PRINTED: 08/01/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES				ķ	THE PERSON OF PURPOSE OF PERSONS ASSESSED.	OMB N	O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	3	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345217	B. WIN	G	※ ★ロゥ ○ 大 7044	07/*	C 19/2011
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		10/2011
PREMIER	NURSING AND REHAB	LITATION CENTER		1	25 WHITE ST SCKSONVILLE, NC 28546	j. Ž	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329 SS=J	UNNECESSARY DR	GIMEN IS FREE FROM RUGS regimen must be free from	F	329			
	unnecessary drugs. drug when used in ex duplicate therapy); o without adequate mo indications for its use adverse consequence	An unnecessary drug is any excessive dose (including or for excessive duration; or enitoring; or without adequate or or in the presence of es which indicate the dose or discontinued; or any					
	resident, the facility r who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradue behavioral intervention	ensive assessment of a must ensure that residents entipsychotic drugs are not aless antipsychotic drug to treat a specific condition ocumented in the clinical so who use antipsychotic al dose reductions, and ons, unless clinically in effort to discontinue these					
	by: Based on record rev and physician intervi- that 1 of 4 residents of unnecessary medica	is not met as evidenced riew, facility staff interviews, ew the facility failed to ensure (Resident #1) was free from tion by giving an excessive mg) rather than the ordered g).			Past noncompliance: no plan of correction required.		
ABORATORY	DIR É CTOR'S OR PROVIDER	SUPPLIER BEPRESENTATIVE'S SIGNATURE	<u></u>	į	TITLE	·	(X6) AT5

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.

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

Event ID: TNL811

Facility ID: 923022

<u>8/3/2011</u>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345217	B. WiN	G		07/	C 19/2011
	ROVIDER OR SUPPLIER	LITATION CENTER		225 V	FADDRESS, CITY, STATE, ZIP CODE WHITE ST KSONVILLE, NC 28546	311	10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	4/30/11 and re-admit cumulative diagnoses effusions with respiral hypertension, periphediabetes mellitus type Resident #1 expired in 12:10 AM. Resident #1's most Data Set (MDS) date Resident was moderathe Resident was ide extensive assistance Activities of Daily Livin The physician admiss 6/29/11 revealed that respiratory failure sect pleural effusions and to the facility on comform. Resident #1's physician admiss 6/29/11 revealed that respiratory failure sect pleural effusions and to the facility on comform. Resident #1's physician admiss 6/29/11 revealed that respiratory failure sect pleural effusions and to the facility on comform. Resident #1's physician admiss 6/29/11 revealed dose of Roxanol. The MAR (medication Resident #1 revealed give Oral Roxanol (M per milliliter (ml) concept (by mouth) or SL	mitted to the facility on ted on 06/28/11 with sof large bilateral pleural story failure, hypoxemia, eral vascular disease, e. 2, and chronic pain. In the facility on 7/3/11 at recent Quarterly Minimum d 6/23/11 revealed that the ately cognitively impaired. entified as requiring from facility staff for	Ц.	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345217	B. WING		C 07/19/2011	
	ROVIDER OR SUPPLIER NURSING AND REHABII	LITATION CENTER	225	ET AODRESS, CITY, STATE, ZIP CODE WHITE ST CKSONVILLE, NC 28546		
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F 329	space for 7/1/11 (nurs spaces to indicate the medication). Resident #1's Contror receipt/count sheet for 20mg/ml was signed to at 4:15 PM with the document at 4:15 PM with the document at 4:15 PM revealed that Morphine at 4:15 PM revealed that Morphine count was in had given 2.5ml of Mostal The nurse's resident #1.5ml.	tten on the MAR in the ses put their initials in those by have administered the olled substance of Roxanol/Morphine by Nurse #1 on July 1, 2011 ose given documented as sered dose of 0.25ml. I's notes dated 7/2/11 at the Nurse #1 gave the resident (on 7/1/11) and that the incorrect. She noted that she orphine which is equal to note also indicated that doctor and the DON was	F 329			
	On 7/18/11 at 2:50 PM (DON) stated that she around 11:30 PM by th Nurse #1 gave Reside Roxanol. She stated to no changes in the resi					
	worked as the 3PM-11 he was informed that the narcotic count. Nurse a showed him a 30ml me	M, Nurse #2 stated that he IPM shift supervisor when here was an error with the #2 stated that Nurse #1 edication cup and pointed I 2.5ml. Nurse #2 stated				

