STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - TREYBURN	2059 TORREDGE ROAD DURHAM, NC 27712

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.4% for 2 of 9 residents (Resident #167 and Resident #110) observed during medication pass. The findings included: 1) On 4/12/16 at 4:38 PM, Nurse #1 was observed as she prepared medications for administration to Resident #167. The medications included three-500 milligrams (mg) calcium carbonate tablets pulled from a floor stock bottle. The nurse was observed as she administered the calcium carbonate tablets to Resident #167. A review of Resident #167 ' s physician ' s medication orders included a current order for 600 mg calcium carbonate with 400 units of Vitamin D3 to be given as one tablet by mouth twice a day. An interview was conducted with Nurse #1 on 4/12/16 at 4:53 PM. Upon request, Nurse #1 reviewed Resident #167 ' s April 2016 Medication Administration Record (MAR) and the manufacturer ' s labeling on the stock bottle of the	F 332	Disclaimer: Peak Resources Treyburn acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions, the Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this plan of correction is in response to the CMS 2567 from the 4/11/16 - 4/14/16 Annual Survey. Peak Resources Treyburn response to the statement of deficiencies and plan does not denote agreement with the deficiency nor does it constitute an admission that the deficiency is accurate. Further Peak Resources Treyburn reserves the right to refute any deficiency through informal dispute resolution, formal appeal, and/or other administrative or legal procedures. Corrective Action: 1. Residents #167 and #110 had no adverse effects from the medication administered by nurse #1 and nurse #2. 2. The calcium supplement orders of Residents #167 and #110 were reviewed by the Director of Nursing on April 14, 2016. The review ensured that the	5/11/16

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

Electronically Signed | 04/27/2016

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F 332	Continued From page 1 calcium carbonate tablets given. At that time, Nurse #1 acknowledged the tablets administered to Resident #167 did not contain the correct dose of calcium prescribed; and, the tablets administered to the resident did not contain Vitamin D as ordered. Nurse #1 stated, " I made a mistake. " An interview was conducted with the facility ' s Director of Nursing (DON) on 4/13/16 at 2:56 PM. During the interview, the DON stated her expectation was for the nurses to administer medications according to the physician ' s orders; and, for the nurses to verify they are giving the correct medication. 2) On 4/13/16 at 8:52 AM, Nurse #2 was observed as she prepared medications for administration to Resident #110. The medications included one tablet from a floor stock bottle containing 1000 units of Vitamin D3 and 25 milligrams (mg) of calcium. The nurse was observed as she administered the Vitamin D/calcium tablet to Resident #110. A review of Resident #110 ' s physician ' s medication orders included a current order for 500 mg calcium carbonate with 400 units of Vitamin D3 to be given as one tablet by mouth twice a day. An interview was conducted with Nurse #2 on 4/13/16 at 9:09 AM. Upon request, Nurse #2 reviewed Resident #110 ' s April 2016 Medication Administration Record (MAR) and the manufacturer ' s labeling on the stock bottle of the tablet administered to the resident. At that time, the nurse acknowledged there was a discrepancy between what was prescribed and what was	F 332	dosages on the Medication Administration Record matched the physician orders and that the prescribed dosage was in stock. 3. The Director of Nursing formally educated nurse #1 on April 15, 2016 on proper medication administration using the facility policy, with successful return demonstration by nurse #1. 4. The Director of Nursing formally educated nurse #2 upon the nurse's return to duty on April 20, 2016. This education was also on proper medication administration using the facility policy, with successful return demonstration by nurse #2. Identification of Others: The Director of Nursing reviewed the Medication Administration Records and physician orders for all residents receiving calcium supplements on April 14, 2016. The review ensured that the dosages on the Medication Administration Record matched the physician orders and that the prescribed dosages were in stock. Systemic Change: 1. The Director of Nursing and assigned Administrative RNs will educate all licensed nursing staff on proper medication administration by May 3, 2016. The education will be delivered by the Administrative RN in an interactive educational format using the facility policy and the completion of a post test. Any nurses on leave/vacation must complete the education before returning to duty. 2. Medication administration education, with post test, will be part of the new hire	

