STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted on 9/8/21. Additional information was obtained on 9/9/21. Therefore, the exit date was changed to 9/9/21. 1 of 1 allegation was substantiated. Event ID# 32EP11.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with staff, Nurse Practitioner and pharmacist, the facility failed to maintain a medication error rate of less than 5% when a medication that was not to be crushed was administered crushed to 2 of 12 residents (Resident #10 and Resident #12) observed during medication administration. This consisted of 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.4%. The findings included: 1. Resident #10 was admitted to the facility on 5/2/18 with diagnoses that included gastroesophageal reflux disease (GERD). Dysphagia (difficulty swallowing), oropharyngeal phase was added to Resident #10's diagnoses list on 3/22/21. The Physician's Orders in Resident #10's electronic medical record indicated an active	F 759	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The facility failed to maintain a medication error rate of less than 5% when a medication that was not to be crushed was administered crushed to 2 of 12 residents which consisted of 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.4%.	9/13/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/16/2021

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 759 Continued From page 1

order for Omeprazole delayed release 20 mg (milligrams): Give 1 tablet by mouth two times a day for GERD symptoms. Administer 30 to 60 minutes before a meal unless otherwise directed by the doctor. Do not crush.

On 9/8/21 at 4:05 PM, Nurse #1 was observed as she prepared and administered Resident #10's medications. Nurse #1 crushed Resident #10's medications which included an Omeprazole delayed release tablet while stating that Resident #10 was unable to swallow whole medications, so she had to crush all of Resident #10's medications and place them in applesauce. Nurse #1 administered Resident #10's crushed medications in applesauce and gave her nectar-thick water.

Further interview with Nurse #1 on 9/8/21 at 4:40 PM revealed she was not sure if it was acceptable for Omeprazole delayed release tablets to be crushed but thought it would be fine to do so. After reviewing Resident #10's Medication Administration Record (MAR) with Nurse #1, she stated she did not notice the additional information on the MAR that stated to not crush the Omeprazole delayed release tablet. Nurse #1 further stated Resident #10 had just started having swallowing issues in the last couple of weeks, but Nurse #1 did not think about consulting the Nurse Practitioner about having to crush the Omeprazole tablet because Resident #10 could not swallow her pills whole.

An interview with the Unit Manager (UM) on 9/8/21 at 4:50 PM revealed she had not been aware that Nurse #1 had to crush Resident #10's Omeprazole because she couldn't swallow whole pills. The UM stated it had been a while since

F 759

How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/8/2021 For resident #10 and resident #12 the Unit Manager notified MD and Pharmacy of medication error. Prilosec 20mg tablets removed from medication cart and replaced with Prilosec 20mg delayed release capsules.

How the facility will identify other residents having the potential to be affected by the same deficient practice.
On 9/8/2021 the Director of Nursing and QA Nurse reviewed 100% of resident medical record for residents with do not crush medications ordered and resident requiring or requesting meds to be crushed. All other potentially affected residents identified with do not crush medication were reviewed by NP and medication orders changed or discontinued on 9/9/2021.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
On 9/8/2021 the Director of Nursing initiated education on Medication Errors and Do Not Crush Medications for 100% of all facility and agency registered nurses, licensed practical nurses. This education will be completed by 9/13/2021. Any staff not completing education will not be allowed to work until it has been completed. This education has been added to facility orientation and agency clinical orientation.

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F 759 Continued From page 2

she had to give Resident #10's medications and she used to be able to swallow her pills whole at that time. The UM also stated she knew Resident #10 had to have a Speech Therapy evaluation recently due to her swallowing issues. The UM further stated that the facility used to have a stock of Omeprazole in the capsule form that could be pulled apart and given to residents who had swallowing issues but was not sure if they currently had any available.

A phone interview with the Nurse Practitioner (NP) on 9/8/21 at 5:04 PM revealed Resident #10 recently had swallowing issues which first started within the last week or so and she had to have her liquids thickened. The NP stated it was not brought to her attention by the nursing staff that Resident #10 had medications that could not be crushed, or she would have switched them to another form that Resident #10 would be able to swallow safely.

