| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345348 | A. BUILDING _____ B. WING _____ | C 12/10/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WHISPERING PINES NURSING & REHAB CENTER | 523 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301 |

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| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interview, the facility failed to maintain the medication error rate below the acceptable rate of 5% (9.4% error rate, 3 errors out of 32 observed opportunities, Resident #50). Findings included:<br><br>Resident #50 was admitted to the facility on 9/28/12 with diagnoses that included chronic pain and constipation. The Minimal Data Set assessment dated 10/10/15 indicated that the resident was moderately cognitively intact and did not have a history of displaying any behaviors or mood changes. The assessment confirmed that the resident did require extensive assistance for most activities of daily living.<br><br>The physicians orders for Resident #50 included "Opana ER (extended release) 20 milligrams (mg), Give 2 tablets (= 40 mg) by mouth every morning and every evening for chronic pain" , "Miralax 17 grams in 8 ounces of fluid, Give by mouth every Monday, Wednesday, and Friday for constipation", and "Senna-Docusate, Give 2 tablets by mouth twice daily."<br><br>1. Medication administration observation for Resident #50 was conducted on 12/8/15 at 8:45 AM, while the resident was lying on the bed in her room. The Medication Aide measured out the Miralax, mixed it with water, and administered the | F 332 | A medication error report was completed on 12/8/15 with no harmful outcome to the resident noted. Medication that was spit out was marked as refused; resident did not want to take another dose. Senakot was replaced in the resident's cart with Senakot S. Miralax order was verified to be correct in electronic medication administration system. Therefore, the medication given on the wrong day was not a software problem but related to human error completely.<br><br>Med Aide was counseled by the Director of Nursing Services (DNS) on 12/8/15 for not providing the correct medication, providing a medication on the wrong day and to observe resident for consuming all of medications before walking away. Med Aide was also re-in-serviced on 12/8/15 regarding the facility policy on Medication Administration which includes the 6 RIGHTS:<br>1. RIGHT RESIDENT<br>2. RIGHT DRUG<br>3. RIGHT DOSE<br>4. RIGHT ROUTE<br>5. RIGHT DAY & TIME<br>6. RIGHT DOCUMENTATION | 1/1/16 |

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

Electronically Signed | 12/22/2015

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| F 332 | Continued From page 1<br>medication to the resident on Tuesday, 12/8/15.<br><br>The Medication Aide was interviewed on 12/8/15 at 1:49 PM about the days of Miralax administration. She stated "I didn't see on the order that the Miralax is supposed to be given only on Mondays, Wednesdays, and Fridays. I did give it today, and today is Tuesday. I am nervous today."<br><br>The Director of Nursing was interviewed on 12/8/15 at 1:55 PM. She stated "I expect that all medication aides give their residents the correct medication, as it is prescribed, and watch the residents swallow them."<br><br>2. Medication administration observation for Resident #50 was conducted on 12/8/15 at 8:45 AM, while the resident was lying on the bed in her room. The Medication Aide took two tablets of regular Senna 8.6 mg each and administered them to Resident #50.<br><br>The Medication Aide was then asked to check her medication cart to pull out both the stock bottles of Senna-Docusate and Senna. The Medication Aide confirmed that her cart did not contain a bottle of Senna-Docusate, it only contained a bottle of Senna. She confirmed that she used the bottle of Senna to retrieve the 2 tablets to administer to Resident #50 and that the resident did not receive the Docusate portion of the medication.<br><br>The Director of Nursing was interviewed on 12/8/15 at 1:55 PM. She stated "I expect that all medication aides give their residents the correct medication, as it is prescribed, and watch the residents swallow them." | F 332 | The 10/10/15 MDS was not coded for behaviors because identified behaviors did not occur within the look back period. However, the resident does have a care plan for behaviors such as attention seeking.<br><br>In-servicing began on 12/8/15 for all licensed staff and med aides on the facility policy for Medication Administration which includes the 6 RIGHTS. In-service was conducted by the facility Director of Nursing Services or designee. Any licensed staff unable to attend the scheduled in-service will be re-in-serviced prior to their scheduled work time. In addition, Medication Administration on-line learning course will be completed by licensed staff and med aides on/before 12/31/15.<br><br>One medication administration observation will be randomly conducted by the Director of Nursing services or designee on a weekly basis X 4 weeks, followed by facility regularly scheduled random medication administration on a monthly basis on-going. Audits will specifically look for the compliance of the 6 RIGHTS.<br>Medication Administration will continue to be re-emphasized during the clinical portion of orientation for all licensed staff and med aides<br>Outcomes of weekly random medication administration audits will be discussed weekly during morning clinical meeting X 4 weeks. Any non-compliance with the 6 RIGHTS will have already been | |

