STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 06/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 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 interviews with facility staff and the Regional Clinical Pharmacist, and review of medical records the facility failed to administer 3 doses of the medication Lasix to 1 of 3 sampled residents who were on Lasix. (Resident #1) Findings include: Resident #1 was admitted in March 2012 with diagnoses including congestive heart failure, dementia, leg varicosity, cellulites of the leg, diabetes, seizures, and chronic kidney disease stage III. His most recent quarterly Minimum Data Set (MDS) was completed on May 23, 2013. The resident was assessed to have a brief interview mental score of 12 of 15 and no behaviors. The resident required extensive or limited assistance with all areas of daily care. A review of the medical orders revealed the resident had an order for Lasix 40 mg 1 tab by mouth (PO) every morning. The Medication Administration Record (MAR) had no signatures or documentation the medication was given on June 1st, 2nd, or 3rd. An interview was conducted with the Nurse Practitioner (NP) who cared for Resident #1 on 6/12/13 at 2:22 PM. She stated she was familiar with him. She revealed he had had blisters on his legs in the past. The NP stated the blisters came	F 333	**Corrective Action:** For resident #1 on 6/4/13the MAR was compared to the current Physician orders and last 30 days of telephone orders to ensure all medications were present on the current MAR. This was completed by the ADON/Nursing Supervisor. Resident #1 continues to have all medications available as ordered by the MD. Medication Error reports were completed for dose omissions for Resident #1, and the PA was made aware on 6/4/13 with no changes made to the residents medication orders. **Identification of other residents who may be involved with this practice:** All residents have the potential to be effected by this alleged deficient practice. On 6/3/13, an audit of all MARs, current Physician orders and the past 30 days of telephone orders was initiated to insure all residents medications ordered were current. Any medication discrepancies noted were reconciled, MD notified if omissions were present and medication errors initiated if indicated. This was completed by the Nurse Management Team and completed on 6/27/13. **Systemic Changes:** Starting on 6/17/13 all Nurses (FT, PT and PRN) was in-serviced on the end of month order reconciliation procedure by the Staff Development Coordinator (see attachment). In addition to this, education was provided to each nurse that when a	6/28/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: S. Gabriel Jr. | TITLE: ADMINISTRATOR | (X6) DATE: 7/3/13

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 333	Continued From page 1 from his chronic Venous stasis where the blood did not circulate back up his legs. The NP stated Resident #1 had congestive heart failure. She revealed he was on the medication Lasix to help remove excess fluid from building up in his legs and backing up into his heart and lungs. The NP stated Resident #1 did not have a significant change in his medical status due to the missing doses of Lasix because he would have developed respiratory problems. She stated his legs became more discolored after the missed doses but the swelling in his legs was based on how well he elevated his legs. The NP stated Resident #1 was often noncompliant and would not elevate his legs which caused them to swell more and increased his chances of developing a blister. She indicated the resident moved about and bumped his legs causing skin tears and swelling. The NP revealed the swelling was now down and the blister was improving. An interview was conducted on 6/12/13 at 3:00 PM with the Physician Assistant (PA) that treated Resident #1. The PA stated Nurse #1 came up to her and said I have to show you a medication error. The PA looked at the MAR and saw Resident #1 had missed 3 doses of Lasix. The PA instructed the nurse to give him a dose right then and be sure he received it daily. An interview was conducted with the first shift nurse usually assigned Resident #1 on 6/12/13 at 3:50 PM. Nurse #1 stated she was familiar with the resident. She stated she had taken care of him since his admission. Nurse #1 revealed the resident did miss several doses of Lasix because it was not transferred to the June Medication Administration Record (MAR). Nurse #1 stated	F 333	one-time order is received increasing a medication in addition to the residents regular routine order, then this should be noted on the telephone order as such. See example provided. Any in-house nurse who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. On 06/26/13, the pharmacy Supervisor was contacted by the QA Nurse Consultant regarding the discontinuation of the routine Lasix order identified for resident #1. Discussed were the guide lines for pharmacy discontinuing orders. The pharmacy supervisor will provide training to all FT, PT and PRN Pharmacist and Pharmacy Tech's who do order entry. See attached in-service details. The in-service was conducted on 6/26/13 and will continue until all employees identified have been in-serviced. Any in-house Pharmacist or Pharmacist Tech who did not receive the in-service training will not be allowed to work until training has been completed. **Monitoring:** Using the QA Tool Orders Review the Director of Nursing will check five residents a week for complete orders. This check will involve comparing the current orders and past 30 days of	

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F 333	Continued From page 2 the resident had been on the diuretic Lasix since his admission for his congestive heart failure. She revealed she worked the night shift for another nurse for a few days and the covering nurse was not as familiar with Resident#1 so she did not realize he was suppose to get Lasix. Nurse #1 stated for some reason the Lasix was not on the preprinted MAR for June. She revealed staff do two checks to make sure all medications are on the new month MAR but the Lasix did not print out and staff did not catch the error. Nurse #1 stated she could not see any difference in the swelling or any respiratory problems on Tuesday (June 4th) after the resident missed doses of the medication on June 1, 2, and 3rd. Nurse #1 revealed the named resident did develop a large blister on his left leg but she stated he had had blisters on his leg before. A telephone interview was conducted with the Regional Pharmacist Clinical Manager on 6/12/13 at 4:10 PM. He stated he was not aware there had been a problem with the printed MARS. He stated he could not understand why the Lasix order would not have transferred over from the May to June MAR. He revealed they were in the process of transition to a new type of software. The new software came into effect on 6/7/13. The Pharmacist Manager revealed the old software did not show any Lasix for May or June. He indicated the Lasix had to be in the computer program because Resident #1 had been on it since his admission. During a review of the MAR with the Pharmacist a one time order for Lasix 40 mg 1 by mouth each day for 3 days on 5/31/13 was discovered. This was to be given in addition to his regular dose but it was not written as an	F 333	telephone orders to the current MARs. This will be done weekly for four weeks then monthly for two months. Identified issues will be corrected reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality of Life Meeting. The weekly Quality of Life Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 333	Continued From page 3 additional dose. The Pharmacist stated the computer would read the new order and automatically discontinue the old one. He indicated that was why the usual Lasix order was not transferred to the new June MAR. An interview was conducted on 6/12/13 at 4:25 PM with Nurse #2 who works the 3-11 shift. She stated she had worked at the facility for 3 months and was familiar with Resident #1. Nurse #2 revealed during a check of the Medication Administration Records (MARS) with the new computer program her supervisor noticed there was no order for Lasix on the June MAR for Resident #1. The Supervisor called the MD and obtained a one time order for that night. Nurse #2 stated she wrote the order on the June MAR and reported it to the day nurse. During an interview with the Director of Nursing (DON) on 6/13/13 at 1:05 PM she stated she did not understand how the pharmacy could have dropped the Lasix order for the month of June. She stated any errors should have been caught during the 2 times the MARS were checked by staff. The DON stated the new pharmacy computer program should ensure that no more errors of this type would occur. The DON revealed staff would continue to do the two checks to double check the accuracy of the MARs.	F 333		