STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 02/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

(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 000	INITIAL COMMENTS On 02/07/17 the Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section completed a complaint investigation at the facility which identified deficient practice. State Agency administrative review revealed immediate jeopardy should have been considered. In order to fully investigate the identified deficient practice, the complaint investigation and the recertification surveys were combined into one survey with a start date of 02/07/17 and an exit date of 02/17/17. Event ID #4Z8O11. 1. 483.10 (F157) at J Immediate Jeopardy began on 01/25/17 when Resident #189 was administered Resident #181's morning medications in error and the nurse who made the error did not inform the physician, the responsible party or the Director of Nursing. Resident #189 was subsequently sent to and admitted to the hospital after developing nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy was removed on 02/17/17 at 2:15 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy) to ensure inservices were completed and monitoring systems are put into place and are effective related to timely notification of medication errors and changes in condition. 2. 483.12 (F224) at J Immediate Jeopardy began on 01/25/17 when Resident #189 was administered Resident #181's	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/14/2017

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F 000	Continued From page 1	F 000		

morning medications in error and the nurse who made the error did not inform the physician, the responsible party or the Director of Nursing. The nurse failed to obtain vital signs, assess or monitor the resident's condition or seek advice related to further medical intervention. Resident #189 was subsequently sent to and admitted to the hospital when he developed nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy was removed on 02/17/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy) to ensure inservices were completed and monitoring systems were put into place and were effective related to timely notification of medication errors, assessment following a medication error or change in condition and monitoring of the resident.

3. 483.24 and 483.25 (F309) at J
Immediate Jeopardy began on 01/25/17 when Resident #189 was administered Resident #181's morning medications in error and the nurse who made the error did not inform the physician to obtain directions and did not monitor the resident's vital signs or assess for a change in condition. Resident #189 was subsequently sent to the emergency room and admitted to the hospital when he developed nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy was removed on 02/17/17 at 2:15 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D

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F 000	Continued From page 2 (isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy) to ensure inservices are completed and monitoring systems are put into place and are effective related to assessing a resident following a medication error and monitoring so that timely identification of problems can be identified. 4. 483.45 (F333) at J Immediate Jeopardy began on 01/25/17 when Resident #189 was administered Resident #181's morning medications in error. Resident #189 was subsequently sent to and admitted to the hospital when he developed nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy was removed on 02/17/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy) to ensure inservices are completed and monitoring systems are put into place and are effective related to avoidance of significant medication errors. On 03/10/17 an amended 2567 report was provided to the facility. The Centers for Medicare and Medicaid Services (CMS) and the State Survey Agency determined the scope and severity levels of tags F-282 and F-318 both needed to be increased from a level "D" to a level "E".	F 000		
F 157 SS=J	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes.	F 157		3/21/17

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F 157	Continued From page 3	F 157		

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or

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F 157	Continued From page 4 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, family interview, staff interview, and physician interview, the facility failed to notify the physician, Director of Nursing and the Responsible Party of a medication error and a change in condition, including nausea and vomiting and a drop in blood pressure and pulse, resulting in 1 of 3 sampled residents being admitted to the hospital (Resident #189). Immediate Jeopardy began on 01/25/17 when Resident #189 was administered Resident #181's morning medications in error and the nurse who made the error did not inform the physician, the responsible party or the Director of Nursing. Resident #189 was subsequently sent to and admitted to the hospital after developing nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy was removed on 02/17/17 at 2:15 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy) to ensure in-services were completed and monitoring systems are put into place and are effective related to timely notification of medication errors and changes in condition. The findings included:	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The facility will ensure that the resident, physician, and the resident□s legal representative are immediately informed when there is a significant change in the resident□s physical condition and/or medication error occurs. Nurse administered incorrect medications to resident # 189 between 8 am-830 am. The affected resident was transferred out of the facility on 1/25/17 at 2:00 pm when the medication error was discovered by administration. The family member of the resident was notified of the error by the DON on 1/25/17. The physician was notified by the Unit Manager on 1/25/17 at 2 pm. The resident was admitted to the hospital and has not returned to the facility. The facility investigation was initiated on	

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F 157	Continued From page 5 Resident #189 was admitted to the facility on 01/19/17. His admission diagnoses included a history of pulmonary embolism, a history of deep vein thrombosis, paroxysmal tachycardia, bradycardia, difficulty walking, atrial fibrillation, long term anticoagulant use, muscle wasting and atrophy. The most recent Minimum Data Set, a 5 day dated 01/27/17, noted he had adequate hearing, he was understood and understands, his cognition and mood were not assessed, he had no behaviors, and required extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. He was noted to have taken 6 days of anticoagulants, 7 days of diuretic and received Occupational and Physical therapies. Review of physician orders included the following morning medications ordered for Resident #189: *Amiodarone HCL 200 Milligrams (mg) at 8 AM - an antiarrhythmic agent; *Diltiazem 24 hour Extended release 120 mg at 8 AM to be held for systolic less than 110 mmHg (milliliters of Mercury) and diastolic less than 60 mmHg - for hypertension and angina; *Lasix 20 mg at 8 AM - a diuretic; *Miralax powder 17 grams per day at 8 AM - for constipation; *Levothyroxine 25 micrograms (mcg) at 6 AM - for thyroid; and *Albuterol sulfate 2.5 mg/3 ml solution four times a days, first at 8 AM ordered 01/25/17 - for breathing. Review of the incident report dated 01/25/17 at 1:30 PM, Resident #189 received a medication error resulting in nausea and vomiting and hypotension. It was determined that Resident	F 157	1/25/17 by the DON. DON was notified at approximately 1:30 pm that a family member was requesting that guest be sent to the hospital. At that time DON questioned assigned nurse reason for need of transfer. Nurse notified DON that she had administered the incorrect medication to the guest during morning medication pass. DON questioned nurse regarding her notification to the physician and family member to which she responded No, I should have. Nurse interviewed by DON on 1/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded the same day on 1/25/17 and POC was initiated. The incident was reported to the NC Board of Nursing according to the disciplinary tree. Their investigation was assigned to a complaint officer with the North Carolina Board of Nursing. This report was made by DON on 2/7/17. All residents have the potential to be affected. On the date of occurrence all alert and oriented residents were interviewed to determine if any had received incorrect medications. No other issues were identified. On the date of occurrence all residents who were not alert and oriented were observed for changes in condition through direct observation and review of medical record by DON. The audit results were reported to the Medical Director. All residents	

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F 157	Continued From page 6 #189 received his roommate's 8 AM medications in error. Review of Resident #189's roommate's (Resident #181) record revealed the roommate's first and last name initials were the same as Resident #189's initials. Review of the picture in the computerized medical record system revealed the two residents were of different races and had an age difference of 31 years. Resident #181 was admitted to the facility on 01/24/17 with diagnoses including injury of C4 cervical spine. Resident #181's morning medications given to Resident #189 included: *Amlodipine Besylate 10mg at 8 AM for hypertension; *Coreg 25mg for hypertension; *Escitalopram 20 mg at 8 AM for depression; *Flomax 0.4mg at 8AM for urinary retention; *Flonase 0.05 % nasal spray at 8 AM for sinus congestion: *Lovenox 40 mg/0.4 ml subcutaneous at 8 AM for anticoagulation therapy; *Multivitamin/mineral at 8 AM; *Senna S 2 tabs at 8 AM for constipation; *Urecholine 50mg Four times a day, first at 8 AM for urinary discomfort.; and *Vitamin D3 1000 unit at 8 AM. The only nursing note in the medical record which related to the medication error was written by the Director of Nursing on 01/25/17 at 2:00 PM. The note stated the resident had nausea and vomiting and hypotension. Blood pressure was 80/60, respirations 20, pulse 61, temperature 97.3 degrees Fahrenheit and oxygen saturation was 95%. The physician was contacted and an order was given to send him to the emergency room for	F 157	observed in the audit had no issues identified and Medical Director notified by the Director of Nursing (DON) on 1/25/17. The physician and the Responsible Party were notified immediately by Nursing Administration upon notification of the medication issue. The resident was sent for hospital evaluation and treatment, and was discharged from the hospital successfully. All licensed nurses were in-serviced by the facility Pharmacist on 2/15/17 on the following: 1. Responsibility of reporting med errors to the physician at the time of knowledge of an occurrence of medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors. 3. The 6 rights of medication pass which include right individual, right medication, right dose, right time, right route and right documentation. 4. The notification of family/responsible party. All licensed nurses were in-serviced on 2/15/17 by the DON and Regional QA Manager. At Clinical Meetings conducted each weekday, the following will be reviewed by Administrative Nurse Team: a. Physician Orders to identify changes, b. Incident Reports, c. Nurse 24 hour reports, d. Chart reviews. Chart audits will be conducted by Nurse Administration Team at 10% weekly for 4 weeks then Monthly thereafter. Results of all audits will be reviewed by the Director of Nursing. Any variances	

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F 157	Continued From page 7 evaluation and treatment. The family was noted to be at bedside. Review of the undated hospital transfer sheet revealed Resident #189 received the wrong medications. His vital signs were listed as temperature 97.3 Fahrenheit, pulse 61 beats per minute, respiration rate 20, and blood pressure 85/58 and 80/60 and the pulse oximetry 95%. Emergency Medical Services (EMS) responded 01/25/17. Review of the EMS report revealed that staff reported Resident #189 was vomiting and his blood pressure was 75 systolic. EMS noted he was awake, slow to respond, had pale mucus membranes and stated he just didn't feel right after taking that handful of pills this morning. 0.5 mg atropine was given and his blood pressure and heart rate increased from 77/49 and 42 pulse at 2:07 PM to 103/65 with a pulse of 59 at 2:13 PM. Review of the hospital history and physical dated 01/25/17 revealed he presented to the hospital with a 1 day history of generalized malaise as well as hypotension and bradycardia. Resident #189 was accidentally given doses of another resident's medication including Coreg, Citalopram, Lovenox, Flomax, Flonase, Senokot and Urecholine. The resident was noted to have some mild nausea and nonbloody vomiting, his blood pressure was 85/58 and his heart rate was in the 40s. He was given 0.5 mg atropine in route and once in the emergency department, the blood pressure was noted to drop to 70/50 and was dosed with another dose of 0.5mg of atropine. He was started on intravenous hydration and his blood pressures improved to the 100-110 systolic range with a heart rate currently around 57-59.	F 157	will be addressed at the time identified and appropriate action taken including any notification needed, re-education and/or disciplinary action. All findings will be reported by the Director of Nursing to the QA Committee monthly FOR 3 MONTHS AND QUARTERLY THEREAFTER with additional education and training provided for any identified issues.	

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Resident #189 stayed in the hospital until discharge to another nursing facility on 01/30/17.

The hospital discharge summary dated 01/30/17 stated Resident #189 was initially admitted for observation status secondary to his bradycardia and hypotension from the medication misuse. His bradycardia and hypotension continued despite IV hydration and holding additional medications. Plans were for discharge the following day, however on 01/27/17 secondary to the resident becoming was somewhat agitated and confused, the resident was started on the delirium protocol.

Review of the Employee Disciplinary Record revealed Nurse #3, who made the medication error related to Resident #189 was terminated on 01/25/17 for "making errors of sufficient magnitude which may jeopardize resident safety and welfare." Additional notes indicated the med error occurred at approximately 8:30 AM to 9:00 AM and the nurse failed to notify the Director of Nursing (DON), Physician or family. The DON became aware of the error at approximately 1:30 PM.

The Responsible Party (RP) was interviewed via phone on 02/07/17 at 10:27 AM. She related that she arrived at the facility on 01/25/17 at 1:00 PM to visit Resident #189. She observed the resident throwing up, with a grey colored face and drooling. She stated she asked the nurse what happened and was told the nurse had administered wrong medication. The RP stated the DON came to the room quickly confirming the medication error. The RP stated she insisted he be sent to the hospital immediately.

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Nurse #3 was interviewed via phone on 02/15/17 at 9:09 AM. Nurse #3 stated on 01/25/17 it was a normal busy day. She stated there were multiple interruptions from therapy during medication pass per usual. She stated she had worked with Resident #189 a couple of times before. She stated the roommate had been admitted the day before. She stated as soon as she gave Resident #189 the wrong medications, she realized it "immediately, immediately." She stated that she had spoken to the physician several times that morning relating to Resident #189's new order for a nebulizer treatment and related to several other residents but never thought to inform the physician of the medication error. She stated she intended to call the physician about the medication error but got busy with another resident. She stated the next time she saw Resident #189 he was with therapy and then after lunch he started vomiting. She stated that she informed the DON and physician about the med error when Resident #189 got ill. Nurse #3 further stated that by the time she went to inform the family of the medication error the family had left with Resident #189 and EMS.

Resident #189's physician was interviewed on 02/15/17 at 11:36 AM. The physician stated he was in the building that morning but was not informed of any medication errors until he had already left the facility. He further stated that Nurse #2 notified him of the medication error and not Nurse #3. He stated he should have been informed and would normally have had the nurse monitor vital signs more closely and possibly adjust dosages of upcoming medications.

On 02/15/17 at 12:13 PM the DON stated that she was informed around 1:00 to 1:30 PM that

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Resident #189's responsible party wanted the resident sent to the hospital. The DON went to the unit immediately and asked Nurse #3 what was going on. It was then that Nurse #3 informed the DON she had given Resident #189, his roommate's morning medications. Nurse #3 then stated she had not notified the DON, the physician or the responsible party of the medication error. DON terminated Nurse #3's employment that day.

Upon follow up interview with the DON on 02/16/17 at 1:36 PM, she revealed was her expectation that a nurse who made a medication error would have reported the error to the DON immediately and then after taking vital signs and making an initial assessment the nurse would contact the physician for additional guidance. The DON stated that once the physician was notified and the nurse gathered information of the resident's status and subsequent orders, the responsible party should be notified.

The facility DON, corporate nurse and administrator of a sister facility were informed of Immediate Jeopardy on 02/15/17 at 2:38 PM.

The facility provided an acceptable credible allegation of compliance on 02/16/17 at 1:20 PM as follows:

Credible Allegation of Compliance

F157
The facility will ensure that the resident, physician and resident's legal representative are immediately informed when there is a significant

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change in the resident's physical condition and / or medication error occurs.

