STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 04/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(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 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to prevent a significant medication error when a nurse failed to correctly identify a resident which resulted in the administration of the wrong medications to the resident. This effected 1 of 3 residents sampled for significant medication error (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/04/16 with diagnoses that included chronic atrial fibrillation, heart failure, and Alzheimer's disease. Review of the most recent comprehensive minimum data set (MDS) dated 01/29/18 revealed that Resident #1 was cognitively impaired and required limited assistance with activities of daily living. The MDS further revealed that Resident #1 received 7 days of an anticoagulant, antidepressant and 3 days of a diuretic medications. Review of Medication Error Form dated 02/14/18 at 10:00 AM revealed that Nurse #1 had administered the following incorrect medications to Resident #1: Duloxetine (antidepressant) 120 milligrams (mg), Losartan (heart failure medication) 50 mg, Montelukast (asthma medication) 10 mg, Clonazepam (antianxiety	F 760	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F760 Resident Free of Significant Medication errors The plan for correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. The charge nurse for resident #1 failed to properly identify the resident which resulted in administering the medication intended for her roommate, resident #2. This is a direct result of the nurse failing to utilize the 5 rights to medication administration. The procedure for implementing the acceptable plan of correction for the specific deficiency cite; corrected and/or	5/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2018

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F 760	Continued From page 1 medication) 1mg, Furosemide (diuretic) 40 mg, iloperidone (antipsychotic) 2 mg, metformin (diabetic agent) 1000 mg, Topiramate (anti-seizure medication) 25 mg, Creon (pancrelipase) 24000 units, pramipexole (Parkinson ' s medication) 1.5 mg, Tylenol (pain medication) 500 mg, and Tramadol (pain medication) 50 mg. The form indicated that the Nurse Practitioner (NP) was notified and new orders obtained. The form was signed by Nurse #1 and the Director of Nursing (DON). Review of a physician order dated 02/14/18 read in part, neurological checks every 15 minutes for 1 hour, then every 30 minutes for 2 hours, and every hour for 2 hours. Review of a nurses note dated 02/14/18 at 10:15 AM read, provider into assess Resident #1 for medication side effects. No further new orders at this time, will continue to monitor Resident #1 for adverse reactions and medication side effects. Neurological checks are within normal limits, Resident #1 was in no acute distress and has had no change in level of consciousness. Resident #1 has had no change in her baseline functioning. Blood pressure: 95/64, Pulse: 86, Respirations: 16, and Temperature: 97. Oxygen saturation was 94% on room air. Will continue to follow up as needed. The note was signed by Nurse #2. Review of nurses note dated 02/14/18 at 9:36 PM read, Resident #1 has had no adverse reactions from medication error. Vital signs within normal limits for Resident #1. Resident #1 has been alert and verbal. Family was into visit and called to check on Resident #1 several times. Signed by Nurse #3.	F 760	in compliance with the regulatory requirements. Nurses that are employed with the facility were in-serviced and given a copy of General Dose Preparation and Medication Administration. Med Pass re-education was started on 2/14/18 with the nurse making the error and nurses in the facility. The remainder of the nurses education was completed on 3/5/18. Once the facility found out a citation was going to be received, the nursing staff was again re-educated on Medication Administration Documentation and the 6 Rights of Medication Administration, 1) Right Individual, 2) Right Medication, 3) Right dose, 4) Right time, 5) Right Route, 6) Right Documentation. How the facility plans to monitor and ensure correction is achieved and sustained. Director of Nursing RN Unit Managers, Weekend Supervisor or Staff Development Coordinator will perform One med pass observation on each medication cart every week for 4 weeks, perform one med pass observation on every cart every other week x2, then one med pass observation on each cart monthly x3, utilizing Medication Pass Observation Forms. There will be no repeat observations of any nurse until all nurses have been observed once, only then will a repeat observation be performed if needed to fulfill the audit requirements through it□s end date for Medication Pass Observation. The Medication Pass Observations will be discussed, during the weekly Risk Meeting. All new Nurses during	