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PREMIER	NURSING AND REHAB	ILITATION CENTER	225	T ADDRESS, CITY, STATE, ZIP CODE WHITE ST CKSONVILLE, NC 28546		
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	that he told Nurse #1 #1 the wrong dose a that the ordered dose stated that he and Nu resident and the reside be aroused and his v stated that Nurse #1 resident 's status. Nu monitor the resident. Nurse #1 a consultat dose of Roxanol. On 7/18/11 at 4:40PM contacted on 7/2/11 a made aware by Nurse given 2.5ml of Roxan ordered dose of 0.25t Resident #1 to be mo anything changed. He instructed the nurse t complete an incident On 7/19/11 at 1:30 Pf worked as the 7AM-3 7/2/11 and that Resid lethargic. She called t made him aware of th received an order for She stated the Narcai any lingering effects of giving the resident Na respond that much. Si ordered half of a norm would not be in pain. Si the MD was made as morphine overdose in	that she had given Resident and too much Roxanol and should be 0.25ml. He curse #3 went to assess the dent was lethargic but able to dital signs were stable. He notified the MD of the curse #1 received orders to Nurse #2 immediately gave tion on giving the wrong M, the MD stated that he was around 1:00AM and was se #1 that Resident #1 was of which was more than the ml of Roxanol. He ordered and to call him if se also stated that he of call the family and report. M, Nurse #10 stated she PM nurse supervisor on the entitle of the more supervisor on the entitle of the more supervisor on the entitle of the more of the morphine and after the morphine and after the stated that the MD only and dose so the resident She stated that the call to an update due the	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	J.	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITATION CENTER	<u> </u>	225 \	T ADDRESS, CITY, STATE, ZIP CODE WHITE ST KSONVILLE, NC 28546		7/19/2011
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	was 12 (within the administered the o 10:45 AM on 7/2/1 responded to quest On 07/19/11 at 11: Pharmacist contract in almost all cases, Roxanol in the mar was a cardboard be of the divider and the package insert when it was dispensin a plastic bag with on it that refers to a warning sheet described of the inciditation of the inciditation of the inciditation of the resident was not order Narcan or notified of the inciditation of the resident was not was still in pain and changed. He stated reverse the effects around 10:30AM be told that the patient not awake. The MD cause of death as be respiratory failure. (the dose of Roxano The facility determination of the	ne resident's respiratory rate normal limit) after he was redered dose of Narcan at 1, he aroused to touch and tions appropriately. 39 AM, Interview with the sted by the facility revealed that the pharmacy dispensed aufacturer's packing which box with the bottle on one side the syringe on the other side. It was left in the cardboard box sed. The box was packaged to a 2x2 adhesive STOP sticker at warning sheet'. The pribed the way to convert from the sted that he did an 7/2/11 when he was first that he condition had not that he ordered the Narcan to the first of the morphine on 7/2/11 ecause he was called and was was still sleeping and would indicated the resident's illateral pleural effusions with the stated it was unrelated to	Ľ.	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER		225 1	T ADDRESS, CITY, STATE, ZIP CODE WHITE ST KSONVILLE, NC 28546		07/19/2011	
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F 329	Continued From page of interventions put in	e 5 to place as a result of the	F	329				
	action plan on 7/19/1 Corrective Action Pla Roxanol Overdose or 1) Resident #1 rece 20mg/mL solution, rec subcutaneous, on 7/2 physician. He was re expired on 7/3/11 at 0 *An immediate discipl direct re-training was the supervision of Nur supervisor, for employ Involved employee sur re-training as of 7/3/1 termed on 7/7/11 2) A detailed review by the Director of Nur review of all narcotic r Two residents had an solution last dose rece and May 2011 for the within facility received morphine medication forms provided as ord 3) 7/5/11 - 100% In- nurses 1:1 regarding p administration given b In-service covered 6 F resident, right medicat method, right time. Tri prior to administration.	in 7/2/11 lived 2.5mL of roxanol ceived narcan 0.5mg /11 at 1045 ordered by ceiving hospice care and loud. inary action on 7/2/11 and initiated on 7/3/11, under ree #10, weekend ree involved in incident. Ispended after direct 1 for further investigation, on 200 Hall was completed sing on 7/4/11, as was a medications in the facility. Order and supply of roxanol eived in Feb 2011 on one other. No other residents roxanol solution, all including tablet and liquid lered. Servicing for all licensed proper medication, right cion, right route, right ple check all medications, Proper documentation assessment, effectiveness,						

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F 329	*Completed 7/15/supervisors 7/11/11- 100% In- 1:1 regarding mor administration, all second nurse veri narcotic count with Re-training regard administration, rig frequency, route, morphine product correctly. Provided supervisors one o	servicing for all licensed nurses phine medication licensed individuals are to have fy dose, double signatures on all morphine products. ing general medication the medication, patient, order, and documentation for all stores, to ensure medication is given by the Director of Nursing and in one. //15/11, by Director of Nursing and in one. //15/11, by Director of Nursing istration and dosing, this eneral monthly in-service of the medication service, using the six rights of grane a second a second nurse medications, and informing that that may take place. In a second a second nurse in the monthly for 3 months ince in completed on 200 Hall by Director of Nursing, noted and morphine sulfate.	F 329				

