STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345001	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CONVALESCENT CENTER	1417 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 000	INITIAL COMMENTS An onsite revisit was conducted on 8/13/19-8/14/19 (Event ID #TFJ812). The exit date for the revisit was extended to 8/15/19 for the completion of an interview. Tag F607 was corrected as of 8/15/19. However, 1 of the 3 complaint allegations was substantiated resulting in a deficiency and a new tag (F760) was cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
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 facility staff, pharmacist, and physician interviews, and facility and hospital record reviews, the facility failed to accurately transcribe a physician's medication order, resulting in a hemodialysis resident (Resident #2) receiving a dose of an injectable anticoagulant medication prescribed for another resident and placing him at an increased risk for bleeding. The findings included: Resident #2 was admitted to the hospital from 6/26/19 to 7/11/19 with a cumulative diagnosis which included end stage renal disease requiring hemodialysis, a history of a myocardial infarction (heart attack), chronic congestive heart failure, atrial fibrillation (a type of irregular heartbeat), and anemia of chronic disease. A review of the hospital discharge summary included	F 760	This plan of correction constitutes Hillcrest Convalescent Center□'s written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. The facility□'s goal is to ensure residents are free of any medication errors. Surveyors document the Staff□s ability to demonstrate medication pass observations with 0% medication error. The facility has a strong medication error procedure in place to encourage reporting and identifying errors promptly. The	8/22/19

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

Electronically Signed | 09/04/2019

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F 760	Continued From page 1 recommendations to continue with the following medications: 75 milligrams (mg) clopidogrel (an antiplatelet agent) to be given by mouth once daily and 81 mg of enteric coated (EC) aspirin to be given once daily. Resident #2 was admitted to the facility on 7/11/19 from the hospital. His admission medication orders included, in part: 75 mg clopidogrel to be given by mouth once daily and 81 mg of EC aspirin to be given once daily. A review of the resident's lab results dated 7/11/19 included: Hemoglobin = 9.3 (normal range = 13.0-18.0); Hematocrit = 30.1 (normal range = 39.0-54.0). A review of the resident ' s Admission Minimum Data Set (MDS) dated 7/18/19 indicated Resident #2 had intact cognitive skills for daily decision making. The resident required extensive assistance for all of his Activities of Daily Living (ADLs), with the exception of needing limited assistance from staff for toileting and walking in his room or corridor. He was assessed to be independent with eating. Section O of the MDS assessment indicated the resident received hemodialysis while a resident. Review of Resident #2's care plan included a Problem/Need (Onset: 7/11/19) related to the resident ' s risk for bruising or bleeding due to daily use of aspirin and clopidogrel. The Goal for this Problem/Need was for the resident to remain free from adverse effects and have no complications from aspirin and clopidogrel use through the date of the next review. The planned interventions included, in part, for the staff to administer the medications per order and to	F 760	facility procedure was successful in allowing staff to identify a single medication error before a second dose was administered. Staff continue the two-nurse verification process for procuring medication from emergency supply which process includes the RN Supervisor verifying medication orders with a review of the handwritten telephone order prior to obtaining any medication from the emergency supply closet. Address how corrective action will be accomplished for affected resident. 1. The order for Lovenox was removed from Resident #2□s record on 7/19/19 by nurse. 2. It was confirmed by DON on 7/19/2019 that Resident #2 received only one dose of Lovenox. 3. Resident #2 was monitored for bleeding and a skin assessment was done by Assistant Director of Nurses on 7/19/19 to rule out bruising or signs and symptoms of bleeding. No bruising or bleeding was noted, as documented in the skin assessment report. 4. On 7/19/19 resident□s attending physician, Medical Doctor (MD), was notified by Nurse #1 regarding the administration of Lovenox. 5. On 7/19/19 dialysis center was notified by Nurse #1 regarding the administration of Lovenox, no changes requested by dialysis providers in treatment provided, or scheduling of dialysis. 6. Resident #2 was assessed by MD on	

