STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345053	A. BUILDING ______ B. WING ______	C 02/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETTIGREW REHABILITATION CENTER	1515 W PETTIGREW STREET DURHAM, NC 27705

(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 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to maintain a medication administration error rate of less than 5% as evidenced by 3 medication errors out of 25 opportunities resulting in a medication error rate of 12% for 2 of 6 residents (Residents #4 and #5) observed during medication pass. Findings included: 1. On 2/15/19 at 9:45 AM Nurse #2 was observed as she prepared and administered medications to Resident #4. The administered medications included two Tums chewable tablets at a strength of 500 mg (milligrams) each. The medication was observed to be taken from a stock bottle stored on the medication cart. Review of Resident #4's February 2019 physician orders included a current order for 500 mg Tums chewable tablet to be given to the resident as one tablet one time a day by mouth for indigestion. An interview was conducted on 2/15/19 at 2:13 PM with Nurse #2. Nurse #2 confirmed, after reviewing the physician orders for Resident #4, she had not followed the physician's order for administration of Tums to Resident #4 during the morning medication pass.	F 759	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws. 1. The physician for Resident #4 was notified at the time of survey, and an order was received to administrator Tums chewable 500mg (milligrams) two tablets one time only. There was no negative outcome for this appointment. The physician for Resident #5 was notified at the time of survey, and an order was received to administer Folic Acid 400 mcg (micrograms) one time only. There was no negative outcome for this appointment. The physician for Resident #4 was notified at the time of survey, and an order was received to administer Magnesium Oxide 500 mg one time only. There was no negative outcome for this appointment. Nurse #2 was in-serviced by the DON (Director of Nursing) regarding the six rights of medication is not available on the	2/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/28/2019

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

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F 759	Continued From page 1 An interview was conducted with the Director of Nursing (DON) on 2/16/19 at 2:19 PM. The DON acknowledged it was her expectation that the physician's orders be followed for administration of a medication. 2. a. On 2/15/19 at 10:05 AM, Nurse #2 was observed as she prepared and administered medications to Resident #5. Nurse #2 was observed to look for a medication for Resident #5 and could not find it in the medication cart. Nurse #2 went down the hallway and returned with a new stock bottle of Folic Acid tablets at a strength of 400 mcg (microgram) for each tablet. Nurse #2 put one tablet from the Folic Acid bottle in a medication cup. Nurse #2 administered the Folic Acid tablet to Resident #5. Review of Resident #5's February 2019 physician orders included a current order for 1 mg (milligram) Folic Acid to be given to the resident as one tablet by mouth one time a day. Because 400 micrograms is equal to 0.4 milligrams, Resident #5 received a fraction of the folic acid dose she was ordered to receive. An interview was conducted on 2/15/19 at 2:13 PM with Nurse #2. Nurse #2 compared the stock bottle of Folic Acid to the MAR (medication administration record) for Resident #5. Nurse #2 confirmed that the Folic Acid dose administered to Resident #5 was not the physician ordered dosage. Nurse #2 stated that she had to use the stock bottle for Folic Acid for Resident #5. An interview was conducted the facility Nurse Consultant on 2/15/19 at 3:30 PM. The Nurse Consultant revealed that the facility did have the correct dosage of Folic Acid available at the	F 759	med (medication) cart, ie. check the stock meds in the medication and to check the Omnicell for availability of the medication. If the medication is not available in those locations, the physician is to be notified for further instructions. 2. A medication cart review was completed by the Administrative Nursing Team on 2/19/19 to ensure all medications are available in the correct dose on each nursing cart. Medication were ordered as needed. The licensed nurses were observed on a med pass and a competency was completed by a member of the Administrative Nursing Team 2/15-2/27/2019 to ensure the licensed nurses are competent to pass medication. Any nurse that was unable to pass the competency with a score of at least 90% will be removed from the schedule until the competency could be passed with a score of at least 90%. The Licensed Nurses were in-serviced by the Administrative Nursing Team regarding the six rights of medication administration, and what to do if a medication is not available on the med (medication) cart, ie. check the stock meds in the medication room and to check the Omnicell for availability of the medication. If the medication is not available in those locations, the physician is to be notified for further instructions. 3. The nursing staff will complete a review	

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F 759	Continued From page 2 facility for Resident #5 and provided an unopened blister package labeled as Folic Acid 1 mg for observation. An interview was conducted with the Director of Nursing (DON) on 2/16/19 at 2:19 PM. The DON stated that it was her expectation that if a nurse was unable to find an ordered medication on her medication cart the nurse should check the medication stock room or the back-up pharmacy stock supply to see if the medication was available. The DON stated that if the medication was not found then the nurse should notify the physician and follow the physician orders. The DON acknowledged it was her expectation that the physician's orders be followed for dosage of a medication. 2. b. On 2/15/19 at 10:05 AM, Nurse #2 was observed as she prepared and administered medications to Resident #5. Nurse #2 administered 500 mg (milligram) Magnesium Oxide given as one tablet to Resident #5. The medication was obtained from a stock bottle stored on the medication cart. Review of Resident #5's February 2019 physician orders included a current order for 400 mg of Magnesium Oxide to be given as one tablet by mouth two times a day. Nurse #2 was interviewed on 2/15/19 at 2:13 PM. Nurse #2 compared the stock bottle of Magnesium Oxide on the medication cart to the MAR (medication administration record) for Resident #5. Nurse #2 confirmed the Magnesium Oxide dose administered to Resident #5 was not the physician ordered dose. Nurse #2 stated she had to use the house stock for Magnesium Oxide.	F 759	of the medication carts weekly to sure medication carts weekly to ensure medications are available in the right dose on the cart as needed. The education regarding the 6 rights of medication administrator will be added to the clinical orientation process for the licensed nurses. 4. The DON will audit 1 medication cart per week for a period of 12 weeks to ensure medications are available in the right dose on the med cart as needed. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on finding.	

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F 759	Continued From page 3 An interview was conducted the facility Nurse Consultant on 2/15/19 at 3:30 PM. The Nurse Consultant revealed that the facility did have the correct dosage of Magnesium Oxide available at the facility for Resident #5 and provided a stock container of 400 mg Magnesium Oxide tablets for observation. An interview was conducted with the Director of Nursing (DON) on 2/16/19 at 2:19 PM. The DON stated that it was her expectation that if a nurse was unable to find an ordered medication on her medication cart the nurse should check the medication stock room or the back-up pharmacy supply to see if the medication was available. The DON stated that if the medication was not found then the nurse should notify the physician and follow the physician orders.	F 759		