STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN HEALTH AND REHABILITATION	1 MARITHE COURT GREENSBORO, NC 27407

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 4/17/18 through 4/18/18. Past-noncompliance was identified at: CFR 483.45 at tag F760 at a scope and severity (J) The tags F760 constituted Substandard Quality of Care. Non-noncompliance began on 3/30/18. The facility came back in compliance effective 4/6/18. An extended survey was conducted.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and pharmacist interviews the facility failed to administer a topical compound medication of Ativan, Benadryl and Haldol (ABH) according to the physician ordered dose and route for one of four sampled residents. (Resident #1) Resident #1 received Ativan 10 milligrams (mg), Benadryl 250 mg and Haldol 10 mg orally instead of the physician ordered dose of Ativan 1 mg, Benadryl 25 mg and Haldol 1 mg topically. : Resident #1 was found to be lethargic and unresponsive on 3/30/18. Resident #1 was transported to a local emergency room and admitted to the hospital with a diagnosis of accidental overdose. The findings included:	F 760	Past noncompliance: no plan of correction required.	4/26/18

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

Electronically Signed | 04/26/2018

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Resident #1 was re-admitted to the facility on 2/17/18 with diagnoses that included respiratory failure, chronic obstructive pulmonary disease (COPD), fracture of shoulder and hip (right), diabetes type 2, dementia with behavioral disturbance of delusions/paranoia, congestive heart failure (CHF), and pleural effusion (PE).

The 14- day Minimum Data Set (MDS) dated 3/3/18 indicated Resident #1 had severe impairment with short and long- term memory, required extensive assistance of one staff for eating, was total assistance with toileting, and extensive assistance of two staff for bed mobility and transfers. This MDS indicated he had no behaviors and no complaints of pain.

Review of the primary physician ' s progress notes dated 3/7/18 indicated he had Alzheimer ' s dementia with behavioral disturbance. Recommendations were to provide supportive care, get palliative care consult, continue Aricept (a medication used to treat Alzheimer ' s disease) for now and Seroquel (an antipsychotic medication) at bedtime.

The psych consult progress notes dated 3/14/18 indicated Resident #1 had a diagnosis that included vascular dementia with delusions, delusional disorders and anxiety. The "recommendations: included in part, multiple medical issues and dementia with psychosis exhibiting labile/irritable mood, distress with anxiety and paranoia impairing function, care and safety ..."

The telephone order, written by the psych nurse practitioner, dated 3/14/18, included ABH gel

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(1:25:1mg) milliliter (m) topically 1 ml twice a day for anxiety and paranoia. ABH gel is a topical compounded medication of Ativan (an antianxiety medication), Benadryl (an antihistamine) and Haldol (an antipsychotic medication).

Review of the Medication Administration Record (MAR) for March indicated the first dose of ABH gel was on 3/16/18 at 8:00 AM. The instructions on the MAR read "Apply 1 ML BID (twice a day) for anxiety/paranoia." The times of administration were at 8 AM and 8 PM. The 8 PM dose on 3/27/18 was held due to lethargy per nursing documentation on the MAR. Resident #1 also received Seroquel 50 mg every night at 9:00 PM.

Review of the March MAR revealed on 3/30/18 the ABH gel was signed by Nurse #1 as being administered at 8:00 AM. Further review revealed a Finger Stick Blood Sugar (FSBS) was obtained at 12:00 PM and was 112 and no Insulin was required to be administered per the sliding scale orders. Other medications administered after the morning medication pass included Tylenol (an analgesic) 325 mg 2 tabs, Lasix (a diuretic) 40 mg 1 tab, Ampicillin (an antibiotic) 500 mg 1 tab and Protonix (a drug to treat reflux) 40 mg 1 tab.
Review of the "Medication Error Report" dated 3/30/18 revealed Nurse #1 administered the entire contents (10ML) of the ABH orally to Resident #1 at 10:00 AM. The report indicated the error was found during the first to second shift narcotic count. The Assistant Director of Nursing (ADON), Director of Nursing (DON) were notified of the error. The on-call physician was notified by Nurse #1 at 3:45 PM of the error. Resident #1 was assessed and found to be lethargic with poor response to verbal or physical stimuli. The

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on-call physician gave orders to send the resident to the local emergency room for evaluation.

