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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING ______ B. WING ______	C 05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK RD FAIRVIEW, NC 28730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility document reviews and staff interviews the facility failed to	F 157	The nurse making the error was written up and counciled. The family was notified of the error at this time. In-service education was done by DON and administrative nurse with all nurses regarding medication error reporting to families, documentation of families notified in medical record, review of medication error policies & procedures,and review of medication error report. QA Coordinator will assign staff to monitor all medication errors to ensure that family has been notified and that it has been documented. Any that were found as not notified will be notified at this time and documented. The monitoring will be turned in to the DON, reviewed and signed to ensure completeness. These reports will then be reviewed monthly and any problems identified and corrected. A summary of these actions will be reviewed and documented in the quarterly QA meetings to ensure compliance.	6/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheri Mitchell
TITLE: admin
(X6) DATE: 6/17/13

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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notify the responsible party after a resident was given an incorrect dosage of a Fentanyl patch in 1 of 8 residents reviewed for medication errors. (Resident #8).

The findings included:

Resident #8 was admitted to the facility on 05/28/12 with diagnoses which included a fractured rib and hip, heart disease, rheumatoid arthritis and lupus erythematosus (chronic disease that can cause inflammation, pain, and tissue damage throughout the body).

Resident #8 was identified by the facility as being alert and oriented to self. Her most recent annual Minimum Data Set dated 04/05/13 revealed Resident #8 was cognitively intact.

A review of monthly physician's orders dated 05/01/13 through 05/31/13 indicated in part Fentanyl (Duragesic) patch 100 micrograms (mcg) per hour. Apply (1) patch to her skin every 3 days.

A review of handwritten physician's orders dated 04/16/13 indicated the following:
On 4/19/13 increase Duragesic patches to 112.5 mcg by using one 100 mcg patch and one 12.5 mcg patch and change every 72 hours.
On 4/22/13 increase Duragesic to 125 mcg by using one 100 mcg. patch and two 12.5 mcg patches and change every 72 hours.
On 4/25/13 continue Duragesic 125 mcg by using one 100 mcg and one 25 mcg patches and change every 72 hours.

A review of nurse's notes dated 04/19/13 at 10:00

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PM indicated in part that two Duragesic patches were applied this shift which included Duragesic 0.25 mcg and Duragesic 100 mcg to Resident #8.

A review of a Medication Error Hard Copy Form dated 04/19/13 at 9:00 PM revealed the medication given to Resident #8 was a Duragesic patch 25 mcg. but the medication that was intended to be given was a 12.5 mcg. patch as ordered by the physician. The primary type of error was "Wrong product strength - wrong strength of medication given." The form listed the possible causes or reasons for error as pharmacy dispensing (other dispensing issues), frequent distractions on floor/multiple care changes (environmental distractions such as noise) and poor communication (verbal, written or other types of communication that are confusing, lacking or intimidating). A section labeled patient impact (outcomes) indicated the error occurred that reached the patient but did not cause harm.

A review of nurse's notes dated 04/20/13 indicated in part the physician's assistant was called concerning a Fentanyl patch. The note revealed a Fentanyl 25 mcg patch was removed and replaced with a 12 mcg patch and would continue to monitor resident. There was no documentation in the nurse's notes that the responsible party/family was notified that Resident #8 had received the wrong dosage of Fentanyl.

During an interview on 05/22/13 at 6:13 PM with Nurse #1 she explained Nurse #7 made her aware of an incorrect dosage of a Fentanyl patch on Resident #8 on 04/20/13 at 9:00 AM. She stated she went with Nurse #7 to Resident #8's

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room and they removed the 25 mcg patch and put a 12.5 mcg patch on Resident #8. She explained if a nurse had a question about a medications they should talk with other nurses in the facility or call the pharmacy or the physician for clarification. Nurse #1 stated she did not remember calling the responsible party/family and did not know if anyone else had contacted the responsible party/family.

During an interview on 05/22/13 at 6:30 PM Nurse # 6 stated he picked the wrong Fentanyl patch for Resident #8 on 04/19/13 at 9:00 PM and the 25 mcg patch had to be changed the next day to a 12.5 mcg patch. He explained he did not notice there were 3 dosages of Fentanyl patches in Resident #8's medication drawer. He stated he did not confirm the medication dosages on the computerized Medication Administration Record but picked up 2 patches, put them on Resident #8 and didn't realize her had made a medication error until he returned to work on 04/20/13 and the nursing supervisor talked to him about it.