Nurse administered incorrect medications to resident #189 between 8am-830am. Nurse failed to notify the physician and family member.

The affected resident was transferred out of the facility on 1/25/17 at 2:00 pm when the medication error was discovered by administration. The family member of the resident was notified of the error by the DON on 1/25/17. The physician was notified by the Unit Manager on 1/25/17 at 2 pm. The resident was admitted to the hospital and has not returned to the facility.

The facility investigation was initiated on 1/25/17 by the DON.

Facility Investigation

DON notified at approximately 1:30pm that a family member was requesting that guest be sent to the hospital. At that time DON questioned assigned nurse reason for need of transfer. Nurse notified DON that she had administered the incorrect medication to the guest during morning medication pass. DON questioned nurse regarding her notification to physician and family member to which she responded, "No, I should have." Nurse interviewed by DON on 01/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded same day 01/25/17 and POC was initiated.

The licensed nurse involved was terminated immediately due to not reporting the medication

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(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
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error at the time of occurrence. The incident was reported to the NC Board of Nursing according to their disciplinary tree. Their investigation was assigned to a complaint officer with the North Carolina Board of Nursing. Report made by the DON on 02/07/17.

The licensed nurse involved was terminated immediately. The incident was reported to the NC Board of Nursing and the investigation was assigned to NCBON Complaint Officer.

All residents have the potential to be affected. On the date of occurrence all alert and oriented residents were interviewed to determine if any had received incorrect medications. No other issues were identified. On the date of occurrence all residents who were not alert and oriented were observed for changes in condition through direct observation and review of medical records by the DON. The audit results were reported to the Medical Director. All residents observed in audit had no issues identified and Medical Director notified by the Director of Nursing (DON) on 01/25/17.

Root Cause Analysis

Nurse failed to notify physician of a medication error that allowed physician to direct staff to direct any monitoring or interventions that would be appropriate with the significance of the error. Nurse failed to notify resident #189.

Nurse failed to notify family member of resident #189.

Nurse stated, "MD was notified but not timely. All of guest's medications were held-other issues

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F 157	Continued From page 13 with another guest occurred just afterward distracting me from reporting this error in timely manner. Guest was observed at lunch and appeared ok- then was assessed and MD was called when he had issues." In servicing All licensed nurses were in-serviced by the facility Pharmacist on 2/15/17 on the following. 1. Responsibility of reporting med errors to the physician at the time of knowledge of an occurrence of medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors. 3. The 6 rights of medication pass which include right individual, right medication, right dose, right time, right route and right documentation. 4. The notification of family/responsible party. All licensed nurses were in-serviced on 2/15/17 by DON and Regional QA Manager on the prohibition of cell phone usage during medication administration. Immediate Jeopardy was removed on 02/17/16 at 2:15 PM when interviews with nurses confirmed they had been in-serviced and knew the steps to take to ensure the DON, physician and responsible party were notified of medication errors immediately and subsequent changes in condition.	F 157		
F 224 SS=J	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident	F 224		3/21/17

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F 224	Continued From page 14 property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, physician interview and pharmacy interview, the facility failed to obtain medical intervention following a medication error for 1 of 3 residents reviewed for medication errors. Notification of the resident's physician, Director of Nursing and the responsible party of Resident #189 related to the resident receiving the wrong morning medication was not made until 1:30 PM when the resident developed nausea and vomiting. The nurse who gave the wrong medication failed to follow up with any assessment of the resident until he became ill with side effects of the wrong medications. The resident was sent to the hospital and admitted. Immediate Jeopardy began on 01/25/17 when Resident #189 was administered Resident #181's morning medications in error and the nurse who made the error did not inform the physician, the	F 224	The facility will ensure that the resident is provided with services necessary to avoid physical harm by reporting a significant medication error at the time of occurrence or when knowledge of a significant medication error has occurred by notifying the physician for direction of interventions and monitoring as appropriate. The affected resident was transferred out of the facility on 1/25/17 at 2:00 pm when the medication error was discovered by administration. The family member of the resident was notified of the error by the DON on 1/25/17. The physician was notified by the Unit Manager on 1/25/17 at 2 pm. The resident was admitted to the hospital and has not returned to the facility.	

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F 224	Continued From page 15 responsible party or the Director of Nursing. The nurse failed to obtain vital signs, assess or monitor the resident's condition or seek advice related to further medical intervention. Resident #189 was subsequently sent to and admitted to the hospital when he developed nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy was removed on 02/17/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy) to ensure inservices were completed and monitoring systems were put into place and were effective related to timely notification of medication errors, assessment following a medication error or change in condition and monitoring of the resident. The findings included: Resident #189 was admitted to the facility on 01/19/17. His admission diagnoses included a history of pulmonary embolism, a history of deep vein thrombosis, paroxysmal tachycardia, bradycardia, difficulty walking, atrial fibrillation, long term anticoagulant use, muscle wasting and atrophy. The most recent Minimum Data Set, a 5 day dated 01/27/17, noted he had adequate hearing, he was understood and understands, his cognition and mood were not assessed, he had no behaviors, and required extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. He was noted to have taken 6 days of anticoagulants, 7 days of diuretic and received	F 224	The facility investigation was initiated on 1/25/17 by the DON. DON notified at approximately 1:30 pm that a family member was requesting that guest by sent to the hospital. At that time DON questioned assigned nurse reason for need of transfer. Nurse notified DON that she had administered the incorrect medication to the guest during morning medication pass. DON questioned nurse regarding her notification to the physician and family member to which she responded No, I should have. Nurse interviewed by DON on 1/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded the same day on 1/25/17 and POC was initiated. The incident was reported to the NC Board of Nursing according to the disciplinary tree. Their investigation was assigned to a complaint officer with the North Carolina Board of Nursing. This report was made by DON on 2/7/17. All residents have the potential to be affected. On the date of occurrence all alert and oriented residents were interviewed to determine if any had received incorrect medications. No other issues were identified. On the date of occurrence all residents who were not alert and oriented were observed for changes in condition through direct observation and review of medical record by DON. The audit results were reported	

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F 224	Continued From page 16 Occupational and Physical therapies. Review of physician orders included the following morning medications ordered for Resident #189: *Amiodarone HCL 200 Milligrams (mg) at 8 AM - an antiarrhythmic agent; *Diltiazem 24 hour Extended release 120 mg at 8 AM to be held for systolic less than 110 mmHg (milliliters of Mercury) and diastolic less than 60 mmHg - for hypertension and angina; *Lasix 20 mg at 8 AM - a diuretic; *Miralax powder 17 grams per day at 8 AM - for constipation; *Levothyroxine 25 mcg at 6 AM - for thyroid; and *Albuterol sul 2.5 mg/3 ml solution four times a days, first at 8 AM ordered 01/25/17 - for breathing. Review of the incident report dated 01/25/17 at 1:30 PM, Resident #189 received a medication error resulting in nausea and vomiting and hypotension. It was determined that Resident #189 received his roommate's 8 AM medications in error. Review of Resident #189's roommate's record revealed, the roommate Resident #181's first and last name initials were the same as Resident #189's initials. Review of the picture in the computerized medical record system revealed the two residents were of different races and had an age difference of 31 years. Resident #181 was admitted to the facility on 01/24/17 with diagnoses including injury of C4 cervical spine. Resident #181's morning medications given to Resident #189 included: *Amlodipine Besylate 10mg at 8 AM for hypertension;	F 224	to the Medical Director. All residents observed in the audit had no issues identified and Medical Director notified by the Director of Nursing (DON) on 1/25/17. All other residents observed gave no indication of neglect as evidenced by no change in condition. On 2/15/17 all residents having the potential to be affected were again interviewed. Alert and oriented residents did not indicate that they were aware of any medications being given incorrectly and well cared for and not neglected. All residents with cognitive issues were reassessed by licensed nurses. No issues were noted that would be related to medication issues. All licensed nurses were reeducated by the Director of Nursing on neglect, with specific emphasis involving medication errors and appropriate responses on 2/17/17 or prior to their next scheduled shift. All licensed nurses were in-serviced by the facility Pharmacist on 2/15/17 on the following: 1. Responsibility of reporting med errors to the physician at the time of knowledge of an occurrence of medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors. 3. The 6 rights of medication pass which include right individual, right medication, right dose, right time, right route and right documentation. 4. The notification of family/responsible party. At clinical meetings held each weekday,	

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F 224	Continued From page 17 *Coreg 25mg for hypertension; *Escitalopram 20 mg at 8 AM for depression; *Flomax 0.4mg at 8AM for urinary retention; *Flonase 0.05 % nasal spray at 8 AM for sinus congestion: *Lovenox 40 mg/0.4 ml subcutaneous at 8 AM for anticoagulation therapy; *Multivitamin/mineral at 8 AM; *Senna S 2 tabs at 8 AM for constipation; *Urecholine 50mg Four times a day, first at 8 AM for urinary discomfort.; and *Vitamin D3 1000 unit at 8 AM. The Occupational Therapy note of 01/25/17 at 1:21 PM stated Resident #189 was noted to suffer from vomiting this date. Treatment ended after cleaning up from activities of daily living skills and nursing was notified. The only nursing note in the medical record which related to the medication error was written by the Director of Nursing on 01/25/17 at 2:00 PM. The note stated the resident had nausea and vomiting and hypotension. Blood pressure was 80/60, respirations 20, pulse 61, temperature 97.3 degrees Fahrenheit and oxygen saturation was 95%. The physician was contacted and an order was given to send him to the emergency room for evaluation and treatment. The family was noted to be at bedside. Review of the undated hospital transfer sheet revealed Resident #189 received the wrong medications. His vital signs were listed as temperature 97.3 Fahrenheit, pulse 61 beats per minute, respiration rate 20, and blood pressure 85/58 and 80/60 and the pulse oximetry 95%. Emergency Medical Services (EMS) responded	F 224	the following will be reviewed by Administrative Nurse Team in order to monitor any change of condition or med errors: a. Physician Orders, b. Incident reports, c. Nurse 24 hour reports, d. Chart Review. In addition, compliance will be monitored thru daily management rounds and guest satisfaction interviews of 10% daily 5 x a week for 4 weeks and random weekly thereafter. There will be immediate follow up for any concerns addressed. Results of all audits and customer satisfaction interviews will be reviewed by the Director of Nursing OR Administrator. Any variances will be addressed at the time identified and appropriate action taken if needed. All findings will be reported by the Director of Nursing to the QA Committee monthly. Additional education and training provided for any identified issues.	

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01/25/17. Review of the EMS report revealed that staff reported Resident #189 was vomiting and his blood pressure was 75 systolic. EMS noted he was awake, slow to respond, had pale mucus membranes and stated he just didn't feel right after taking that handful of pills this morning. 0.5 mg atropine was given and his blood pressure and heart rate increased from 77/49 and 42 pulse at 2:07 PM to 103/65 with a pulse of 59 at 2:13 PM.

Review of the hospital history and physical dated 01/25/17 revealed he presented to the hospital with a 1 day history of generalized malaise as well as hypotension and bradycardia. Resident #189 was accidentally given doses of another resident's medication including Coreg, Citalopram, Lovenox, Flomax, Flonase, Senokot and Urecholine. The resident was noted to have some mild nausea and nonbloody vomiting, his blood pressure was 85/58 and his heart rate was in the 40s. He was given 0.5 mg atropine in route and once in the emergency department, the blood pressure was noted to drop to 70/50 and was dosed with another dose of 0.5mg of atropine. He was started on intravenous hydration and his blood pressures improved to the 100-110 systolic range with a heart rate currently around 57-59. Resident #189 stayed in the hospital until discharge to another nursing facility on 01/30/17.

The hospital discharge summary dated 01/30/17 revealed Resident #189 was diagnoses with medication misadministration resulting in bradycardia and hypotension. The summary indicated that his bradycardia and hypotension continued despite treatments including intravenous hydration and holding additional medications. The resident was not discharged on

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01/27/17 as planned due to him being somewhat agitated and confused and the hospital started the delirium protocl.

Review of the Employee Disciplinary Record revealed Nurse #3, who made the medication error related to Resident #189 was terminated on 01/25/17 for "making errors of sufficient magnitude which may jeopardize resident safety and welfare." Additional notes indicated the med error occurred at approximately 8:30 AM to 9:00 AM and the nurse failed to notify the Director of Nursing (DON), Physician or family. The DON became aware of the error at approximately 1:30 PM.

Nurse #3 was interviewed via phone on 02/15/17 at 9:09 AM. Nurse #3 stated on 01/25/17 it was a normal busy day. She stated there were multiple interruptions from therapy during medication pass per usual. It was her first day back from several days off and she was tired from getting little sleep the night before. She stated she had worked with Resident #189 a couple of times before. She stated the roommate had been admitted the day before. She stated as soon as she gave Resident #189 the wrong medications, she realized it "immediately, immediately." She stated she intended to call the physician about the medication error but got busy with another resident. She further stated that she had spoken to the physican several times that morning relating to Resident #189's new order for a nebulizer treatment and related to several other residents but never thought to inform the physician of the med error. She stated the next time she saw Resident #189 he was with therapy and then after lunch he started vomiting. She stated she thought staff took his blood pressure

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after the med error but she was not sure. She stated that she informed the DON and physician about the med error when Resident #189 got ill.

On 02/15/17 at 10:14 AM an interview was conducted with the occupational Therapist (OT) who worked with Resident #189 on 01/25/17. The OT stated he went in to work with the resident and found him in the bathroom covered in vomit. He stated he and the nurse aide got him cleaned up and he vomited again. Resident #189 was described by the OT as awake but much less verbal than his usual and OT could not understand him. OT stated the resident vomited "a good bit" and he required maximum assistance to transfer which was definitely different.

Resident #189's physician was interviewed on 02/15/17 at 11:36 AM. The physician stated he was in the building that morning but was not informed of any medication errors until he had already left the facility. He further stated that it was a different nurse, not Nurse #3, who notified him of the medication error. He stated normally he would have had the nurse monitor vitals signs more closely after a medication error and possibly adjust dosages of upcoming medications.

