

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345458	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/30/2020
NAME OF PROVIDER OR SUPPLIER TREYBURN REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712		
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F 000	INITIAL COMMENTS Complaint investigation survey conducted from 7/28/2020 through 7/30/2020 Event ID# LR9811. One of the 3 allegations was substantiated resulting in a deficiency.	F 000			
F 760 SS=D	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 reviews and staff interviews and Nurse Practitioner (NP) interview, the facility failed to prevent a significant medication error resulting in the resident's decreased respiration, receiving emergency medication (Narcan) and was sent to the hospital emergency department for evaluation for 1 (resident #1) of 4 residents reviewed. Findings Included: Resident #1 was admitted to the facility on 06/2015 with diagnoses that included: stroke with left side paralysis, congestive heart failure, hypertension, seizure disorder, major depression and dysphagia. A review of the quarterly minimum data set (MDS) dated 6/10/2020 revealed resident #1 was severely cognitively impaired, non-verbal and required 2 person assist with activities of daily living (ADL), transfers and bed mobility. A physician's orders dated 06/10/2017 revealed	F 760	8/11/20		
			F760 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiency. The plan of correction is prepared and/ or executed solely because it is required by both Federal and State laws. Root Cause Analysis Based on the root cause analysis completed by the Facility's administrative staff, it was determined that Nurse #1 administered Oxycodone to resident #1 instead of the Vimpat that was ordered. Resident #1 did not have an active order for		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/11/2020

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 760	<p>Continued From page 1</p> <p>oxycodone 5mg/5ml solution to be given every 6hrs as needed. This order was discontinued on 05/24/2020.</p> <p>An order by the physician dated 05/28/2020 indicated an active order for Vimpat Solution 200mg/20ml, give 15ml via g-tube every 12 hours for seizures.</p> <p>A review of the progress notes dated 06/08/2020 indicated the nurse administered Oxycodone 15ml instead of the Vimpat 15ml in which the nurse practitioner (NP) was then informed of the medication error. The NP indicated to monitor the resident's vital signs every 15 minutes.</p> <p>A further review of the progress notes dated 06/08/2020 indicated the resident's respirations began to decrease to 6 breaths per minute and an oxygen saturation was 88% on 2 liters of oxygen. The NP was informed, and a verbal order was given to administer Narcan 0.4mg=1ml via intramuscular injection to the left deltoid. The order was carried out and the resident's oxygen saturation increased to 98% on 2 liters of oxygen. The NP then gave a verbal order to transfer the resident to the hospital for evaluation.</p> <p>A review of Hospital Emergency Room records dated 06/08/2020 indicated resident #1 arrived at 3:58pm on 4 liters of oxygen with an oxygen saturation of 98% and 16 breaths per minute. Further review indicated basic laboratory tests and electrocardiogram was completed and no further medical interventions preformed. resident #1 was transferred back to the facility on 06/08/2020 at 11:56pm.</p> <p>An interview with the Nurse #1 on 07/28/2020 at</p>	F 760	<p>Oxycodone at that time.</p> <p>Immediate Action: Resident #1 was transferred to the emergency room for evaluation on 6/8/2020. Resident #1 did not admit to hospital and returned the same day. MD and family were notified of resident's status upon return to facility. Close monitoring was conducted and no further changes in resident's condition were noted.</p> <p>Director of Nursing in-serviced Nurse #1 by 8/11/2020 regarding the six rights of medication administration, ensuring the label on the med card is being read to ensure right medication and right dose, and completing checks prior to administering. On 6/8/2020 Nurse #1 was removed from floor duty for reorientation on medication administration.</p> <p>On 6/8/2020 Director of Nursing removed Oxycodone from med cart and contacted pharmacy to arrange pick-up.</p> <p>Like Residents: Physician's orders were reviewed and a MAR to cart</p>		

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F 760	<p>Continued From page 2</p> <p>12:35pm revealed that she mistakenly administered the Oxycodone instead of the Vimpat. Upon realizing the medication error, she immediately called the NP and informed the Assistant Director of Nursing (ADON). The nurse indicated she continued to monitor the resident every 15 minutes per the order and when the resident #1 respirations decreased, she called the NP and received an order for Narcan. The NP then ordered the resident to be transferred to the hospital for further evaluation.</p> <p>A telephone interview on 07/29/2020 at 10:49am with the NP revealed the named resident to be non-verbal, required oxygen and difficulty handling secretions. The NP indicated she was informed via telephone of the nurse medication error and recalls giving verbal order to monitor the resident vital signs every 15 minutes. The NP further revealed receiving a call regarding the resident decreasing oxygen saturation in which it was decided to transfer the resident to the hospital for further evaluation. The NP indicated that it was likely the oxycodone that caused resident #1 to have a decrease in respirations and oxygen saturation resulting in the need to be transferred to the hospital.</p> <p>A telephone interview on 07/29/2020 at 2:08pm with the former Director of Nursing (DON) revealed the nurse informed her of the medication error. The DON further revealed resident #1 was transferred to the hospital after calling the NP.</p> <p>An interview with the administrator on 07/28/2020 at 12:40pm indicated when nurse #1 informed the ADON about the medication error they made sure the resident was safe and care for and a plan of</p>	F 760	<p>audit was completed on 6/8/2020 by the Director of Nursing and the Assistant Director of Nursing on to ensure no other discontinued medications remained on the carts. On 6/8/2020 the Director of Nursing contacted the Pharmacy to arrange pick-up of identified discontinued medications.</p> <p>Medication pass observations of licensed staff were completed on 6/8/2020 by the Staff Development Coordinator.</p> <p>Systematic Changes: Nurse #1 was required to successfully complete re-education regarding medication administration and preventing medication errors. Nurse #1 then was audited by the Assistant Director of Nursing during medication pass. Nurse #1 had to pass the audit with at least a 95% no error rate before being released to pass medications on own.</p> <p>100% of licensed nurses were in-serviced by the Director of Nursing regarding the six rights of medication administration which included signing out narcotics on the narcotic</p>		

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F 760	Continued From page 3 correction was made for proper medication administration.	F 760	<p>sheet, documenting on the MAR, ensuring the label on the card is being read to ensure you are giving the right medication and the right dose, and complete checks against order before giving. This education was completed by 8/11/2020 and will be provided to newly hired licensed nurses.</p> <p>Monitoring: The Director of Nursing will review physicians <input type="checkbox"/> orders daily 5 times a week in Clinical Morning Meeting indefinitely. The Unit Manager will then ensure discontinued medications have been removed from the medication carts. The Unit Managers will complete a medication cart audit weekly. The med cart audits will be reviewed by the Director of Nursing to identify any trends.</p> <p>The SDC will complete monthly random medication administration audits to ensure licensed nurses are maintaining at least a 95% no error rate.</p> <p>Quality Assurance & Performance Improvement Committee was notified of this plan of action on 6/10/2020.</p>		

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

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F 760	Continued From page 4	F 760	The Director of Nursing will report findings of this monitoring process to the QAPI committee monthly for three months for review and further recommendations to ensure ongoing substantial compliance.		