During an interview on 05/23/13 at 12:25 PM Nurse #7 explained on 04/19/13 Nurse #6 placed a Fentanyl 100 mcg patch and a Fentanyl 25 mcg patch on Resident #8. She further explained she found the error on 04/20/13 when she was counting the narcotics and the count was incorrect. She stated she told Nurse #1 who was the nursing supervisor and she called a physicians assistant. She explained that Nurse #1 went with her to Resident #8's room and they removed the 25 mcg patch and put a 12.5 mcg patch on Resident #8. Nurse #7 stated she monitored Resident #8 throughout her shift because she felt that this was a major medication

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F 157	Continued From page 4 error and they had to be careful with dosages of Fentanyl in elderly residents. She explained that it was the usual process to contact the responsible party/family when a medication error occurred and stated she should have called the family but she didn't and that was a mistake on her part. During an interview on 05/23/13 at 4:23 PM the Nursing Service Coordinator (NSC) stated Nurse #7 should have checked the MAR and the Fentanyl patch packages for each medication and should have given the correct dosage to Resident #8 on 04/19/13. She explained that in addition to the physician notification, which should be done first, the responsible party/family should have been called to inform them that Resident #8 had received the wrong Fentanyl patch dosage on 04/19/13. During an interview on 05/23/13 at 6:31 PM the Administrator stated she would expect for the responsible party/family to be notified whenever a medication error occurred with a resident which included wrong medication or wrong dosage of medication.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe and clarify physician telephone orders for 1 of 3 sampled residents.	F 281	In-service education with all nurses by DON and Administration nurse regarding correct transcription of MD orders and ensuring that all orders are clearly understood and clarified by the MD as needed-including stop dates for monitoring, entering vital sign monitoring in Accuflo, etc. and transcribing the order on a telephone order sheet.	

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F 281	Continued From page 5 Resident #5's blood pressure monitoring every hour was not transcribed as a physician's order nor was there a duration for the length of monitoring following a medication error. The findings included: Resident #5 was admitted to the facility with diagnoses including chronic airway obstruction, esophageal reflux, rheumatoid arthritis, hypertension, osteoporosis, depression, degenerative joint disease, and constipation. Resident #5 was identified by the facility as being alert, oriented and a reliable source of information. Her most recent Minimum Data set (MDS), an admission dated 04/11/13, coded her as having intact cognition with a score of 14 out of 15 on the brief interview for mental status. Review of the May 2013 physician orders and the May 2013 Medication Administration Record (MAR) revealed Resident #5 received all of her 9:00 AM medications on 05/19/13 which were initialed as given by Nurse #2. Review of the nursing notes for Resident #5, written by Nurse #1, dated 05/19/13 at 9:00 AM, revealed the entry "Resident received Coreg, Lasix, Plavix, Klor-con, Lisinopril, Januvia, and Glimpande (sic for Glimepiride) by mistake." The note continued stating Resident #5's blood pressure was 99/45 and her blood sugar was 243. At 8:40 AM her blood pressure was 110/50. The physician was called and stated he wanted staff to monitor the resident's blood pressure every hour.	F 281	All telephone orders are currently reviewed for accuracy at least three times weekly by the DON and Nursing Administration. Any errors found are corrected at that time and documented. QA Coordinator will assign someone to review all medication errors for accuracy of follow-up including reviewing nurses notes, MAR/TAR, MD orders, and medication error report. This will be documented and reviewed monthly and quarterly in the QA meetings with any problems or changes addressed and corrected with plan of action documented. This will ensure that this does not occur again with any of the residents.	6/20/13

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Review of the physician telephone orders revealed no written order for the blood pressure monitoring and no indication in any nursing note as to how long blood pressures were to be monitored every hour.

Review of the vital sign record revealed Resident #5's blood pressures normally ranged from 124/51 to 166/76 from 04/01/13 to 05/14/13 (with only 2 lower blood pressures in that time period).