Nurse Aide (NA) #1 was interviewed on 02/15/17 at 8:26 AM. NA #1 stated she routinely worked with Resident #189 and on 01/25/17 Resident #189 was not able to stand and do for himself per his usual. He was unable to get himself off the commode which she said was different for him. She stated that she informed Nurse #3 of Resident #189 vomiting and believed the nurse took his blood pressure. NA #1 stated she did not take his vital signs. A few minutes after she and

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OT transferred him into the chair, Resident #189's responsible party came in mentioned that she thought he had taken a turn for the worse. NA #1 stated she had noticed a change in Resident #189 throughout the morning.

On 02/15/17 at 12:13 PM the DON stated that she was informed around 1:00 to 1:30 PM that Resident #189's responsible party wanted the resident sent to the hospital. The DON stated she immediately went to the unit and asked Nurse #3 what was going on with Resident #189 and it was then that Nurse #3 informed the DON she had given Resident #189, his roommates morning medications. Nurse #3 then stated she had not notified the DON, the physician or the responsible party of the medication error. DON terminated Nurse #3's employment that day.

On 02/15/17 at 3:19 PM Nurse #2 stated that on 01/25/17 nurse aides approached her to ask if she could help get Resident #189 ready to transport to the hospital. She went to the hall and found Nurse #3 looking for equipment to give him a nebulizer treatment. Nurse #2 proceeded to print out the Medication Administration Record for the hospital. It was after that that Nurse #3 informed Nurse #2 and the DON that she administered the wrong medications. Nurse #2 stated she never entered the room to assess Resident #189 as she was only helping with the paperwork. Nurse #2 then called the physician to inform him of the medication error and the impending transport to the hospital and took over the medication cart for Nurse #3.

On 02/16/17 at 8:38 AM the pharmacist who owned the pharmacy company used by the facility was interviewed. He reviewed the medications

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Resident #189 received and compared them to the medications he was ordered. He revealed that some of the medications Resident #189 actually received the morning of 01/25/17 were similar to his own. He further stated the Urecholine may have made him nauseous and the addition of coreg and lasix would have "absolutely" affected his blood pressure.

The facility DON, corporate nurse and administrator of a sister facility were informed of Immediate Jeopardy on 02/15/17 at 2:38 PM.

The facility provided an acceptable credible allegation of compliance on 02/16/17 at 2:32 PM as follows:

Credible Allegation of Compliance

The facility will ensure that each resident is provided with services necessary to avoid physical harm by reporting a significant medication error at the time of occurrence or when knowledge of a significant medication error has occurred by notifying the physician for direction of interventions and monitoring as appropriate.

Nurse administered incorrect medications to resident #189 between 8am-830am. Nurse failed to notify the physician and family member. The nurse failed to assess/monitor the resident upon discovery of the medication error and failed to monitor the resident between the time of error and when resident was transferred to the hospital.

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Resident #189 was transferred out of the facility on 1/25/17 at 2:00pm when the medication error was discovered by administration. Director of Nursing notified the family member at approx. 130-145pm. Unit Manager notified physician and order to transfer resident to hospital received. The resident was admitted to the hospital and has not returned to the facility.

The facility investigation was initiated on 01/25/17 by the DON.

Facility Investigation

The Director of Nursing (DON) was notified at approximately 1:30pm that a family member was requesting that the resident be sent to the hospital. At that time the DON questioned the assigned nurse regarding the reason for the need to transfer the resident to the hospital. The nurse notified the DON that she had administered the incorrect medication to the resident during morning medication pass. The DON questioned the nurse regarding her notification of physician and family member to which she responded, "No, I should have." Nurse interviewed by DON on 01/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded the same day 01/25/17 and POC (Plan of Correction) was initiated.

The licensed nurse involved was terminated immediately due to not reporting the medication error at the time of occurrence. The incident was reported to the NC Board of Nursing according to

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their disciplinary tree. Their investigation was assigned to a complaint officer with the North Carolina Board of Nursing. Report made by the DON on 02/07/17.

All residents who receive medications have the potential to be affected. On the date of occurrence (1/25/17) all alert and oriented residents were interviewed by the DON to determine if any had received incorrect medications. No other issues were identified. On the date of occurrence all residents who were not alert and oriented were observed by the DON for changes in condition through direct observation and review of medical records. These audit results were reported to the Medical Director. All other residents observed gave no indication of neglect as evidenced by no change of condition.

On 2/15/17 all residents having the potential to be affected were again reviewed. Alert and oriented residents did not indicate that they were aware of any medications being given incorrectly. All residents with cognitive issues were reassessed by licensed nurses. No issues were noted that would be related to medication issues.

Root Cause Analysis

The nurse failed to perform an initial assessment on resident #189 using nursing judgment to gather baseline data after the medication error occurred.

The nurse failed to notify physician of medication error that would have allowed the physician to direct staff on monitoring or interventions that would be appropriate with the significance of the error.

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THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

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F 224	Continued From page 25	F 224		

Nurse stated, "MD was notified but not timely. All of guest's medications were held-other issues with another guest occurred just afterward distracting me from reporting this error in timely manner. Guest was observed at lunch and appeared ok- then was assessed and MD was called when he had issues."

In-servicing

All licensed nurses were in-serviced by the DON on the Six Rights of Medication Administration and the prohibition of cell phone use during medication administration between February 5th thru the 9th.

All licensed nurses were in serviced by the facility's Pharmacist on 2/15/17 on the following: 1. Responsibility of reporting med errors to the physician at the time of knowledge of an occurrence of medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors which is "Any error that occurs in the medication use process." 3. The 6 rights of medication pass which included documentation. 4. The notification of family/responsible party.

DON and Regional QA Nurse in-serviced all Licensed Nurses on 2/15/17 on the prohibition of cell phone use during medication administration.

All licensed nurses will be re-educated by the Director of Nursing (DON) on neglect, with specific emphasis involving medication errors and appropriate responses on 02/17/17 or prior to their next scheduled shift.

System Change

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F 224	Continued From page 26 The orientation process for new licensed nurses will include. 1. Responsibility of reporting med errors to the physician at the time of the knowledge of an occurrence of a medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors which is "Any error that occurs in the medication use process." 3. The 6 right of medication pass which include right individual, right medication, right dose, right time, right route and right documentation. 4. The notification of family/responsibility party. 5. Neglect, with specific emphasis involving medication errors and appropriate responses. Immediate jeopardy was removed on 02/17/17 at 2:15 PM when interviews with nurses confirmed they had been inserviced and knew the steps to take to ensure the correct medications were administered to the right individual, to report medication errors immediately to the DON and to visually assess and take vital signs of the resident. The nurses knew to then inform the physician and follow any further instructions for assessing and monitoring for a change in condition. Nurse interviews verified they were inserviced on documenting all findings and on what constituted neglect of a resident including failure to intervene and seek additional medical intervention.	F 224		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 253		3/21/17

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F 253	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep the walls clean in 2 of 21 resident rooms, rooms 206 and 208 on 1 of 2 resident halls and failed to keep bathroom floors clean and free of stains around the base of the commodes in 5 of 21 resident rooms, rooms 201, 205, 206, 208 and 209 on 1 of 2 resident halls. The findings included: 1. Observations of room 201 on 02/13/17 at 10:10 AM, 02/14/17 at 1:20 PM, 02/15/17 at 8:23 AM, 02/16/17 at 8:34 AM and 02/17/17 at 8:48 AM revealed the bathroom floor to be sticky with dark brown/black gummy areas on the floor. In addition the area around the base of the toilet was stained and rusty. An interview conducted on 02/17/17 at 8:48 AM with the Housekeeping Supervisor revealed it was her expectation for the housekeepers to empty the trash, dust the surfaces of the room, clean the toilet all way down to the floor and sweep and mop the room and bathroom every day. She further stated that she was in agreement that the bathroom floor was sticky and the base of the commode was stained and rusty and needed to be cleaned. 2. Observations of room 205 on 02/13/17 at 10:15 AM, 02/14/17 at 1:25 PM, 02/15/17 at 8:33, 02/16/17 at 8:44 AM and 02/17/17 at 8:58 AM revealed the bathroom floor to be sticky with dark brown/black gummy areas on the floor. In addition the area around the base of the toilet was stained and rusty.	F 253	The facility will continue to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. The walls of rooms 206 and 208 have been cleaned. The bathroom floors of rooms 201, 205, 206, 208, and 209 have been stripped of wax which removed discolorations on the floor and around the commodes. Current residents have the potential to be affected. All rooms have been inspected for cleanliness and stains by housekeeping supervisor. Any dirty soiled rooms identified were cleaned upon observation. The Director of Housekeeping services was in-serviced by the Regional Housekeeping Consultant on facility□'s policy in regards to expectations on providing services to maintain a sanitary, orderly, and comfortable interior. The Director of Housekeeping Services in-serviced housekeeping staff in regards to expectations on providing services to maintain a sanitary, orderly, and comfortable interior. All in-servicing was completed on 3/11/17. A QA Environmental monitoring tool which lists all areas of room and bathroom, will be utilized to ensure ongoing compliance	

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F 253	Continued From page 28 An interview conducted on 02/17/17 at 8:58 AM with the Housekeeping Supervisor revealed it was her expectation for the housekeepers to empty the trash, dust the surfaces of the room, clean the toilet all way down to the floor and sweep and mop the room and bathroom every day. She further stated that she was in agreement that the bathroom floor was sticky and the base of the commode was stained and rusty and needed to be cleaned. 3. Observations of room 206 on 02/13/17 10:20 AM, 02/14/17 at 1:35 PM, 02/15/17 at 8:38 AM, 02/16/17 at 8:49 AM and 02/17/17 at 9:04 AM revealed the bathroom floor to be sticky with dark brown/black gummy areas on the floor and the area around the base of the toilet was stained and rusty. In addition, the wall behind bed B was stained with what appeared to be brown coffee stains. An interview conducted on 02/17/17 at 9:04 AM with the Housekeeping Supervisor revealed it was her expectation for the housekeepers to empty the trash, dust the surfaces of the room, clean the toilet all way down to the floor, sweep and mop the room and bathroom every day and clean any stains off the walls in resident rooms. She further stated that she was in agreement that the bathroom floor was sticky and the base of the commode was stained and rusty and the wall behind bed B needed to be cleaned. 4. Observations of room 208 on 02/13/17 10:25 AM, 02/14/17 at 1:40 PM, 02/15/17 at 8:43 AM, 02/16/17 at 8:59 AM and 02/17/17 at 9:08 AM revealed the bathroom floor to be sticky with dark brown/black gummy areas on the floor and the area around the base of the toilet was stained	F 253	with cleanliness by the Director of Housekeeping or Administrator or QA Manager for room rounds. 5 rooms will be inspected daily x 5 days for 1 week by Director of Housekeeping or Administrator using the QA monitoring tool. Then Housekeeping Director will systematically inspect at least 3 rooms weekly on an ongoing basis to ensure ongoing compliance. Any issues at that time will be corrected at the time of inspection and additional training to be provided as indicated. Inspection results will be monitored by the QA committee quarterly to ensure ongoing compliance.	

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F 253	Continued From page 29 and rusty. In addition, the wall behind bed A was stained with what appeared to be brown coffee stains. An interview conducted on 02/17/17 at 9:09 AM with the Housekeeping Supervisor revealed it was her expectation for the housekeepers to empty the trash, dust the surfaces of the room, clean the toilet all way down to the floor, sweep and mop the room and bathroom every day and clean any stains off the walls in resident rooms. She further stated that she was in agreement that the bathroom floor was sticky and the base of the commode was stained and rusty and the wall behind bed A needed to be cleaned. 5. Observations of room 209 on 02/13/17 at 10:30 AM, 02/14/17 at 1:45 PM, 02/15/17 at 8:50 AM, 02/16/17 at 9:05 AM and 02/17/17 at 9:14 AM revealed the bathroom floor to be sticky with dark brown/black gummy areas on the floor. In addition the area around the base of the toilet was stained and rusty. An interview conducted on 02/17/17 at 9:14 AM with the Housekeeping Supervisor revealed it was her expectation for the housekeepers to empty the trash, dust the surfaces of the room, clean the toilet all way down to the floor and sweep and mop the room and bathroom every day. She further stated that she was in agreement that the bathroom floor was sticky and the base of the commode was stained and rusty and needed to be cleaned.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments	F 272		3/21/17

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(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with the resident, as well as communication with licensed and
non-licensed direct care staff members on all shifts.

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F 272	Continued From page 31 The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for psychotropic drug use and nutrition for 2 of 16 sampled residents (Resident #75 and #104). The findings included: 1. Resident #75 was admitted to the facility on 09/16/15 with diagnoses of heart failure, anxiety and depression. Review of the significant change Minimum Data Set (MDS) dated 05/16/16 revealed Resident #75 was cognitively intact and received antianxiety and antidepressant medications daily during the assessment period. Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated 06/01/16 revealed Resident #75 had a diagnoses of anxiety that required the use of an antianxiety medication and depression that required the use of an antidepressant medication and was at risk for adverse psychotropic medication side effects. The CAA summary did not analyze how the psychotropic medications actually affected Resident #75's day to day function and activities. The CAA summary also did not indicate if there had been any adverse drug reactions or	F 272	The facility will continue to complete Care Area Assessments for residents as triggered by the MDS. Resident #75 The Care Area Assessment for Psychotropic Drug Use was completed to summarize how the psychotropic medications affected Resident #75'□s day to day function and activities. The Care Area Assessment summary will be completed to indicate if there has been any adverse drug reactions or attempted dose reductions. Resident #104 The Care Area Assessment for Nutrition was completed to summarize and analyze how the mechanically altered and therapeutic diet actually affected Resident #104 and the implications of using a therapeutic diet on the resident□s nutritional status and quality of life, nutritional imbalances and medication interactions. All Residents have potential to be affected. All Residents Care Area Assessments have been reviewed and updated as needed. All MDS's were reviewed and monitored for completed	

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F 272	Continued From page 32 attempted dose reductions. An interview with the MDS Nurse on 02/16/17 at 9:57 AM revealed she had been employed by the facility as the MDS Nurse since July 2016. She stated she received periodic training from the facility MDS Consultant. The MDS revealed she had not completed Resident #75's CAA summary for psychotropic drug use and the person that completed Resident #75's was no longer employed by the facility. She stated the CAA summary should have included more resident specific information and a more in-depth analysis of findings. 2. Resident #104 was admitted to the facility on 11/23/16 with diagnoses of chronic obstructive pulmonary disease and diabetes. Review of the admission Minimum Data Set (MDS) dated 11/30/16 revealed Resident #104 was moderately cognitively impaired. The MDS further revealed Resident #104 was coded for a mechanical/therapeutic diet. Review of the Care Area Assessment (CAA) for Nutrition dated 12/06/16 revealed Resident #104 triggered due to a mechanically altered, therapeutic no sugar added diet. Contributing factors to consider were diagnoses of chronic obstructive pulmonary disease and congestive heart failure and daily diuretic use. The CAA summary did not analyze how the mechanically altered and therapeutic diet actually affected Resident #104 and the implications of using a therapeutic diet on the resident's nutritional status and quality of life, nutritional imbalances and medication interactions.	F 272	CAA's by MDS Coordinator on 3/16/2017. Dietary Manager, Social Services and MDS/Care plan team WAS in-serviced by the Director of Clinical Reimbursement on appropriately completing CAAs triggered by the MDS ON 3/14/2017. A QA monitoring tool will be utilized by the DON or Regional Clinical Specialist to review CAAs from the Comprehensive assessments weekly x 1 month and then x 2 weeks for 2 months with any identified issues corrected at that time. Thereafter, monitoring and review of 10% of assessments will be done by Regional Clinical Specialist on a quarterly basis. Results will be reviewed by the QA committee monthly x 3 monthly and quarterly thereafter for continued compliance with additional education or training provided for any identified issues.	

