STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 04/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to administer an antibiotic per a physician's order for one (Resident # 7) out of four residents whose medications were reviewed. The findings included: Record review revealed Resident # 7 was admitted to the facility on 9/21/12 and had a history of urinary tract infections. The resident was also documented as legally blind and relied on staff to administer her medications. Record review revealed a 4/17/17 physician's order for a UA & C & S (urine analysis and culture and sensitivity). Review of the resident's lab results revealed the urine culture was completed on 4/21/17 and showed a growth of greater than 100,000 colonies of the bacteria Proteus Mirabilus. Review of physician orders revealed an order on 4/21/17 at 2:55 PM for Cipro 250 mg (milligrams) to be administered twice per day for five days due to a urinary tract infection. On 4/23/17 Resident # 7's April 2017 MAR (medication administration record) was reviewed. The Cipro order had been inaccurately	F 281	1. The MD was notified of resident□s #7 transcription error. A new order was received and the Unit Manager correctly transcribed the order on the medication administration record and another nurse (RN) verified the transcription. The Director of Clinical Services also verified the order and the transcription. The Director of Clinical Services assessed the resident and the resident indicated that the symptoms were resolving. The Nurses who did not give the medication as originally ordered due to the transcription error were re-educated by the Director of Clinical Services on proper transcription to prevent medication errors. 2. On 4/24/2017 through 4/28/2017 a quality review was completed on all medication administration records to ensure all medications were transcribed correctly per physician orders. There were no other medication transcription errors found during this audit. 3. On 4/24/2017 through 5/1/2017 the Director of Clinical Services re-educated licensed nursing staff on proper transcription of physician orders to prevent medication error/ transcription	5/15/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/03/2017

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F 281	Continued From page 1 transcribed to the resident's MAR. The order had been written on the MAR as a twice per day medication, but only one time had been scheduled on the MAR for the Cipro to be administered. This was at 4 PM. A time had not been transcribed to the MAR to reflect when the second dose should be given each day. According to the MAR, the resident had received three doses thus far since the initiation of the order. All of these doses had been given at 4 PM. Nurse # 1 was Resident # 7's medication nurse on the evening of 4/23/17. Nurse # 1 was asked to review the MAR on 4/23/17 at 6:55 PM. Nurse # 1 stated he had given the antibiotic earlier that shift and had not detected the error. Nurse # 1 was observed to remove the resident's supply of Cipro from the medication cart. It was observed that there were eight of the ten doses remaining from the supply which had been filled by the pharmacy on 4/21/17. Nurse # 1 stated he would call Nurse # 2, who was the nursing supervisor. Nurse # 2 immediately came and reviewed the MAR and the resident's supply of Cipro. Nurse # 2 stated the Resident's first dose of Cipro on 4/21/17 had been given from the emergency supply of medications, and therefore Resident # 7 had received three doses since 4/21/17. Nurse # 2 stated Resident # 7 should have received five doses thus far and validated the medication had not been given as ordered.	F 281	errors, 24 hour chart checks to assure all new orders are transcribed correctly, and the documentation of using medications from the facility Emergency Kit. 4. The Director of Clinical Services/Unit Manager/Assistant Director of Clinical Services will use the Quality Improvement monitor tool to monitor medication administration records and new physician orders to prevent transcription/medication errors 5 times a week for 2 weeks and then 3 times weekly for 4 weeks, then weekly for 8 weeks, and then monthly.. The results of this monitoring will be reported monthly in the Quality Assurance meeting and any areas identified for improvement will be addressed as appropriate.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional	F 514		5/15/17

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F 514	Continued From page 2 standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to accurately transcribe a medication order to a medication administration record for one (Resident #7) out of four residents whose medications were reviewed. The findings included:	F 514	1. The MD was notified of resident's #7 transcription error. A new order was received and the Unit Manager correctly transcribed the order on the medication administration record and another nurse (RN) verified the transcription. The Director of Clinical Services also verified	

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F 514	Continued From page 3 Record review revealed Resident # 7 was admitted to the facility on 9/21/12 and had a history of urinary tract infections. Review of physician orders revealed an order on 4/21/17 at 2:55 PM for Cipro 250 mg (milligrams) to be administered twice per day for five days due to a urinary tract infection. On 4/23/17 Resident # 7's April 2017 MAR (medication administration record) was reviewed. The Cipro order had been inaccurately transcribed to the resident's MAR. The order had been written on the MAR as a twice per day medication, but only one time had been scheduled on the MAR for the Cipro to be administered. This was at 4 PM. A time had not been transcribed to the MAR to reflect when the second dose should be given each day. According to the MAR, the resident had received three doses thus far since the initiation of the order. All of these doses had been given at 4 PM. On 4/23/17 at 6:55 PM the MAR was reviewed with Nurse # 1 and Nurse # 2. It was clarified at that time with the nurses that the order had not been accurately transcribed to the MAR, and the resident had missed two of her antibiotic doses.	F 514	the order and the transcription. The Director of Clinical Services assessed the resident and the resident indicated that the symptoms were resolving. The Nurses who did not give the medication as originally ordered due to the transcription error were re-educated by the Director of Clinical Services on proper transcription to prevent medication errors and assure medical record accuracy. 2. On 4/24/2017 through 4/28/2017 a quality review was completed on all medication administration records to ensure all medications were transcribed correctly per physician orders. There were no other medication transcription errors found and medical administration records were found to be accurate. 3. On 4/24/2017 through 5/1/2017 the Director of Clinical Services re-educated licensed nursing staff on proper transcription of physician orders to prevent medication error/ transcription errors, 24 hour chart checks to assure all new orders are transcribed correctly, and the documentation of using medications from the facility Emergency Kit to assure medical record accuracy. 4. The Director of Clinical Services/Unit Manager/Assistant Director of Clinical Services will use the Quality Improvement monitor tool to monitor medication administration records and new physician orders to prevent transcription/medication errors and assure medical record accuracy- 5 times a week for 2 weeks and then 3 times weekly for 4 weeks, then weekly for 8 weeks, and then monthly.. The results of this monitoring	

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F 514	Continued From page 4	F 514	will be reported monthly in the Quality Assurance meeting and any areas identified for improvement will be addressed as appropriate.	