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F 760	Continued From page 2 An interview was conducted with the Assistant Director of Nursing (ADON) on 04/12/18 at 12:02 PM. The ADON stated that on 02/14/18 he was shadowing (mentoring) Nurse #1 who was still in orientation at the facility. The ADON stated that Nurse #1 had been in orientation for several weeks and was just about to complete her orientation. He stated that during the medication pass he got called away from the cart for a minute and when he returned to the medication cart Nurse #1 informed him that she thought she had given the wrong medication to Resident #1. The ADON stated that he verified that she indeed had given Resident #1 the wrong medications. The ADON stated that they immediately obtained a set of vital signs for Resident #1 and pulled Nurse #1 from the medication cart and he assumed the hall for the remainder of the day. He added that he asked Nurse #2 to go over and completed the paperwork with Nurse #1. The ADON stated that the NP was notified and neurological assessments were ordered and were completed as ordered with no change to her baseline vital signs or level of consciousness. The ADON stated that Resident #1 ran a low blood pressure normally and after the medication error they ran on the low side but nothing that was outside of her baseline or normal range. He stated that he asked Resident #1 how she felt throughout the day and she replied she felt tired so they just allowed her to rest for the remainder of the day. At the end of his shift the ADON stated Resident #1 was her usual self with no change in her condition. An interview was conducted with the DON on 04/12/18 at 12:33 PM. The DON stated that after she was notified of the medication error she verified that Nurse #1 had immediately been	F 760	orientation will have a Medication Pass Observation completed which includes the following; Administers meds correctly: Right Patient □ Calls patient by name □ Verifies photo or ID band Right Medication □ Verifies medication by comparing label and MAR Right Dosage □ Verifies dosage by comparing label and MAR Right Route □ Verifies route by comparing label and MAR Right Time □ Verifies time by MAR □ Adm. within an hour before or hour after scheduled times □ Given as ordered before (ac) or after meals (pc) Any nurse that fails to complete each of; 1) Right Patient, 2) Right Medication, 3) Right Dosage, 4) Right Route, 5) Right time, 6 Right documentation, will be required to meet with DON and be required to again be re-educated on Medication Administration and have meeting and education documented and place in employee file. If another observation is observed and the nurse again fails to follow all 6 medication rights will receive written counselling. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing will ensure that the implementation of the plan is followed.	

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F 760	Continued From page 3	F 760		

pulled from the medication cart and the family, NP, and Medical Director (MD) had been notified. She added that the staff monitored her vital signs and neurological checks and she was very stable.

An interview was conducted with Nurse #1 on 04/12/18 at 3:17 PM. Nurse #1 stated that she had worked at the facility for a few months but added that at the time of the medication error she had only worked at the facility for 3 weeks and was still progressing through the orientation program. Nurse #1 stated that on 02/14/18 she was working the unit with the ADON who was just there for questions. She stated that the ADON got pulled away from the medication cart and she began to pull medications for another resident. Nurse #1 stated that after she pulled the medications she entered the room where Resident #1 was sitting in her wheelchair. She added that it appeared that Resident #1 was in the room by herself and so Nurse #1 stated she asked Resident #1 if she was the other resident and Resident #1 stated "yes" and grabbed the cup of medication out of her hand and proceeded to swallow them. Nurse #1 stated that she was still unsure of which resident was in the room and she asked Resident #1 to spit the medications out but she had already swallowed them. She stated she returned to the medication cart and then realized that she had given Resident #1 the wrong medications. Nurse #1 stated that when she realized that she had given Resident #1 the wrong medication she went and obtained her vital signs and reported the error to the ADON. The ADON called Nurse #2 and asked her to assist in completing the paper work while he took over the medication cart for the remainder of the day. Nurse #1 stated that she was immediately pulled from the medication cart and went with Nurse #2

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F 760	Continued From page 4	F 760		

to complete the paper work and notify the NP. She added that Nurse #2 provided one to one education on the medication administration and correctly identifying the residents. Nurse #1 stated that she did not ask Resident #1 for her date of birth, she did not look for her arm band, and she did not verify the identity of Resident #1 by looking at the picture on her computer that was used for mediation administration like she had been trained to. Nurse #1 stated that she was a new nurse and was still learning and that after the error she remained in orientation for an additional week with another nurse to be sure she was comfortable and to ensure she was correctly identifying the residents.

