse will review printed orders with original orders and each will sign as verified as accurate. All original admission orders will be faxed to the pharmacy to fill new orders. If a medication received is not what was printed on the medical administration record, the Director of Nursing will be notified and will follow up with identifying the appropriate medication. An in-service will be given to nursing staff on April 22, 2004 to review policy and procedure of admission orders. Monitoring will be done by the Director of Nursing to assure compliance. The findings will be reviewed in the monthly quality assurance meeting.	~~5/16/04~~ 5/3/04 as per telephone contact c admin. Ron Kapp 4/12/04 SD

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ronald Kapp
TITLE: Administrator
(X6) DATE: 4/5/04

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 333	Continued From page 1 seizure disorder. Per the Utah State Nurse Practice Act a licensed nurse "shall verify and evaluate the orders." The DON (Director of Nursing) signed the computer generated physician's order sheet dated 12/18/03. Review of the pharmacy order sheet, dated 12/20/03, that was handwritten by the facility charge nurse, who was assigned to care for resident 1 on the day of admission, documented that "Dilantin 90 mg (milligrams)1/1 tab (tablet) q (each) day" was ordered. The pharmacy order sheet was faxed to the pharmacy on 12/20/03 at 3:30 AM. Review of resident 1's MAR (Medication Administration Record) for December 2003 and January 2004 documented that Dilantin was administered to resident 1 on December 19, 2003 through January 2, 2004. This resulted in the resident receiving fifteen doses of Dilantin instead of Diltiazem ER. In an interview with a facility pharmacist via the telephone, on 3/16/04 at 12:10 PM, the pharmacist stated that according to their records a Dilantin 100 mg capsule was dispensed from the facility's PIXIS (a secured computerized machine used to store and dispense medications) on December 19, 2003 for resident 1. On December 20, 2003 the pharmacy received the order for "Dilantin 90 mg 1/1 tab q day". Since Dilantin does not come in 90 mg capsules the pharmacist stated that the pharmacy sent 30 mg capsules of Dilantin. Resident 1 was to receive 3 capsules each day equaling 90 mg. The order for Dilantin was discontinued on 1/2/04. Review of the nurse's admission note, dated	F 333		

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F 333	Continued From page 2 12/18/03, at 3:00 PM, documented resident 1 was on "Dilizatem (sic) ER 90 mg po q day". The "Dilizatem (sic)" was crossed out with one line and Dilantin written above the "Dilizatem (sic)". Review of the nurse's notes on 1/2/04 documented "Today it was discovered that admitting orders were transcribed wrong. Dilantin was not ordered; instead it was Diltiazem 90 mg ER". Per the Nursing 2003 Handbook page 421 Dilantin's adverse reactions included drowsiness, lethargy, hangover, nausea, vomiting, and couldpossibly interact with oral anticoagulants (e.g. Coumadin). Per Drug Interaction Facts* copyright April 1994 by Facts and Comparisons documented that "Phenytoin (Dilantin) increased prothrombin time when it was added to the regimen of patients taking warfarin (Coumadin): this has resulted in severe bleeding." Review of the facility Medication Error Form dated 1/2/04 documented that the Dilantin caused "...? (decreased) appetite, lethargy, ? (increased) PT (prothrombin time) level, unsteady gait; need for Vit (vitamin) K inj (injection) d/t (due to) ? PT". (Effects of Coumadin can be neutralized by vitamin K injections.) Resident 1 was being administered "Coumadin 2 mg 1 tablet oral QD" for a diagnosis of "Atrial Fibrillation" per the MAR. Atrial fibrillation puts the resident at risk of forming blood clots. Coumadin is classified as an anticoagulant (blood thinner). "Prothrombin times (PT) and international normalization ratio (INR) are the coagulation tests used to monitor the anticoagulation effects of Coumadin" because "there is a risk of bleeding in any patient receiving anticoagulants." (The	F 333		

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F 333	Continued From page 3 Lippincott Manuel of Nursing Practice, copyright 2001, page 404). The Coumadin was being administered to prevent the formation of blood clots. Review of resident 1's laboratory results dated 12/31/03 included a PT of "82.5 H (high)" (normal therapeutic range is 11.0 to 14.0 seconds) with an INR of "7.1 HC (high critical)" (normal therapeutic range is 2.0 to 3.0). Review of the nurses notes and the MAR dated 12/31/03 documented that resident 1 received "10 units of Vit K (a vitamin used to reverse the anticoagulant effects of Coumadin) IM" per the physician's order. Two separate interviews with the facility DON were conducted; one on 3/16/04 at 4:45 PM and another on 3/17/04 at 10:12 AM. The DON was asked about resident 1 receiving Dilantin instead of Diltiazem ER. The DON stated that the medical records (MR) clerk had incorrectly entered the medication Dilantin instead of Diltiazem onto the computer generated physician's orders. The DON then went on to explain that on "3 separate occasions" she had told the MR clerk that the medication resident 1 had ordered was Diltiazem, not Dilantin. The DON was asked who co-signed the computer generated physician's orders for resident 1. The DON stated that she had signed the orders without checking for accuracy. The DON also stated that she felt that resident 1 experienced weakness, fatigue, slurred speech and an increase in his PT level that necessitated an injection of Vitamin K due to the resident receiving the wrong medication. The DON stated that by the end of December (of 2003), resident 1 was "... sick, really tired, and really lethargic" and that he needed "quite a bit of help" to get around. (This was during the time period that resident 1 had been mistakenly recieving the Dilantin daily.)	F 333		

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