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F 760	Continued From page 2 monitor for any signs and symptoms of bleeding. Review of Resident #2's medical record included an appointment note which indicated the resident went out to the dialysis center for his appointment on 7/18/19 at 11:30 AM. A review of Resident #2's electronic physician's orders included an order dated 7/18/19 for the following medication: "enoxaparin 100 mg/milliliter (ml) syringe - Inject (0.9 ml = 90 mg) subcutaneous every 24 hours. Discard the remainder." The start date for the medication was 7/18/19; it was scheduled to be given at 8:30 PM. Enoxaparin is an injectable anticoagulant medication. However, a review of the handwritten paper copy of this Physician ' s Order revealed enoxaparin was ordered for Resident #9 (not Resident #2). The paper copy indicated the order was received by Nurse #1 on 7/18/19 at 1:24 PM. According to Lexi-Comp, a comprehensive electronic medication database used by medical professionals, enoxaparin's elimination from the body is primarily via the renal route (by the kidneys). The area under the curve (a representation of the drug concentration in the blood plasma versus time) is increased 65% in patients with severe renal impairment. Enoxaparin is not dialyzable (removed via dialysis). Enoxaparin is not approved by the Food and Drug Administration (FDA) for use in hemodialysis patients. A review of Resident #2's July 2019 Medication Administration Record (MAR) was conducted. The MAR revealed on 7/18/19 at 8:30 PM, the resident received one dose of 0.9 milliliters (ml) enoxaparin 100 mg/ml (for a total dose of 90 mg).	F 760	7/19/19. Assessment was unremarkable. MD was aware of the Lovenox injection that had been given and noted no adverse consequences or concerns related to the Lovenox. MD ordered Resident #2 to continue with his regular therapy and routine. There was no order to hold his enteric coated aspirin or clopidogrel. 7. Resident #2 continued to show progress in Physical Therapy whereas he ambulated 200 feet on 7/19/19, that being an improvement over 80-125 feet previously. A review of the therapy record showed no adverse reaction to Lovenox. Address how corrective action will be accomplished for those residents having a potential to be affected. The Director of Nurses (DON) reviewed all charts for active residents with Lovenox ordered. The DON verified all Lovenox orders were accurate and no other errors were noted. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. 1. Medication error form completed on July 19, 2019. On July 19, 2019, DON reviewed the details of the medication error with Nurse #1. Nurse #1 stated she will confirm correct resident file is open before entering orders, and verify correct name before submitting orders. 2. Staff in-service of all hall nurses to verify resident name and correct file	

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F 760	Continued From page 3 Further review of Resident #2's medical record revealed the order for the enoxaparin was discontinued on 7/19/19. Review of the resident's medical record included a Progress Note dated 7/19/19 (not timed) and written by the Medical Doctor (MD). The MD's notation indicated Resident #2 was seen on 7/19/19. His notes read, in part: "Pt (patient) inadvertently rec'd (received) one dose of Lovenox (enoxaparin)." A physician ' s order was received on 7/19/19 for Resident #2 which instructed staff to apply a pressure dressing to the resident's left forearm for 48 hours. A review of the resident's lab results dated 7/24/19 included: Hemoglobin = 9.2; Hematocrit = 29.4. An interview was conducted on 8/14/19 at 2:10 PM with Nurse #1. Nurse #1 was identified as the nurse who had received and input into the computer the medication order for enoxaparin given to Resident #2 on 7/18/19. During the interview, the nurse was asked to describe the process used to receive and transcribe a medication order. Nurse #1 stated if a physician called in a new medication order, she would handwrite a telephone order and read it back to verify its accuracy. Then, she would input the order into the computer. Nurse #1 reported all hall nurses were trained to input orders into the computer. Nurse #1 reported 1 of the 5 copies of the handwritten telephone orders would go to the facility's in-house pharmacy.	F 760	opened with new order entry before sending order to pharmacy. In-services completed on 7/19/19, 8/14/19, 8/15/19, 8/16/19, 8/20/19, 8/21/19, and 8/22/19. Individuals who conducted in-services were DON, ADON, and RN Supervisors. No instructor in-serviced themselves. Effective 8/22/19 forward, this training has been added to new training orientation process for all nurses. 3. On July 19, 2019, DON reviewed the details of medication error with Pharmacist. On July 19, 2019, Pharmacist was in-serviced by DON on not filling new order until handwritten order is verified. Pharmacists confirmed understanding of need to verify prescriptions by using 5 rights (resident, drug, dose, route and time) as well as verifying handwritten orders. On July 19, 2019, Pharmacist subsequently in-serviced 100% of his pharmacy staff. The in-service covered verifying all prescriptions entered into AHT (electronic record) using 5 rights (resident, drug, dose, route, and time) before delivery of medication. Such verification to include review of handwritten orders prior to dispensing of medication. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 1. DON to review all Lovenox orders weekly x 4 then monthly x 4. DON to review 10 new orders on charts chosen randomly for all medication order entry accuracy weekly x 4 then monthly x 4.	

