STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and observations, the facility failed to maintain a medication administration error rate below an acceptable level of 5% for 26 opportunities observed (3 of 26 opportunities, Medication error rate of 11.5%, Resident #216). Findings included: Medication administration observation was conducted on 9/17/15 at 9:00 AM. Resident #216 was admitted to the facility on 9/8/2015 with diagnoses that included hypertension and vitamin deficiency for which she was prescribed Metoprolol 25 milligram (mg) by mouth twice daily, Thiamine (unknown mg strength) 1 tablet by mouth daily, and Multivitamin 1 tablet by mouth daily. The Nurse was observed signing off medications as given for Resident #216 prior to taking them out of the medication cart and preparing the medications for administration. The nurse was then observed putting Thiamine 100 mg 1 tablet into a medication cup, and a Multivitamin with Minerals 1 tablet into the medication cup for administration. Metoprolol 25 mg was not taken out for administration from the medication cart. During the observation, the Multivitamin with minerals was verbally verified with the nurse, who stated "Yes, multivitamin with minerals." However when pointed out to the nurse after reconciliation at 11:00 AM on 9/17/15, she stated	F 332	The filing of this plan of correction does not constitute an admission that the deficiencies alleged, did in fact exist. This plan of correction is filled as evidence of the facility's desire to comply with the regulations and to provide high quality resident care. F322-Free of Medication Error 1. Resident #216 is no longer in the facility at the time of the survey, the NP D. Slotsky was notified regarding the need for the Thiamine to be given a dosage amount, the Multivitamin with mineral and the missed metoprolol. The Thiamine order was clarified to be 100mg daily. The resident was monitored and the Blood pressure was monitored throughout the day. 2. The LPN working at the time of the survey with Resident #216 reviewed the 6 rights of Medication Administration with the Nurse Practice Educator to ensure accurate medication administration per Drs'. orders on 9-17-15. Other residents receiving Thiamine had their medication orders checked to ensure that they had accurate doses on 9-17-15.	10/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/06/2015

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

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F 332	Continued From page 1 "No, I gave Multivitamin with minerals to another resident, I know I gave (Resident #216) the Multivitamin only." At that same time, when asked what dose of Thiamine the nurse knew to dispense, the nurse indicated that 100 mg is the only strength that the facility carries and so assumed that 100 mg is what the order meant. She indicated that it never occurred to her to get the order clarified. Also at 11:00 AM on 9/17/15, when the nurse was asked about the missing Metoprolol dose, she stated "I know I gave that. I am not going to give another one to (the resident)." The Director of Nursing was interviewed at 12:30 PM on 9/17/15. She indicated that her expectations are that the residents are given the prescribed medications at the prescribed doses, and orders are clarified if questionable.	F 332	3. Licensed nurses were in-serviced beginning on 9-17-15 and continued through 10-16-15 on the 6 Rights of Medications well as Med Pass Observation with the nurse Practice Educator to ensure accurate medication administration. All Thiamine orders in the facility were checked to ensure that they have dosage included as part of the order. 4. Nurse practice educator will conduct weekly random medication pass audits for four weeks and then every two weeks for 2 months with the licensed nursing staff to ensure that the 6 rights of Medication Administration are be followed. Findings will be presented to the PI Committee monthly for three months. The Director of Nursing/Designee will be responsible for compliance of this practice	
F 333 SS=D	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 staff interview, medical record review, and observations, the facility failed to ensure a significant medicatior error was not made for 1 of 3 residents observed for Medication Administration Observation (Resident #216). Findings included: Medication administration observation was conducted on 9/17/15 at 9:00 AM. Resident #216 was admitted to the facility on 9/8/2015 with	F 333	F333-Residents free of Significant Med Error 1. Resident #216 is no longer in the facility. At the time of the survey, the NP D.Slotsky was notified of the medication given, missed and the need for dosage clarification. She clarified for the Thiamine to be 100mg tablets daily. The	10/16/15

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F 333	Continued From page 2 diagnoses that included vitamin deficiency for which she was prescribed Thiamine (unknown milligram strength) 1 tablet by mouth daily on 9/9/15. According to the prescription drug information, Thiamine tablets are avialable as 25 mg, 50 mg, 100 mg, 250 mg, 500 mg. Thiamine enteric coated tablets are avialable as 20 mg tablets. The Nurse was observed putting Thiamine 100 mg 1 tablet into a medication cup and administering the medication to Resident #216. Upon interview at 11:00 AM on 9/17/15 the nurse indicated that 100 mg is the only strength that the facility carries so she assumed that 100 mg is what the order meant. She indicated that it never occurred to her to get the order clarified. The Thiamine 100 mg was repeatedly given to the resident 8 times prior to the discovery on 9/17/15, qualifying this error as "significant". The Director of Nursing was interviewed at 12:30 PM on 9/17/15. She indicated that her expectations are that the residents are given the prescribed medications at the prescribed doses, and orders are clarified if questionable.	F 333	LPN who was working reviewed with the NP the order for the Thiamine, as well as reviewed the 6 rights of Medication Administration on 9-17-15. 2. At risk residents were any resident in the building receiving Thiamine tablets. Four other residents were found to be ordered Thiamine at the time of the survey and all have orders that include a dosage amount for the Thiamine of 100mg. 3. Licensed staff has been in-serviced regarding P &P for medication administration and the need for accurate dose on the Drs' order for medications starting on 9-7-17-15and continuing through 10-16-15. 4. A weekly audit x four weeks and then monthly audit x two months will be completed for all Thiamine orders in the facility to ensure they have accurate doses. Findings will be presented to the PI Committee monthly for three months. The Director of Nursing/Designee will be responsible for compliance of this practice.	