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F 272	Continued From page 33 An interview with the Dietary Manager (DM) on 02/17/17 at 2:15 PM revealed she completed the Care Area Assessment summary for Nutrition for Resident #104. DM stated she had not had any formal training on how to write a CAA summary and was not aware it should be resident specific and analyze how nutrition affected them day to day.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F 278		3/21/17

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F 278	Continued From page 34 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident (Resident #9) identified as a Level II PASRR resident. Findings included: Resident #9 was admitted to the facility on 01/23/2017 with diagnoses including schizophrenia. A review of Resident #9's admission Minimum Data Set (MDS) dated 01/30/17 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents which was provided on 02/13/17 during the entrance conference indicated Resident #9 was determined as Level II PASRR.	F 278	The facility will continue to accurately code the Minimum Data Set to reflect the Level II PASRR. MDS for resident #9 has been corrected to accurately reflect the resident□s status. All residents with Level 2 PASRR were identified at the time of survey and MDS reviewed by the DON for accurate coding of the MDS. No further issues were noted. The MDS/Care Plan nurse WAS re-educated by Director of Clinical Reimbursement services regarding the correct coding for a level 2 PASRR ON 3/14/2017. All MDS's have been reviewed and monitored for completion and accurate CAA's on 3/16/2017. The DON or Administrative Nurse will review all new admissions with a Level 2 PASRR to ensure proper coding on the MDS, weekly for 4 weeks and then monthly for 2 months. Results will be reported to monthly Quality Assurance	

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F 278	Continued From page 35 On 02/15/2017 at 8:25 AM an interview was conducted with the MDS Coordinator who stated the Clinical Resource Specialist (CRS) coded Resident #9's admission assessment dated 01/30/17. The MDS Coordinator verified the PASRR Level II was not coded for Resident #9 and should have been coded on the admission MDS assessment. The MDS Coordinator stated the (CRS) missed coding Resident #9 as PASRR Level II. The MDS Coordinator stated she would have to submit a modification to the admission MDS to reflect Resident #9 was determined as PASRR Level II. On 02/15/2017 at 8:31 AM a telephone interview was conducted with the CRS who stated she coded Resident #9 ' s admission MDS assessment and had not received the PASSR Level II status prior to coding the assessment and missed coding that Resident #9 was determined as PASRR Level II. The CRS stated a modification to Resident #9's admission MDS assessment would be completed immediately and submitted by the MDS Coordinator. An interview was conducted with the Director of Nursing (DON) on 02/15/2017 at 8:44 AM who stated her expectation was that the admission MDS assessment dated 01/30/17 would have been accurately coded to reflect Resident #9 was determined as PASRR Level II. The DON stated it was her expectation that a modification of the admission MDS assessment would be submitted immediately to indicate Resident #9 was PASRR level II. The DON stated the corporate MDS employee was helping out with coding MDS assessments and the PASRR Level II for Resident #9 was missed.	F 278	Committee for 3 months and quarterly thereafter for any further recommendations. The DON will be responsible to follow □up on any recommendation from the committee with further education and/or training as indicated.	

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F 278	Continued From page 36 On 02/15/2017 at 8:48 AM an interview was conducted with the Interim Administrator (IA) who stated her expectation was that the admission MDS assessment dated 01/30/17 should have been accurately coded to indicate Resident #9 was determined as PASRR Level II. The IA stated she would expect that a modification of the admission MDS assessment would be submitted immediately to reflect Resident #9 was determined as PASRR Level II. The IA stated the MDS Coordinator from the corporate office was assisting in coding MDS at the facility and the PASRR Level II for Resident #9 was missed.	F 278		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to follow physician's orders to take weights as ordered for 1 of 8 reviewed residents (Resident #15). The findings included: Review of the hospital records for the discharge of Resident #15 on 09/13/16 indicated Resident #15 "must be weighed daily". The hospital records also clarified Resident #15 should be weighed after urination and before breakfast.	F 281	Resident #15 no longer resides in the facility. All residents with physician orders for weights have the potential to be affected. Charts of residents with physician orders for weights have been reviewed with no issues identified. Licensed nurses will be in serviced by the DON/Regional QA Manager regarding	3/21/17

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F 281	Continued From page 37 Resident #15 was admitted to the facility on 09/13/16 with diagnoses which included heart failure and kidney failure among others. The 5 day admission Minimum Data Set (MDS) dated 09/20/16 indicated Resident #15 required extensive assistance with most ADL's (Activities of Daily Living). The MDS also indicated Resident #15 was 5'7", weighed 87 pounds, and took a diuretic. Record review of care plans with an onset date of 09/26/16 for Resident #15 indicated a problem was identified as an alteration in fluid volume related to dehydration. The goal was for Resident #15 to receive an adequate amount of fluids daily. One of the approaches listed to meet this goal was to "obtain weight as ordered". Record review of the physician's orders for September 2016 indicated the following: A. physician's order on 09/14/16 stated for daily weights to be done and to call if there was a 3 pound (lb.) weight gain B. physician's order on 09/29/16 stated to continue encouraging fluids and weights every day and to call if there was a 3 lbs. weight gain or shortness of breath Review of the Medication Administration Record for 09/13/16 through 10/11/16 indicated the following order listed under vital signs: obtain weight every morning due to heart failure and notify provider for weight gain greater than 3 lbs. Record review for charting for the weights of Resident #15 between 09/13/16 and 10/11/16 indicated the daily weight for Resident #15 was not taken 14 out of 29 days. Dates recorded with	F 281	expectations in following physician□s orders by 3/20/2017. At each clinical meeting the Nurse Administrative Team will review new Physician orders and the medical record to ensure the order was transcribed and implemented correctly with any issues noted corrected at the time of observation. Chart audits will be conducted by Nurse Administration Team at 10% weekly for 4 weeks then monthly thereafter to ensure physician orders are followed. DON will review findings and bring results to monthly QA Committee meeting for 3 months and quarterly thereafter with additional training or education provided if indicated.	

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F 281	Continued From page 38 no weights included the following: 09/15, 09/18, 09/19, 09/22, 09/23, 09/24, 09/26, 09/27, 10/02, 10/03, 10/06, 10/07, 10/10 and 10/11. During an interview with the Director of Nursing (DON) on 02/16/17 at 10:18 AM, the DON stated her expectations were for physician's orders to be followed. During an interview with Nurse Aide (NA) #1 on 02/16/17 at 11:06 AM, NA #1 stated the nurse is responsible to let the NAs know daily if vital signs or weights are needed on a resident. NA #1 also stated the NA's looked at the Nursing Care Card (NCC) for what needed to be done daily for each resident. During a 2nd interview with the DON on 02/16/17 at 11:49 AM, the DON stated the Unit Manager would be the nurse to update the NCC for each resident daily but she currently did not have a Unit Manager.	F 281		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to implement care plan intervention for 2 of 15 residents reviewed	F 282	The facility will continue to provide daily weights and restorative services as indicated by the care plan.	3/21/17

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F 282	Continued From page 39 for care plan. Resident #58 did not receive restorative nursing services to improve range of motion (ROM) and Resident #15 was not weighed per resident ' s care plans. Findings included: 1. Resident #58 was admitted to the facility on 12/13/16 and diagnoses included cerebral vascular accident (CVA) and hemiplegia. The annual Minimum Data Set (MDS) assessment dated 01/06/17 indicated Resident #58 was cognitively intact and required limited assistance of 1 person for bed mobility, and personal hygiene and extensive assistance of 2 person for dressing and toileting. A review of a physician ' s order dated 01/06/17 indicated Resident #58 was to receive restorative nursing services for assisted range of motion (AROM) 3-4 times per week. A review of the Restorative Active Range of Motion Program Daily Record (AROMPDR) indicated Resident #58 was to receive restorative nursing 3-4 times a week until April of 2017. Documentation on the daily record indicated Resident #58 received AROM to bilateral lower extremities on 01/10/17, 01/11/17, 01/12/17, 01/13/17, 01/17/17, 01/18/17, 01/19/17, 01/20/17, and 01/23/17. The PROM was not documented as given the rest of January 2017. No restorative nursing services were documented for the month of February 2017. A review of Resident #58 ' s care plan dated 01/19/17 indicated the following problems:	F 282	Resident # 15 no longer resides in the facility. Resident #58 has had a restorative program initiated on 2/17/17 as directed by therapy. All residents who have interventions for qualified professional services related to restorative programs or weights indicated on their care plan have the potential to be affected. All care plans have been reviewed and no other issues were identified. Licensed Nurses, Care Plan team, Qualified Professionals responsible for interventions on the care plan will be in serviced by the DON or Regional QA Manager regarding expectations for providing services according to the plan of care BY 3/20/2017. All restorative referrals from therapy will be given to DON for review who will then communicate restorative needs to the restorative aides. Chart audits will be conducted by Nurse Administration Team at 10% weekly for 4 weeks then monthly thereafter to ensure that all care plan interventions are followed. All findings will be reviewed by the DON and presented to the QA committee monthly x 3 months and quarterly	

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F 282	Continued From page 40 ROM: The resident had a potential for contractures related to CVA with left hemiplegia and had a contracture of the left elbow, wrist, and left knee stump. The goal was for the resident not to develop any further contractures through next review period of 04/19/17. Interventions to address the problem were as follows: Staff were to assess and record current ROM of extremities, observe and record any increased stiffness in joints, staff were to encourage exercise to all extremities as able, staff were to refer to physical therapy (PT) for evaluation of potential need for an assistive device as needed, and refer to restorative nursing as needed. Restorative, AROM, resident was unable to perform ROM exercises and was at risk for further decline in ROM secondary to muscle weakness related to history of CVA, functional impairment, history of CVA with left sided hemiparesis and paralysis. The goals were for the resident not to incur any loss of ROM, would have restorative nursing services 3-4 times a week and would maintain functional status through next review period of 04/19/17. Interventions to address problem were as follows: Resident was to complete each AROM exercise slowly, gently, and rhythmically, AROM, hip flexion, hip adduction, and hip abduction, gluteal sets, left kicks and knee extension. On 02/15/17 at 9:10 AM an interview was conducted with the Director of Nursing (DON) who was responsible for the restorative nursing program. The DON stated Resident #58 was to receive restorative nursing services for AROM for bilateral lower extremities 3-4 times a week related to having a below knee amputation on the left and above the knee amputation on the right	F 282	thereafter. Any further education or training provided as indicated.	

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F 282	Continued From page 41	F 282		

lower extremity. The resident was to be reevaluated in April of 2017. The DON stated she had one restorative aide (RA) who provided restorative services for Resident #58 and stated due to a miscommunication between herself, the restorative aide (RA), and therapy Resident #58 had not been receiving restorative nursing services since 01/23/17 as per the care plan. The DON stated she had not realized that the restorative services had not been performed as per the care plan on Resident #58 because she had been busy with other duties.

On 02/15/17 at 9:32 AM an interview was conducted with the RA who stated she was the only RA in the facility and had time to perform her restorative duties. The RA stated she had not performed AROM to Resident #58 ' s bilateral lower extremities since 01/23/17 as per care plan schedule because she thought the occupational therapist (OT) had placed the resident back on therapy services and restorative services were no longer required. The RA stated she had not discussed stopping restorative services on Resident #58 with the DON or the occupational therapist. The RA stated she should have clarified with the DON if Resident #58 was still required to receive restorative services as per care plan schedule for AROM before she decided to stop providing restorative services for Resident #58.

On 02/15/17 at 10:35 AM an interview was conducted with the Interim Administrator (IA) who stated it was her expectation that the DON would have assured Resident #58 was receiving restorative nursing services for ROM to prevent a decline in Resident #58 ' s ROM status.

On 02/16/17 at 10:02 AM an interview was

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conducted with the DON who stated Resident #58 was care planned to receive ROM and AROM and the care plan for the resident was not followed. The DON stated it was her expectation that the RA would have provided restorative services for Resident #58 as per the restorative care plan schedule.

On 02/16/17 at 10:06 AM an interview was conducted with the IA who stated it was her expectation that Resident #58's care plan would have been followed and the resident would have received ROM.

2. Review of the hospital records for the discharge of Resident #15 on 09/13/16 indicated Resident #15 "must be weighed daily". The hospital records also clarified Resident #15 should be weighed after urination and before breakfast.

Resident #15 was admitted to the facility on 09/13/16 with diagnoses which included heart failure and kidney failure among others. The 5 day admission Minimum Data Set (MDS) dated 09/20/16 indicated Resident #15 required extensive assistance with most ADL's (Activities of Daily Living). The MDS also indicated Resident #15 was 5'7", weighed 87 pounds, and took a diuretic.