Review of Resident #5's nursing notes and vital sign record revealed documented blood pressures as follows:
*05/19/13: 8:00 AM 99/45;
*05/19/13 at 9:00 AM 110/50;
*05/19/13 at 10:00 AM 130/68;
*05/19/13 at 11:00 AM 116/60;
*05/19/13 at 12:00 noon 98/60;
*05/19/13 at 1:00 PM 98/62;
*05/19/13 at 1:30 PM 96/62;
*05/19/13 at 4:00 PM 106/70;
*05/19/13 at 5:00 PM 102/64:
*05/19/13 at 7:00 PM 112/64;
*05/19/13 at 8:00 PM 114/64;
*05/19/13 at 10:00 PM 120/64;
*05/20/13 at 2:00 AM 128/68;
*05/20/13 at 6:00 AM 124/64;
*05/20/13 at 5:00 PM 116/58; and
*05/21/13 at 9:00 AM 136/74.

On 05/22/13 at 6:24 PM Nurse #1 stated during interview she was the supervisor on duty on 05/19/13 when Resident #5 received Resident #7's medications during the morning medication pass. Nurse #1 further stated she called the physician who instructed staff to monitor Resident #5's blood pressures every hour. She stated the

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physician did not give specific instructions as to how long to take Resident #5's blood pressures or parameters to indicate a need to recontact the physician. She stated she should have obtained specific instructions for the blood pressure monitoring. Nurse #1 stated she passed this error on to administration in the form of a weekend report. Nurse #1 stated Resident #5's blood pressures varied over the course of the day but she experienced no other side effects. She stated administration had not discussed this incident in any way since she filed the report.

Resident #5 was interviewed on 05/23/13 at 9:54 AM. Resident #5 stated her medications got mixed up with another's recently and she got the wrong medications. She stated they checked her blood pressures hourly and her blood sugars 3 times. She stated it was an accident and she experienced no ill effects from it. She further stated she noticed nothing, however, staff noticed her blood pressure dropped.

Interview with Nurse #2 via telephone on 05/23/13 at 11:59 AM revealed she was the nurse who administered Resident #7's medication to Resident #5. Nurse #2 stated she immediately realized her error and reported it to Nurse #1. She stated that the physician was called, and blood pressures were monitored every hour for 12 hours. She further stated the physician came in later that day and discussed the medication errors and stated that maybe he would consider more blood sugar checks later but not at the current time. She offered no explanation for no blood pressure checks between 1:30 PM and 4 :00 PM. She stated that the blood pressure monitoring should have been written on a

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telephone order and included the expected duration of the blood pressure checks.

There were no physician notes related to the 05/19/13 visit or conversation.

On 05/23/13 at 5:05 PM, the Nursing Service Coordinator (NSC) stated she had not seen Nurse #2 since the medication error but read the supervisors report about the medication error of 05/19/13. She stated the Director of nursing has been out of town since this occurrence. NSC stated that the physician order for Resident #5's blood pressure monitoring should have been placed on a telephone order and included the duration that monitoring was to be completed.

On 05/23/13 at 6:31 PM, the Administrator stated the monitoring of blood pressures for Resident #5 should have been transcribed to a telephone order with the stop time clarified.

Nurse #3 who worked second shift on 05/19/13 was interviewed by telephone on 05/24/13 at 3:21 PM. She reported that she was instructed by Nurse #1 to monitor the blood pressures of Resident #5 every hour for the 8 hours since the time of the medication error. She stated she was unaware of what the wrong medications were which had been administered to Resident #5 and she did not look for any physician orders relating to the monitoring of blood pressures. She stated she felt comfortable with instructions given by Nurse #1. She further stated that after 8:00 PM, she then took blood pressures every 2 hours and then she left it up to the oncoming third shift to determine how much longer to monitor Resident #5's blood pressures.