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F 760	Continued From page 4 The interview with Nurse #1 conducted on 8/14/19 at 2:10 PM continued as she discussed the events surrounding the administration of enoxaparin to Resident #2 on 7/18/19. The nurse reported when she came in to work the next day (on 7/19/19), a 3rd shift nurse informed her it had been discovered the enoxaparin order she had taken on 7/18/19 for Resident #9 had not been put into the computer. However, Nurse #1 stated she recalled putting this order into the computer. After reviewing the medical records, she found the enoxaparin order had been input into the computer for the wrong resident (Resident #2, not Resident #9 as intended). Nurse #1 stated, "It was clearly an error." The nurse reported she immediately notified the facility's Director of Nursing (DON) and the resident's physician of the error. A telephone interview was conducted on 8/14/19 at 3:18 PM with the pharmacist who dispensed medications from the facility's in-house pharmacy. The pharmacist reported he dispensed enoxaparin for Resident #2 on 7/18/19. When he came in to work the following day (7/19/19), he learned an error had been made when the enoxaparin order was put into the computer and the enoxaparin had actually been ordered for another resident (not Resident #2). When asked about the verification process for dispensing this medication, the pharmacist stated he did not have the paper (handwritten) Physician ' s Order in hand at the time the enoxaparin was labeled and dispensed for administration to Resident #2. The pharmacist reported he did not normally send a medication to the floor without verifying the order via a handwritten telephone order or a nurse's verbal confirmation of the order. He stated, "Because we have an internal	F 760	DON to audit 10 medications delivered to the hall by pharmacy and confirm that the receipt and review of order was verified by pharmacy prior to filling the medication order weekly x 4 then monthly x4. 2. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance and Assessment meeting. The dates and results of Lovenox review, random checks, and audits are subject to the review of the Quality Assurance committee to determine if the plan is complete or should be extended.	

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F 760	Continued From page 5	F 760		

pharmacy, I try to recheck it." However, the pharmacist reported he filled and dispensed enoxaparin for Resident #2 on 7/18/19 directly from the information put into the computer by the nurse. When asked, the pharmacist stated the paper copies of physician orders were picked up from the floor first thing in the morning, after lunch, and around 3:30 PM daily. He thought the order for the enoxaparin dispensed for Resident #2 may have been generated after the last paper copies of the orders were picked up for the day. The pharmacist stated that because enoxaparin was kept in the facility's backup supply closet, he figured the medication would have been obtained and administered by the nurse even if he had not dispensed it.

A telephone interview was conducted on 8/14/19 at 12:54 PM with Nurse #2. Nurse #2 was identified as the nurse who had administered enoxaparin to Resident #2 on 7/18/19. The nurse stated she knew an order must have been written for the resident to receive enoxaparin because it was included on his electronic MAR. Nurse #2 also reported the enoxaparin had been filled by the facility's pharmacy and was labeled with Resident #2's name on it.

A telephone interview was conducted on 8/15/19 at 12:54 PM with the MD who was caring for Resident #2. Upon inquiry, the MD stated he remembered seeing the resident on 7/19/19 and recalled he had received dialysis the preceding day (on 7/18/19). The MD reported he went to check on the resident to be sure the dressing on the resident ' s shunt site (for dialysis) was appropriate. When asked, the MD indicated he could not say the resident receiving a dose of enoxaparin the night before had caused an

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F 760	Continued From page 6	F 760		

adverse side effect.

An interview was conducted on 8/14/19 at 1:53 PM with the facility's Director of Nursing (DON). During the interview, the administration of enoxaparin to Resident #2 on 7/18/19 was discussed. Upon request, the DON checked the resident's electronic medical record and reported from what she could tell, the order for enoxaparin was entered by Nurse #1 on 7/18/19 at 1:19 PM. The DON confirmed the paper copy of the Physician ' s Order was written with the correct name of the resident intended to receive the enoxaparin (Resident #9), but Nurse #1 entered the order on the wrong resident (Resident #2) into the computer system. The order entered into the computer then went onto Resident #2's electronic MAR for administration. When the 3rd shift nurse did a chart check on the night of 7/18/19 - 7/19/19, it was noted the order had not been entered into the computer for the correct resident. When Nurse #1 was questioned about it the morning of 7/19/19, she found it had been put in on the wrong resident. The DON confirmed the enoxaparin was reported to have been labeled and dispensed for Resident #2 by the pharmacy, but stated she was not sure how that happened. The DON reported she expected the nurses inputting orders into the computer to double check the resident's name an order was written for. During a follow-up interview conducted on 8/14/19 at 4:23 PM with the DON, the DON acknowledged that not all licensed nurses who were responsible to input medication orders into the computer had been in-serviced on the topic of order entry and educated to double check the resident's name before an order was confirmed and sent to the pharmacy.