Record review of care plans with an onset date of 09/26/16 for Resident #15 indicated a problem was identified as an alteration in fluid volume related to dehydration. The goal was for Resident #15 to receive an adequate amount of fluids daily. One of the approaches listed to meet this goal was to "obtain weight as ordered".

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F 282	Continued From page 43 Record review of the physician's orders for September 2016 indicated the following: A. physician's order on 09/14/16 stated for daily weights to be done and to call if there was a 3 pound (lb.) weight gain B. physician's order on 09/29/16 stated to continue encouraging fluids and weights every day and to call if there was a 3 lbs. weight gain or shortness of breath Review of the Medication Administration Record for 09/13/16 through 10/11/16 indicated the following order listed under vital signs: obtain weight every morning due to heart failure and notify provider for weight gain greater than 3 lbs. Record review for charting for the weights of Resident #15 between 09/13/16 and 10/11/16 indicated the daily weight for Resident #15 was not taken 14 out of 29 days. Dates recorded with no weights included the following: 09/15, 09/18, 09/19, 09/22, 09/23, 09/24, 09/26, 09/27, 10/02, 10/03, 10/06, 10/07, 10/10 and 10/11. During an interview with the Director of Nursing (DON) on 02/16/17 at 10:18 AM, the DON stated her expectations were for the care plan to be followed as written. During an interview with Nurse Aide (NA) #1 on 02/16/17 at 11:06 AM, NA #1 stated the nurse is responsible to let the NA's know daily if vital signs or weights are needed on a resident.	F 282		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that	F 309		3/21/17

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F 309	Continued From page 44 applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, pharmacist interview and staff interviews, the facility failed to monitor, assess for and recognize a change in condition for 1 of 1 sampled resident following a significant medication error. Resident	F 309	The facility will ensure that each resident receives and provides the necessary care and services to attain or maintain the highest practicable physical well being, by administrating physician orders	

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F 309	Continued From page 45 #189 was given his roommate's medications the morning of 01/25/17 and subsequently experienced nausea, vomiting, bradycardia nad hypotension. There was no evidence that any assessment or monitoring was completed by nursing staff until he was sent to the emergency room. Resident #189 developed nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy began on 01/25/17 when Resident #189 was administered Resident #181's morning medications in error and the nurse who made the error did not inform the physician to obtain directions and did not monitor the resident's vital signs or assess for a change in condition. Resident #189 was subsequently sent to the emergency room and admitted to the hospital when he developed nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy was removed on 02/17/17 at 2:15 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy) to ensure inservices are completed and monitoring systems are put into place and are effective related to assessing a resident following a medication error and monitoring so that timely identification of problems can be identified. The findings included: Resident #189 was admitted to the facility on 01/19/17. His admission diagnoses included paroxysmal tachycardia, bradycardia, a history of deep vein thrombosis, a history of pulmonary	F 309	accurately, and by notification of physician when any medication error occurs for direction for any monitoring or interventions that would be appropriate with the significance of the error. The Resident # 189 was transferred out of the facility on 1/25/17 at 2:00 pm when the medication error was discovered by administration. The family member of the resident was notified of the error by the DON on 1/25/17. The physician was notified by the Unit Manager on 1/25/17 at 2 pm. The resident was admitted to the hospital and has not returned to the facility. The facility investigation was initiated on 1/25/17 by the DON. DON notified at approximately 1/30 pm that a family member was requesting that guest by sent to the hospital. At that time DON questioned assigned nurse reason for need of transfer. Nurse notified DON that she had administered the incorrect medication to the guest during morning medication pass. DON questioned nurse regarding her notification to the physician and family member to which she responded No, I should have. Nurse interviewed by DON on 1/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded the same day on 1/25/17 and POC was initiated. The incident was reported to the NC Board of Nursing according to the	

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embolism, difficulty walking, atrial fibrillation, long term anticoagulant use, muscle wasting and atrophy.

The most recent Minimum Data Set, a 5 day dated 01/27/17, noted he had adequate hearing, he was understood and understands, his cognition and mood were not assessed, he had no behaviors, and required extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. He was noted to have taken 6 days of anticoagulants, 7 days of diuretic and received Occupational and Physical therapies.

Review of physician orders included the following morning medications ordered for Resident #189:
*Amiodarone HCL 200 Milligrams (mg) at 8 AM - an antiarrhythmic agent;
*Diltiazem 24 hour Extended release 120 mg at 8 AM to be held for systolic less than 110 mmHg (milliliters of Mercury) and diastolic less than 60 mmHg - for hypertension and angina;
*Lasix 20 mg at 8 AM - a diuretic;
*Miralax powder 17 grams per day at 8 AM - for constipation;
*Levothyroxine 25 mcg at 6 AM - for thyroid; and
*Albuterol sulfate 2.5 mg/3 ml solution four times a days, first at 8 AM ordered 01/25/17 - for breathing.

Per review of the incident report dated 01/25/17 at 1:30 PM, Resident #189 received a medication error resulting in nausea and vomiting and hypotension. It was determined that Resident #189 received his roommate's 8 AM medications in error.

Review of Resident #189's roommate's record (Resident #181) revealed the roommate's first

disciplinary tree. Their investigation was assigned to a complaint officer with the North Carolina Board of Nursing. This report was made by DON on 2/7/17.

All residents have the potential to be affected. On the date of occurrence all alert and oriented residents were interviewed to determine if any had received incorrect medications. No other issues were identified. On the date of occurrence all residents who were not alert and oriented were observed for changes in condition through direct observation and review of medical record by DON. The audit results were reported to the Medical Director. All residents observed in the audit had no issues identified and Medical Director notified by the Director of Nursing (DON) on 1/25/17.

The facility has reviewed Incident Reports, 24 hour reports and Physician orders for the past 30 days to identify any deficient areas of assessments for follow up monitoring. Education and documentation was completed as needed.

All licensed nurses were in-serviced by the facility Pharmacist on 2/15/17 on the following: 1. Responsibility of reporting med errors to the physician at the time of knowledge of an occurrence of medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors. 3. The 6 rights of medication pass which include right individual, right medication, right dose, right time, right

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F 309	Continued From page 47 and last name initials were the same as Resident #189's initials. Review of the picture in the computerized medical record system revealed the two residents were of different races and had an age difference of 31 years. Resident #181 was admitted to the facility on 01/24/17 with diagnoses including injury of C4 cervical spine. Resident #181's morning medications given to Resident #189 included: *Amlodipine Besylate 10mg at 8 AM for hypertension; *Coreg 25mg for hypertension; *Escitalopram 20 mg at 8 AM for depression; *Flomax 0.4mg at 8AM for urinary retention; *Flonase 0.05 % nasal spray at 8 AM for sinus congestion: *Lovenox 40 mg/0.4 ml subcutaneous at 8 AM for anticoagulation therapy; *Multivitamin/mineral at 8 AM; *Senna S 2 tabs at 8 AM for constipation; *Urecholine 50mg Four times a day, first at 8 AM for urinary discomfort.; and *Vitamin D3 1000 unit at 8 AM. The only nursing note in the medical record for 1st shift (7AM to 7PM) on 01/25/17 was written by the Director of Nursing on 01/25/17 at 2:00 PM. The note stated the resident had nausea and vomiting and hypotension. Blood pressure was 80/60, respirations 20, pulse 61, temperature 97.3 degrees Fahrenheit and oxygen saturation was 95%. The physician was contacted and an order was given to send him to the emergency room for evaluation and treatment. The family was noted to be at bedside. There were no other vital signs or any assessment of Resident #189's health documented in his medical record except for the hospital transfer sheet.	F 309	route and right documentation. 4. The notification of family/responsible party. The licensed nurse involved was terminated immediately due to not reporting the medication error at the time of occurrence. The incident was reported to the NC Board of Nursing. The orientation process for new licensed nurses will include: 1. Responsibility of reporting med errors to the physician at the time of the knowledge of an occurrence of a medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication error. 3. The 6 rights of medication pass, which includes documentation. 4. The notification of family/responsible party. Education on acute change of condition, post incident follow-up, notification process and documentation requirements regarding assessment, notification and follow-up monitoring will be completed with licensed nurses by 3/20/2017 by the DON or QA Regional Manager. The Nurse Administrative Team will review new Physician orders, incident reports, and 24 hour reports. The Medical Record will be reviewed to ensure that appropriate assessments and monitoring occurred and appropriate documentation made. Nursing Administration will conduct random audits of 10% of Residents for 4 weeks to ensure compliance. Any variances will be addressed immediately. Results of all audits will be forwarded to	

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F 309	Continued From page 48 The Occupational Therapy note of 01/25/17 at 1:21 PM stated Resident #189 required total dependence for lower body and upper body bathing, dressing and transfers. He was noted suffering from vomiting this date. Treatment ended after cleaning up from activities of daily living skills and nursing was notified. On 02/15/17 at 10:14 AM an interview was conducted with the occupational Therapist (OT) who worked with Resident #189 the day of the med error. OT stated he went in to work with him after lunch and found him in the bathroom covered in vomit. He stated he and the nurse aide got him cleaned up and he vomited again. OT described Resident #189 as awake but much less verbal than his usual and OT could not understand him. OT stated he vomited "a good bit." OT also stated he required maximum assistance to transfer which was definitely different. OT stated he reported this to the nurse and went on to his next resident. Review of the undated hospital transfer sheet revealed Resident #189 received the wrong medications. His vital signs were listed as temperature 97.3 Fahrenheit, pulse 61 beats per minute, respiration rate 20, and blood pressure 85/58 and 80/60 and the pulse oximetry 95%. Emergency Medical Services (EMS) responded 01/25/17 and was noted with the resident at 1:44 PM. Review of the EMS report revealed that staff reported Resident #189 was vomiting and his blood pressure was 75 systolic. EMS noted he was awake, slow to respond, had pale mucus membranes and stated he just didn't feel right after taking that handful of pills this morning. 0.5	F 309	the Director of Nursing. All findings will be reported by the Director of Nursing to the QA Committee monthly for 3 months and quarterly thereafter. Additional education and training provided for any identified issues.	

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mg atropine (a drug used to treat a slow heart rate) was given and his blood pressure and heart rate increased from 77/49 and 42 pulse at 2:07 PM to 103/65 with a pulse of 59 at 2:13 PM.

Review of the hospital history and physical dated 01/25/17 revealed he presented with a 1 day history of generalized malaise as well as hypotension and bradycardia. Resident #189 was accidentally given doses of another resident's medication including Coreg, Citalopram, Lovenox, Flomax, Flonase, Senokot and Urecholine. The resident was noted to have some mild nausea and nonbloody vomiting, his blood pressure was 85/58 and his heart rate was in the 40s. He was given 0.5 mg atropine in route and once in the emergency department, the blood pressure was noted to drop to 70/50 and was dosed with another dose of 0.5mg of atropine. He was started on intravenous hydration and his blood pressures improved to the 100-110 systolic range with a heart rate currently around 57-59. Resident #189 stayed in the hospital until discharge to another nursing facility on 01/30/17.

The hospital discharge summary dated 01/30/17 stated Resident #189 was initially admitted to observation status secondary to his bradycardia and hypotension from the medication misuse. This continued despite IV hydration holding additional medications. Plans were for discharge the following day, however on 01/27/17 secondary to no rest the night before, the resident was somewhat agitated and confused. As such, the resident was started on the delirium protocol.

Review of the Employee Disciplinary Record revealed Nurse #3, who made the medication error related to Resident #189, was terminated on

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01/25/17 for "making errors of sufficient magnitude which may jeopardize resident safety and welfare." Additional notes indicated the medication error occurred at approximately 8:30 AM to 9:00 AM and the nurse failed to notify the Director of Nursing (DON), Physician or family. The DON became aware of the error at approximately 1:30 PM. Nurse #3 noted on this form that she held Resident #189's morning medications on 01/25/17 and she was distracted from reporting this error. The note stated she observed him at lunch and he appeared okay. Once he had a change in condition, he was assessed and the physician was called.

Nurse Aide (NA) #1 was interviewed on 02/15/17 at 8:26 AM. NA #1 stated she routinely worked with Resident #189 and on 01/25/17 Resident #189 was not able to stand and do for himself per his usual. He was unable to get himself off the commode which she said was different for him. She stated that she informed Nurse #3 of Resident #189 vomiting and believed the nurse took his blood pressure. NA #1 stated she did not take his vital signs. A few minutes after she and OT transferred him into the chair, Resident #189's responsible party came in and mentioned that she thought he had taken a turn for the worse. NA #1 stated she had noticed a change in Resident #189 throughout the morning.

Nurse #3 was interviewed via phone on 02/15/17 at 9:09 AM. Nurse #3 stated on 01/25/17 it was a normal busy day. She stated there were multiple interruptions from therapy during medication pass per usual. She stated she had worked with Resident #189 a couple of times before but because he had no treatments, her interactions with him were during medication administration.

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She stated the roommate had been admitted the day before. Both residents' last name started with the same letter. She stated as soon as she gave Resident #189 the wrong medications, she realized the error "immediately, immediately." She stated that she had spoken to the physician several times that morning relating to Resident #189's new order for a nebulizer treatment and related to several other residents but never thought to inform the physician of the medication error. She stated she got busy with other residents and didn't recall writing a note. Nurse #3 stated she thought "they" took his blood pressure after the medication error but was not sure. She stated the next time she saw Resident #189 he was with therapy. She stated he was fine until he ate lunch then he started vomiting. She stated that she informed the DON and physician about the medication error when Resident #189 got ill. Nurse #3 further stated that he was nauseated and vomited about 12:30 PM and as a nurse she would not have assessed the vomiting as being related to medication errors since it occurred after the resident ate. She stated she felt he needed his nebulizer treatment but could not administer it as she could not locate tubing for it.

Resident #189's physician was interviewed on 02/15/17 at 11:36 AM. The physician stated if he had been notified of the medication error he most likely would have had the nurse monitor vital signs more closely and possibly adjust upcoming medication orders.