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F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to prevent two residents from receiving wrong medications and one resident from receiving the wrong dosage of a Fentanyl patch in 3 of 8 residents reviewed for medication errors. (Resident #1, #8 and #5). The findings included: 1. Resident #1 was admitted to the facility on 07/24/12 with diagnoses which included Alzheimer's dementia, low thyroid hormone, osteoporosis, vitamin B deficiency, cataracts and orthostatic hypotension (low blood pressure when suddenly standing up). The most recent quarterly Minimum Data Set (MDS) dated 01/30/13 indicated Resident #1 had problems with short term and long term memory and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #1 required supervision with dressing and eating and needed extensive assistance with personal hygiene. A review of monthly physicians orders dated 05/01/13 through 05/31/13 indicated Resident #1 was ordered the following medications by mouth for the 9:00 AM medication administration:	F 333	Regarding the resident's who received the wrong medication due to a medication error-the MD and family was notified of the error, the medication had been administered the one time and then NEVER given again. Regarding the resident who received the wrong dose-the medication patch was removed and the correct dose applied as soon as the error was discovered. The MD and family was notified and the incorrect dose has not been administered again. In-service education with all nurses by DON and nursing administration regarding correct medication administration and review of medication administration policies and procedures. Pharmacy nurse consultant in-service with all nurses on June 20, 2013 regarding actual medication pass techniques. Pharmacy nurse consultant to perform individual medication pass observation on at least 6 nurses before June 20th and then monitor at least 6 nurses every quarter and document. Report to be given to DON and reviewed with individual nurses and any issues found corrected. QA Coordinator will ensure that all medication errors and medication pass observation reports are reviewed monthly in the QA meetings and any areas concern will be addressed with an action plan. Follow-up will be done at the quarterly meetings and documented. This will ensure medications are given as ordered.	6/20/13

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Acetaminophen (for pain) 500 milligrams (mg) by mouth three times a day.
Levothyroxine (for low thyroid hormone) 50 micrograms (mcg) by mouth daily.
Namenda (for memory loss and mental changes) 10 mg by mouth daily.
Preservision Areds 2 formula (Age related eye disease vitamins) 2 tablets by mouth once daily.

A review of the Medication Administration Record dated 05/05/13 indicated Resident #1 received these medications during the 9:00 AM medication pass by Nurse #2.

A review of a Medication Error Hard Copy Form dated 05/05/13 revealed Resident #1 received the following medications in error at 9:00 AM: Wellbutrin, Potassium chloride and Celexa as reported by Nurse #4. The primary type of error was "Wrong patient - medication administered to a patient for whom the medication was not intended." The form listed the possible causes or reasons for error as staff did not follow current policies and procedures (for any reason including forgetfulness, carelessness, orders overlooked) and frequent distractions on floor/multiple care changes (environmental distractions such as noise). A section labeled patient impact (outcomes) indicated the error occurred that reached the patient and required monitoring or intervention to preclude harm.

A review of nurses notes dated 05/05/13 at 10:00 AM indicated Resident #1 accidentally took Resident #4's medications which included Wellbutrin (for depression), Celexa (for depression), Klor-CON (potassium supplement), Zantac (for heartburn and acid indigestion), slow

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release iron and Aldactone (for high blood pressure). The notes further revealed a physician's assistant was called and she stated to monitor Resident #1's blood pressure for 3 days every shift and draw labs for a basic metabolic panel (BMP) in the morning.

A review of a handwritten physicians order dated 05/05/13 at 10:30 AM indicated blood pressure times 3 days every shift and BMP in the morning for medication evaluation.

A review of laboratory results for a BMP dated 05/06/13 revealed the following abnormal results:
Glucose was 147 (high). [Reference range 70 -105 milligrams per deciliter].
Estimated Glomerular Filtration Rate (for kidney function) was 50 (low). [Reference range was greater than or equal to 60].

A review of monthly physician orders dated 05/01/13 through 05/31/13 indicated the following 09:00 AM medications for Resident #4:
Buspirone Hydrochloride (for anxiety) 7.5 mg by mouth three times a day.
Calcium Antacid (for indigestion) 500 mg chewable by mouth after meals.
Celexa (for depression) 30 mg by mouth daily.
Klor-Con (potassium supplement) 10 millequivalents by mouth daily.
Claritin (for nasal congestion) 10 mg by mouth daily.
Oxycodone Hydrochloride (for pain) 5 mg by mouth twice daily.
Zantac (for heartburn and acid indigestion) 150 mg by mouth twice daily.
Slow release iron (iron supplement) (1) tablet by mouth daily.

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Aldactone (for high blood pressure) 25 mg by mouth daily.
Multi-vitamin (1) tablet by mouth daily.
Vitamin B complex (1) tablet by mouth daily
Vitamin D-3 1000 international units (1) capsule by mouth daily.