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| F 332 | Continued From page 2<br><br>3. Medication administration observation for Resident #50 was conducted on 12/8/15 at 8:45 AM, while the resident was lying on the bed in her room. During the time that the resident was still taking the medications from the medication cup and in the process of swallowing the medications, the Medication Aide left Resident #50's bedside to go wash her hands in the in-room bathroom. At this time of the Medication Aide's absence, Resident #1 spit out 2 green tablets from her mouth; one of which landed inside of her cup of Miralax fluid, and the other which landed on her bed sheet. The Medication Aide returned from the bathroom, administered a medicated nasal spray, and continued conversing with Resident #50 for an additional 20 minutes, which included positioning herself very closely to the resident for a hug, prior to exiting the room.<br><br>The Medication Aide confirmed that she was entirely finished with the process of medication administration for Resident #50 prior to having the spit out medications pointed out to her. She then scooped up the medications with a spoon and re-attempted to administer them to Resident #50, at which time Resident #50 verbalized her refusal to take them.<br><br>The Medication Aide stated "The resident has never behaved like this; I did not think that she would do this (spit out medications) when I went to go wash my hands."<br><br>The Director of Nursing was interviewed on 12/8/15 at 1:55 PM. She stated "I expect that all medication aides give their residents the correct medication, as it is prescribed, and watch the | F 332 | addressed at the time of medication administration observation, and corrective actions will be discussed along with other outcomes of the medication administration process.<br>Outcomes of the random medication administration observations will be brought before the facility QAA committee on a monthly basis X 3 months - and as needed, by the DNS, or appropriate designee.<br>Any non-compliance with medication administration to include the 6 RIGHTS will be corrected when observed by the person performing the audit or by the person administering the medication.<br>Any negative trends identified during the audits, will be discussed in the QAA meeting which will cause the plan of action to be modified. Any such modification will be documented in the meeting minutes and the appropriate staff re-in-serviced as to the modifications. | |

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| F 332 | Continued From page 3<br>residents swallow them." | F 332 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | F 431 | | 12/29/15 |

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| F 431 | Continued From page 4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to store stock medications in a secure and limited access environment. Findings included:<br>Medication storage observations was conducted with the Quality Care Coordinator on 12/7/15 at 4:40 PM. Although the facility had two locked medication storage rooms available, each one located behind the nurses ' stations, the stock medication supply was found to be stored in the Nursing Secretary ' s office which was unlocked during observation. The stock medications were stored on an open metal warehouse shelving device within the secretary ' s office. The office did have a door to which there was locking capability, however during observation it was found to be closed and unlocked.<br>The Quality Care Coordinator was interviewed at 4:45 PM on 12/7/15. She stated " Yes, this office is where we store the stock medication supply. I don ' t really know why we don ' t store them in our locked medication rooms. The medications were moved here by our former Director of Nursing, who last worked at the facility sometime during this past summer. "<br><br>The Director of Nursing was interviewed on 12/7/15 at 4:53 PM. She confirmed that she did not know why the stock medications were stored outside of the locked and designated medication rooms. She stated " I know that the nursing secretary locks her office when she leaves the facility for the day but she does not lock it every time she leaves her office. I didn ' t know that the stock medication supply access needed to be restricted. " | F 431 | On 12/8/15, all stock medications were immediately removed from secretary's office and placed appropriately in the medication room by designated licensed nursing staff. Surveyor was notified on 12/8/15 that stock medication had been moved.<br><br>Secretary was inserviced by the QA nurse as to the appropriate placement of any OTC/stock medications, and who (licensed staff) are allowed to place any medication in the medication room.<br><br>QA nurse, appropriate designee will monitor weekly X 4 weeks for correct placement of ordered OTC/stock medications.<br>Identification of the incident, results of investigation, corrective actions will be brought before the next facility QAA committee meeting by the QA nurse, or appropriate designee and recorded in the meeting minutes.<br>QAA committee members will review outcomes of the four weeks of monitoring and address any non-compliance issues or negative outcomes.<br>Any negative outcomes will be addressed by the QA nurse or appropriate designee, at the time of discovery and results brought before the QAA committee members.<br>If needed, a plan of action for on-going corrective action and monitoring will be developed by the QAA committee members and appropriate staff inserviced | |

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| F 431 | Continued From page 5 | F 431 | by the DNS, or appropriate designee, to the plan of action and expected outcomes.<br>All actions taken will be documented in the QAA/QAPI committee meeting minutes to be reviewed at the next scheduled QAA committee meeting or as needed. | |