On 02/15/17 at 12:13 PM, the DON stated that she was informed around 1:00 to 1:30 PM that Resident #189's responsible party wanted the resident sent to the hospital. The DON went to

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the unit and asked Nurse #3 what was going on and it was then that Nurse #3 informed the DON and Nurse #2 that Nurse #3 had given Resident #189 his roommate's morning medications. Nurse #3 then stated she had not notified the DON, the physician or the responsible party of the medication error. The DON stated she (the DON) did not go to the resident's room to assess Resident #189 and told Nurse #2 to assist with the hospital transport. The DON terminated Nurse #3's employment that day.

On 02/15/17 at 3:19 PM Nurse #2 stated that on 01/25/17 nurse aides approached her to ask if she could help get Resident #189 ready to transport to the hospital. Nurse #2 went to the hall and found Nurse #3 looking for equipment to give him a nebulizer treatment. Nurse #2 proceeded to print out the Medication Administration Record for the hospital. It was after that, that Nurse #3 informed Nurse #2 and the DON that she administered the wrong medications. Nurse #2 stated she never entered the room to assess Resident #189 as she was only helping with the paperwork. Nurse #2 then called the physician to inform him of the medication error and the impending transport to the hospital and took over the medication cart for Nurse #3.

On 02/16/17 at 8:38 AM the pharmacist was interviewed. He reviewed the medications Resident #189 received and compared them to the medications he was ordered. He revealed that some of the medications Resident #189 actually received the morning of 01/25/17 were similar to his own. He further stated the Urecholine may have made him nauseous and the addition of Coreg and Lasix would have

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"absolutely" affected his blood pressure.

The facility DON, corporate nurse and administrator of a sister facility were informed of Immediate Jeopardy on 02/15/17 at 2:38 PM.

The facility provided an acceptable credible allegation of compliance on 02/17/17 at 1:20 PM as follows:

Credible Allegation of Compliance

The facility will ensure that each resident receives and provides the necessary care and services to attain or maintain the highest practicable physical well-being, by administrating physician orders accurately and by notification of physician when any medication error occurs for direction for any monitoring or interventions that would be appropriate with the significance of the error.

Resident #189 was transferred out of the facility on 1/25/17 at 2:00pm when the medication error was discovered by administration. The resident was admitted to the hospital and has not returned to the facility.

Facility Investigation

The Director of Nursing (DON) was notified at approximately 1:30 pm that a family member was requesting that the resident be sent to the hospital. At that time the DON questioned the assigned nurse regarding the reason for the need to transfer the resident to the hospital. The nurse notified the DON that she had administered the incorrect medication to the resident during morning medication pass. The DON questioned the nurse regarding her notification of physician

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and family member to which she responded, "No, I should have." Nurse interviewed by DON on 01/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded the same day 01/25/17 and POC (Plan of Correction) was initiated.

The licensed nurse involved was terminated immediately due to not reporting the medication error at the time of occurrence. The incident was reported to the NC Board of Nursing according to their disciplinary tree. Their investigation was assigned to a complaint officer with the North Carolina Board of Nursing. Report made by the DON on 02/07/17.

All residents who receive medications have the potential to be affected. On the date of occurrence (1/25/17) all alert and oriented residents were interviewed by the DON to determine if any had received incorrect medications. No other issues were identified. On the date of occurrence all residents who were not alert and oriented were observed by the DON for changes in condition through direct observation and review of medical records. These audit results were reported to the Medical Director.

On 2/15/17 all residents having the potential to be affected were again reviewed. Alert and oriented residents did not indicate that they were aware of any medications being given incorrectly. All residents with cognitive issues were reassessed by licensed nurses. No issues were noted that would be related to medication issues.

Root Cause Analysis

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The nurse failed to perform an initial assessment on resident #189 using nursing judgment to gather baseline data after the medication error occurred.
The nurse failed to notify physician of medication error that allowed physician to direct staff on monitoring or interventions that would be appropriate with the significance of the error.

In-Servicing

All licensed nurses were in serviced by the facility Pharmacist on 2/15/17 on the following. 1. Responsibility of reporting med errors to the physician at the time of knowledge of an occurrence of medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors. 3. The 6 rights of medication pass which include right individual, right medication, right dose, right time, right route and right documentation. 4. The notification of family/responsible party.

All licensed nurses were in-serviced on 2/15/17 by DON and Regional QA Manager on the prohibition of cell phone usage during medication administration.

All licensed nurses will be re-educated by The Director of Nursing (DON) on nursing assessment in relation to change in condition using nursing judgment or professional standard of practice on 02/17/17 or prior to the start of their next scheduled shift.

System Change

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F 309	Continued From page 56 The orientation process for new licensed nurses will include. 1. Responsibility of reporting med errors to the physician at the time of the knowledge of an occurrence of a medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors which is "Any error that occurs in the medication use process." 3. The 6 right of medication pass which include right individual, right medication, right dose, right time, right route and right documentation. 4. The notification of family/responsibility party. 5. Nursing assessment in relation to change in condition using nursing judgment or professional standard of practice. Immediate Jeopardy was removed on 02/17/16 at 2:15 PM when interviews with nurses confirmed they had been inserviced and knew the steps to take to ensure the correct medications were administered to the right individual, to report medication errors immediately to the DON and to visually assess and take vital signs of the resident. The nurses knew to then inform the physician and follow any further instructions for assessing and monitoring for a change in condition. Inservicing also included documenting all findings.	F 309		
F 318 SS=E	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		3/21/17

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F 318	Continued From page 57 (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews the facility failed to provide range of motion (ROM) services for 1 of 1 resident (Resident #58) reviewed for range of motion (ROM). The findings included: Resident #58 was admitted to the facility on 12/13/16 and diagnoses included cerebral vascular accident (CVA) and hemiplegia. A review of a Restorative Program Therapy to Nursing Communication form dated 12/20/16 indicated physical therapy (PT) was discontinued on 12/20/16 and recommended restorative nursing for bilateral lower extremities assisted range of motion (AROM) and strength with bed mobility with goal to maintain range of motion (ROM), strength, and maintain bed mobility for rolling. The communication form indicated nursing would write a program for AROM for bilateral lower extremities. The annual Minimum Data Set (MDS) assessment dated 01/06/17 indicated Resident #58 was cognitively intact and required limited assistance of 1 person for bed mobility, and personal hygiene and extensive assistance of 2 person for dressing and toileting.	F 318	The facility will continue to provide restorative services as ordered by physician. Resident #58 will have restorative ROM according to orders and care plan interventions. All residents who have had an increased need for ADL help/decrease in range of motion as identified by the MDS process have the potential to be affected. Residents identified will be re-screened by therapy and Restorative services initiated and care planned. All restorative referrals will be reviewed by DON as ordered and communicated to the Restorative Aides. Licensed staff, nursing assistants and restorative aides will be in-serviced by Administrative nurses on providing restorative care according to orders and care plan interventions to prevent further decline in ROM. In-servicing will be completed by 3/20/2017. Restorative program audits will be conducted by Nurse Administration Team at 10% weekly for 4 weeks then monthly	

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F 318	Continued From page 58 A review of a physician's order dated 01/06/17 indicated Resident #58 was to receive restorative nursing services for AROM 3-4 times per week. A review of a restorative progress note dated 01/06/17 indicated Resident #58 was referred to restorative for AROM program to maintain ROM and strength. Resident #58 had a history of CVA and had bilateral lower extremity amputation. The progress note indicated Resident #58 would benefit from a restorative nursing program to prevent secondary complications that could develop from disability and chronic disease. A review of the Restorative Active Range of Motion Program Daily Record (AROMPDR) indicated Resident #58 was to receive restorative nursing 3-4 times a week until April of 2017. Documentation on the daily record indicated Resident #58 received AROM to bilateral lower extremities on 01/10/17, 01/11/17, 01/12/17, 01/13/17, 01/17/17, 01/18/17, 01/19/17, 01/20/17, 01/23/17 and was not continued for the rest of January 2017 and no restorative nursing services were documented for the month of February 2017. A review of Resident #58's care plan dated 01/19/17 indicated the following problems: ROM: The resident had a potential for contractures related to CVA with left hemiplegia and had a contracture of the left elbow, wrist, and left knee stump. The goal was not to develop any further contractures through next review period of 04/19/17. Interventions to address the problem were as follows: Staff were to assess and record current ROM of extremities, observe and record any increased stiffness in joints, staff were to	F 318	thereafter to ensure care plan interventions are followed. All findings will be reviewed by the DON and presented to the QA committee monthly x 3 months and quarterly thereafter. Any further education or training provided as indicated.	

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encourage exercise to all extremities as able, staff were to refer to PT for evaluation of potential need for an assistive device as needed, and refer to restorative nursing as needed.

Restorative, AROM, resident was unable to perform ROM exercises and was at risk for further decline in ROM secondary to muscle weakness related to history of CVA, functional impairment, history of CVA with left sided hemiparesis and paralysis. The goal was resident was not to incur any loss of ROM and would have restorative nursing services 3-4 times a week and would maintain functional status through next review period of 04/19/17. Interventions to address problem were as follows: resident was to complete each AROM exercise slowly, gently, and rhythmically, AROM, hip flexion, hip adduction, and hip abduction, gluteal sets, left kicks and knee extension.

A review of a Restorative Program Therapy to Nursing Communication form dated 01/24/17 indicated occupational therapy (OT) was discontinued on 01/24/17 and recommended restorative nursing for increase contracture of left upper extremity with goal for passive range of motion (PROM) to left upper extremity, shoulder, elbow, wrist, hand, and fingers to prevent further contracture and increase skin integrity.

On 02/13/17 at 10:44 AM Resident #58 was observed in bed in his room and no restorative nursing services were observed being provided with the resident. Resident was noted to have left hand and wrist contracture.

On 02/14/17 at 8:29 AM Resident #58 was observed in bed in his room and no restorative

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nursing services were observed being provided with the resident.

On 02/15/17 at 9:10 AM an interview was conducted with the Director of Nursing (DON) who was responsible for the restorative nursing program. The DON stated Resident #58 was to receive restorative nursing services for AROM for bilateral lower extremities 3-4 times a week related to having a below knee amputation on the left and above the knee amputation on the right lower extremity and was to be reevaluated in April of 2017. The DON stated she had one restorative aide (RA) who provided restorative services for Resident #58 and stated due to a miscommunication between herself, the restorative aide (RA), and therapy Resident #58 had not been receiving restorative nursing services since 01/23/17. The DON stated she had not realized that the restorative services had not been performed on Resident #58 because she had been busy with other duties. The DON stated she had not spoken with the restorative aide and therapy and had not reviewed the AROMPDR that indicated per documentation that Resident #58 had not received restorative nursing since 01/23/17. The DON stated she had not obtained a physician's order for restorative nursing as recommended from OT on 01/24/17 and had not created a restorative nursing program as recommended by OT on 01/24/17 to provide PROM to Resident #58's left upper extremity to prevent further contracture and promote increased skin integrity because she had been busy with other duties. The DON stated Resident #58 had not received PROM to his left upper extremity since 01/24/17. The DON stated it was her expectation that the RA would have continued providing restorative services of AROM

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to Resident #58. The DON stated Resident #58 would be placed back on restorative nursing services. The DON stated she became busy with other duties and the restorative program was missed for Resident #58.

On 02/15/17 at 9:32 AM an interview was conducted with the RA who stated she was the only RA in the facility and had time to perform her restorative duties. The RA stated she had not performed AROM to Resident #58's bilateral lower extremities since 01/23/17 because she thought OT had placed the resident back on therapy services and restorative services were no longer required. The RA stated she had not discussed stopping restorative services on Resident #58 with the DON or the occupational therapist. The RA stated she should have clarified with the DON if Resident #58 was still required to receive restorative services for AROM before she decided to stop providing restorative services for Resident #58. The RA stated she had not been informed by the DON that Resident #58 required PROM to his left upper extremity.

On 02/15/17 at 9:57 AM an interview was conducted with the Director of Rehabilitation (DOR) who stated the DON was in charge of the restorative nursing program and a recommendation for restorative nursing was provided to the DON on 01/24/17 for Resident #58 for PROM of the left upper extremity to prevent further contractures and increase skin integrity. The DOR stated instructions were provided to the RA by the OT on how to perform PROM exercised with Resident #58. The DOR stated OT had not verified with the DON on how Resident #58 had been progressing with restorative nursing and was not aware Resident

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#58 had not been receiving restorative nursing for AROM and PROM as recommended since 01/23/17. The DOR stated his expectation was that the restorative nursing program would have been implemented and continued as recommended by therapy for Resident #58. The DOR stated a breakdown in communication occurred between the DON and therapy services.

On 02/15/17 at 10:35 AM an interview was conducted with the Interim Administrator (IA) who stated it was her expectation that the DON would have implemented a restorative nursing program as recommended by PT/OT for Resident #58. The IA stated it was her expectation that the DON would have assured Resident #58 was receiving restorative nursing services as per the schedule to prevent a decline in Resident #58 ' s ROM status. The IA stated it was her expectation that Resident #58 would resume restorative nursing services or be placed back on PT/OT services. The IA stated she felt a breakdown in communication occurred between therapy and the DON.

On 02/15/17 at 11:02 AM an interview was conducted with Resident #58 who stated he had not received any therapy services since the end of January 2017. Resident #58 stated he had been performing exercises on his own in bed that he learned from the therapist. The resident stated no nursing staff member had been performing exercises with him since the end of January 2017. Resident #58 stated he would like to receive more therapy services so that he could wear a prosthesis on his left lower leg.