Per the written statement of events dated 3/30/18 by Nurse #1, vital signs were obtained at 4:00 PM on 3/30/18 and were as follows: blood pressure 105/51, pulse 63, respirations 18 and oxygen saturation 93% on 2 liters/min of oxygen.
Per the Emergency Management Service ' s (EMS) report log dated 3/30/18 they arrived at 4:15 PM and left for the hospital at 4:20 PM. The vital signs by EMS at 4:20 PM were Blood Pressure 100/60, pulse 70 and respirations 18. EMS documented Resident #1 would respond to painful stimuli only. EMS arrived at the hospital at 4:43 PM on 3/30/18.
Review of the hospital admission documentation, Resident #1 was seen at (name of hospital) in the emergency room. On arrival to the emergency department, per the physician ' s admission note on 3/30/18 at 5:15 PM, Resident #1 responded briefly to sternal rub and would shake his head for yes/no. The Poison Control Center was called on 3/30/18 at 5:30 PM and recommended to provide supportive care and assess the resident.
According to the hospital admission documentation records, Resident #1 remained in the hospital acute on chronic respiratory failure and left side pleural effusion, CHF and questionable aspiration pneumonia. The white blood count (WBC) was elevated above normal indicating an infection was present.

Further review of the hospital emergency room physician notes revealed the plan and assessment included:
1. Accidental overdose, Poison Control had advised monitoring and supportive care, Patient was protecting his airway on admission, but in

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some respiratory distress with increased O2 (oxygen) requirement. Plan to continue telemetry monitoring with supportive care.
2. Acute on chronic hypoxic respiratory failure, Patient required 2 Lpm (liters per minute) supplemental O2 at baseline. He is in respiratory distress on admission requiring 4 Lpm via nasal cannula in emergency department (ED). Chest X-ray with moderate to large left sided effusion, rhonchi bilaterally on auscultation and concern for aspiration clinically. He also has chronic CHF (Congestive Heart Failure) with preserved EF (Ejection Fraction) and was given 40 mg IV (intravenous) Lasix 1 time in the ER. Suspect the effusion and possible aspiration to be responsible for the acute hypoxia.
3. Pleural effusion, left, moderate to large left pleural effusion noted on admission chest X-ray and patient has increased supplemental O2 requirement and is in mild distress.
Resident #1 had 7 additional areas of concern and treatment management. These areas were Chronic diastolic CHF, Chronic atrial fibrillation, COPD, OSA (Obstructive Sleep Apnea), Anemia, Insulin Dependent Diabetes, Chronic wounds, and agitation.
Per interview with the DON on 4/17/18 at 10:00 AM, Nurse #1 informed her of the medication error and assessed Resident #1. The resident was lethargic and difficult to arouse.
Interview with the pharmacist at the facility contracted pharmacy on 4/17/18 at 2:12 PM revealed the compound of the medications was made with the medication tablet(s) and compounded in a gel. The medications would be absorbed, but at a slower rate than if administered topically. He explained it would be absorbed slower, delayed and at a reduced amount when given orally. The pharmacist

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explained the packaging had a red sticker with a label that informed the nurses the gel was for external use only.
Interview with Nurse #1 on 4/17/18 at 1:16 PM revealed on 3/30/18, this was her third day of orientation as the floor nurse. She did the medication pass on Resident #1 ' s hall independently. She explained she had not worked on his hall, and the residents were new to her. During the med pass, Nurse #1 obtained the prefilled syringe containing the ABH gel from the medication refrigerator. She explained she did not see a route for the medication on the MAR. The instructions were to "apply" 1 ml of the ABH gel. Nurse #1 explained she had not given this medication topically before, but had given it orally. She did not realize it was 10ml and not 1 ml. Nurse #1 gave the entire contents (10 ml) orally to Resident #1. During her shift, Nurse #1 explained she did a blood sugar check at 12 noon, and gave afternoon medications to him around 1:30 PM. At each visit with the resident, he was alert, verbal and sitting up. During the narcotic count at the end of the shift, the second shift nurse asked why the count was not correct. It was at that time, Nurse #1 realized she had given 10 ml and not 1 ml. Nurse #1 explained she informed the Assistant Director of Nursing and called the on- call physician.