An interview was conducted with the MD on 04/12/18 at 3:35 PM. The MD stated that with the medications that Resident #1 received they would not give her anything to counter act those medication, we just needed to monitor her blood pressure. She added that she was not allergic to any of the medications and that it was very reasonable to watch Resident #1 and monitor her blood pressure at the facility. The MD stated that the medications she received were similar to medications that she was prescribed and nothing that she received would have caused any irreversible heart damage. The MD added that Resident #1 received one of dose of the incorrect medications and with her baseline kidney function that was good the medications would have been eliminated from her body within a 24-hour period. The MD added that she could not identify any negative or adverse effects to Resident #1 that came from the medication error.

An interview was conducted with Nurse #2 on 04/12/18 at 4:06 PM. Nurse #2 explained that she

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F 760	Continued From page 5	F 760		

was a NP but worked at the facility as a nurse on the weekends and occasionally through the week. Nurse #2 stated that on 02/14/18 she was notified that Nurse #1 had administered the wrong medications to Resident #1. She added that she pulled Nurse #1 off the medication cart and provided her with one on one reeducation on medication administration and how to correctly identify residents. Nurse #1 stated that she explained to Nurse #1 that you could not address cognitively impaired residents by their names because they would answer yes to any question that was asked. She stated she explained that she had to verify the identity of the resident by using the picture that was in the electronic medical record used to dispense medications. Nurse #2 stated she also ran the interaction checker so she could alert the nurses of what to monitor. She further stated she contacted the family and went over what medications Resident #1 had received and what the facility was going to monitor and for how long. In additional to notifying Resident #1's family the NP was also notified and orders obtained for neurological checks were ordered. Nurse #2 stated that she completed an assessment of Resident #1. Nurse #2 stated Resident #1 had a history of bradycardia (low heart rate) and hypotension (low blood pressure) and at the time of the assessment her vital signs were stable, she had no neurological changes, no cardiac changes and nothing that would indicate any abnormalities.

An interview was conducted with the Corporate Nurse Consultant on 04/13/18 at 10:10 AM. The Corporate Nurse Consultant stated that the staff were educated to correctly identify residents using the picture in the electronic medical record that was used for medication administration. He

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F 760	Continued From page 6	F 760		

added that the facility had no formal policy on that but that was what they were instructed to do.

An interview was conducted with the NP on 04/13/18 at 10:14 PM. The NP stated that she was notified of the medication error on 02/14/18 and gave the staff parameters in which to monitor her. The staff reported to me that at the time her vital signs were stable. She stated that the staff told her that that Resident #1 was alert and was able to answer questions at the time. The NP stated that if the medication error would have caused any blood pressure issues it would have done so within a 24-hour period. The NP stated that the medications that Resident #1 had been given should have been eliminated from her system within a 24-hour period as well. She added that she certainly expected the staff to administer the correct medications to the correct patient but did not feel like Resident #1 had any true side effects from the medications she received incorrectly.

An observation was made on 04/13/18 at 10:30 AM of Nurse #1 medication administration. Nurse #1 was observed to pull and prepare medication for a resident. Nurse #1 visually verified the identity of the resident utilizing the picture in the electronic medical record. Once in the room Nurse #1 also verified the identity of the resident using an arm band that contained the residents name and date of birth.

An interview was conducted with Nurse #3 on 04/13/18 at 12:04 PM. Nurse #3 confirmed that she worked with Resident #1 on 02/14/18 after she had received the wrong medications. She stated that during that shift Resident #1 was her usual self she went to the dining room and

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F 760	Continued From page 7	F 760		

returned to her room and had a big smile on her face. Nurse #3 stated that Resident #1 was confused and would often answer questions inappropriately both before the medication error and after so that was nothing new for her. She stated that on 02/14/18 on 2nd shift Resident #1 vital signs were stable and she was her usual self.

An follow up interview was conducted with the DON on 04/13/18 12:24 PM. The DON stated that all the nurses were educated on the 5 rights of medication administration and the correct way to identify the residents. She added that Nurse #1 did not correctly identify the resident and that caused the error. The DON added that she expected the nursing staff to correctly identify the residents and administer medication using the 5 rights of medication administration (right medication, right resident, right dose, right time, and the right route).

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F 000	INITIAL COMMENTS On April 13, 2018, The Division of Health Service Regulation, Nursing Home Licensure and Certification conduted a revisit. The facility was found to be in compliance with F 842 but remains out of compliance due to deficient practice identified during the revisit.	F 000		

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

Electronically Signed | 04/26/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.