A review of a vital sign record revealed Resident #1's blood pressures were recorded as follows:
05/05/13 at 5:00 PM 160/75
05/06/13 at 2:00 AM 140/67
05/06/13 at 9:00 AM 118/59
05/06/14 at 5:00 PM 139/67
05/07/14 at 9:00 AM 119/67
05/08/13 at 5:00 PM 130/59

A review of nurse's notes dated 05/05/13 through 05/08/13 revealed there were no additional blood pressures documented.

During an interview on 05/22/13 at 1:50 PM Nurse #4 stated Resident #4 was the spouse of Resident #1 but they lived on separate halls. She verified she worked on 05/05/13 and Resident #4 had walked to Resident #1's room to visit with her. She explained she pulled Resident #4's medications into a medicine cup and mixed the pills whole with applesauce between 9:00 AM and 9:30 AM and walked toward Resident #1's room. She further explained as she got to Resident #1's room she remembered she had forgotten Resident #4's pain medication so she sat the cup of pills on Resident #1's over bed table and walked back to her medication cart at the nurse's station. She stated when she returned to Resident #1's room NA #1 was in the room and the pills were no longer on Resident #1's over bed table. She explained she asked where the

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pills were and NA #1 stated she gave them to Resident #1. Nurse #4 stated she should not have left the pills unattended and she reported what had happened to the nursing supervisor. She explained it was a very busy day and she did not know why she left the medications on the over bed table. She stated the physician's assistant was called to tell her what happened and she gave orders to monitor Resident #1's blood pressure and get labs drawn in the morning. She further stated she told the 3:00 PM to 11:00 PM nurse that Resident #1 had gotten the wrong medication during shift report on 05/05/13.

During an interview on 05/22/13 at 2:21 PM Nurse Aide (NA) #1 stated she was not assigned to Resident #1 on 05/05/13 but was helping other NA's pick up breakfast trays and walked into Resident #1's room and saw pills on her over bed table with her breakfast tray. She explained she thought the nurse had forgotten to give Resident #1 her medications so she gave the medications to Resident #1. She further explained when Nurse #4 walked back into the room she asked where the medications were and she told her she gave them to Resident #1. She stated Nurse #4 informed her they were Resident #4's medications and she should not have given medications to the resident. NA #1 verified the pills were in a cup with applesauce and she fed them to Resident #1 with a spoon. She further stated she did not know why she gave Resident #1 medication but she should have reported to the nurse the medications were on the over bed table.

During an interview on 05/22/13 at 2:33 PM

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Nurse #5 stated she was assigned to Resident #1 on 05/06/13 and she was told in morning report that Resident #1 had been given the wrong medications on 05/05/13. She explained the night shift nurse reported Resident#1 had slept all night and had no changes in her condition. She further explained Resident #1 was oriented to self but she could not remember the day, time or year. She stated NA's were not allowed to give medications in the facility and if they saw medications in a resident's room they should tell the nurse immediately.

During an interview on 05/22/13 at 3:10 PM NA #2 stated she worked from 3:00 PM until 11:00 PM on 05/05/13 and was told by another NA to watch Resident #1 for any changes in condition or unusual behaviors because she had been given another resident's medication earlier that day. She explained nurse aides were not allowed to administer medications to residents in the facility.

During an interview on 05/22/13 at 6:00 PM Nurse #1 stated she was the weekend supervisor from 7:00 AM until 7:00 PM on 05/05/13. She explained she was called to the medication room for the 400, 500 and 600 halls between 9:00 AM and 10:00 AM by Nurse #4. She further explained Nurse #4 reported that she had placed Resident #4's medications in Resident #1's room and had walked away and when she went back into Resident #1's room she found out that NA #1 had given the medications for Resident #4 to Resident #1. She stated she called the Director of Nursing (DON) and was told to fill out a medication error report. She further stated they called the physician's assistant and placed Resident #1 on the acute list for her vital signs to

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be monitored every shift for 24 to 48 hours or longer depending on the resident's condition. She explained the physician and the situation usually determined the length of time to monitor the resident. Nurse #1 stated she did not see or assess Resident #1 on 05/05/13 but she left the medication error report for administration.