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' i		CONSTRUCTION	(X3) DATE SU	
	345217	B. WIN	G		i	C 9/2011
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weekly to discuss issuaudit and the need for *QI meeting 7/18/11 Staff development traiwith pharmacy consuladministration, focusing	ue and/or trends regarding r future interventions held on 7/4/11, 7/11/11, and lining, has been scheduled ltant, regarding medication ng on morphine dosing, will	F	329			
the survey. Nurse #1 's employee #1 received an immed a drug screen on 7/2/medication pass audit nurse supervisor on 7/2 Nurse #1 was termina poor work performance work role. Nurse #1 w Carolina Board of Nur 7/18/11. On 7/4/11 a record revisor of 3/2 sinitial audits 200, 300, 700, and 80 completed the audits that all narcotic logs and of administration records There were two reside morphine. Review of the forms of morphine admand documented corrected.	e record revealed that Nurse diate disciplinary action and 11 and direct re-training per tunder the supervision of a 1/3/11. The record indicated ated on 7/7/11 due to her ce and inability to adapt to vas also reported to North rsing by the facility on view revealed that the were completed on 100, 00A/B Halls. The DON that consisted of a review of current medication is of residents on morphine. The audits revealed that all ministration were correct ectly.					
	CONTIDER OR SUPPLIER NURSING AND REHABIT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L. Continued From page weekly to discuss issuadit and the need for *QI meeting 7/18/11 Staff development trai with pharmacy consult administration, focusin be completed prior to The corrective action the survey. Nurse #1 's employed #1 received an immediation pass audit nurse supervisor on 7/2/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 weekly to discuss issue and/or trends regarding audit and the need for future interventions *QI meeting held on 7/4/11, 7/11/11, and 7/18/11 Staff development training, has been scheduled with pharmacy consultant, regarding medication administration, focusing on morphine dosing, will be completed prior to staff taking floor The corrective action plan was validated during the survey. Nurse #1 's employee record revealed that Nurse #1 received an immediate disciplinary action and a drug screen on 7/2/11 and direct re-training per medication pass audit under the supervision of a nurse supervisor on 7/3/11. The record indicated Nurse #1 was terminated on 7/7/11 due to her poor work performance and inability to adapt to work role. Nurse #1 was also reported to North Carolina Board of Nursing by the facility on	A BUIL 345217 B WMN A BUIL A BUIL A BUIL A BUIL A BUIL A BUIL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 Weekly to discuss issue and/or trends regarding audit and the need for future interventions A Cl meeting held on 7/4/11, 7/11/11, and 7/18/11 Staff development training, has been scheduled with pharmacy consultant, regarding medication administration, focusing on morphine dosing, will be completed prior to staff taking floor The corrective action plan was validated during the survey. Nurse #1 's employee record revealed that Nurse #1 received an immediate disciplinary action and a drug screen on 7/2/11 and direct re-training per medication pass audit under the supervision of a nurse supervisor on 7/3/11. 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Record review revealed that 1:1 in-servicing	TOWNDER OR SUPPLIER NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 weekly to discuss issue and/or trends regarding audit and the need for future interventions "QI meeting held on 7/4/11, 7/11/11, and 7/18/11 Staff development training, has been scheduled with pharmacy consultant, regarding medication administration, focusing on morphine dosing, will be completed prior to staff taking floor The corrective action plan was validated during the survey. Nurse #1 's employee record revealed that Nurse #1 received an immediate disciplinary action and a drug screen on 7/2/11 and direct re-training per medication pass audit under the supervision of a nurse supervisor on 7/3/11. The record indicated Nurse #1 was terminated on 7/7/11 due to her poor work performance and inability to adapt to work role. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 228 WHITE ST JACKSONVILLE, NC 28546 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 weekly to discuss issue and/or trends regarding audit and the need for future interventions "O'l meeting held on 7/4/11, 7/11/1/1, and 7/18/11 Staff development training, has been scheduled with pharmacy consultant, regarding medication administration, focusing on morphine dosing, will be completed prior to staff taking floor The corrective action plan was validated during the survey. Nurse #1 's employee record revealed that Nurse #1 received an immediate disciplinary action and a drug screen on 7/2/11 and direct re-training per medication pass audit under the supervision of a nurse supervisor on 7/3/11. The record indicated Nurse #1 was terminated on 7/7/11 due to her poor work performance and inability to adapt to work role. 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F 329	compliance of all lice aides. This was compliance of all lice aides. This was compliance. This was compliance in-service records shown in-service topics inclusively practice introduced to have a second nurdouble signature on a morphine products from the DON and nurses record indicated 100°s staff by 7/15/11. Record review reveal in-service/ general mand addressed the total administration, admir second nurse to veriff informed of continuin. The Quality Improver minutes revealed me 7/11/11, and 7/18/11 audits and areas of coneed for the frequence. Record review reveal was completed to review reveal was completed	proper medication occumentation with 100% nsed staff and medication obleted on 7/15/11. Index on 7/11/11 for licensed rephine administration. The oded a mandatory new obstaff requiring every nurse rese to verify dose including marcotic count sheet with all acility policy to be revised. The index were completed by supervisors. The in-service wattendance of all licensed and that on 7/15/11, a nursing monthly in service was held upics of medication mistration of morphine with a ny dose and the staff was	F 329			