Interview with Nurse #2 on 4/17/18 at 3:30 PM revealed she usually worked on Resident #1 ' s hall. Nurse #2 detailed the events of 3/30/18 as follows: She came to work at 3:00 PM, Nurse #1 gave her shift report and then the narcotics were counted. During the narcotic count, she realized the ABH gel count was not correct. At that time, she explained to Nurse #1 the dose was 1 ml and the syringe was a 10 ml, multi-dose syringe.

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Nurse #2 went to Resident #1 ' s room to do an assessment. Upon entering his room, he was lethargic, in a deep sleep and not waking up when his named was called or she shook him. The estimated time of the assessment was around 3:30 PM. Nurse #1 notified the ADON and the on call physician. Nurse #2 prepared the paper work to send the resident by EMS to the emergency room. Nurse #2 explained her method of administration of the ABH gel included putting 1 ml of the gel in a medication cup, locking the multi-dose syringe up and taking the medication cup to the room to apply it to his skin. Interview with the primary physician on 4/18/18 at 10:35 AM revealed she was made aware of the medication error on 3/30/18. The on call physician was notified and gave orders to send to the emergency room. During the interview she explained she would not be able to say the overdose led to his death. She would need to read the hospital records to see the course that was taken at the hospital. From his records up to the day of discharge, he had an infection that was not responding (wound) and he may have developed an acquired infection on top of his existing infection. With multiple antibiotic usage, his immune system was compromised. With additional testing that may have been completed at the hospital, the records would give a better indication of his prognosis. The ABH gel would not have the same effect orally as topically, due to the compound was made to be absorbed topically. It would have some effect, but the total effect would be unknown. The resident was referred to palliative care at the facility and was seen on 3/9/18. The palliative care notes indicated his wounds would become worse, even with antibiotic treatment. The resident had vascular problems which also hindered the

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healing process. When asked what would supportive care and monitoring mean to her, she explained it would be supportive for respiratory, cardiovascular and neurological. The resident would be assessed for respiratory depression, low blood pressure and neurological changes.
On 4/18/18 at 11:09 AM the medical examiner was interviewed via telephone regarding Resident #1. The resident had expired on 4/14/18 at the hospital. She said the death happened after 14 days of the drug overdose. She said Resident #1 ' s case was referred to the medical examiner office because it was a drug overdose and it might be the policy of the hospital to refer the case to the medical examiner if there is a drug overdose. She said the investigation just started since they got the referral 4 days ago and they do not have results of the toxicology. But in her opinion, it is going to be difficult to prove that the drug overdose had contributed to the death because of the lapse of time between the overdose and the date of death. The medical examiner will do a toxicology test (which she is not expecting that there will conclusive results), they will do an autopsy and they will read the resident ' s medical records, then they will make a decision.
The policy for "Administering Medications dated 12/12 included in part: "3. Medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 26. New personnel authorized to administer medications will not be permitted to prepare or administer medications until they have been oriented to the medication