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F 332	Continued From page 2 given. Nurse #2 reported she knew the dosage of calcium and Vitamin D given to Resident #110 wasn't the same as what was indicated on the MAR. However, the nurse stated couldn't find the stock bottle with the correct dosage on the medication cart at the time of the medication pass. An interview was conducted with the facility ' s Director of Nursing (DON) on 4/13/16 at 2:56 PM. During the interview, the DON stated her expectation was for the nurses to administer medications according to the physician ' s orders; and, for the nurses to verify they are giving the correct medication.	F 332	orientation for all licensed nurses. The education will be provided by the Assistant Director of Nursing (Acting Staff Development Coordinator - SDC, until a new SDC can be hired. Monitoring: 1. A Medication Administration Audit Tool will be utilized to monitor staff compliance through observation of the Med Pass by an assigned Administrative RN. The audit will record the nurse's competence in all aspects of the facility medication administration policy. 2. The medication administration observation audits will be conducted with five licensed nurses per week for four weeks. The audits will be random across all days and all shifts. After the first four-week period, audits will be conducted with five licensed nurses per month for four months. The audits will be random across all days and all shifts. 3. The Director of Nursing will review the audit results for trends weekly and take action, such as additional staff education, accordingly. 4. The Director of Nursing will bring the results of the medication administration audits to the facility QAPI meeting monthly for five months. The need for continued audits will be determined by the QAPI committee based on the prior five months of audit results.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		5/11/16

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F 441	Continued From page 3 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the	F 441	Corrective Action:	

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F 441	Continued From page 4 facility failed to proper hand-washing or sanitizing between residents (Resident #225, #237, and #145) during 1 of 3 continuous observations of a medication pass; and, failed to use a sharps container for the disposal of a single-use lancet for 1 of 4 residents (Resident #145) observed to have their blood glucose monitored. The findings included: 1) A review of the facility's policy dated March 2003 on Handwashing/Hand Hygiene included the following Policy Statement: "Handwashing/Hand Hygiene is regarded by this facility as the single most important means of preventing the spread of infections." The Policy Interpretation and Implementation read, in part: " 1. All personnel shall follow our established handwashing/hand hygiene procedures to prevent the spread of infection and disease to other personnel, residents and visitors. 2. Employees must perform appropriate ten (10) to fifteen (15) second handwashing procedures using antimicrobial or non-antimicrobial soap and water under the following conditions: (b) After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; (c) After handling items potentially contaminated with blood, body fluids, or secretions; 3. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: (a) Before direct contact with residents; (d) Before preparing or handling medications; (j) After removing gloves.	F 441	1. Residents #225, #237 and #145 had no adverse effect related to nurse #3 not using gloves properly, not washing hands timely and not disposing of sharps properly. 2. The Director of Nursing formally educated nurse #3 on April 15, 2016 regarding the facility policy on proper hand washing, use of gloves and disposal of sharps. Nurse #3 provided a successful return demonstration and was found to be in compliance with the facility policy. Identification of Others: All residents have the potential to be affected. The Director of Nursing formally educated nurse #3 on April 15, 2016 regarding the facility policy on proper hand washing, use of gloves and disposal of sharps. Nurse #3 provided a successful return demonstration and was found to be in compliance with the facility policy. Systemic Change: 1. The Director of Nursing and assigned Administrative RNs will educate all nursing staff on proper hand washing, use of gloves and disposal of sharps per facility policy. The education will be completed by May 9, 2016. The education will be delivered in an interactive format with return demonstration by the staff members. Any nursing staff on leave/vacation must complete the education before returning to duty. 2. Proper hand washing, use of gloves and disposal of sharps, with return demonstration will be part of all new hire orientation for nursing staff. The education	