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F 329	was in-serviced on The nurse explaine administration and and back of the me She stated there ha and witness dosage that Morphine came errors should be reland MD as soon as On 7/18/11 at 9:13 she did not adminis the nurse to adminis She stated that she needed a second needed a second needed and that she needed a second needication adminis medication was madocumentation was count was correct. The hall with the onlorder for Roxanol. On 7/18/11 at 2:02 used a syringe to anot the concentrate calibrated syringe to anot the concentrate calib	AM, Nurse #7 stated that she medication administration. d the steps of medication how to document on the front dication administration record. In the two nurses to verify the to prevent errors. She stated that a special syringe. Medicorted to supervisor, family the it happens. AM, Med Aide #1 stated that the morphine and had to ask ster it if a resident needed it. It was aware that nurses surse to witness liquid she was in-serviced on tration. PM, Observation of tration of a PRN controlled de without error, completed and the narcotic This observation was made on the president that had a PRN PM, Nurse #4 stated that she diminister Morphine if it was d form and only used the nat came packaged with the narmacy to administer that had a PRN order it resident had not used it in the prefore the Roxanol was not	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	NOVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 225 WHITE ST JACKSONVILLE, NC 28546	DDE		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	had to be a second dosage to give more syringe should be On 7/18/11 at 8:56 morphine usually. She stated that she medication adminevery time there have the supervisor and paperwork/incider the med error worresident 's family. On 7/19/11 at 5:00 the QI committee weeks and then medications and had that in the supervisor and paperwork/incider the med error worresident 's family. On 7/19/11 at 5:00 the QI committee weeks and then medications up as need that all new licens current in-service and morphine adr by the Staff Devel working on the floor 7/19/11 at 5:30 morphine had to be unuse to verify dosattended inservice. The nurse explain medications and hat in the event at	B PM, Nurse #5 stated there d nurse present to check the orphine and that a calibrated used. B AM, Nurse #6 stated that came with a calibrated syringe. e was in-serviced on stration and that each and ad to be a second nurse to e to assure it was correct. The she did not have anyone on her red Morphine liquid. She stated hedication error she would notify it complete the at report. The nurse that made had have to call the MD and that will audit results weekly for 4 nonthly for 3 months and will is determined. DON also stated ed employees will receive on medication with a second nurse opment Coordinator prior to	F3	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUII	LDING		JOINI LE	
· · · · · · · · · · · · · · · · · · ·	Mark	345217	B. WIN	G		07/	C 19/2011
	ROVIDER OR SUPPLIER NURSING AND REHAL	BILITATION CENTER		2:	EET ADDRESS, CITY, STATE, ZIP CODE 25 WHITE ST ACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X6) COMPLETION DATE
F 329	family and MD and complete the paperwork. 483.25(m)(2) RESIDENTS FREE OF			329 333			
SS=J		sure that residents are free of					
	by: Based on record re pharmacist interview facility failed to ensu #1) was free from a by administering a d	view, facility staff interviews, v and physician interview the tre 1 of 4 residents (Resident significant medication error lose of Roxanol (50mg) rather se of Roxanol (5mg).			Past noncompliance: no plan of correction required.		
	4/30/11 and re-admi cumulative diagnose effusions with respir hypertension, periph diabetes mellitus typ	: Imitted to the facility on Ited on 06/28/11 with as of large bilateral pleural atory failure, hypoxemia, leral vascular disease, le 2, and chronic pain. In the facility on 7/3/11 at					
	Data Set (MDS) date Resident was moder The Resident was id extensive assistance Activities of Daily Liv	from facility staff for ing.					
	6/29/11 revealed that respiratory failure se	sion assessment note dated at the resident had chronic condary to bilateral large I was re-admitted on 6/28/11	700				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345217	A. BUI B. WIN			07/	C 19/2011
	NOVIDER OR SUPPLIER	BILITATION CENTER	•	225 V	ADDRESS, CITY, STATE, ZIP CODE WHITE ST KSONVILLE, NC 28546	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333	care. Resident #1 's physistated, "Oral Roxal (mg) per milliliter(m 0.25ml PO (by mouthours PRN (as need The ordered dose o Roxanol. The MAR (medication Resident #1 revealed give Oral Roxanol (Iper milliliter(ml) cor PO (by mouth) or SI PRN (as needed) for #1 's initials were we space for 7/1/11. Resident #1 's Con receipt/count sheet 20mg/ml was signed at 4:15 PM with the 2.5ml and not the oral control of the provided in the side of the control of	sician orders dated 6/29/11 nol (Morphine) 20 milligram I) concentration in every th) or SL (sublingual) every 2 ded) for pain or air hunger. " f 0.25ml contained 5 mg of on administration record) for d an order was transcribed to Morphine) 20 milligram (mg) acentration in every 0.25ml L (sublingual) every 2 hours or pain or air hunger Nurse or pain or air hunger Nurse or pain or the MAR in the trolled substance for Roxanol/Morphine d by Nurse #1 on July 1, 2011 dose given documented as ordered dose of 0.25ml.	F	333			
	2:17 AM revealed the Morphine at 4:15 PM Morphine count was had given 2.5ml of Morg. The nurse 's	se 's notes dated 7/2/11 at nat Nurse #1 gave the resident of (on 7/1/11) and that the sincorrect. She noted that she worphine which is equal to so note also indicated that ne doctor and the DON was rvisor.					
		ohone order dated 7/1/11 was at 1:15 AM stated, "Keep					