During an interview on 05/23/13 at 4:23 PM the Nursing Service Coordinator (NSC) explained she relied on Nurse #1 as weekend supervisor to investigate any incidents that occurred on weekends, talk with staff involved, take employee actions, write up the incident and leave the documentation under her door because the DON had been out of town. She stated NAs were not permitted to give medications in the facility and NA #1 should have talked to the nurse instead of giving Resident #1 the medications. She further stated she expected nurses should not leave medications in a residents room unattended but they should slow down and think about what they were doing. She stated recent medication errors "was a red flag." She further stated there was currently no change in their system for monitoring to determine the cause of the errors or to reduce medication errors.

2. Resident #8 was admitted to the facility on 05/28/12 with diagnoses which included a fractured rib and hip, heart disease, rheumatoid arthritis and lupus erythematosus (chronic disease that can cause inflammation, pain, and tissue damage throughout the body).

Resident #8 was identified by the facility as being alert and oriented to self. Her most recent annual Minimum Data Set dated 04/05/13 revealed

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Resident #8 was cognitively intact.

A review of monthly physician's orders dated 05/01/13 through 05/31/13 indicated in part Fentanyl (Duragesic) patch 100 micrograms (mcg) per hour. Apply (1) patch to her skin every 3 days.

A review of handwritten physician's orders dated 04/16/13 indicated the following:
On 4/19/13 increase Duragesic patches to 112.5 mcg by using one 100 mcg patch and one 12.5 mcg patch and change every 72 hours.
On 4/22/13 increase Duragesic to 125 mcg by using one 100 mcg patch and two 12.5 mcg patches and change every 72 hours.
On 4/25/13 continue Duragesic 125 mcg by using one 100 mcg and one 25 mcg patches and change every 72 hours.

A review of nurse's notes dated 04/19/13 at 10:00 PM indicated in part that two Duragesic patches were applied this shift which included Duragesic 0.25 mcg and Duragesic 100 mcg to Resident #8.

A review of a Medication Error Hard Copy Form dated 04/19/13 at 9:00 PM revealed the medication given to Resident #8 was a Duragesic 25 mcg patch but the medication that was intended to be given was a 12.5 mcg patch as ordered by the physician. The primary type of error was "Wrong product strength - wrong strength of medication given." The form listed the possible causes or reasons for error as pharmacy dispensing (other dispensing issues), frequent distractions on floor/multiple care changes (environmental distractions such as noise) and poor communication (verbal, written or other

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types of communication that are confusing, lacking or intimidating). A section labeled patient impact (outcomes) indicated the error occurred that reached the patient but did not cause harm.

A review of nurse's notes dated 04/20/13 indicated in part the physician's assistant was called concerning a Fentanyl patch. The note revealed a Fentanyl 25 mcg patch was removed and replaced with a 12 mcg patch and would continue to monitor resident.

During an interview on 05/22/13 at 6:13 PM with Nurse #1 who was the nursing supervisor explained Nurse #7 made her aware of an incorrect dosage of a Fentanyl patch on Resident #8 on 04/20/13 at 9:00 AM. She stated she went with Nurse #7 to Resident #8's room and they removed the 25 mcg patch and put a 12.5 mcg patch on Resident #8.

During an interview on 05/22/13 at 6:30 PM Nurse #6 stated he picked the wrong Fentanyl patch for Resident #8 on 04/19/13 at 9:00 PM and the 25 mcg Fentanyl patch had to be changed to a 12.5 mcg patch the next day. He explained he did not notice there were 3 dosages of Fentanyl patches in Resident #8's medication drawer. He stated he did not confirm the medication dosages on the computerized Medication Administration Record (MAR) but just picked up 2 Fentanyl patches, put them on Resident #8 and didn't realize he had made a medication error until the nursing supervisor talked to him about it when he returned to work on 04/20/13.