A phone interview with the Pharmacist on 9/9/21 at 9:02 AM revealed Omeprazole delayed released tablets should not be crushed because these tablets were extended release. The Pharmacist stated crushing the Omeprazole delayed release tablet would destroy the extended-release component of the medication which would cause all the medication to be released at one time. The Pharmacist further stated that Omeprazole was formulated as an enteric-coated tablet to avoid inactivation of the drug by gastric acid. Crushing the tablet compromised the protective coating, which resulted in loss of efficacy. The Pharmacist also said there were other drugs in the same category as Omeprazole which could be crushed and given safely to residents with swallowing

F 759

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements
Beginning on 9/9/2021 The Director of Nursing or designee will complete Quality assurance tools for Medication Cart Monitoring. The DON or designee will monitor 4 medication carts to assure that medications ordered for the resident are available in the medication cart and to be completed weekly x 4 then monthly x 3 and Quality assurance tool for Monitoring Medication Pass to be completed by the DON or designee. The DON or designee will observe med pass twice a day, to include 4 nurses - 2 day shift and 2 evening shift nurses daily 5 days a week x one week, then 3 x week x 1 week then monthly x 3 months. The results of this audit will be reviewed at the weekly Quality of Life Meeting. Reports will be presented to the monthly Quality Assurance Team meeting by the Director of Nursing and/or RN, Unit Manager to ensure corrective action initiated is appropriate. Any immediate concerns will be brought to the Administrator or Director of Nursing for appropriate action.
Compliance will be monitored and ongoing auditing program to be reviewed at the Weekly Quality of Life / Quality Assurance Committee meeting attended by Administrator, Director of Nursing Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Social Worker and Dietary Manager.

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F 759	Continued From page 3 difficulties. An interview with the Director of Nursing (DON) on 9/8/21 at 5:10 PM revealed the nurses should administer medications as ordered and if the resident had swallowing issues, they should have notified the physician or the NP and obtained further instructions from them. 2. Resident #12 was re-admitted to the facility on 1/8/21 with diagnoses that included gastroesophageal reflux disease (GERD). The Physician's Orders in Resident #12's electronic medical record indicated an active order for Omeprazole delayed release 20 mg (milligrams): Give 1 tablet by mouth two times a day for GERD symptoms. Take on an empty stomach, 1 hour before or 2-3 hours after a meal unless otherwise directed by the doctor. Do not crush. On 9/8/21 at 4:10 PM, Nurse #1 was observed as she prepared and administered Resident #12's medications. Nurse #1 pulled all of Resident #12's medications out of the medication cart that were due to be given. She placed all pills which included an Omeprazole delayed release tablet in a plastic sleeve, crushed them and placed them in applesauce. Nurse #1 stated that Resident #12's medications had to be crushed and given in applesauce because she had difficulty swallowing them whole. Further interview with Nurse #1 on 9/8/21 at 4:40 PM revealed she was not sure if it was acceptable for Omeprazole delayed release tablets to be crushed but thought it would be fine to do so. After reviewing Resident #12's	F 759		

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F 759	Continued From page 4 Medication Administration Record (MAR) with Nurse #1, she stated she did not notice the additional information on the MAR that stated to not crush the Omeprazole delayed released tablet. Nurse #1 further stated Resident #12 had been having swallowing issues, but Nurse #1 did not think about asking the Nurse Practitioner if the Omeprazole could be switched to a different form which Resident #12 would be able to swallow safely without having to crush it. An interview with the Unit Manager (UM) on 9/8/21 at 4:50 PM revealed she had not been aware that Nurse #1 had to crush Resident #12's Omeprazole because she couldn't swallow whole pills. The UM stated it had been a while since she had to give Resident #12's medications but she used to be able to swallow her pills whole at that time. The UM also stated Resident #12 had good days and bad days in terms of being able to swallow her medications whole. The UM further stated that the facility used to have a stock of Omeprazole in the capsule form that could be pulled apart and given to residents who had swallowing issues but was not sure if they currently had any available. A phone interview with the Nurse Practitioner (NP) on 9/8/21 at 5:04 PM revealed she was not aware that Resident #12 had been having swallowing issues. The NP stated she did not know that Resident #12 had medications that could not be crushed, or she would have switched them to another form that Resident #12 would be able to swallow safely. A phone interview with the Pharmacist on 9/9/21 at 9:02 AM revealed Omeprazole delayed released tablets should not be crushed because	F 759		

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F 759	Continued From page 5 these tablets were extended release. The Pharmacist stated crushing the Omeprazole delayed release tablet would destroy the extended-release component of the medication which would cause all the medication to be released at one time. The Pharmacist further stated that Omeprazole was formulated as an enteric-coated tablet to avoid inactivation of the drug by gastric acid. Crushing the tablet compromised the protective coating, which resulted in loss of efficacy. The Pharmacist also said there were other drugs in the same category as Omeprazole which could be crushed and given safely to residents with swallowing difficulties. An interview with the Director of Nursing (DON) on 9/8/21 at 5:10 PM revealed the nurses should administer medications as ordered and if the resident had swallowing issues, they should have notified the physician or the NP and obtained further instructions from them.	F 759		