On 02/15/17 at 11:46 AM an interview was conducted with the physician who stated if PT/OT

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F 318	Continued From page 63 recommended restorative nursing for Resident #58 than his expectation was that Resident #58 would have received restorative nursing to prevent a decline in ROM.	F 318		
F 333 SS=J	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, pharmacist interview and staff interviews, the facility failed to prevent significant medications errors for 1 out of 3 sampled residents reviewed for medication errors. Resident #189 was given his roommate's medications the morning of 01/25/17 which resulted in him being hospitalized. Immediate Jeopardy began on 01/25/17 when Resident #189 was administered Resident #181's morning medications in error. Resident #189 was subsequently sent to and admitted to the hospital when he developed nausea and vomiting and a drop in his blood pressure and pulse. Immediate Jeopardy was removed on 02/17/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy) to ensure inservices are completed and monitoring systems are put into place and are effective related to avoidance of	F 333	The facility will ensure that residents are free of any significant medication errors. The affected resident was transferred out of the facility on 1/25/17 at 2:00 pm when the medication error was discovered by administration. The family member of the resident was notified of the error by the DON on 1/25/17. The physician was notified by the Unit Manager on 1/25/17 at 2 pm. The resident was admitted to the hospital and has not returned to the facility. The facility investigation was initiated on 1/25/17 by the DON. DON notified at approximately 1/30 pm that a family member was requesting that guest by sent to the hospital. At that time DON questioned assigned nurse reason for need of transfer. Nurse notified DON that she had administered the incorrect medication to the guest during morning	3/21/17

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F 333	Continued From page 64 significant medication errors. The findings included: Resident #189 was admitted to the facility on 01/19/17. His admission diagnoses included a history of pulmonary embolism, a history of deep vein thrombosis, paroxysmal tachycardia, bradycardia, difficulty walking, atrial fibrillation, long term anticoagulant use, muscle wasting and atrophy. The most recent Minimum Data Set, a 5 day dated 01/27/17, noted he had adequate hearing, he was understood and understands, his cognition and mood were not assessed, he had no behaviors, and required extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. He was noted to have taken 6 days of anticoagulants, 7 days of diuretic and received Occupational and Physical therapies. Review of physician orders included the following morning medications ordered for Resident #189: *Amiodarone HCL 200 Milligrams (mg) at 8 AM - an antiarrhythmic agent; *Diltiazem 24 hour Extended release 120 mg at 8 AM to be held for systolic less than 110 mmHg (milliliters of Mercury) and diastolic less than 60 mmHg - for hypertension and angina; *Lasix 20 mg at 8 AM - a diuretic; *Miralax powder 17 grams per day at 8 AM - for constipation; *Levothyroxine 25 mcg at 6 AM - for thyroid; and *Albuterol sul 2.5 mg/3 ml solution four times a days, first at 8 AM ordered 01/25/17 - for breathing. Review of the incident report dated 01/25/17 at	F 333	medication pass. DON questioned nurse regarding her notification to the physician and family member to which she responded No, I should have. Nurse interviewed by DON on 1/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded the same day on 1/25/17 and POC was initiated. The incident was reported to the NC Board of Nursing according to the disciplinary tree. Their investigation was assigned to a complaint officer with the North Carolina Board of Nursing. This report was made by DON on 2/7/17. All residents that receive medications have the potential to be affected. On the date of occurrence all alert and oriented residents were interviewed to determine if any had received incorrect medications. No other issues were identified. On the date of occurrence all residents who were not alert and oriented were observed for changes in condition through direct observation and review of medical record by DON. The audit results were reported to the Medical Director. All residents observed in the audit had no issues identified and Medical Director notified by the Director of Nursing (DON) on 1/25/17. The physician and the Responsible Party were notified immediately by Nursing Administration upon notification of the medication issue. The resident was sent for hospital evaluation and treatment, and was discharged from the hospital	

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F 333	Continued From page 65 1:30 PM, Resident #189 received a medication error resulting in nausea and vomiting and hypotension. It was determined that Resident #189 received his roommate's 8 AM medications in error. Review of Resident #189's roommate's record revealed, the roommate Resident #181's first and last name initials were the same as Resident #189's initials. Review of the picture in the computerized medical record system revealed the two residents were of different races and had an age difference of 31 years. Resident #181 was admitted to the facility on 01/24/17 with diagnoses including injury of C4 cervical spine. Resident #181's morning medications given to Resident #189 included: *Amlodipine Besylate 10mg at 8 AM for hypertension; *Coreg 25mg for hypertension; *Escitalopram 20 mg at 8 AM for depression; *Flomax 0.4mg at 8AM for urinary retention; *Flonase 0.05 % nasal spray at 8 AM for sinus congestion: *Lovenox 40 mg/0.4 ml subcutaneous at 8 AM for anticoagulation therapy; *Multivitamin/mineral at 8 AM; *Senna S 2 tabs at 8 AM for constipation; *Urecholine 50mg Four times a day, first at 8 AM for urinary discomfort.; and *Vitamin D3 1000 unit at 8 AM. The only nursing note in the medical record which related to the medication error was written by the Director of Nursing on 01/25/17 at 2:00 PM. The note stated the resident had nausea and vomiting and hypotension. Blood pressure was 80/60, respirations 20, pulse 61, temperature 97.3	F 333	successfully. All licensed nurses were in-serviced by the facility Pharmacist on 2/15/17 on the following: 1. Responsibility of reporting med errors to the physician at the time of knowledge of an occurrence of medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors. 3. The 6 rights of medication pass which include right individual, right medication, right dose, right time, right route and right documentation. 4. The notification of family/responsible party. The orientation process for new licensed nurses will include: 1. Responsibility of reporting med errors to the physician at the time of the knowledge of an occurrence of a medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication error. 3. The 6 rights of medication pass, which includes documentation. 4. The notification of family/responsible party. Nursing Administration will conduct random medication administration observations 5 times/week for 4 weeks to ensure compliance with the 6 rights of medication pass. QA monitoring will be initiated by the administrative nurses during clinical meetings 5 days/week to determine if changes of condition have been adequately assessed with documentation present. Results of all audits will be forwarded to the Director of Nursing. Any variances will be	

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F 333	Continued From page 66 degrees Fahrenheit and oxygen saturation was 95%. The physician was contacted and an order was given to send him to the emergency room for evaluation and treatment. The family was noted to be at bedside. Review of the undated hospital transfer sheet revealed Resident #189 received the wrong medications. His vital signs were listed as temperature 97.3 Fahrenheit, pulse 61 beats per minute, respiration rate 20, and blood pressure 85/58 and 80/60 and the pulse oximetry 95%. Emergency Medical Services (EMS) responded 01/25/17. Review of the EMS report revealed that staff reported Resident #189 was vomiting and his blood pressure was 75 systolic. EMS noted he was awake, slow to respond, had pale mucus membranes and stated he just didn't feel right after taking that handful of pills this morning. 0.5 mg atropine was given and his blood pressure and heart rate increased from 77/49 and 42 pulse at 2:07 PM to 103/65 with a pulse of 59 at 2:13 PM. Review of the hospital history and physical dated 01/25/17 revealed he presented with a 1 day history of generalized malaise as well as hypotension and bradycardia. Resident #189 was accidentally given doses of another resident's medication including Coreg, Citalopram, Lovenox, Flomax, Flonase, Senokot and Urecholine. The resident was noted to have some mild nausea and nonbloody vomiting, his blood pressure was 85/58 and his heart rate was in the 40s. He was given 0.5 mg atropine in route and once in the emergency department, the blood pressure was noted to drop to 70/50 and was dosed with another dose of 0.5mg of atropine. He was	F 333	addressed at the time identified. All findings will be reported by the Director of Nursing to the QA Committee monthly for 3 months with additional education and training provided for any identified issues.	

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started on intravenous hydration and his blood pressures improved to the 100-110 systolic range with a heart rate currently around 57-59. Resident #189 stayed in the hospital until discharge to another nursing facility on 01/30/17.

The hospital discharge summary dated 01/30/17 stated Resident #189 was initially admitted to observation status secondary to his bradycardia and hypotension form the medication misuse. This continued despite IV hydration holding additional medications. Plans were for discharge the following day, however on 01/27/17 secondary to no rest the night before, the resident was somewhat agitated and confused. As such, the resident was started on the delirium protocol.

Review of the Employee Disciplinary Record revealed Nurse #3, who made the medication error related to Resident #189 was terminated on 01/25/17 for "making errors of sufficient magnitude which may jeopardize resident safety and welfare." Additional notes indicated the med error occurred at approximately 8:30 AM to 9:00 AM and the nurse failed to notify the Director of Nursing (DON), Physician or family. The DON became aware of the error at approximately 1:30 PM.

Nurse #3 was interviewed via phone on 02/15/17 at 9:09 AM. Nurse #3 stated on 01/25/17 it was a normal busy day. She stated there were multiple interruptions from therapy during medication pass per usual. It was her first day back from several days off and she was tired from getting little sleep the night before. She stated she had worked with Resident #189 a couple of times before. She stated the roommate had been admitted the day before. She stated as soon as she gave

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Resident #189 the wrong medications, she realized it "immediately, immediately." She stated that she had spoken to the physican several times that morning relating to Resident #189's new order for a nebulizer treatment and related to several other residents but never thought to inform the physician of the med error. She stated the next time she saw Resident #189 he was with therapy and then after lunch he started vomiting. She stated she thought staff took his blood pressure after the med error but she was not sure. She stated that she informed the DON and physician about the med error when Resident #189 got ill.

On 02/15/17 at 10:14 AM an interview was conducted with the occupational Therapist (OT) who worked with Resident #189 the day of the med error. OT stated he went in to work with him and found him in the bathroom covered in vomit. He stated he and the nurse aide got him cleaned up and he vomited again. OT described Resident #189 as awake but much less verbal than his usual and OT could not understand him. OT stated he vomited "a good bit." OT also stated he required maximum assistance to transfer which was definitely different.

Resident #189's physician was interviewed on 02/15/17 at 11:36 AM. The physician stated he was in the building that morning but was not informed of any medication errors until he had already left the facility. He further stated that it was a different nurse, not Nurse #3, who notified him of the medication error. He stated normally he would have had the nurse monitor vitals signs more closely after a medication error and possibly adjust dosages of upcoming medications.

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Nurse Aide (NA) #1 was interviewed on 02/15/17 at 8:26 AM. NA #1 stated she routinely worked with Resident #189 and on 01/25/17 Resident #189 was not able to stand and do for himself per his usual. He was unable to get himself off the commode which she said was different for him. She stated that she informed Nurse #3 of Resident #189 vomiting and believed the nurse took his blood pressure. NA #1 stated she did not take his vital signs. A few minutes after she and OT transferred him into the chair, Resident #189's responsible party came in mentioned that she thought he had taken a turn for the worse. NA #3 stated she had noticed a change in Resident #189 throughout the morning.

On 02/15/17 at 12:13 PM DON stated that she was informed around 1:00 to 1:30 PM that Resident #189's responsible party wanted the resident sent to the hospital. DON went to the unit and asked Nurse #3 what was going on and it was then that Nurse #3 informed the DON she had given Resident #189, his roommates morning medications. Nurse #3 then stated she had not notified the DON, the physician or the responsible party of the medication error. DON terminated Nurse #3's employment that day.

On 02/16/17 at 8:38 AM the pharmacist who owned the pharmacy company used by the facility was interviewed. He reviewed the medications Resident #189 received and compared them to the medications he was ordered. He revealed that some of the medications Resident #189 actually received the morning of 01/25/17 were similar to his own. He further stated the Urecholine may have made him nauseous and the addition of coreg and lasix would have "absolutely" affected his blood pressure.

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The facility DON, corporate nurse and administrator of a sister facility were informed of Immediate Jeopardy on 02/15/17 at 2:38 PM.

The facility provided an acceptable credible allegation of compliance on 02/16/17 at 2:32 PM as follows:

The facility will ensure that residents are free of any significant medication errors.
The affected resident was transferred out of the facility on 1/25/17 at 2:00pm when the medication error was discovered by administration. The family member of the resident was notified of the error by DON on 01/25/17. The physician was notified by Unit Manager on 01/25/17 at 2pm. The resident was admitted to the hospital and has not returned.
The facility investigation was initiated on 01/25/17 by the DON.

Facility Investigation
The Director of Nursing (DON) was notified at approximately 1:30 pm that a family member was requesting that the resident be sent to the hospital. At that time the DON questioned the assigned nurse regarding the reason for the need to transfer the resident to the hospital. The nurse notified the DON that she had administered the incorrect medication to the resident during morning medication pass. The DON questioned the nurse regarding her notification of physician and family member to which she responded, "No, I should have." Nurse interviewed by DON on 01/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded the same day

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01/25/17 and POC (Plan of Correction) was initiated.
The licensed nurse involved was terminated immediately due to not reporting the medication error at the time of occurrence. The incident was reported to the NC Board of Nursing according to their disciplinary tree. Their investigation was assigned to a complaint officer with the North Carolina Board of Nursing. Report made by the DON on 02/07/17.
All residents who receive medications have the potential to be affected. On the date of occurrence (1/25/17) all alert and oriented residents were interviewed by the DON to determine if any had received incorrect medications. No other issues were identified. On the date of occurrence all residents who were not alert and oriented were observed by the DON for changes in condition through direct observation and review of medical records. These audit results were reported to the Medical Director.
On 2/15/17 all residents having the potential to be affected were again reviewed. Alert and oriented residents did not indicate that they were aware of any medications being given incorrectly. All residents with cognitive issues were reassessed by licensed nurses. No issues were noted that would be related to medication issues.

Root Cause Analysis
After reviewing all details of the event, facility determined that the error likely occurred due to the nurse failing to follow the 6 Rights of Medication Administration which include: Right individual, right medication, right dose, right time, right route and right documentation of the administration, and a distraction, which was the use of the nurse's personal cell phone. The nurse was familiar with the layout of the facility which

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THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

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include the room numbers and the unit the nurse was assigned. There were similarities between the resident's names, however the race was different.

In-servicing
All licensed nurses (who are the only staff who administer medications) were in-serviced by the DON on the Six Rights of Medication Administration and the prohibition of cell phone use during medication administration between February 5th thru the 9th.
All licensed nurses were in serviced by the facility's Pharmacist on 2/15/17 on the following: 1. Responsibility of reporting med errors to the physician at the time of knowledge of an occurrence of medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors which is "Any error that occurs in the medication use process." 3. The 6 rights of medication pass which included documentation. 4. The notification of family/responsible party.
DON and Regional QA Nurse in-serviced all Licensed Nurses on 2/15/17 on the prohibition of cell phone use during medication administration.