During an interview on 05/23/13 at 12:25 PM

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Nurse #7 explained Resident #8 had orders to increase her Fentanyl patch dosage on 04/19/13 with a 100 mcg patch and a 12 mcg patch. She further explained that 3 days later Resident #8 was supposed to get one Fentanyl 100 mcg patch and two Fentanyl 12.5 mcg patches and in 3 days she increased to 100 mcg with a 25 mcg patch. She stated the first time she was made aware of the Fentanyl patch changes she was afraid something might go wrong. Nurse #7 explained on 04/19/13 Nurse #6 placed a Fentanyl patch of 100 mcg and a Fentanyl patch of 25 mcg on Resident #8. She further explained she found the error on 04/20/13 when she was counting the narcotics and the count was incorrect. She stated she told Nurse #1 who was the nursing supervisor and she called a physicians assistant. She explained that Nurse #1 went with her to Resident #8's room and they removed the 25 mcg patch and put a 12.5 mcg patch on Resident #8. Nurse #7 stated she monitored Resident #8 throughout her shift because she felt this was a major medication error and they had to be careful with the dosages of Fentanyl in elderly residents.

During an interview on 05/23/13 at 4:23 PM the Nursing Service Coordinator (NSC) stated the physician orders dated 04/16/13 to increase the Fentanyl patch dosages for Resident #8 was confusing. She explained the computerized MAR would have had the correct dosages for each day and that Nurse #7 should have checked the MAR with the Fentanyl patch packages and should have given the correct dosage on 04/19/13 to Resident #8.

3. Resident #5 was admitted to the facility with diagnoses including chronic airway obstruction,

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esophageal reflux, rheumatoid arthritis, hypertension, osteoporosis, depression, degenerative joint disease, and constipation.

Resident #5 was identified by the facility as being alert, oriented and a reliable source of information. Her most recent Minimum Data set (MDS), an admission dated 04/11/13, coded her as having intact cognition with a score of 14 out of 15 on the brief interview for mental status.

Review of the May 2013 physician orders revealed she was ordered the following medications by mouth for the 9:00 AM administration:
*Calcium 500 mg
*Detrol LA 2 mg
*Fluoxetine HCL 40 mg
*Hydroxychloroquine 200 mg
*Norco 5/325 mg
*Ranitidine 150 mg
*Senna Plus tablet
*Spironolactone 25 mg
Review of the May 2013 Medication Administration Record, she was administered these Medications during the 9:00 AM medication pass by Nurse #2.

According to the nursing notes, written by Nurse #1 and dated 05/19/13 at 9:00 AM, "Resident received Coreg, Lasix, Plavix, Klor-con, Lisinopril, Januvia, and Glimpande (sic for Glimepiride) by mistake ... " The note continued stating her blood pressure was 99/45 and her blood sugar was 243. At 8:40 AM her blood pressure was 110/50. The physician was called and stated he wanted staff to monitor the resident's blood pressure every hour. The resident was placed on the

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acute board to monitor. The resident was noted to be alert and verbal with staff.

Review of the Medication Error Hard Copy Form revealed the error occurred at 8:30 AM, reported by Nurse #1. The primary type of error checked was "Wrong Patient - med administered to a patient for whom the medication was not intended" . The form listed the possible causes or reasons for error as staff did not follow current polices and procedures and exhaustion. The form marked the error occurred that reached the patient and required monitoring or intervention to preclude harm. Attached to this error report was a nurses note including 15 medications listed for Resident #7 administered to Resident #5 in error.

Resident #7's May 2013 physician's orders revealed his 9:00 AM by mouth medications included:
*Aspirin EC 81 mg
*Bisacodyl (dulcolax) 5mg EC
*Carvedilol (coreg)12.5 mg (used for heart failure)
*Citalopram HBR (celexa) 10 mg (antidepressant)
*Clopidogrel (plavix)75 mg (antiplatelet agent)
*Furosemide (lasix) 40 mg (diuretic)
*Isosorbide MN ER (imdur) 60 mg (for angina)
*Januvia 50 mg (diabetic medication)
*Klor-Con 10 meq (potassium)
*Lisinopril (privinil) 5 mg (for hypertension)
*Pantoprazole SOD DR (protonix) 40 mg (for heartburn)
*Prednisone 30 mg (a corticosteroid)
*Senna Plus (for constipation)
*Spironolactone (aldactone) 25 mg (a diuretic)
The Glimepiride 2 mg (an anti-diabetic agent) was actually ordered for 9:00 PM but was listed as being administered with the 9:00 AM

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medication in the nurses note and in the medication error report.

Review of the vital sign record revealed Resident #5's blood pressures ranged from 124/51 to 166/76 from 04/01/13 to 05/14/13 (with only 2 lower blood pressures in that time period).