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administration system used by the facility. 27. The Charge Nurse must accompany new nursing personnel on their medication rounds for a minimum of three (3) days to ensure established procedures are followed and proper resident identification methods are learned.
Interview with the Administrator and the DON on 4/17/18 at 10:00 AM revealed a plan of correction was instituted on 3/30/18 after Resident #1 was transported to the hospital. In-service regarding the 6 rights of medication administration was given to Nurse #1, a statement of the events surrounding the medication error was provided and an investigation was initiated using root cause analysis. Nurse #1 was suspended pending outcome of the facility investigation. They explained Nurse #1 had the support of the charge nurse for her hall, the ADON and supervisor were also available. During the interview, the DON explained the packaging of the ABH gel had a red sticker with instructions the medication was for external use only.
In-services for all nurses and medication aides began on 3/30/18 and was completed on 4/1/18. Assessments of all residents was completed on 3/30/18 by the nursing administration that received Ativan or ABH gel medications. There were no negative findings. There were 3 residents (Residents 4, 5 and 6) who had orders for that type of medication.
Pharmacy was informed the labels for gel compounds would require the word "topical" on the label and to send single use syringes instead of multi-dose syringes. The narcotic storage unit was checked for the new labels for Residents #4, 5 and 6. The syringes were single dose with the label using the word "topical" provided by the pharmacy. Red stickers indicating the medication was "For External Use Only" was present on the

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packaging.
Audits were present beginning 4/6/18 of new medication orders and continued a weekly basis. The facility obtained compliance as of 4/6/18.
The facility plan of correction was as follows:
Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law.
Resident was admitted to the facility 1/29/18 with dx that included Left foot diabetic ulcer respiratory failure, muscle weakness, gait abnormality, anxiety and paranoia. Resident had a fall 2/1/18 resulting in a fracture to his right shoulder, Resident was readmitted 2/17/18 and continued to receive therapy services.

Resident physician orders included Ativan/ Benadryl/ Haldol gel 1:25:1mg/ ml (ABH gel), apply 1ml BID for anxiety/ paranoia.
On 3/30/18 at 3:30 pm nurse reported administering 10ml of ABH gel to resident by mouth.
The resident was assessed by attending nursing staff and was noted to have decreased level of consciousness. The physician was notified regarding the error and current resident assessment and gave new orders to send the resident to ER for further evaluation. Resident RP notified. The resident left the facility via EMS at 4:05 pm. Resident was admitted to the hospital on 3/30/18. The medical examiner contacted administrator on 4/16/18 indicating that the resident had expired on or about 4/14/18. The administrator sent the medical examiner additional information from the resident medical

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records as requested. As of 4/18/18 the cause of the resident ' s death is still pending.

The nurse was immediately interviewed regarding the medication error. The nurse stated that she thought the syringe provided for the resident was a 1ml syringe. The root cause of the medication error was determined to be failure of the nurse to adhere to the six rights of medication administration. The nurse administering the medications was on her third day of a five-day orientation plan. The medication label did include a warning that stated for external use only. The instructions on the medication label stated to apply, however the instructions on the medication label did not specify the route of administration.

The nurse administering incorrect dose of ABH gel was educated 3/30/18 by the director of nursing regarding the six rights of medication administration to include: 1) verification the correct medication is being administered 2) Verification of the dosage being administered 3) Verification the correct resident is receiving the medication 4) Verification the medication is being administered at the correct time and 5) verification the medication is being administered the correct route, and 6) Verification the medication administration is correctly documented. Education was also specific to include instructions for the nurse not to administer the medication if any of the six routes are not included in the administration instructions and to seek further clarification from pharmacy, nurse supervisor or physician.

Nurse completing the medication error was suspended pending investigation on 3/30/18. Nurse completing the medication error never

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returned to the facility to determine any subsequent personnel action.

Beginning 3/30/18 and ending 4/1/18, the staff development nurse, DON or RN supervisor educated 100% nurses and medication aides regarding the six rights of medication administration. This education included; 1) verification the correct medication is being administered 2) Verification of the dosage being administered 3) Verification the correct resident is receiving the medication 4) Verification the medication is being administered at the correct time and 5) verification the medication is being administered the correct route, and 6) Verification the medication administration is correctly documented. Education was also specific to include instructions for the nurse not to administer the medication if any of the six routes (rights) are not included in the administration instructions and to seek further clarification from pharmacy, nurse supervisor or physician.
On 3/30/18 the director of nursing clarified physician order for ABH gel from "ABH (ATIVAN/BENADRYL/HALDOL) GEL (1:25:1 MG/ML) APPLY 1ML BID FOR ANXIETY/PARANOIA" to "ABH (Ativan/ Benadryl/ Haldol) Gel (1:25:1 MG/ML) Apply 1ml BID topically to bilateral arms alternating sites for anxiety/ paranoia".