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F 441	Continued From page 5 4. The use of gloves does not replace handwashing/hand hygiene. " On 4/13/16 at 11:17 AM, a continuous observation was made as Nurse #3 prepared an insulin injection for administration to Resident #225. He entered the resident ' s room, put on gloves, and administered the insulin to the resident. The nurse was observed as he removed his gloves before leaving the resident's room and returning to the medication cart. Nurse #3 did not wash his hands nor use hand sanitizer after removing his gloves. The observation continued as Nurse #3 prepared a medication to be administered orally to Resident #237 on 4/13/16 at 11:26 AM. After the nurse administered this medication to the resident, he exited the room, obtained supplies for blood glucose monitoring; reentered the room, and put on gloves. Nurse #3 retrieved a glucometer from the resident's drawer, used a single-use retractable lancet to obtain a blood sample, and checked her blood glucose level. The nurse removed his gloves and threw them in the resident's trashcan. The observation was unclear as to where the used lancet was disposed. Nurse #3 put the glucometer back in the resident ' s drawer and exited the room. The nurse was then observed as he checked the electronic Medication Administration Record (MAR) on the medication cart to determine the required insulin dosage for Resident #237. The nurse was observed as he prepared the insulin for injection, re-entered the resident's room, put on gloves, and injected the insulin for Resident #237. After the nurse left the room, he disposed of the used insulin needle into the Sharps container on his medication cart. Nurse #3	F 441	will be provided by the Assistant Director of Nursing (Acting Staff Development Coordinator - SDC), until a new SDC can be hired. Monitoring: 1. An infection control audit tool was developed that included the following observations during resident care: proper hand washing, use of gloves and disposal of sharps. The audit tool is to be completed by assigned Administrative RNS. Audits will be conducted randomly across all shifts throughout the week and weekend. A sample (nurses and CNAs) of ten staff will be observed each week for four weeks, followed by five nursing staff per week for two months, followed by three nursing staff per week for two months. 2. The Director of Nursing will review audits weekly for trends and adjust auditing accordingly. 4. The Director of Nursing will report trends to the QAPI committee monthly. The committee will determine action is needed and make adjustments accordingly.	

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re-checked the MAR for Resident #237 again, pulled a second insulin from the med cart, dropped an unwrapped alcohol pad onto the floor, picked the alcohol pad up off the floor, and then drew up the dose of insulin needed for Resident #237. Nurse #3 entered the resident's room, put on gloves, and injected the insulin. He removed the gloves, exited the room, and disposed of the used insulin syringe in the Sharps container on his med cart. Nurse #3 did not wash his hands nor use hand sanitizer at any point during the observation.

The observation continued as Nurse #3 reviewed the electronic MAR on his medication cart. The nurse was observed as he touched his left hand to his mouth on 4/13/16 at 11:40 AM. On 4/13/16 at 11:43 AM, Nurse #3 was observed as he retrieved medication cart keys from his pocket. He unlocked the med cart, retrieved blood glucose monitoring supplies, pulled two gloves out from the box on top of the medication cart, and entered Resident #145 ' s room. Upon entering Resident #145 ' s room, Nurse #3 retrieved the glucometer from the resident ' s nightstand drawer and put the gloves on. The nurse then inserted a testing strip into the glucometer, used a single-use retractable lancet to obtain a blood sample, and checked the resident ' s blood glucose level. After obtaining the blood glucose reading, Nurse #3 removed his gloves and threw the gloves, used alcohol pad, and used lancet into the resident's room trashcan. On 4/13/16 at 11:48 AM, an observation was made as Nurse #3 went to the medication cart and used the hand sanitizer stored on top of the med cart to perform hand hygiene.

An interview was conducted on 4/13/16 at 11:49

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AM with Nurse #3. During the interview, inquiry was made as to why this was the first time during the observation period the nurse performed hand hygiene. The nurse acknowledged he had not used hand sanitizer or washed his hands between residents during the observation up to that point. He indicated he had been nervous during the observation but knew he should have used the hand sanitizer.

An interview was conducted on 4/13/16 at 2:56 PM with the Director of Nursing (DON). During the interview, the
DON reported she expected nursing staff to use hand sanitizer or handwashing between residents when they administered medications and in accordance with the facility ' s policy.

2) A review of the facility's policy (revised on 6/2012) on Obtaining a Glucose Level included a section entitled, The Steps in the Procedure. One of the procedural steps read, in part: "15. Dispose of the lancet in the sharps disposal container."

During an observation on 4/13/16 at 11:46 AM, Nurse #3 was observed as he used a single-use retractable lancet to obtain a blood glucose sample from Resident #145. After the blood glucose sample was drawn and the reading was taken, the nurse was observed as he threw the used lancet in the trash container located in the resident ' s room.

An interview was conducted on 4/13/16 at 11:49 AM with Nurse #3. When asked where he discarded the used lancet, Nurse #3 stated he threw it in the resident ' s trash. However, the nurse indicated he knew he should have put the

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F 441	Continued From page 8 used lancet in the Sharps container on his med cart. Nurse #3 reported he was nervous during the observation and attributed this mistake to his nerves. An interview was conducted on 4/13/16 at 2:56 PM with the Director of Nursing (DON). When asked about the disposal of a used lancet in a resident ' s trash can, the DON stated that was, " an infection control issue and potential for sticks. " Upon further inquiry, the DON reported she would expect all used lancets to be disposed of into a Sharps container.	F 441		