Review of Resident #5's nursing notes and vital sign record revealed hourly blood pressures were taken on 05/19/13 from 8:00 AM to 1:30 PM at which time her blood pressure was recorded as 96/62. No blood pressures were taken again until 4:00 PM which recorded her blood pressure as 106/70. Blood pressures were recorded hourly up through 8:00 PM at 114/64 and the next was recorded at 10:00 PM at 120/64. On 05/20/13 at 2:00 AM Resident #5's blood pressure was recorded at 128/68, at 6:00 AM it was 124/64 and not taken again until 5:00 PM as 116/58.

On 05/22/13 at 6:24 PM Nurse #1, stated during interview she was supervising on 05/19/13 when Resident #5 received Resident #7's medications in the morning medication pass. Nurse #1 identified Nurse #2 as the nurse who made the mistake. Per Nurse #1, Nurse #2 had pulled both residents' medications at the same time. Nurse #2 stated nurses should not pull more than one resident's medication at a time. She further stated she did not go over in detail why the nurse pulled two residents' medications. She stated she did not look to see if other residents' medications were also pulled at the time of the medication error. She stated Nurse #2 told her she was tired and mixed the medications up. Per Nurse #1, she called the physician who stated to monitor the blood pressures every hour. She

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further stated Nurse #2 continued to work the hall and a half as scheduled. Nurse #1 stated no one in administration further discussed this with her and she passed it on to administration in her weekend report. Nurse #2 stated Resident #5's blood pressures varied over the course of the day but she experienced no other side effects.

Resident #5 was interviewed on 05/23/13 at 9:54 AM. Resident #5 stated her medications got mixed up with another's recently and she got the wrong medications. She stated they checked her blood pressures hourly and her blood sugars 3 times. She stated it was an accident and she experienced no ill effects from it. She further stated she noticed nothing, however, staff noticed her blood pressure dropped.

Interview with Nurse #2 via telephone on 05/23/13 at 11:59 AM revealed she was the nurse who administered Resident #7's medication to Resident #5. She described her usual routine was to pull up a resident's name on the computer which showed the medications due at that time. She then checked to make sure the medications were available, and at the correct dosage. She then administered the medications to the resident and entered in the computer that she administered the medications to the resident. She stated that if she cannot locate a resident after she had pulled their medications, she will mark the cup of medications with the resident's name and place it in the drawer to administer later. She then would go onto the next resident. She stated when she has a hall and a half to cover, she found it hard to pass the medications in the allotted time frame. She also explained that she did not have to sign off on the

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stated that maybe he would consider more blood sugar checks later but not now. She stated there had been no changes in the system or inservices since the error.

There were no physician notes related to the 05/19/13 visit or conversation.

On 05/23/13 at 5:05 PM the Nursing Service Coordinator (NSC) stated she had not seen Nurse #2 since the medication error but read the supervisors report about the medication error. She stated she relied on Nurse #1 to investigate the medication errors that occur on the weekends, take employee actions and talk with staff. The Director of nursing has been out of town since this occurrence. NSC stated nursing staff are not supposed to pre-pour medications. NSC stated that the computerized medication system helped on medication errors until recently. She stated she was not sure why the recent medication errors and that it "was a red flag." She further stated there was currently no change in the system or monitoring to determine the cause of the errors or reduce medication errors. She further stated she did not know how the Glimepiride even got pulled for the 9:00 AM medication pass when scheduled for 9:00 PM.

Nurse #3 who worked second shift on 05/19/13 was interviewed by telephone on 05/24/13 at 3:21 PM. She reported that she was instructed by Nurse #1 to monitor the blood pressures of Resident #5 every hour for 8 hours since the time she received the wrong medications. She stated she was unaware of what the wrong medications were which had been administered to Resident #5 and she did not look for any physician orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING ______ B. WING ______	C 05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK RD FAIRVIEW, NC 28730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 25 relating to the monitoring of blood pressures. She stated she felt comfortable with with instructions given by Nurse #1 and did not clarify the duration of blood pressure checks. She further stated that after 8:00 PM, staff took blood pressures every 2 hours and then she left it up to the oncoming third shift to determine how much longer to monitor Resident #5's blood pressures. She noted no changes in Resident #5 due to the medication errors and the blood pressures were moving in the right direction.	F 333		