On 4/2/18, the director of nursing services, SDC, and ADON conducted 100% audit of all orders for medications applied topically to ensure the route is indicated in the physician order to remove any immediate jeopardy that may exist to other residents

Starting on 4/2/18 the pharmacy repackaged all

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Ativan gel and ABH gel, to 1ml unit dosing. The facility has no other multi dose medications that are provided by the pharmacy in a syringe.

Any staff not in-serviced by March 30, 2018 did not work until in-servicing was completed by Director of Nursing, Staff Development Coordinator/Assistant Director of Nursing, RN Nurse Manager, with inservicing 100% complete on 4/1/18.

All New Admission orders will be verified by the physician. All orders transcribed will be verified by the Nurse Administration Team including the Director of Nursing, Staff Development Coordinator/Assistant Director of Nursing, Treatment Nurse, and RN Nurse Managers five times weekly beginning 4/2/18. All new orders for the previous day are verified by the Nurse Administration Team including the Director of Nursing, Staff Development Coordinator/Assistant Director of Nursing, Treatment Nurse, and RN Nurse Managers in the morning clinical quality meeting which is held five times weekly. New orders received on Friday, Saturday and Sunday are reviewed for accuracy by the Nurse Administration Team including the Director of Nursing, Staff Development Coordinator/Assistant Director of Nursing, Treatment Nurse, and RN Nurse Managers each Monday.

On March 30, 2018, all residents receiving prescription Ativan or ABH gel were assessed by the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, and Unit RN Manager for level of consciousness with no abnormal findings.
The Administrator, Staff Development Coordinator/Assistant Director of Nursing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345547	A. BUILDING _____ B. WING _____	C 04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN HEALTH AND REHABILITATION	1 MARITHE COURT GREENSBORO, NC 27407

(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 760	Continued From page 13	F 760		

Regional Clinical Manager, and IDT Team updated a Facility Self-Assessment Tool and a QAPI Self-Assessment Tool on March 30, 2018 to ensure the facility had resources and systems in place to efficiently attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Administration has been integrally involved in developing the policies and procedures described above with respect to this incident. Administration has reinforced to all staff the expectation of adherence to all policies and procedures described above. Administration is actively committed to creating and maintaining a culture of compliance within the facility, including but not limited to being free of significant medication errors. It has been reinforced to all staff that any incidents of actual or suspected medication errors be reported directly to the administrator, Director of Nursing, or Assistant Director of nursing immediately.
Staff development coordinator will conduct medication pass audits five times weekly starting 4/6/18 for twelve weeks. Findings of these audits will be presented in the Quality Assurance Performance Improvement Meeting for a minimum of three consecutive meetings and ongoing as indicated.

The Regional Clinical Manager will review the daily clinical meeting documentation and review of order transcription verification weekly for four weeks, monthly for three months and ongoing as indicated. Findings of these audits will be presented in the Quality Assurance Performance Improvement Meeting for a minimum of three consecutive meetings and ongoing as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 760	Continued From page 14 Validation of the allegation of compliance was conducted on 4/18/18 at 3:00PM. Residents # 4, 5 and 6 were added to the sample for record review. Record review revealed orders for gel compound medications included the word "topical." Review of the in-service training revealed staff were in serviced on the 6 rights of medication administration, with instructions on how to handle situations if any of the 6 rights were missing. Interviews of staff working 7-3 and 3-11 shifts revealed they had received the in-service training, knew the 6 rights of medication administration and what to do if any of the 6 rights were missing. There were no new hires for licensed nurses since 3/30/18. Review of the audits for medication orders was found to be completed and on-going. Review of the medication pass audits were completed and on-going.	F 760		