	A. BUILDIN		(X3) DATE SURVEY COMPLETED	
	A. BOILDIN		c	
345217	B. WNG		07/19/2011	
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER	:	REET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE ST JACKSONVILLE, NC 28546		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET	
F 333 Continued From page 13 watch on resident during night for decreased respirations and pulse". Nurse #1 was not available to be interviewed. On 7/18/11 at 2:50 PM, the Director of Nursing (DON) stated that she was made aware on 7/1/11 around 11:30 PM by the nurse supervisor that Nurse #1 gave Resident #1 an incorrect dose of Roxanol. She stated that the supervisor reported no changes in the resident 's condition. She stated that Nurse #2 did determine how Nurse #1 administered the dose incorrectly and Nurse #1 was immediately counseled, given a drug screen test and told to leave at the end of the shift and was to be notified when to return to work pending an investigation. The DON stated she started her investigation and quality improvement plan on 7/2/11. On 7/18/11 at 4:28 PM, Nurse #2 stated that he worked as the 3PM-11PM shift supervisor when he was informed that there was an error with the narcotic count. He stated that on 7/1/11 around 11:00 PM Nurse #3 made him aware that the count for Resident #1 's Roxanol was incorrect and Nurse #3 refused to take the cart until it was fixed. Nurse #2 stated that he questioned Nurse #1 and asked her how she administered the Roxanol. Nurse #2 stated that Nurse #1 showed him a 30ml medication cup and pointed to the line that showed 2.5ml. Nurse #2 stated that he told Nurse #1 that she had given Resident #1 the wrong dose and too much Roxanol and that the ordered dose should be 0.25ml. He stated that he and Nurse #3 went to assess the resident and the resident was lethargic but able to be aroused and his vital signs were stable. He stated that Nurse #	F 333	3		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345217	A. BUII B. WIN			07	C /19/2011
	ROVIDER OR SUPPLIER			225 V	ADDRESS, CITY, STATE, ZIP CODE NHITE ST KSONVILLE, NC 28546		71972011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC !DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
F 333	1 notified the MD of #1 received orders to #2 immediately gave giving the wrong do helped Nurse # 1 ac amount of Roxanol DON was also calle incident. On 7/18/11 at 4:40F contacted on 7/2/11 made aware by Nur given 2.5ml of Roxa ordered dose of 0.2 Resident #1 to be manything changed. It instructed the nurse complete an incider he also spoke to Nutold him to take Nur due the medication On 7/18/11 at 5:28 on 7/1/11 around 10 oncoming 11PM-7A narcotics on 200 Ha #1. She stated that the Roxanol missing that it was a brand and it was documer 0.25ml per dose we there was less than the count. She stated "no." Nurs take the medication	the resident 's status. Nurse o monitor the resident. Nurse o Nurse # 1 a consultation on se of Roxanol. Nurse #2 fjust the count to the correct that was in the bottle. The d more than once during this PM, the MD stated that he was around 1:00AM and was se #1 that Resident #1 was mol which was more than the 5ml of Roxanol. He ordered nonitored and to call him if the also stated that he to call the family and at report. The MD stated that turse #2, the supervisor, and se #1 off the floor immediately	F	333			