System Change
The orientation process for new licensed nurses will include: 1. Responsibility of reporting med errors to the physician at the time of the knowledge of an occurrence of a medication error in order to determine what monitoring and assessment needs to be initiated. 2. Definition of medication errors. 3. The 6 right of medication pass which included identifying residents via their picture and name (if the nurse is unsure confirmation will be obtained with an administrative nurse and documentation. 4. The

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F 333	Continued From page 73 notification of family/responsible party. Immediate Jeopardy was removed on 02/17/16 at 2:15 PM when interviews with nurses confirmed they had been inserviced and knew the steps to take to ensure the correct medications were administered to the right individual, in the correct dosage, at the correct time, by the correct route and the documentation was accurate.	F 333		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by:	F 371		3/21/17

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F 371	Continued From page 74 Based on observations and staff interviews the facility failed to ensure expired strawberries and undated beverages were discarded in 1of 2 nourishment refrigerators and failed to discarded expired milk in 1 of 2 walk in refrigerators. The Findings included: 1 a. An initial tour of the 100 hall nourishment room was conducted on 02/13/17 at 8:55 AM with Nurse #1. An observation of the nourishment refrigerator revealed 1 full ½ gallon of orange juice in a clear container with a lid, 1 full ½ gallon of cranberry juice in a clear container with a lid, 1 full ½ gallon of apple juice in a clear container with a lid, and ¾ empty ½ gallon of tomato juice in a clear container with a lid that was undated and available for resident use and 1 clear plastic container dated 1/20/17 that contained 18 strawberries that were dried and had a fuzzy substance on the strawberries. Nurse #1 stated he did not know how long the juice had been in the nourishment refrigerator because the juice was not dated. Nurse #1 immediately removed the orange juice, cranberry juice, apple juice and tomato juice and poured them down the sink in the nourishment room. Nurse #1 verified the strawberries had a fuzzy substance on them and were outdated and were in the nourishment refrigerator ready for resident use. Nurse #1 immediately removed the strawberries and discarded them in a trash bin in the nourishment room. On 02/13/17 at 9:00 AM an interview was conducted with Nurse #1 who stated the orange juice, cranberry juice, apple juice, and tomato juice should have been dated by the dietary staff when placed in the nourishment refrigerator per	F 371	The facility will ensure that food is stored, prepared, distributed and served under sanitary conditions. The identified food was discarded immediately on observation by staff. All current residents have the potential to be affected. All items in the facility dietary storages areas and dietary refrigerators were inspected with no other issues noted. The Food Service Director was in-serviced by the Registered Dietician on the facility'□s policies on food storage according to sanitary conditions ON 3/7/2017. All dietary staff will be in-serviced by the Food Service Director on the facility'□s policies on food storage according to sanitary conditions ON 3/7/2017. A QA monitoring tool will be utilized to ensure ongoing compliance in all food storage areas by the Food Service Director 5 times a week x 4 weeks and then weekly thereafter. A QA monitoring tool will be utilized to ensure ongoing compliance by the Administrator weekly for 3 months. Administrator will report findings to the QA committee monthly x 3 months and quarterly thereafter. Additional education or training will be provided for any issue identified.	

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facility policy. Nurse #1 stated the strawberries were expired on 01/20/17 and should have been discarded. Nurse #1 stated he was not sure who was responsible to check the nourishment refrigerator for outdates and assure the juice was dated.

On 02/13/17 at 11:34 AM an interview was conducted with the Interim Dietary Manager (IDM) who stated juice that was placed in containers and stored in the nourishment refrigerator should have been dated when placed in the nourishment refrigerator and the juice would have been outdated 3 days from the date when placed in the refrigerator and the strawberries with a date of 01/20/17 should have been discarded by 01/23/17 per facility policy. The IDM stated it was her expectation that the orange juice, cranberry juice, apple juice, and tomato juice would have been dated when placed in the nourishment refrigerator and the strawberries would have been discarded when outdated on 01/23/17. The IDM stated it was the responsibility of the DM to check the nourishment refrigerator daily for outdated food and beverages.

On 02/14/2017 at 5:00 PM an interview was conducted with the Interim Administrator (IA) who stated her expectation was that the expired strawberries would have been discarded from the 100 hall nourishment refrigerator and the orange juice, cranberry juice, apple juice, and tomato juice would have been dated when placed in the 100 hall nourishment refrigerator as per facility policy. The administrator stated the DM or designee was responsible to check the nourishment refrigerator daily for appropriate dating of beverages and food and to check for

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any outdated food and beverages and discard as appropriate.

1 b. An initial tour of the kitchen was conducted on 02/13/17 at 8:35 AM with the Cook. An observation of the walk in refrigerator #2 revealed an unopened gallon of whole milk and a ¾ empty gallon of whole milk that had a stamped expiration date of 02/09/17 and was available for resident use. The Cook immediately removed the expired whole milk from the walk in refrigerator.

On 02/13/17 at 8:40 AM an interview was conducted with the Cook who stated the expired whole milk should not have been in walk in refrigerator #2 available for resident use. The Cook stated the dietary aides checked the walk in refrigerator #2 on a schedule of 2-3 times a week and must have missed the expired whole milk.

On 02/13/17 at 11:34 AM an interview was conducted with the Interim Dietary Manager (IDM) who stated milk had a use by date stamped on the container and if the date was past the use by date than the milk should have been discarded. The IDM stated as per facility policy the full gallon of whole milk and the ¾ empty gallon of whole milk with a use by date stamped as 02/09/17 should have been discarded and not have remained in the walk in refrigerator on 02/13/17. The IDM stated it was the responsibility of the Dietary Manager (DM) and the Cook to assure foods and liquids were not outdated in walk in refrigerator #2. The IDM stated it was the responsibility of the DM to check the walk in refrigerator #2 daily to assure foods and liquids were not outdated. The IDM stated it was her expectation that the expired whole milk would have been discarded as per the expiration date.

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F 371	Continued From page 77 On 02/14/2017 at 5:00 PM an interview was conducted with the Interim Administrator (IA) who stated her expectation was that the 1 gallon of whole milk and the 3/4 empty gallon of whole milk in the walk in refrigerator # 2 would have been discarded per the stamped expiration date on the container that indicated a date of 02/09/17. The IA stated the DM or designee was responsible to check the walk in refrigerator for appropriate dating of beverages and discard as appropriate.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		3/21/17

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F 441	Continued From page 78 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 441		

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F 441	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow droplet precautions per facility policy and procedure for 1 of 1 resident reviewed for infection control (Resident #31). The findings included: The transmission based precautions of the facility for droplet precautions from the Infection Control Manual for the facility and revised on 01/2013 indicated the following: Policy: The facility will utilize Droplet Precaution, for specified guests known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the guest during coughing, sneezing, talking or the performance of procedures such as suctioning or trach care. Procedure: Masks 1. Wear a mask when working within three feet of the guest (resident). Resident #31 was admitted to the facility on 01/10/17. During tray delivery to rooms during lunch on 02/13/17 at 11:40 AM, Nurse Aide (NA) #2 was observed knocking on the exterior door from the hallway into the room for Resident #31. The exterior door had a sign posted that stated "Droplet Precautions". This sign also stated the following:	F 441	The facility will continue to provide a safe environment for residents by observing droplet precautions. Resident # 31 had completed the course of medication and had been asymptomatic for 2 days. Proper signage and isolation cart were in place. Nurse Aide #2 was re-educated at the time of survey regarding droplet precautions. All guests have the potential to be affected when isolation precautions are not observed. No other residents in the facility were under isolation precautions. Staff (including all departments) will be in-serviced by SDC or DON or Regional QA Manager for observing isolation precautions according to facility policy by 3/20/2017. A QA monitoring tool will be utilized by the charge nurses to ensure that staff are observing precaution signs when entering rooms of residents with precaution signs 5 times a week x 4 weeks. Then 3 times weekly x 2 months. Any issue will be corrected at the time of the observation and additional education provided when indicated. Observation results will be reported to the DON weekly for the next 3 month and concerns will be reported to the Quality	

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F 441	Continued From page 80 A. Perform hand hygiene B. Wear mask when entering room C. Dietary may not enter NA #1 was observed going into the room with the meal tray with no mask, coming back to the door and receiving another meal tray for the 2nd resident in the room again with no mask, then observed exiting the room without a mask on. During an interview on 02/13/17 at 12:15 PM NA#2 stated she delivered the meal trays into the room for Resident #31 and his roommate without having a mask on. NA #2 also stated she knew she was supposed to wear a mask, but she was trying to get the meal trays delivered quickly and forgot to put the mask on. During an interview on 02/13/17 at 12:21 PM Nurse #1 (N #1) stated Resident #31 had tested positive for influenza (flu), started medications for treatment, and had a sign posted regarding the steps for droplet precautions for staff and visitors on 02/07/17. During an interview on 02/13/17 at 12:25 PM the Medical Director (MD) stated there were no other residents with the flu in the facility other than Resident #31. During an interview on 02/14/17 at 3:46 PM the Director of Nursing (DON) acknowledged droplet precautions had been necessary for Resident #31. The DON stated it was the facility policy to put any resident who tested positive for the flu on droplet precautions. The DON also stated that staff have mandatory training on-line regarding infection control. The DON also acknowledged she expected staff to follow the instructions to	F 441	Committee monthly meetings. Continued compliance will be monitored by the QA Committee for 3 months and quarterly thereafter. Additional education or training will be provided for any issues identified.	

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F 441	Continued From page 81 wear a mask per the droplet precaution protocol and the sign on the door.	F 441		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 514		3/21/17

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F 514	Continued From page 82 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to maintain 1 of 15 clinical records reviewed with complete and accurate information. Resident #189's clinical record was not complete and did not accurately reflect the circumstances occurring which precipitated him being sent to the hospital for nausea and vomiting following a medication error. The findings included: Resident #189 was admitted to the facility on 01/19/17. His admission diagnoses included a history of pulmonary embolism, a history of deep vein thrombosis, paroxysmal tachycardia, bradycardia, difficulty walking, atrial fibrillation, long term anticoagulant use, muscle wasting and atrophy. The most recent Minimum Data Set, a 5 day dated 01/27/17, noted he had adequate hearing, he was understood and understands, his cognition and mood were not assessed, he had no behaviors, and required extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. He was noted to have taken 6 days of anticoagulants, 7 days of diuretic and received Occupational and Physical therapies. Review of physician orders included the following morning medications ordered for Resident #189: *Amiodarone HCL 200 Milligrams (mg) at 8 AM - an antiarrhythmic agent; *Diltiazem 24 hour Extended release 120 mg at 8 AM to be held for systolic less than 110 mmHg (milliliters of Mercury) and diastolic less than 60 mmHg - for hypertension and angina;	F 514	The facility will continue to have complete accurate nursing notes regarding assessments in relation to medication errors. Resident # 189 no longer resided in the facility at the time of survey. Medical records of residents who have been identified as having a change in condition have had their charts reviewed for complete and accurate nursing notes with any issues addressed if indicated. Licensed nurses will be in-serviced on documentation expectations regarding, change of condition, falls, acute episodes by DON or Regional QA Manager by 3/20/2017. At clinical meetings conducted each weekday, the following will be reviewed by Nurse Administrative Team: a. Physician order to identify any changes, b. Incident Reports, c. 24 hour report, d. Chart Review. The clinical record will be reviewed to determine that the medical record contains the appropriate documentation regarding assessment, observations and satisfactions as appropriate. A QA Chart Audit tool will be utilized by	

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F 514	Continued From page 83 *Lasix 20 mg at 8 AM - a diuretic; *Miralax powder 17 grams per day at 8 AM - for constipation; *Levothyroxine 25 micrograms (mcg) at 6 AM - for thyroid; and *Albuterol sulfate 2.5 mg/3 ml solution four times a days, first at 8 AM ordered 01/25/17 - for breathing. Review of the incident report dated 01/25/17 at 1:30 PM, Resident #189 received a medication error resulting in nausea and vomiting and hypotension. It was determined that Resident #189 received his roommate's 8 AM medications in error. Review of Resident #189's roommate's (Resident #181) record revealed, the roommate's first and last name initials were the same as Resident #189's initials. Review of the picture in the computerized medical record system revealed the two residents were of different races and had an age difference of 31 years. Resident #181 was admitted to the facility on 01/24/17 with diagnoses including injury of C4 cervical spine. Resident #181's morning medications given to Resident #189 included: *Amlodipine Besylate 10mg at 8 AM for hypertension; *Coreg 25mg at 8 AM for hypertension; *Escitalopram 20 mg at 8 AM for depression; *Flomax 0.4mg at 8 AM for urinary retention; *Flonase 0.05 % nasal spray at 8 AM for sinus congestion: *Lovenox 40 mg/0.4 ml subcutaneous at 8 AM for anticoagulation therapy; *Multivitamin/mineral at 8 AM; *Senna S 2 tabs at 8 AM for constipation;	F 514	Administrative nurses to review 10% for 4 weeks then monthly thereafter. The DON will review findings every month x 3 months and quarterly thereafter with the QA committee to ensure ongoing compliance. Additional education, training or monitoring to occur as indicated.	

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F 514	Continued From page 84	F 514		

*Urecholine 50mg Four times a day, first at 8 AM for urinary discomfort.; and
*Vitamin D3 1000 unit at 8 AM.

The only nursing note in the medical record for the 7 AM to 7 PM shift on 01/25/17 was written by the Director of Nursing on 01/25/17 at 2:00 PM. The note stated the resident had nausea and vomiting and hypotension. Blood pressure was 80/60, respirations 20, pulse 61, temperature 97.3 degrees Fahrenheit and oxygen saturation was 95%. The physician was contacted and an order was given to send him to the emergency room for evaluation and treatment. The family was noted to be at bedside.

A telephone interview with Nurse #3 who made the medication error was conducted on 02/15/17 at 9:09 AM. Nurse #3 stated it was a busy day as usual and she realized immediately she had given Resdient #189 his roommate;s medications in error at the morning medication pass. She stated that she should have written notes about the incident but "probably did not." She stated she informed the Director of Nursing (DON) about the medication error, after he began having nausea and vomiting which was after he ate lunch. After informing the DON about the medication error and Resident #189's vomiting, she stayed about one hour longer to give report, finish paperwork and count off medications to another nurse. She was then terminated. Nurse #3 stated she had not notified the physician, DON or family of the medication error.

Interview with the DON on 02/16/17 at 1:36 PM revealed she expected Nurse #3 to write a nursing note and include enough information in the nursing note to explain preceding events, vital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 02/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

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F 514	Continued From page 85 signs and notification of the physician and responsible party.	F 514		