Event ID: TNLB11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ultiple Ding	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345217	B. WIN	G		07/	C 19/2011	
	NOVIDER OR SUPPLIER	LITATION CENTER		225 \	FADDRESS, CITY, STATE, ZIP CODE WHITE ST KSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 333	On 7/19/11 at 11:30 A 7/2/11 at 9:17 AM, Re and "he had apnea stated that she was r before and that was I him. She stated she of morphine on 7/1/1 aware and the same 7/1/11 was called age stated that the MD or resident closely and icurrent condition to o he would then take o supervisor, the hospi On 7/19/11 at 1:30 P worked as the 7AM-3 7/2/11 and that Resid lethargic. She called made him aware of the received an order for She stated the Narca any lingering effects giving the resident Narca any lingering	AM, Nurse #8 stated that on esident #1 was assessed and rales really bad. " She not able to compare him to her first time taking care of was aware of the overdose 1. She made her supervisor MD who was called on ain 7/2/11 at 10:15 AM. She dered to monitor the f there was no change in his all him back by 1:00PM and ther steps. She notified her ce nurse and the family. M, Nurse #10 stated she sPM nurse supervisor on dent #1 was extremely the MD at 10:30AM and he resident 's status and Narcan 0.4mg/ml-0.5ml. In was ordered to reverse of the morphine and after arcan at 10:45AM, he did not she stated that the MD only mal dose so the resident She stated that the call to an update due the	F	333				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WIN		-		C	
	ROVIDER OR SUPPLIER NURSING AND REH	ABILITATION CENTER		225 W	ADDRESS, CITY, STATE, ZIP CODE HITE ST (SONVILLE, NC 28546	1 0771	19/2011	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 333	in a plastic bag wi on it that refers to warning sheet desing to ml. The Phainto the early part shortage of the shime the pharmacibut always include warnings and stick are now available packaging to dispond order Narcan notified of the incithe resident was riwas still in pain ar changed. He state reverse the effects around 10:30AM told that the patier not awake. The Midiscontinue the Recould have neede MD stated that he regarding the incition how to give Mc resident's cause effusions with respunrelated to the difference on 7/1/1 improvement plant investigation, the	th a 2x2 adhesive STOP sticker a 'warning sheet'. The scribed the way to convert from armacist stated, "Last year and of this year (2011), there was a nail bottles of Roxanol. At that y pre-poured from stock bottles and a syringe and all of the above ker. However, the small bottles and we use the manufacture's ense." 38PM, the MD stated that he did for 7/2/11 when he was first dent because he was told that not doing anything different, he and his condition had not at that he ordered the Narcan to so of the morphine on 7/2/11 pecause he was called and was not was still sleeping and would D stated that he did not exanol because the resident did tagain due to his pain. The spoke with the DON on 7/4/11 dent and to do staff education orphine. The MD indicated the of death as bilateral pleural poiratory failure. (He stated it was one of Roxanol). Anined that all residents had the pected by the incident that and initiated a quality on 7/2/11. During the facility provided documentation at into place as a result of the	F	333				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:]	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345217	8. WIN	G		İ	C 9/2011
	OVIDER OR SUPPLIER	LITATION CENTER	1	2	REET ADDRESS, CITY, STATE, ZIP CODE 125 WHITE ST JACKSONVILLE, NC 28546	1 0771	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 333	Continued From page	÷ 17	F	333		;	
	action plan on 7/19/1 Corrective Action Plate Roxanol Overdose or 1) Resident #1 received 20mg/mL solution, resubcutaneous, on 7/2 physician. He was reexpired on 7/3/11 at 0 *An immediate disciping direct re-training was the supervision Nurse for employee involved employee suspended 7/3/11 for further inversionally 2) A detailed review by the Director of Nurreview of all narcotic Two residents had an solution last dose received and May 2011 for the within facility received morphine medication forms provided as or 3) 7/5/11 - 100% In nurses 1:1 regarding administration given In-service covered 6 resident, right medical method, right time. Times 200 medical right medical method, right time.	in 17/2/11 sived 2.5mL of roxanol ceived narcan 0.5mg ceiving hospice care and 0010. Ilinary action on 7/2/11 and initiated on 7/3/11, under a #10, weekend supervisor, of in incident. Involved after direct re-training as of estigation, termed on 7/7/11 or 0200 Hall was completed asing on 7/4/11, as was a medications in the facility. In order and supply of roxanol eived in Feb 2011 on one other. No other residents of roxanol solution, all including tablet and liquid dered. -servicing for all licensed proper medication by Director of Nursing. Rights of medication, right					
	signing, documenting and dose, route, time	assessment, effectiveness,					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345217	B. WIN	G		07	C /19/2011	
	OVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER		225 V	ADDRESS, CITY, STATE, ZIP CODE WHITE ST KSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 333	1:1 regarding morphic administration, all lice second nurse verify of narcotic count with all Re-training regarding administration, right of frequency, route, order morphine products, to correctly. Provided by supervisors one on o *Completed 7/15 and supervisors 7/15/11- Nursing in-service was a gene covering a review of administration in-service was a gene covering a review of administration in-service was a gene covering all morphine medication, having a verify all morphine medication, having a verify all morphine medication products by the appointed personnel, to ensure compliance *Audit on 200 Hall cocompleted 7/4/11, by one resident on liquid 10mg/5mL. *Audit on 300 Hall cocof Nursing, noted rox resident, has not received and the second surface 20mg/mL since *Audit on 100, 200, 3 completed 7/19/11, by Audit - The executive	vicing for all licensed nurses the medication ansed individuals are to have lose, double signatures on all morphine products. general medication medication, patient, er, and documentation for all to ensure medication is given to the Director of Nursing and the. 1/11, by Director of Nursing ervice, addressing ation and dosing, this eral monthly in-service the medication vice, using the six rights of second a second nurse edications, and informing to that may take place. In audits will be done weekly Director of Nursing or then monthly for 3 months the moleted on 200 Hall Director of Nursing, noted the morphine sulfate Impleted 7/13/11, by Director anol in cart and ordered for elived roxanol/morphine the May of 2011 00, 700, 800A/B Hall	F	333				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE (.DING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345217	B. WN	G		07	C //19/2011	
	OVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER	•	225 V	r ADDRESS, CITY, STATE, ZIP CODE WHITE ST KSONVILLE, NC 28546			
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F 333	7/18/11 Staff development tra with pharmacy consu	r future interventions held on 7/4/11, 7/11/11, and ining, has been scheduled itant, regarding medication ng on morphine dosing, will	F	333				
	the survey. Nurse #1 's employe #1 received an immed a drug screen on 7/2/medication pass audi nurse supervisor on 7 Nurse #1 was terminate poor work performance work role. Nurse #1 w	e record revealed that Nurse diate disciplinary action and 11 and direct re-training per tunder the supervision of a 1/3/11. The record indicated ated on 7/7/11 due to her be and inability to adapt to was also reported to North resing by the facility on						
	facility 's initial audits 200, 300, 700, and 80 completed the audits all narcotic logs and cadministration record There were two resid morphine. Review of forms of morphine ad and documented corre	s of residents on morphine. ents in the facility on the audits revealed that all ministration were correct ectly. ed that 1:1 in-servicing censed nurses and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WIN	G			C 9/2011	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		225	T ADDRESS, CITY, STATE, ZIP CODE WHITE ST CKSONVILLE, NC 28546		0/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 333	In-service records stin-servicing took place nurses regarding modern in-service topics included to have a second nurse signature on morphine products free-training on general was also covered. In the DON and nurse strecord indicated 100 staff by 7/15/11. Record review reveatin-service/ general nurse service/ general nurse strecord nurse to verifinformed of continuing the Quality Improved minutes revealed medication and areas of continuing the products of the frequence of the f	nsed staff and medication pleted on 7/15/11. nowed that additional 1:1 te on 7/11/11 for licensed rphine administration. The uded a mandatory new to staff requiring every nurse rise to verify dose including narcotic count sheet with all facility policy to be revised. The in-services were completed by supervisors. The in-service attendance of all licensed field that on 7/15/11, a nursing nonthly in service was held opics of medication nistration of morphine with a fig dose and the staff was	F	333				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345217	B. WING		07	C 7/19/2011	
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER	· ·	STREET ADDRESS, CITY, STATE, ZIP COD 225 WHITE ST JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 333	was in-serviced on The nurse explaine administration and and back of the me She stated there had witness dosag that Morphine camerrors should be reand MD as soon as On 7/18/11 at 9:13 she did not administ the nurse to administ the nurse count was correct. The hall with the on order for Roxanol. On 7/18/11 at 2:02 used a syringe to a not the concentrate calibrated syringe to a not the concentr	medication administration. In the steps of medication how to document on the front dication administration record. In the top of the trong of	F 33	33			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345217	A. BUILD B. WING		07	C 7/19/2011	
	ROVIDER OR SUPPLIER NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CO 225 WHITE ST JACKSONVILLE, NC 28546		71072011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 333	On 7/18/11 at 2:08 F had to be a second dosage to give morp syringe should be used. On 7/18/11 at 8:56 A morphine usually cashe stated that she medication administ every time there had witness the dosage nurse stated that she hall that was ordered that if there was medicated the supervisor and opaperwork/incident in the medication administive supervisor and opaperwork/incident in the grown would resident in sample. On 7/19/11 at 5:05 F the QI committee will weeks and then more follow up as need is that all new licensed current in-service or and morphine admire by the Staff Developmorking on the floor. On 7/19/11 at 5:39 P morphine had to be nurse to verify dose attended inservices. The nurse explained medications and how that in the event a more reported to the services.	PM, Nurse #5 stated there hurse present to check the hine and that a calibrated sed. AM, Nurse #6 stated that me with a calibrated syringe. was in-serviced on ration and that each and I to be a second nurse to to assure it was correct. The edid not have anyone on hered Morphine liquid. She stated dication error she would notify complete the eport. The nurse that made have to call the MD and that I audit results weekly for 4 hithly for 3 months and will determined. DON also stated employees will receive medication administration histration with a second nurse ment Coordinator prior to	F 3:	33			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILE			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345217	B. WIN	≀G		07/	C 19/2011
	ROVIDER OR SUPPLIER R NURSING AND REHABI	LITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE ST JACKSONVILLE, NC 28546			1072011
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Premier Nursing and Rehabilitation Center

225 White Street Jacksonville, NC 28546-6351 Telephone: (910) 353-7222

Fax: (910) 353-8010

Corrective Action Plan

Roxanol Overdose on 7/2/11

- 1) Resident in room 218B received 2.5mL of roxanol 20mg/mL solution, received narcan 0.5mg subcantenous, on 7/2/11 at 1045 ordered by physician. He was receiving hospice care and expired on 7/3/11 at 0010.
 - *An immediate disciplinary action on 7/2/11 and direct re-training was initiated on 7/3/11, under the supervision on Ann Kottal, RN, weekend supervisor, for employee involved in incident. Involved employee suspended after direct re-training as of 7/3/11 for further investigation, terminated on 7/7/11
- 2) A detailed review on 200 Hall was completed by the Director of Nursing on 7/4/11, as was a review of all narcotic medication in the facility to including 100, 300, 700, 800A/B halls. Two residents had an order and supply of roxanol solution last dose received in Feb 2011 on one and May 2011 for the other. No other residents within facility received roxanol solution, all morphine medication including tablet and liquid forms provided as ordered.
- 3) 7/5/11 100% In-servicing for all licensed nurses 1:1 regarding proper medication administration given by Director of Nursing and supervisors. In-service covered 6 Rights of medication, right resident, right medication, right route, right frequency, right documentation, and right dose. Triple check all medications, prior to administration. Proper documentation signing, documenting assessment, effectiveness, and dose, route, time and date.

*Completed 7/15/11, Director of Nursing and supervisors

7/11/11- 100% In-servicing for all licensed nurses 1:1 regarding morphine medication administration, all licensed individuals are to have second nurse verify dose, double signatures on narcotic count with all morphine products. Re-training regarding general medication administration, right medication, patient, frequency, route, dose, and documentation for all morphine products, to ensure medication is given correctly. Provided by the Director of Nursing and supervisors one on one.

*Completed 7/15/11, by Director of Nursing and supervisors

7/15/11- Nursing in-service, addressing medication administration and dosing, this in-service was a general monthly in-service covering a review of the medication administration in-service, using the six rights of medication, having a second a second nurse verify all morphine medications, and informing staff of random audits that may take place.

Monitor - Random audits, controlled substance documentation inspection form, with focus on monitoring double signatures of morphine administration, declining count sheets, wasting



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narcotics, correct form, as needed medication adminstration noting reason, route, timing, and effectiveness. Random audit using medication pass audit form, including transcribing orders, resident rights, documentation, observing direct administration method, and calculation of medication error. This will be done weekly for four weeks by the Director of Nursing or appointed personnel, then monthly for 3 months to ensure compliance.

*Audit on 200 Hall completed on 200 Hall completed 7/4/11, by Director of Nursing, noted one resident on liquid morphine sulfate 10mg/5mL.

*Audit on 100, 300, 700, 800A/B, completed on 7/4/11, Director of Nursing reviewed narcotic log, and current morphine medication administration, reviewing last dose received for use as needed medication. Two residents has supply and order for roxanol 20mg/mL, last dose received for one on Feb 2011, and the other received dose on May 2011. All forms of morphine medication administration were correct and documented in narcotic log.

*Audit on 300 Hall completed 7/13/11, by Director of Nursing, noted roxanol in cart and ordered for resident, has not received roxanol/morphine sulfate 20mg/mL since May of 2011

4) Executive QI Committee will review results of audits weekly X's 4 weeks and then monthly X's 3 months for any identified trends and/or area of concerns and will follow up as indicated to determine the need for and the frequency of continuing monitoring.

*QI meeting held on 7/4/11, 7/11/11, and 7/18/11

Staff development – new licensed employees will receive current in-service of medication administration regarding morphine administration, all licensed individuals are to have second nurse verify dose, double signatures on narcotic count with all morphine products. Inform new licensed nurses regarding general medication administration and that random audits will be conducted. Right medication, patient, frequency, route, dose, and documentation for all morphine products, to ensure medication is given correctly. Provided by the Staff Development Coordinator prior to being assigned to medication administration.

Staff development training has been scheduled with pharmacy consultant regarding medication administration, focusing on morphine dosing. Will be completed prior to staff taking floor

Mary K. Pleps NIA